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

Good morning. I'm Daniel Abrahamson, director of legal affairs for the Drug Policy Alliance, the nation's leading organization advocating alternatives to the failed war on drugs. I want to thank the subcommittee for inviting me to testify on alternatives to incarceration for drug-using people within the criminal justice system. As a co-author of California's voter-approved, treatment-instead-of-incarceration law, I will focus on the genesis of that law – known both as Proposition 36 and the Substance Abuse and Crime Prevention Act, 2000 – as well as its role over the last ten years in expanding access to treatment, reducing incarceration, and cutting state costs.

I will also address alternatives to incarceration – primarily Proposition 36, drug courts and HOPE – through a broader policy lens. For two decades, the question has been: Do drug courts work? The Drug Policy Alliance would pose the larger question: What works best? In brief, the policy conversation on alternatives to incarceration has been too narrow and focused almost exclusively within the criminal justice system. We urge a more robust discussion aimed at

identifying ways to further reduce the role of the criminal justice system – and increase the role of public health and medicine – in responding to drug use, a quintessential health issue.

Proposition 36, California's Landmark Treatment-Instead-of-Incarceration Law

In November 2000, California voters approved a landmark statewide measure, called the Substance Abuse and Crime Prevention Act of 2000 (Proposition 36), that requires the state to provide drug treatment, rather than jail or prison time (or probation without treatment), for most people convicted of a first or second drug possession offense. Prop 36 remains the most significant piece of sentencing reform – in terms of the number of people diverted from prison and dollars saved – since the repeal of alcohol Prohibition in 1933.

The problem, before Prop 36, was that too many people in California did not have access to treatment before they faced jail or prison sentences for simple drug possession. As the nation's war on drugs intensified in the 1980s and '90s, California followed national trends by relying increasingly on punishment and prisons as its primary response to arrests for illicit drug use. During that same time, spending on community-based drug treatment remained flat. Hundreds of thousands of people were arrested, convicted and imprisoned for a personal drug possession offense, disrupting families and dimming future employment prospects. As a result, between 1988 and 2000, the number of people imprisoned in California for drug possession quadrupled.

Since its passage, Prop 36 has:

Provided treatment to 30,000+ people a year. Over 300,000 people have entered community-based treatment under Prop 36, half of whom had never received treatment before. About one-third of participants complete treatment and probation; about half stay for at least 90 days, "the minimum threshold for beneficial treatment."[1]

Sharply reduced the number of people in state prison for simple drug possession. In the 12 years prior to Prop 36, the number of people in state prison for drug possession quadrupled, peaking at 20,116 in June 2000. That number dropped by one-third shortly after Prop 36 took effect, and remained lower by 8,000 (40%) as of December 2008.[2]

Reduced state costs by over $2 billion. For every $1 invested in Prop 36, the state saves a net $2.50-$4[3]. Average per-person treatment costs are about $3,300, while incarceration costs $49,000 per year. The University of California at Los Angeles (UCLA) calculated that the program cut costs by $173 million its first year; the Legislative Analyst's Office put annual savings for later years at $200-300 million.

Achieved expected rates of "progress" and "completion". According to UCLA, Prop 36 completion rates are "fairly typical" of drug users referred to treatment by the criminal justice system.[4] The statewide completion rate reached 40% in 2007. At the county level, Prop 36 completion rates range from 26% to over 50%.

Did not lead to increased crime. According to UCLA, despite diverting over 36,000 people to probation and drug treatment each year, Prop 36 has had no negative impact on crime trends.[5]

Importantly, Prop 36 achieved these results *without* exclusionary gatekeeping by prosecutors or judges, punitive drug testing, short-term jail sanctions or dedicated court calendars – all components often declared to be critical to the operation of drug courts.[6] Prop 36 also expressly allows for participants to receive narcotic replacement therapy, the gold-standard of opoid treatment, which is unfortunately still barred in the vast majority of drug courts.

Prop 36 represents a positive modification of drug courts, taken to scale. In 2001-2006, when Prop 36 was funded at $120 million a year, 36,000 people were enrolled annually[7] (nearly ten times the number in all of California's drug courts and more than one-half of all people admitted to drug courts nationwide each year)[8] and completion rates were comparable to those of other criminal justice programs.[9] An estimated $2,861 was saved per participant, or $2.50 for every dollar invested,[10] and there was no adverse effect on crime trends.[11]

However, even with these outcomes, California – like all other states – has continued to incarcerate people for personal drug possession, either because they are ineligible for the program or because they are unable to stop using drugs. Indeed, as long as drug use remains criminalized, the people most likely to be incarcerated for drug possession offenses are those who struggle most mightily with their addictions.

Drug Courts Help People *And* Perpetuate the Criminalization of Addiction

There is no doubt that drug courts were created and continue to be run with unflagging dedication and concern for the health and wellbeing of individuals and communities. Nor is there any question that drug court judges and their staffs have helped change, even save, many lives. Indeed, there is no shortage of success stories.

The issue, however, is not whether drug courts do some good – they undoubtedly do – but rather whether the proliferation and expansion of drug courts is good social policy as compared with other available approaches and interventions to address drug use. We find that, based on the published evidence to date, drug courts produce more costs than they do benefits at a policy level.

The NIJ's Multi-Site Adult Drug Court Evaluation (MADCE) study currently under way should help begin to address some of the questions that previous research has left unanswered.[12] The limited drug court research literature that is both available and methodologically-sound reveals significant shortcomings in drug court practices – for example, "cherry picking" of clients most likely to succeed, poor treatment options for clients, and woefully inadequate access to effective therapies for opioid dependence (including methadone) – and drug court outcomes – for example, no reduction and possible increase in incarceration rates, and little or no cost savings.

The available drug court literature suggests that although many individuals will benefit from drug courts each year, many others may ultimately be worse off than if they had access to health services, had been left alone, or even been conventionally sentenced. In short, drug courts, as currently devised, may provide little or no benefit over the wholly punitive system they intend to improve upon.

Certainly, the national drug court movement is trying to improve practices and outcomes. The National Association of Drug Court Professionals, for example, encourages courts to allow participants access to narcotic replacement therapies, emphasizes that incentives are as important as sanctions and urges drug courts to identify and implement best practices as they are identified.

There is no getting around the fact, however, that drug courts can only exist as long as drug use is criminalized. And, while drug courts will help some, many more will continue to be arrested and incarcerated for their drug use.

Roughly 55,000 people enter the more than 2,100 drug courts in the U.S. annually,[13] representing a tiny fraction of the 1.8 million people arrested on drug charges.[14] With drug court completion rates ranging widely from 30 percent to 70 percent,[15] somewhere between 16,500 and 38,500 will graduate. The rest are deemed to have "failed." Even if drug courts were expanded to cover all people arrested for drug possession, between 500,000 and 1 million people would still be ejected from a drug court and sentenced conventionally every year.[16]

This is the drug court paradox. Drug courts are grounded in two contradictory models. The disease model assumes that people who misuse drugs are unable to think rationally about their drug use.[17] It is therefore the state's duty to compel people into treatment. The rational actor model, which underlies principles of punishment, assumes that people weigh the benefits of their actions against the potential consequences of those actions.[18]

These dueling models result in people being "treated" through a medical lens while the symptoms of their condition – chiefly, the inability to maintain abstinence – are addressed through a penal one. The person admitted into drug court is regarded as not fully rational and only partially responsible for their drug use; yet the same person is considered rational and responsible when they do not respond to the carrots and sticks of drug court.[19]

Short-term jail sanctions for drug relapse and the punitive use of drug testing are two central practices of drug courts that lack evidentiary support and are deeply problematic. Though drug courts vary in their practices, the use of short jail sanctions, or "flash incarceration" to punish clients who use drugs or violate program rules is standard. The power of drug court judges to order the incarceration of people who do not abstain from drug use is thought by many drug court proponents to be a critical component of drug court success. However, as the California Society of Addiction Medicine has noted, not a single study has shown that incarceration sanctions improve substance use treatment outcomes.[20] (Or, as UCLA researchers put it, "the benefits of flash incarceration are not well established."[21])

Treatment retention is consistently and positively linked to treatment readiness[22] as well as marital bonds, employment and education.[23] Jail sanctions, however, have been associated with a higher likelihood of re-arrest and a lower probability of program completion.[24] A person's sense of autonomy and motivation – integral to progress in treatment – can be undermined if they feel they are sanctioned unfairly.[25] Moreover, for days or weeks at a time, flash incarceration places a person who is struggling with drugs into a stressful, violent and humiliating environment, where drugs are often available (and clean syringes almost never), where sexual violence is common (and condoms rare), where HIV, hepatitis C, tuberculosis and other communicable diseases are

prevalent, where medical care is often substandard, and where drug treatment is largely nonexistent.

In drug court, jail sanctions for drug relapse interrupt the treatment process, disrupt a person's attempts to maintain employment and stable social bonds, and reinforce the notion that the person is deviant. The pain, deprivation and atypical, dehumanizing routines that people experience while incarcerated can create long-term negative consequences.[26]

Drug testing can be an important tool in the treatment process. Drug courts, however, often rely on drug test results as the main, if not sole, factor for assessing the progress of clients in the program. When used thus, drug tests are transformed from a tool to determine how well a treatment regimen is working into a stand-alone measure of success or failure. The over-emphasis of drug test results by drug courts can often lead to negative consequences for clients, including the improper imposition of jail sanctions and lower rates of full-time employment.[27] Of particular concern, drug testing can trigger a cat-and-mouse game where the client's goal is to beat the test. For example, some youth who are subjected to frequent drug testing in juvenile drug courts have reported switching from using drugs that are frequently and easily tested for, such as marijuana, to drugs that metabolize more quickly and so are more difficult to detect, such as cocaine, methamphetamine, or opiates such as heroin.[28]

Under the drug court approach, those suffering more serious drug problems are most likely to "fail" drug court and be punished.[29] In the end, the person who has the greatest ability to control his or her own drug use will be much more likely to complete treatment and be deemed a "success."

With drug courts, there is also significant opportunity cost. Drug courts appear to have flourished at the expense of support services that are more accessible and that are more effective at improving health and reducing crime.[30] Absent efforts to help people *before* they are in crisis and absent policies to stem the flow of people into the criminal justice system for petty drug law violations, drug courts and other criminal justice-based treatment programs (including Prop 36) will not meaningfully reduce the harms of drug use or the use of imprisonment.[31]

Short-Term Reforms Urgently Needed

As long as drug courts aim to "treat" addiction within the criminal justice system, they should adopt more health-oriented practices, offer proven health interventions, and focus their treatment resources on persons who would otherwise face lengthy terms of incarceration. Improvements include:

- Focusing drug court resources on more seriously criminally-involved people to ensure that drug court is actually a diversion from incarceration and not more restrictive than the conventional sentence;[32]
- Using a pre-plea rather than a post-plea model;[33]
- Adopting objective admission/eligibility criteria and reducing the prosecutor's role as gate-keeper to treatment;[34]
- Ensuring due process protections and enhance the role of defense counsel;[35]

- Empowering treatment professionals in decision-making;
- Improving data collection and rigor of research;[36]
- Using drug tests as a treatment tool, not as punishment;
- Prohibiting the use of jail sanctions for drug relapse;
- Adopting a wider range of health measures – not simply abstinence – into program goals;
- Employing evidence-based practices, such as opioid maintenance treatments;
- Ensuring that practices are more health-oriented than punitive; and
- Ensuring that punishment for "failing" the program is not worse than the original penalty for the offense.

While these changes would help improve the functioning, transparency and accountability of drug courts, policymakers must also ask whether, *as long as drug use is criminalized*, probation or parole departments could oversee low-level offenders in community-based treatment in a less costly and equally effective way than drug courts.

Neither Drug Courts nor the "HOPE" Program are Public Health Approaches to Drug Use

Public health interventions to address problematic drug use are wise, necessary long-term investments. They reduce the harms associated with drug use, prevent crime against people and property, and cut associated costs.[37] We recommend reducing the role of the criminal justice system in addressing drug use and emphasizing a health-centered approach instead.

Some states have demonstrated steps toward a health approach to drug use by rolling back the most punitive drug sentencing policies. However, these changes fall short of what is needed: an end to the criminalization of drug use absent harm – or substantial risk of harm, such as driving under the influence – to others. As long as 1.4 million people are arrested every year for nothing more than drug possession, drug cases will continue to flood the criminal justice system and cause unnecessary misery.

There has been increased discussion of late about courts that impose "swift and certain sanctions." This approach is premised on the belief that short periods of incarceration can reduce criminal recidivism. The HOPE Program in Hawaii[38] is an example of such a program. Because it appears that roughly one-third of HOPE participants are drug offenders, the program merits attention in this discussion of alternatives to incarceration for drug-involved offenders.

The HOPE program, however, has received publicity far more favorable than is warranted by the data published to date. Indeed, the data is quite thin and preliminary. But even if the HOPE program is shown to reduce criminal activity, it is far from clear that the outcomes achieved by the program in Hawaii are replicable with different populations and different criminal justice actors. Without careful safeguards (and perhaps even with them), it is likely that attempts to replicate HOPE will actually increase costs, jail stays and probation revocations for the most addicted participants. Indeed, HOPE-like programs have existed in various forms for thirty years but never have been taken successfully to scale.

Toward a Public Health Approach to Drug Use

Forty years after the United States embarked on a war on drugs, President Obama signed legislation in 2010 that promises to make drug treatment widely accessible within the mainstream health care system. This high-level political acknowledgement that drug use is fundamentally a health issue did not occur in a vacuum, but builds on the passage of the federal *Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act of 2008* and on the passage of similar bills in many states. The political development follows a social one, with national surveys revealing that a large majority of Americans believe that drug use is a health issue. Nevertheless, U.S. policy remains dominated by a punitive approach to drug use.

This legacy of punishment – and its inherent conflict with a health-centered approach – has persisted throughout the 20-year-old drug court experiment.

Drug courts have been an important experiment in reducing the harms associated with U.S. drug policies. Throughout the 1990s, people on the front lines of the drug war – primarily judges and prosecutors – came to understand that handing down long sentences for petty drug violations is as unjust as it is ineffective. Drug courts were developed in an attempt to develop more humane and effective interventions in the lives of people struggling with drug problems. Drug courts have undoubtedly helped many people find their way to a more stable and productive life outside of the criminal justice system.

On a policy level, however, drug courts have done little to mitigate – and in many instances may have aggravated – the harms associated with the mass-criminalization of people for illicit drug use and the failure to provide adequate and effective treatment to those who need and want it. The expansion of drug courts has helped create the myth that U.S. drug policy is more compassionate than it used to be and that help is available within the criminal justice system, even as the number of people incarcerated for drug possession continued to increase and funding for treatment in the community declined dramatically.

To create a successful health paradigm in the U.S., policymakers must end the criminalization of drug use, shift investments into public health programs that include harm reduction and treatment, and set health-oriented measures of success that focus on reducing the cumulative death, disease, crime and suffering associated with both drug use and drug prohibition. Our nation's drug policies should be evaluated – and funded – according to their ability to meet these goals.

Thank you for inviting me to testify before you today.

Endnotes

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[2] California Department of Corrections and Rehabilitation. *Prison Census Data (December 2008)*. February 2009.

[3] Douglas Longshore, Angela Hawken, Darren Urada, M. Douglas Anglin, *Evaluation of the Substance Abuse and Crime Prevention Act: Cost-Analysis Report* (Los Angeles, CA: UCLA Integrated Substance Abuse Program, 2006).

[4] UCLA Evaluation 2008
[5] Longshore et al., *Evaluation of the Substance Abuse and Crime Prevention Act: Final Report.*
[6] California Department of Alcohol and Drug Programs, "Proposition 36 Ballot Initiative (2000 General Election)," http://www.adp.state.ca.us/SACPA/Proposition_36_text.shtml
[7] Longshore, Douglas et al, *Evaluation of the Substance Abuse and Crime Prevention Act: 2003 Report*, Los Angeles, CA: UCLA Integrated Substance Abuse Programs, 2004.
[8] California Department of Alcohol and Drug Programs and Judicial Council of California, Administrative Office of the Courts, *Drug Court Partnership Act of 1998, Chapter 1007, Statutes 1998 – Technical Report*, June 2002.
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[12] *See* "Drug Courts, Better DOJ Data Collection and Evaluation Efforts Needed to Measure Impact of Drug Court Programs," Government Accountability Office, April 2002 ("Despite a significant increase in the number of drug court programs . . . that are required to collect and maintain performance and outcome data, DOJ continues to lack vital information on the overall impact of federally funded drug court programs. . . [The public] lacks sufficient information to (1) measure long-term program benefits, if any; (2) assess the impact of federally funded drug court programs on the criminal behavior of substance abuse offenders; or (3) assess whether drug court programs are an effective use of federal funds." "As a result, DOJ cannot provide Congress, drug court stakeholders, and others with reliable information on the performance and impact of federally funded drug court programs.").
[13] Bhati et al., *To Treat or Not to Treat: Evidence on the Effects of Expanding Treatment to Drug-Involved Offenders.*
[14] U.S. Department of Justice, *Estimated Arrests For Drug Abuse Violations by Age Group, 1970-2007.*
[15] United States General Accounting Office, *Adult Drug Courts: Evidence Indicates Recidivism Reductions and Mixed Results from Other Outcomes*, Washington D.C.: GPO, February 2005.
[16] These drug court failure estimates are based on 1.4 million people who were arrested for drug possession in 2007. See U.S. Department of Justice, *Estimated Arrests for Drug Abuse Violations by Age Group, 1970-200.*
[17] See generally Boldt, "Rehabilitative Punishment and the Drug Treatment Court Movement"; Hoffman, "Therapeutic Jurisprudence, Neo-Rehabilitationism, and Judicial Collectivism"; Miller, "Embracing Addiction."
[18] Ibid.
[19] Bowers, "Contraindicated Drug Courts." Ethnographic descriptions of how this paradox manifests in practice are provided by study of a juvenile drug court in Whiteacre, Kevin, "Strange Bedfellows: The Tension of Coerced Treatment," *Criminal Justice Policy Review* 18, no. 3 (2007): 260-273: "staff members experienced personal ambivalence over the efficacy of sanctions as a therapeutic tool, particularly when faced with some juveniles' continued noncompliance despite the sanctions. Staff neutralized this tension by attributing noncompliance to the juveniles' lack of motivation, concluding coerced treatment only works for those who are "ready" for treatment. This would appear to pose a paradox for coerced treatment, which is meant to induce compliance specifically among those who are not motivated." See also Whiteacre, "Drug Court Justice."
[20] California Society of Addiction Medicine, "Proposition 36 Revisited," http://www.csam-asam.org/prop36article.vp.html; See also Goldkamp et al., "Do Drug Courts Work?"; Hepburn, John R., and Angela Harvey, "The Effect of the Threat of Legal Sanction on Program Retention and Completion: Is That Why They Stay in Drug Court?," *Crime and Delinquency* 53, no. 2 (2007): 255-280.
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[24] Goldkamp et al., "Do Drug Courts Work?"

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[29] Hoffman, "Therapeutic Jurisprudence, Neo-Rehabilitationism, and Judicial Collectivism."
[30] Stevens, "Alternatives to What? Drug Treatment Alternatives as a Response to Prison Expansion and Overcrowding."
[31] Bhati et al., *To Treat or Not to Treat: Evidence on the Effects of Expanding Treatment to Drug-Involved Offenders*; Stevens, "Alternatives to What? Drug Treatment Alternatives as a Response to Prison Expansion and Overcrowding"; Pollack, Harold, Peter Reuter and Eric Sevigny, "If Drug Treatment Works So Well, Why Are So Many Drug Users in Prison?" http://www.nber.org/confer/2010/CRIs10/Reuter.pdf. See also Austin, James and Barry Krisberg, "The Unmet Promise of Alternatives to Incarceration," *Crime and Delinquency* 28, no. 3 (1982): 374-409.
[32] Stevens et al., "On Coercion"; National Association of Criminal Defense Lawyers, *America's Problem-Solving Courts: The Criminal Costs of Treatment and the Case for Reform.*
[33] Ibid.
[34] National Association of Criminal Defense Lawyers, *America's Problem-Solving Courts: The Criminal Costs of Treatment and the Case for Reform.*
[35] Boldt, "Rehabilitative Punishment and the Drug Treatment Court Movement"; Miller, "Embracing Addiction"; National Association of Criminal Defense Lawyers, *America's Problem-Solving Courts: The Criminal Costs of Treatment and the Case for Reform.*
[36] Belenko, "Research on Drug Courts: A Critical Review"; Belenko, *Research on Drug Courts: A Critical Review (2001 Update)*; Fischer, B., "Doing Good with a Vengeance: A Critical Assessment of the Practices, Effects and Implications of Drug Treatment Courts in North America"; United States General Accounting Office, *Drug Courts: Overview of Growth, Characteristics, and Results;* United States General Accounting Office, *Drug Courts: Better DOJ Data Collections and Evaluation Efforts Needed to Measure Impact of Drug Court Programs;* King and Pasquarella, *Drug Courts: A Review of the Evidence*; National Association of Criminal Defense Lawyers, *America's Problem-Solving Courts: The Criminal Costs of Treatment and the Case for Reform.*
[37] *See* Ettner et al., "Benefit-Cost in the California Treatment Outcome Project;" Rydell, Peter C. and Susan S. Everingham, *Controlling Cocaine: Supply Versus Demand Programs*, Santa Monica, CA: RAND, 1994; Substance Abuse and Mental Health Services Administration, *The National Treatment Improvement Evaluation Study (NTIES), Final Report,* 1997.
[38] *See, e.g.* THE PEW CENTER ON THE STATES, THE IMPACT OF HAWAII'S HOPE PROGRAM ON DRUG USE, CRIME AND RECIDIVISM (January 2010).