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Quitting Hard Habits: Efforts to Expand and Improve Alternatives to Incarceration for Drug-Involved Offenders

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Testimony of
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Chairman Kucinich, Ranking Member Jordan, and distinguished Members of the Subcommittee, I am honored to have the opportunity to appear before this Subcommittee on the critically important matter of front-end alternatives to incarceration for drug-involved offenders. This Subcommittee is already well aware of what is at stake, so I will not dwell on the striking national statistics. Suffice it to say that more than 1 out of every 100 adult American citizens is now behind bars, with the burden borne disproportionately by racial and ethnic minority citizens and the poor (Pew Center on the States, 2008). Our prisons are overcrowded with nonviolent offenders charged with drug-related offenses, and our budgets are buckling under the weight of enormous correctional expenditures; yet, crime rates and drug-use initiation rates are barely budging or are merely shifting in character.

As requested by the Subcommittee, I will focus my comments on the following key issues:

- the extent to which drug courts are cost-effective in reducing recidivism, drug use, and improving other outcomes; and
- the advisability of and practical obstacles to altering current eligibility restrictions for drug courts.

As was also requested, I will secondarily address the following issues:

- lessons learned from state-level initiatives such as Proposition 36 in California;
- evidence for the effectiveness of coerced abstinence programs, such as H.O.P.E. (Hawaii Opportunity Probation with Enforcement); and
- how different types of illegal drug using populations respond to and benefit from formal clinical assessment, a court-ordered treatment plan, and sanctions and monitoring.

My position is straightforward: The sciences of corrections and substance abuse treatment have advanced considerably in recent decades. We know a lot more now than we did in the 1970s, 1980s and even 1990s. We understand the basic parameters for intervening effectively with drug-involved offenders in community-based settings. We know how to supervise drug offenders closely; reliably detect drug use; apply gradually escalating sanctions for infractions and incentives for achievements; and treat the underlying disease of addiction, where it is present.

Unfortunately, our laws and policies have not kept pace with this knowledge. They are still based on outdated sentiments from decades past, when we did not appreciate the neurobiology of addiction; when we did not have validated risk-and-needs assessment instruments that could predict recidivism and match drug-involved offenders to the most suitable programs; and when we did not know how to develop effective treatment and supervision care plans that could maintain drug offenders safely in our communities.

I will argue that, based upon a substantial body of research evidence, we now know several important and reliable facts:

- Drug courts reduce crime, reduce drug abuse, improve family relationships, and save considerable money for taxpayers.

- Drug courts are best suited to a specific sub-population of offenders who are (a) compulsively addicted to drugs and/or alcohol, and (b) at high-risk for failure in less stringently supervised programs.

- Adherence to the "10 Key Components" (NADCP, 1997) of drug courts is necessary for success with this high-risk, addicted population; therefore, watering down the model for these offenders is contraindicated.

- Other types of drug-involved offenders, of which there are *many*, can be safely and effectively supervised using other evidence-based models, including H.O.P.E. and Proposition 36. The challenge is to develop a full continuum of evidence-based programs for a given jurisdiction, and match drug-involved offenders to the most effective and cost-efficient interventions given their clinical needs and prognosis for success.

- Validated risk-and-needs assessment tools exist, or can be readily developed, to assist in the process of matching drug-involved offenders to the most effective and efficient dispositions.

Several concrete policy recommendations stem directly from these science-based observations:

1. Drug court eligibility criteria in many states or localities may be unduly restrictive and do not incorporate the lessons of research. Congress can play an important role by directing Federal grants toward drug courts that target more serious offenders, and by removing the categorical violence exclusion from the Crime Control Act.

2. Drug courts are treating, at best, 5 to 10 percent of the population in need of their services. It is time to fill this service-gap by directing the large population of drug-addicted offenders who can be managed safely in the community away from costly and ineffective incarceration and toward evidence-based drug court programs.

3. Criminal sentences in many states are based predominantly on offense-based factors, to the near exclusion of offender-level characteristics, such as risks and needs. Congress should encourage the incorporation of validated risk-and-needs assessment information into sentencing decisions. Under the rubric of what is now being called *evidence-based sentencing*, courts should be permitted or required to include data on effectiveness and cost-effectiveness in their calculus of decision-making when rendering criminal dispositions. The U.S. Sentencing Guidelines should be amended in this regard, and the states should be encouraged through grants from DOJ and other agencies to revise their sentencing policies to incorporate evidence-based practices into sentencing determinations.

EFFECTIVENESS OF DRUG COURTS

Criminal Recidivism

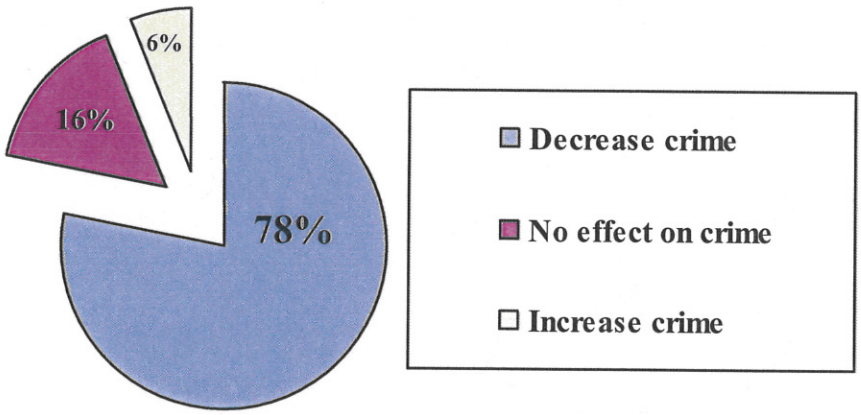
More research has been published on the effects of adult drug courts than virtually all other criminal justice programs combined. By 2006, the scientific community had concluded from advanced statistical procedures called *meta-analyses*[1] that drug courts reduce criminal recidivism, typically measured by lower re-arrest rates for new offenses and technical violations. The Table below summarizes the results of *five* meta-analyses performed by independent research organizations unconnected with the drug court field. In each analysis, the results revealed superior effects for drug courts over randomized or matched comparison samples of drug offenders who were on probation or undergoing traditional criminal justice case processing.

On average, the drug courts were found to have significantly reduced crime rates by an average of approximately 8 to 26 percent more than the comparison conditions. The "average of the averages" across all five meta-analyses represents approximately a 10 to 15 percent greater reduction in criminal recidivism for drug courts over the alternatives.

Citation	Institution	Number of Drug Courts	Crime Reduced on Avg. by . . .
Wilson et al. (2006)	Campbell Collaborative	55	14% to 26%
Latimer et al. (2006)	Canada Dept. of Justice	66	14%
Shaffer (2006)	University of Nevada	76	9%
Lowenkamp et al. (2005)	University of Cincinnati	22	8%
Aos et al. (2006)	Washington State Inst. for Public Policy	57	8%

Because these figures are *averages*, they mask substantial variability in the performance of individual drug courts. As can be seen from the following pie chart, more than three quarters of the drug courts (78%) were found to have significantly reduced crime (Shaffer, 2006), **with the best drug courts reducing crime by as much as 35 to 45 percent** (Lowenkamp et al., 2005; Shaffer, 2006; Carey et al., 2008).

[1] Meta-analysis is an advanced statistical procedure that yields the most conservative and rigorous estimate of the average effects of an intervention. Independent researchers systematically review the research literature, select out only those studies that are scientifically acceptable according to standardized criteria, and then statistically average the effects of the intervention across all of those good-quality studies (e.g., Lipsey & Wilson, 2002). The result provides the best probability estimate of how the intervention is likely to work under typical real-world conditions.



These results were anything but fleeting. In well-controlled, experimental studies, the **reductions in recidivism were determined to have lasted at least 3 years post-entry** (Gottfredson et al., 2005, 2006; Turner et al., 1999) **and in one study the effects lasted an astounding 14 years** (Finigan et al., 2007). Researchers are still following the participants in some of those studies to determine how long the effects of the drug courts might persist.

On the other hand, as can also be seen from the pie chart, a substantial minority of the drug courts (16%) was found to have had no impact on crime, and a small number (6%) were actually associated with higher re-arrest rates. It is here that the most critically important information may be gleaned from two decades of practical experience. Researchers have devoted considerable energy and resources to pinpointing what it is, exactly, that distinguishes effective drug courts from ineffective or harmful ones. The lessons learned from this research have provided critical guidance to the field for designing effective, safe and cost-effective programs for drug-involved offenders, and crafting rational evidence-based drug policies for the U.S. These best-practice findings and their policy implications are discussed in greater detail below in the testimony that follows. First, however, as requested by the Subcommittee, I will review the research on the effects of drug courts on outcomes other than criminal recidivism, as well as their cost-effectiveness and return-on-investment for U.S. taxpayers.

Other Outcomes

In 2005, the U.S. Government Accountability Office (GAO, 2005) concluded that drug courts reduce crime; however, relatively little information was available at that time about their effects on other important outcomes, such as substance abuse, employment, family functioning and mental health. In response to the GAO Report, the National Institute of Justice (NIJ) sponsored a national study of adult drug courts, entitled the *Multisite Adult Drug Court Evaluation* (or *MADCE*). The *MADCE* compared outcomes for participants in 23 adult drug courts located in seven geographic clusters around the country (n = 1,156) to those of a matched comparison sample of drug offenders drawn from six non-drug court sites in four geographic clusters (n = 625). The participants in both groups were interviewed at entry and

at 6 and 18-month follow-ups, provided oral fluid specimens at the 18-month follow-up, and their official criminal records are being examined for up to 24 months.

The 6 and 18-month findings were recently reported at the 2009 Annual Conference of the American Society of Criminology (Rempel & Green, 2009; Rossman et al., 2009). In addition to significantly less involvement in criminal activity, the drug court participants also reported significantly less use of illegal drugs and heavy use of alcohol[2]. These self-report findings were confirmed by saliva drug tests, which revealed significantly fewer positive results for the drug court participants at the 18-month assessment (29% vs. 46%, $p < .01$).

The drug court participants also reported significantly better improvements in their family relationships, reduced family conflicts (which might translate into reduced incidences of child abuse, child neglect and domestic violence), and trends favoring higher employment rates and higher incomes. These findings now confirm that drug courts elicit substantial improvements in other outcomes apart from merely criminal recidivism.

Cost-Benefits

In line with their positive effects on crime reduction, drug courts have also proven highly cost-beneficial (Belenko et al., 2005). A recent cost-related meta-analysis performed by The Urban Institute concluded that drug courts produce an average of $2.21 in direct benefits to the criminal justice system for every $1 invested — a 221% return on investment (Bhati et al., 2008). When drug courts target their services to the more serious, higher-risk offenders, the average return on investment was projected to be even higher: $3.36 for every $1 invested.

These savings reflect provable, measurable cost-offsets to the criminal justice system stemming from reduced re-arrests, law enforcement contacts, court hearings, and jail or prison beds. When other indirect cost-offsets to the community were also taken into account — such as savings from reduced foster care placements and healthcare service utilization — studies have reported economic benefits ranging from approximately $2 to $27 for every $1 invested (Carey et al., 2006; Loman, 2004; Finigan et al., 2007; Barnoski & Aos, 2003). The result has been **net economic benefits to local communities ranging from approximately $3,000 to $13,000 per drug court participant** (Aos et al., 2006; Carey et al., 2006; Finigan et al., 2007; Loman, 2004; Barnoski & Aos, 2003; Logan et al., 2004).

BEST PRACTICES IN DRUG COURTS

As stated previously, some drug courts are decidedly more impactful and cost-efficient than others. Research is now providing clear guidance about the specific characteristics that distinguish effective from ineffective drug courts. In short, the findings reveal that drug courts have significantly better outcomes when they (1) treat their optimal target population of high-risk addicted offenders, and (2) avoid diluting the intervention by maintaining careful fidelity to the original drug court model specified in the "10 Key Components of Drug Courts" (NADCP, 1997).

[2] "Heavy use" of alcohol was defined as $\geq$ 4 drinks per day for women, and $\geq$ 5 drinks per day for men.

Target Population

High Risk Offenders. No program should be expected to work for all drug-involved offenders. Decades of research in corrections has uncovered a reliable finding known as the *Risk Principle*, in which intensive programs such as drug courts have been shown to have the greatest effects for *high-risk* offenders who have more severe antisocial backgrounds or poorer prognoses for success in standard treatments (e.g., Andrews & Bonta, 2006; Taxman & Marlowe, 2006). Such high-risk individuals ordinarily require a combined regimen of intensive supervision, graduated consequences for misbehavior, and evidence-based treatment services in order to succeed. Low-risk offenders, on the other hand, are less likely to be on a fixed antisocial trajectory and are already predisposed to "adjust course" readily following a run-in with the law. Therefore, intensive treatment and supervision may offer little incremental benefits for these low-risk individuals, but at a substantial cost (DeMatteo, et al., 2006).

Consistent with the predictions of the Risk Principle, drug courts have been proven to have the greatest effects for high-risk drug offenders who were relatively younger, had more prior felony convictions, were diagnosed with antisocial personality disorder, or had previously failed in less intensive dispositions (Lowenkamp et al., 2005; Fielding et al., 2002; Marlowe et al., 2006, 2007; Festinger et al., 2002). In one meta-analysis, the effect size for drug court was determined to be twice the magnitude for high-risk participants as for low-risk participants (Lowenkamp et al., 2005). In another countywide evaluation of drug courts in Los Angeles, virtually all of the positive effects of the drug courts were determined to have been attributable to the higher-risk participants (Fielding et al., 2002).

Importantly, in this context the term "high risk" does *not* refer to a risk for violence or dangerousness, but rather to a risk of failing to respond to standard interventions, and thus for continuing to engage in the same level of drug abuse and crime as in the past. This distinction is crucial because some corrections departments or probation agencies may screen high-risk offenders out of more intensive programs because they perceive them as being a threat to others or somehow less worthy of the services. On the contrary, research reveals that the higher the risk level, the more intensive the services should be. Many high-risk offenders can, in fact, be maintained safely and effectively in the community if they are closely monitored and receive the appropriate dosage of evidence-based services.

High-Need Addicted Offenders. Related to the issue of risk is the issue of *clinical needs*. It is unwarranted to assume that all drug-involved offenders are clinically addicted to drugs or alcohol. In fact, evidence suggests more than half of drug offenders *abuse* or *misuse* substances, but are not addicted (e.g., Fazel et al., 2006). They may repeatedly use drugs or alcohol in ways that are potentially dangerous to themselves or others, but their use is under voluntary control. Addicts, in contrast, suffer from severe cravings or compulsions to use the substance, and may experience painful or uncomfortable withdrawal symptoms whenever they attempt to become abstinent. We now know that these latter symptoms reflect a form of neurological or neuro-chemical damage to the brain, which requires formal treatment intervention (e.g., Baler & Volkow, 2006).

As a result of their brain damage, addicts cannot realistically be expected to respond to the mere threat of punishment. Addicts are notorious for continuing to abuse drugs or alcohol despite experiencing severe and persistent negative consequences. Indeed, patients cannot receive a diagnosis of drug or alcohol dependence unless they continue to use drugs or alcohol in the face of recurrent adverse repercussions (American Psychiatric Association, 2000). A person who readily quits drugs to avoid punishment would, by definition, typically not qualify for the diagnosis of addiction.

For addicted offenders, formal treatment is required to ameliorate their cravings and withdrawal symptoms, provide them with concrete skills to resist drugs and alcohol, and teach them effective coping strategies to deal with life's stressors and challenges (e.g., Chandler et al., 2009). For the drug abuser, on the other hand, threats of punishment might be sufficient to squelch drug use, if several conditions are met: (1) drug use must be reliably detected through urine testing and other means; (2) punishment must be administered with relative certainty and immediacy, and (3) the punishment must be gradually increased in magnitude over time in response to successive infractions. This approach lies at the heart of coerced-abstinence programs such as H.O.P.E. (Hawaii Opportunity Probation with Enforcement), which are showing early promise for enhancing probation outcomes.

Reaching the Target Population. Admittedly, drug courts did not begin by focusing on high-risk addicted offenders. Largely for political reasons, they began as pre-plea diversion programs for first-time drug-possession offenders. Prosecutors — who did not want to appear soft on crime — were generally unwilling to extend this diversionary opportunity to other than the lowest-risk individuals. Unfortunately, judges and other drug court team members had little recourse but to accede to the prosecutors' wishes, because the prosecutor is legally and constitutionally empowered to serve as the "gatekeeper" for such dispositions. Prosecutors enjoy broad and largely unfettered discretion in charging and plea-bargaining practices,[3] and challenges to the prosecutor's gate-keeping function in drug courts have been consistently rebuffed by the appellate courts.[4]

This process has, however, evolved appreciably over the ensuing two decades. As the research evidence indicated that drug courts should be targeting more serious offender populations, they moved decidedly toward treating recidivist and higher-risk participants. In so doing, prosecutors required them to shift their practices to a *post-plea, pre-adjudication* model. Pursuant to this model, defendants are required to plead guilty to the charge(s) or to stipulate to (acknowledge) the facts in the arrest report as a condition of entry. The plea or stipulated agreement is then held in abeyance and may be vacated or withdrawn upon successful completion of treatment. This arrangement provides leverage for drug courts to keep offenders engaged in treatment and ensure they meet their obligations to public safety.

Recently, some advocacy organizations have argued that all drug courts should continue to follow a pre-plea model that does not require a guilty plea for entry (National Association of Criminal Defense Lawyers, 2009). At least one proposed amendment to the drug court reauthorization legislation would require a pre-plea model for all drug courts funded through the DOJ Drug Court Discretionary Grant Program. This proposal is untenable for several reasons. First, without the leverage afforded by a guilty plea, prosecutors will simply go back to permitting only low-level offenders to enter drug courts. In fact, statutes in many jurisdictions do not even permit pre-plea diversion opportunities for serious or recidivist

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[3] *See* Wayte v. United States, 470 U.S 598 (1985); U.S. v. Armstrong, 517 U.S. 456 (1996).

[4] *See, e.g.,* Woodward v. Morrissey, 991 P.2d 1042, 1045 (Okla. 1999) (holding judicial review of D.A.'s decision to admit defendant to Drug Court would violate separation of powers doctrine); State v. Taylor, 769 So.2d 535, 538 (La. 2000) (finding statutory authorization making prosecutor the initial gatekeeper to Drug Court was proper prosecutorial function which passes constitutional separation of power scrutiny); Flynt v. Commonwealth, 105 S.W.3d 415, 426 (Ky. 2003) (concluding trial court could not permit pre-trial diversion to Drug Court over objection of District Attorney because it would violate constitutional separation of powers doctrine); State v. Diluzio, 90 P.3d 1141 (Wash. App. 2004) (holding prosecutor retained authority to make initial Drug Court referrals pursuant to separation of powers doctrine and consistent with plea bargain powers).

offenders. Because low-level offenders are rarely jail or prison-bound to begin with, such an approach would have no appreciable impact on our prison system, nor would it keep us any safer.

Second, in many jurisdictions offenders can only be placed on probation if they have entered a guilty plea or been convicted. Lacking a plea, judges would not be able to access the intensive level of community supervision that probation departments can provide. Finally, a pre-plea model raises the serious problem of cases going "cold" while offenders are attending treatment. In most drug courts, it takes several months before a noncompliant participant is sanctioned with termination. This is because drug courts typically offer multiple chances for offenders to get and stay clean and sober. After several months, however, the evidence is likely to become stale and witnesses' recollections are apt to fade. Prosecutors therefore understandably want a guilty plea to be entered before allowing defendants several months to engage in trial-and-error efforts at treatment. For all of these reasons, it should be clear that returning to a pre-plea model for drug courts is simply not tenable or desirable.

Most recently, drug courts have also begun to apply a *post-conviction* model for probationers or probation violators, and a *reentry* model for parolees and inmates conditionally released from prison or jail. Because these individuals have already been convicted and sentenced, the prosecution no longer holds sway over the proceedings and the court has greater freedom to fashion a disposition that includes the drug court model. In fact, programs for repeat probation violators are now among the most rapidly developing model of drug courts in the U.S. (Huddleston et al., 2008).

Critics of drug courts might argue that the pace of change has not been rapid or decisive enough. But in the scheme of things in the criminal justice system, 20 years is a miraculously short span of time for any program to take hold across the country, marshal hundreds of empirical studies to identify best practices, and then adapt its fundamental model to align with those best practices. Critics would be hard-pressed to identify any other program that has made such decisive strides within such a short time.

Regardless, more can and should be done to expand eligibility criteria for drug courts. There are still many counties or localities that have elected to treat low-risk, non-addicted individuals on the happenstance that they were arrested for a drug-possession offense. This has the potential to waste scarce treatment and supervision resources, and may unnecessarily deny those services to the very people who need them the most. Under such circumstances, the impact on public health and public safety could be negligible, while the costs could be substantial and prohibitive.

Bear in mind, however, that there are no centralized eligibility standards for drug courts. Like any other sentencing option, drug courts are the product of a negotiated agreement between various agencies within a given county or judicial district. The court, prosecution, defense bar, treatment agencies and probation department must come to mutual terms about what type of program they need and want for their community. So long as prosecutors or judges perceive a political, economic or public-safety risk in accepting more serious offenders, they may resist following the lessons of research. But this problem is in no way specific to drug courts; rather, it applies to *all* criminal justice programs that serve as alternatives to incarceration.

This is where the Federal government could play an important role. Federal grant programs, such as the DOJ Drug Court Discretionary Grant Program, might through their rules and solicitations for funding actively encourage drug courts to serve recidivist offenders, probation violators and parolees. They might further encourage or require drug courts to perform standardized risk-and-needs assessments

using validated assessment tools, and target their services to the higher-risk and higher-need individuals. Grants could be specifically steered toward drug courts that seek out these more serious offender populations. Such seed funding could go a long way toward encouraging experimentation with more serious offenders; and, if the results are as positive as the research would predict, states could be expected to maintain those programs once the federal funding ended.

Federal legislation could also play a role in providing political "cover" for local officials, or at least not exposing them to increased pressure or criticism. For example, the Crime Control Act prohibits the use of federal dollars for drug courts to treat "violent" offenders. There is no empirical justification for this prohibition. Research indicates that violent offenders perform at least as well, and often appreciably better, than other offenders in drug courts — assuming, of course, that drug addiction is fueling their violent behavior (Carey et al., 2008; Saum et al., 2001).

Many people may assume that by denying drug court to violent offenders, they are instead kept locked up. But that is not the case. Most violent offenders are returned to their community fairly rapidly, often within a few months or years. Offenses such as simple assault, domestic violence, vehicular assault and stalking often do not receive very long sentences to begin with, and prison and jail overcrowding have had the practical effect of causing many violent inmates to be released prematurely. Denying these offenders access to drug court means, in effect, that they are likely to receive *less* community supervision than a simple drug-possession offender. This makes no sense. If violent offenders are to be released into the community (and many are), then intensive programs such as drug courts are exactly where they ought to be. Federal legislation should drop the categorical violence exclusion and should encourage drug courts to make greater contributions to public safety by taking on those individuals who pose the greatest threats to their communities.

Fidelity to the 10 Key Components

In fiscally challenging times, there is always the pressure to do more with less. And there is no shortage of policy advocates asserting that they can serve large numbers of drug offenders at a reduced cost. These too-good-to-be-true promises are just that. If there is one lesson that researchers and program evaluators have learned from bitter experience, it is that there are no easy short cuts for treating high-risk, drug-addicted offenders. Every effort to water-down what we know to be the essential ingredients for success has been met not only with disappointment, but sometimes with outright harm. Poor-quality programs may not merely fail to help, they can make matters worse.

Examples of this abound in the research literature. Proposition 36 in California diverted large numbers of drug-possession offenders into treatment in lieu of incarceration, and the courts were effectively disabled from responding to noncompliance with appreciably more than an extension of probation and relatively toothless demands for more treatment. Lacking adequate behavioral contingencies, including graduated sanctions, the results were predictably lackluster. Roughly one-quarter of the offenders never arrived for a single treatment session, 50 percent of those who did arrive for treatment dropped out in less than 3 months, and only one quarter ever completed treatment (UCLA, 2007). Worse still, criminal recidivism actually increased. Re-arrest rates for drug and property offenses were significantly higher among Proposition 36 participants than among comparably matched drug offenders who did not participate in Proposition 36 (Farabee et al., 2004; UCLA, 2007).

Similarly, a program known as Project Greenlight in New York City offered treatment services for parolees, but little else in the way of supervision or accountability after release. The results there, too, were painfully disappointing, including increased re-arrest rates, probation violations and revocations (Wilson & Davis, 2006; see also Marlowe, 2006).

Drug courts have been forced to learn these same lessons. Drug courts that have held fast to the original drug court model and maintained the full panoply of services denoted in the 10 Key Components have had positive outcomes and returned financial benefits to their communities that were several times the initial investments. Those that dropped central ingredients of the model or reduced the dosage of services have had less beneficial effects or sometimes caused more harm than good.

The "10 Key Components" of drug courts include, but are not limited to: (1) a multidisciplinary team approach to managing cases, (2) an ongoing schedule of judicial status hearings, (3) weekly drug testing, (4) contingent sanctions and incentives, and (5) a standardized regimen of substance abuse treatment (NADCP, 1997). Each of these hypothesized key components has been studied by researchers or evaluators to determine whether it is, in fact, necessary for effective results. The results have confirmed that fidelity to the full drug court model is necessary for optimum outcomes — assuming, again, that the programs are treating their correct target population of high-risk, addicted offenders.

Multidisciplinary Team Approach. One of the more novel features of drug courts is the practice of having professionals from various disciplines meet regularly to coordinate their functions as a team (NADCP, 1997). At regularly scheduled staff meetings, which are held before the court sessions, the various team members contribute information from their perspectives about the participants' progress in the program and may offer recommendations for suitable responses, such as rewards, sanctions or changes to the participants' treatment plans.

Research confirms that the most effective drug courts require regular attendance by the judge, defense counsel, prosecutor, treatment providers and law enforcement officers at the staff meetings and court hearings (Carey et al., 2008). When any one of these professional disciplines was regularly absent from team discussions, the programs tended to have outcomes that were, on average, approximately 50 percent less favorable (Carey et al., in press). In other words, if any one professional discipline is excluded from the intervention, there is reason to anticipate the effectiveness of a drug court could be cut by as much as one half.

There should be nothing surprising about this finding. Addiction and associated crime are severe and chronic conditions that require an intensive and coordinated response. No one profession could be expected to have the knowledge, expertise and authority to deal effectively with this intransigent social problem. It should not be surprising that a coordinated team approach involving the continuous input of several professional disciplines would be required to intervene effectively with high-risk drug-addicted offenders.

Judicial Status Hearings. Unlike traditional court proceedings, participants in drug courts attend status hearings in court, during which the judge regularly reviews their progress in treatment and may impose a range of consequences contingent upon their performance. Research unequivocally demonstrates that judicial status hearings are an indispensible element of the success of drug courts (Carey et al., 2008; Festinger et al., 2002; Marlowe et al., 2004a, 2004b, 2006, 2007). The optimal schedule appears to be no less frequently than bi-weekly hearings for at least the first phase (first several

months) of the program. It seems that the power and authority of a judge may be necessary to gain control over high-risk addicted offenders' behaviors and keep them regularly engaged in treatment.

Drug Testing. The most effective drug courts perform drug testing at least twice per week during the first several months of the program (Carey et al., 2008). Because the metabolites of most common drugs of abuse remain detectable in human bodily fluids for only about one to four days, testing less frequently leaves an unacceptable time gap during which participants can use drugs and evade detection. In addition, drug testing is most effective when it is performed on a random basis. If participants know in advance when they will be drug tested, they may adjust their usage accordingly or take other countermeasures in an effort to beat the tests. Programs that do not perform random, twice-weekly drug testing are simply not engaged in effective evidence-based practices.

Graduated Sanctions & Rewards. The pervasive perception among both staff members and participants in drug courts is that punitive sanctions for infractions and rewards for achievements are strong motivators of positive behavioral change (Lindquist et al., 2006; Goldkamp et al., 2002; Harrell & Roman, 2001; Farole & Cissner, 2007). Two randomized controlled experiments have confirmed that the imposition of swift, certain, and gradually escalating sanctions for infractions, including brief intervals of jail detention, significantly improves outcomes among drug offenders (Harrell et al., 1999; Hawken & Kleiman, 2009).

This is the central approach employed in coerced-abstinence programs such as H.O.P.E., but it is also one critical ingredient of the drug court model. In fact, drug courts were the *first* to apply this approach in day-to-day criminal justice practice. Drug courts view graduated sanctions as one component of a multi-component model, whereas other programs may rely primarily on this specific intervention to achieve their effects.

Substance Abuse Treatment. As discussed earlier, punishment, or the threat of punishment, alone may be effective at reducing substance abuse among non-addicted drug abusers; however, it is unlikely to elicit long-term change among addicted individuals without the addition of evidence-based treatment services. Formal treatment is required to ameliorate addicts' cravings and withdrawal symptoms, provide them with concrete skills to resist drugs and alcohol, and teach them effective coping strategies to deal with life's stressors and challenges. This is the conclusion of the National Institute on Drug Abuse in its guiding criminal justice document, *Principles of Drug Abuse Treatment for Criminal Justice Populations* (NIDA, 2006).

Significantly better outcomes have, in fact, been achieved when drug courts adopted standardized evidence-based treatments, which go by such names as Moral Reconation Therapy (MRT; Heck, 2008; Kirchner & Goodman, 2007), the MATRIX Model (Marinelli-Casey et al., 2008) and Multi-Systemic Therapy (MST; Henggeler et al., 2006); as well as culturally proficient services (Vito & Tewksbury, 1998). What all of these evidence-based treatments share in common is that they are highly structured, are clearly specified in a manual or workbook, apply behavioral or cognitive-behavioral interventions, and take participants' communities of origin into account.

The results of this substantial body of research demonstrate beyond peradventure that treatment is not a dispensable element of criminal justice policy. For individuals suffering from the brain damage known as addiction, punishment is not enough. They also need formal evidence-based treatment.

TAKING DRUG COURTS TO SCALE

There is no question that drug courts are, at best, serving only about 5 to 10 percent of the high-risk, addicted, prison-bound offender population. According to NADCP's most recent data, which have not yet been published, there are roughly 110,000 to 120,000 individuals currently in drug courts. The Urban Institute estimates there are approximately 1.5 million potentially prison-bound arrestees each year in the U.S. who are "at risk" for drug dependence or abuse (Bhati et al., 2008).

Data are lacking to know precisely what proportion of those arrestees are clinically addicted to drugs or alcohol, at high-risk for failure in standard treatment, and meet other (rational) eligibility criteria for drug courts. Regardless, the sum is obviously many times the current drug court census. And that does not include the huge number of individuals who are already under correctional supervision on probation or parole, or are in our jails and prisons and about to be released back into our communities.

The time has come to fill the service-gap for this large population of high-risk, drug-addicted individuals who require drug court services to become sober, law-abiding and productive citizens. Before policymakers pursue the latest program du jour, with promises of high returns on small up-front investments, consider the five meta-analyses, hundreds of scientific studies, and decades of professional experience and wisdom emanating from drug courts. The GAO (2005) and NIJ (2006) have each reviewed the scientific evidence and concluded that drug courts work. What other program for drug offenders can say that? The current Administration is committed to supporting and promoting "what works" and endorsing evidence-based practices. Drug courts are the very definition of this concept.

Some policy advocates argue that we should infuse drug court precepts and practices throughout the justice system, including in the traditional criminal courts, probation and parole agencies, and corrections departments. No one could argue with that proposition. But underlying this position, in some cases, is the goal of watering down or fundamentally altering the intervention. The sad truth is that many effective programs have, in the due course of policy administration, been made cheaper simply by lowering the dosage or providing fewer services to more participants. In many cases, effectiveness was lost as a result and then chalked up to a "failure to replicate." The success of drug courts has already been replicated hundreds of times across the country. That is what meta-analysis tells us. Cheapening or weakening the model, therefore, is by definition not evidence-based. If advocates want to propose an alternative model that provides less service, then the burden of proof falls squarely upon them to prove that their alternative is as effective and safe as the current standard of care, which is drug court.

A Criminal Justice Continuum of Care

This does *not* mean that all drug-involved offenders should be in drug courts. As was already discussed, research indicates the drug court model is unnecessary or unsuited for low-risk offenders, and for non-addicted drug abusers. It may also not be suited, or may require substantial modifications, for other types of offender populations, such as sex offenders.

Coerced-abstinence programs like H.O.P.E. hold considerable promise for intervening with non-addicted offenders, including those who are high-risk. In addition, programs such as California's Proposition 36, which focus on treatment rather than accountability, might hold promise for low-risk addicted offenders. There are plenty of drug-involved offenders to go around, and the critical task now is to determine, empirically, which types of offenders should go into which types of programs.

This is where *risk and needs assessment* comes in. When our criminal justice system moved from indeterminate sentencing to determinate sentencing a few decades ago, the practical effect was to render pre-sentencing investigations (PSI's) essentially irrelevant. If sentences were to be based almost exclusively on the nature of the current charge and past convictions, rather than on the characteristics of the offender, then offender-based assessments were largely a waste of time and resources.

Research now demonstrates that offender-based assessments, when properly validated and standardized, can greatly enhance correctional outcomes by matching offenders to the best programs and services. And recent case-law precedent at the state and Federal levels permits or requires greater discretion in sentencing based, in part, on offender characteristics. The newest draft of the Model Penal Code includes risk and needs factors as fodder in sentencing determinations, and many states are beginning to follow suit.

The U.S. Sentencing Commission, with guidance from Congress, should require risk-and-needs assessments to be performed and considered in sentencing decisions. In addition to (not instead of) taking other value-laden issues into consideration, such as victims' sentiments and society's legitimate interest in general deterrence, judges, defense counsel and prosecutors should be encouraged, if not required, to include data on effectiveness and cost-effectiveness in their calculus of decision-making when advocating for or rendering sentencing dispositions.

Ideally, risk-and-need information should be explicitly referenced in sentencing guidelines or statutes as permissible or mandatory factors to be considered in sentencing. Congress can lead by encouraging amendments to the U.S. Sentencing Guidelines in this regard. Congress can also lead by providing grants to the states through DOJ and other agencies to amend their sentencing laws to require consideration of this information, to develop procedures to streamline the availability of risk-and-needs assessment information, to empirically validate assessment tools, and to measure the actual effects of various sentencing frameworks to determine which approaches are most effective at reducing recidivism, saving money and saving lives.

Science has advanced greatly in recent decades. We know a lot more now than we did in the 1970s, 1980s and 1990s. We know the basic parameters for intervening effectively with drug-involved offenders in community-based settings. We know how to supervise them closely, reliably detect drug use, apply graduated sanctions and incentives effectively, and treat the underlying disease of addiction where it is present. Unfortunately, our laws and policies have not kept pace. They are still based on outdated sentiments from decades past, when we didn't know much about the disease of addiction, how to perform valid risk-and-needs assessments, and how to develop effective treatment and supervision care plans. If Congress leads in infusing science into policy, the states and the country will follow.

I want to again thank this august Committee for the opportunity to address you on these critically important issues for our nation's domestic agenda. I am happy to answer any questions you may have and to provide relevant supporting documentation for the scientific facts I have asserted.

Respectfully submitted,

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