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EFFECTIVE STRATEGIES FOR INTERVENING WITH DRUG ABUSING OFFENDERS

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THE United States has the western world's most serious drug problem, whether expressed in (per capita) terms of addiction to illicit drugs, crime or IVDU [intravenous drug use]-related HIV [human immunodeficiency virus]. It is also the nation which, as a result both of its size and wealth, has committed more to analytical research in support of development of social policies than any other. One might expect that policy research would inform efforts to reduce America's drug problems. Instead little research has been funded and its findings largely ignored.[1]

I. INTRODUCTION

Substance involvement[2] is highly prevalent in correctional populations and drug and alcohol use is a substantial causative factor in crime

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1. Peter Reuter, *Why Does Research Have So Little Impact on American Drug Policy?*, 96 ADDICTION 373, 373 (2001) (citation omitted).

2. As used in this Article, the term "substance involvement" refers to any substantial nexus between an individual and illicit drugs or alcohol including current or past ingestion, intoxication, substance abuse treatment, possession, dealing, manufacturing or diversion of prescription medication. The term "substance use" refers to the ingestion of a psychoactive substance, including alcohol, regardless of whether the individual meets formal diagnostic criteria for a substance use disorder. In contrast to substance use, "substance abuse" is a formal diagnosis referring to the recurrent use of a psychoactive substance, including alcohol, under dangerous or inappropriate circumstances. *See* AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 182-83 (4th ed. 1994) (describing diagnostic criteria for substance abuse). Finally, the term "substance dependence" (also called "addiction") is a more severe diagnostic category involving the compulsive use of drugs or alcohol despite significant substance-related problems. *See id.* at 181 (describing diagnostic criteria for substance dependence). The terms "drug involvement," "drug use," "drug abuse" and "drug dependence" do not include

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and violence.[3] Historically, drug policy in the United States has vacillated in a pendulum-like manner between viewing drug abuse either as a *public safety* concern requiring a punitive correctional response or as a *public health* concern requiring a treatment-oriented response. Neither of these single-minded approaches has produced meaningful or consistent reductions in drug use or criminal recidivism among offenders. Public safety strategies including imprisonment, in-prison rehabilitation, civil commitment and intermediate community sanctions have generally had a small impact on recidivism and virtually no impact on drug use.[4] Similarly, public health strategies aimed at diverting substance abusing offenders into community-based treatment have generally failed to retain offenders in treatment or reduce recidivism or drug use.[5]

The only strategy that has produced meaningful or consistent reductions in criminal recidivism and drug use is an *integrated public health/public safety* strategy exemplified in such programs as drug courts[6] and work-release therapeutic communities (TCs).[7] These programs combine community-based substance abuse treatment and case management services with on-going criminal justice supervision, urinalysis monitoring, graduated sanctions for program infractions and a realistic threat of a criminal conviction, incarceration or return-to-custody if the offender does not demonstrably succeed in treatment. Importantly, substance abuse treatment assumes a central role in these programs rather than being viewed as peripheral to punitive ends and is provided in the community where offenders can maintain family and social contacts and seek or continue in gainful education or employment. Responsibility for ensuring offenders' adherence to treatment and avoidance of drug use and criminal activity is not, however, delegated to treatment personnel who may be unprepared or disinclined to deal with such matters or who may have limited power to intervene. The criminal justice system maintains substantial supervisory control over offenders and has enhanced authority to respond rapidly and consistently in response to infractions.

Recent statewide policy initiatives such as California's "Proposition 36"[8] seek to extend substance abuse treatment to a larger class of drug

alcohol, but encompass illicit drugs and the diversion or use of prescription medication in a non-prescribed manner.

3. For a discussion of the relationship between substance use and crime, see *infra* notes 9-35 and accompanying text.

4. For a review of public safety strategies for drug-abusing offenders, see *infra* notes 36-80 and accompanying text.

5. For a review of public health strategies for drug-abusing offenders, see *infra* notes 81-106 and accompanying text.

6. For a discussion of drug courts, see *infra* notes 107-19 and accompanying text.

7. For a discussion of correctional therapeutic communities, see *infra* notes 120-32 and accompanying text.

8. For a discussion of California Proposition 36, see *infra* notes 161-75 and accompanying text.

offenders *in lieu of* intensive supervision by criminal justice authorities. This public health strategy differs substantially from the integrated public health/public safety strategies that have proved successful in drug courts and work-release TC programs and signals yet another ideological shift in the political landscape concerning drug abuse and crime. Decades worth of research yields important lessons about the most effective ways to improve the lives of drug abusing offenders and lessen their negative impacts on society. Policy initiatives in this area should be guided, at least in part, by these empirical lessons of history.

II. SUBSTANCE INVOLVEMENT AND CRIME

Substance users are disproportionately represented in correctional settings.[9] Employing a broad definition of substance involvement, a recent national study concluded that *80%* of state and federal inmates were incarcerated for a drug or alcohol-related offense, were intoxicated at the time of their offense, committed the offense to support a drug habit, had a history of regular drug use or had a history of prior alcohol or drug treatment.[10] If these criteria are narrowed to require a demonstrable connection between criminal activity and substance use, two thirds (67%) of state prison inmates, one third (33%) of federal prison inmates and three quarters (76%) of state jail inmates reported being intoxicated at the time of their offense or committing the offense to support a drug habit.[11]

9. *See, e.g.*, Douglas B. Marlowe, *Coercive Treatment of Substance Abusing Criminal Offenders*, 1 J. FORENSIC PSYCHOL. PRAC. 65, 65-66 (2001) [hereinafter Marlowe, *Coercive*] (noting that substance abuse is most prevalent psychiatric disorder in forensic and correctional populations); Douglas B. Marlowe et al., *Voluntary Intoxication and Criminal Responsibility*, 17 BEHAV. SCI. & L. 195, 197-98 (1999) [hereinafter Marlowe et al., *Voluntary*] (same). Conversely, criminal involvement is disproportionately represented among clients in community-based substance abuse treatment programs. A national study found that approximately two-thirds (64%) of clients in long-term residential drug abuse treatment, over one-half (57%) of clients in outpatient drug abuse treatment and approximately one-quarter (27%) of clients in methadone maintenance treatment were currently involved with the criminal justice system. *See* S. Gail Craddock et al., *Characteristics and Pretreatment Behaviors of Clients Entering Drug Abuse Treatment: 1969 to 1993*, 23 AM. J. DRUG & ALCOHOL ABUSE 43, 51-53 (1997); *see also* Matthew L. Hiller et al., *Legal Pressure and Treatment Retention in a National Sample of Long-Term Residential Programs*, 25 CRIM. JUST. & BEHAV. 463, 470 (1998) (finding that 48% of clients in long-term residential drug treatment were under "moderate" legal pressure and 16% were under "high" legal pressure).

10. *See* STEVEN BELENKO, BEHIND BARS: SUBSTANCE ABUSE AND AMERICA'S PRISON POPULATION 2 (Nat'l Ctr. on Addiction & Substance Abuse at Colum. Univ., 1998) (analyzing data from BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, SURVEY OF STATE PRISON INMATES, 1991 (1993); BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, PROFILE OF JAIL INMATES, 1989 (1991)). Approximately 81% of state prison inmates, 80% of federal prison inmates and 77% of local jail inmates met one or more of the criteria for substance involvement. *See id.* at 2-3.

11. *See id.* at 3; *see also* BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, PROFILE OF JAIL INMATES, 1996, at 9 (1998) (finding that 60% of jail inmates reportedly were under influence of drugs or alcohol at time of offense).

Similar figures are reported for individuals under correctional supervision in the community. Approximately two thirds of probationers[12] and 80% of parolees[13] are seriously drug or alcohol involved. Moreover, in 1999, over 60% of adult arrestees and 20% to 40% of juvenile arrestees tested positive by urinalysis for illicit drugs in the large majority of U.S. booking facilities.[14]

It is tempting to attribute these staggering figures to the war on drugs,[15] which has had the effect in many jurisdictions of providing severe criminal penalties for drug possession and, perhaps indirectly, for an indi-

12. *See* BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, SUBSTANCE ABUSE AND TREATMENT OF ADULTS ON PROBATION, 1995, at 1 (1998) (finding that one-half of U.S. probationers were under influence of drugs or alcohol at time of offense and approximately two-thirds may be characterized as drug or alcohol-involved).

13. *See* BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, TRENDS IN STATE PAROLE, 1990-2000, at 8 (2001) (finding that approximately 25% of state parolees are currently alcohol dependent and 59% used drugs regularly during month prior to arrest) (analyzing data from the BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, SURVEY OF INMATES IN STATE ADULT CORRECTIONAL FACILITIES, 1997 (1998)); *see also* JEREMY TRAVIS ET AL., FROM PRISON TO HOME: THE DIMENSIONS AND CONSEQUENCES OF PRISONER REENTRY 25 (Urban Instit. ed., 2001) (reporting that 74% of inmates expected to be released within next twelve months have history of drug or alcohol use); NAT'L DRUG COURT INST., REENTRY DRUG COURTS: CLOSING THE GAP 34 (1999) (reporting that approximately 80% of adult felony offenders incarcerated or under post-incarceration community supervision have substance abuse problems and substance abuse has direct correlation with their criminality).

14. *See* ARRESTEE DRUG ABUSE MONITORING PROGRAM, NAT'L INST. JUSTICE, 1999 ANNUAL REPORT ON DRUG USE AMONG ADULT AND JUVENILE ARRESTEES 1 (2000) [hereinafter ADAM] (providing national summary of data on drug use among offenders). The National Institute of Justice administers the Arrestee Drug Abuse Monitoring Program (ADAM), formerly know as Drug Use Forecasting (DUF), in adult male booking facilities in thirty-four U.S. cities, in adult female booking facilities in thirty-two cities and in juvenile booking facilities in nine cities. *See id.* at 1, 4, 6. Consenting arrestees are administered a comprehensive structured interview and submit urine samples that are tested for the metabolites of cocaine, marijuana, methamphetamine, opiates and phencyclidine (PCP). *See id.* at 1 nn.5 & 11. Between 50% and 77% of adult male arrestees and between 22% and 81% of adult female arrestees tested positive for illicit drugs across all target sites. *See id.* at 1. Among adult male arrestees, the most common metabolites detected in urine were cannabis and cocaine, respectively, and among female adult arrestees, the most common metabolites were cocaine, cannabis and methamphetamine, respectively. *See id.* Among juvenile arrestees, the most common metabolite detected in urine was cannabis, followed distantly by cocaine and methamphetamine, respectively. *See id.* at 4.

15. In 1973, former President Richard Nixon declared an "'all-out global war on the drug menace'" focusing primarily on coordinating the federal response to interdiction efforts at the U.S. borders and substantially expanding federal funding and privacy protections for substance abuse treatment. *See, e.g.*, Drug Enforcement Administration, *History of the DEA, 1970-1975, at* http://www.usdoj.gov/dea/deamuseum/historyhome.htm. Subsequently, in the early to mid 1980's, former President Ronald Reagan declared the "War on Drugs" proper in National Security Decision Directive No. 221. Federal laws enacted pursuant to this formal war on drugs substantially increased prison penalties and established mandatory minimum sentences for various drug offenses, including some drug possession offenses. *See, e.g.*, Drug Enforcement Administration, *History of the DEA, 1985-1990*

vidual's status as a drug user.[16] Indeed, the lion's share of the growth in the U.S. inmate population, which has increased roughly three-fold since the early 1980s,[17] is attributable to drug law violators.[18] Drug violations similarly accounted for more than half (52%) of the roughly two-fold increase in parole revocations and return-to-custody rates over the past decade.[19]

These data have been used to argue that decriminalizing drug possession would go far in reducing the overall size of the U.S. correctional population. Decriminalization would do little, however, to attenuate the relationship between drug use and other forms of criminal activity. Drug users commit a disproportionate amount of *all* types of crime, not just drug possession offenses. Removing drug possession from consideration, drug use remains closely linked with virtually all other categories of crime,[20] includ-

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(referring to Anti-Drug Abuse Act of 1988 as example), *at* http://www.usdoj.gov/dea/deamuseum/historyhome.htm (last visited Apr. 9, 2002).

16. A prominent example of state laws enacted at the time of former President Nixon's "War on Drugs" initiative was the "Rockefeller Laws" enacted in New York State in 1973. The Rockefeller Laws provide harsh penalties, including mandatory minimum prison sentences, for the possession or sale of various scheduled drugs of abuse. *See* N.Y. PENAL LAW §§ 220.00 *et seq.* (McKinney 2000). The Rockefeller Laws have been severely criticized as being harsh and draconian. *See, e.g.*, Morris B. Hoffman, *The Drug Court Scandal*, 78 N.C. L. REV. 1437, 1460 n.97 (2000); Spiros A. Tsimbinos, *Is It Time to Change the Rockefeller Drug Laws?*, 13 ST. JOHN'S J. LEGAL COMMENT. 613, 628-29 (1999). Efforts are currently underway in New York State to repeal or modify some of the harsher provisions of the Rockefeller Laws. *See* Assem. 2823, Reg. Sess. (N.Y. 2001-2002) (amending penal law relating to authorized sentences and lifetime probation), *available at* http://leginfo.state.ny.us (last visited Apr. 9, 2002); S. 840, Reg. Sess. (N.Y. 2001-2002) (same).

17. *See* BELENKO, *supra* note 10, at 5 (noting that overall U.S. inmate population increased 239%—229% for males and 439% for females—between 1980 and 1996).

18. *See id.* at 6 (outlining impact on prison populations). From 1980 to 1995, drug law violators accounted for 30% of the increase in the U.S. state prison population, rising from 6% to 23% of state prison inmates, and accounted for 68% of the increase in the federal prison population, rising from 25% to 60% of federal inmates. *See id.* at 6-7; *see also* BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, PRISONERS IN 1999, at 10 (2000) [hereinafter PRISONERS IN 1999] (noting that drug offenders accounted for largest proportion of increase in inmates since 1990—36% of increase of female inmates and 18% of increase of male inmates).

19. *See* PRISONERS IN 1999, *supra* note 18, at 11 (analyzing number of sentenced inmates admitted to state prison by offense).

20. *See, e.g.*, David N. Nurco et al., *The Drugs-Crime Connection*, *in* HANDBOOK OF DRUG CONTROL IN THE UNITED STATES 71, 79 (James A. Inciardi ed., 1990) (stating uniform finding that frequency of narcotics use is associated with higher crime rates). Longitudinal studies following the "addiction careers" of narcotics addicts generally reveal persistent involvement in criminal activity over many years, in some studies averaging between 230 and 330 crime days per year. *See id.* at 76. These rates decline precipitously, by up to 75%, during periods of demonstrable abstinence from narcotics. *See id.* Apart from simple drug possession, characteristic criminal acts include, in order of prevalence, drug sales, robberies and assaults, burglaries, car theft, shoplifting, larceny and fraud. *See id.* at 79.

ing violent crimes,[21] domestic violence crimes,[22] theft and property crimes,[23] prostitution,[24] and drug dealing or manufacturing.[25] This relationship exists irrespective of whether subjects have been identified by the criminal justice system. In a nationally representative sample of U.S. citizens,[26] severity of drug use was found to be directly and substantially re-

21. *See Numerous Factors Implicated in Drug-Related Violence,* NIDA NOTES (NIDA, Wash., D.C.), Nov./Dec. 1993, at 1) (estimating that approximately one-half of violent incidents in United States are drug-related); *see also* Jan M. Chaiken & Marcia R. Chaiken, *Drugs and Predatory Crime, in* DRUGS AND CRIME 212-13 (Michael Tonry & James Q. Wilson eds., 1990) (stating that high frequency drug users were likely to be high-rate predators and to commit many types of crimes, including violent offenses). ADAM data are disaggregated by jurisdiction in terms of specific offense categories. In Philadelphia, over half (51% of males and 54% of females) of arrestees for violent crimes tested positive for illicit drugs at booking during 1999. *See* ADAM, *supra* note 14, at 64. Nationally, 21% of state prison inmates self-reported being under the influence of alcohol at the time of a violent offense, 12% reported being under the influence of illicit drugs at the time of a violent offense and 16% reported being under the influence of both drugs and alcohol at the time of a violent offense. *See* BELENKO, *supra* note 10, at 9. Among jail inmates, 26% reported being under the influence of alcohol at the time of a violent offense, 10% reported being under the influence of illicit drugs and 15% reported being under the influence of both drugs and alcohol. *See id.* Among federal prison inmates, 11% reported being under the influence of alcohol at the time of a violent offense, 16% reported being under the influence of illicit drugs and 6% reported being under the influence of both drugs and alcohol. *See id.*

22. Substance use is implicated in 80% of substantiated child abuse and neglect cases. *See* Lenette Azzi-Lessing & Lenore J. Olsen, *Substance Abuse—Affected Families in the Child Welfare System: New Challenges, New Alliances,* 41 SOC. WORK 15, 15 (1996) (citing CHILD WELFARE LEAGUE OF AMERICA, CRACK AND OTHER ADDICTIONS: OLD REALITIES AND NEW CHALLENGES (1990)) (reporting that unprecedented number of single-parent families entered child welfare system because mother had identified substance use problem). Substance use is also implicated in one-half of domestic violence incidents. *See* CENTER FOR SUBSTANCE ABUSE TREATMENT, SUBSTANCE ABUSE AND MENTAL HEALTH SERVICES ADMINISTRATION, LINKING SUBSTANCE ABUSE TREATMENT AND DOMESTIC VIOLENCE SERVICES: A GUIDE FOR TREATMENT PROVIDERS 1-2 (2000) (reporting that one-quarter to one-half of men who commit domestic violence have substance abuse problems, 50% of spousal batterers have addiction problems and over one-half of spousal murderers were drinking alcohol at time of murder).

23. In Philadelphia, for example, 71% of male arrestees and 53% of female arrestees for property and theft offenses tested positive for illicit drugs at booking during 1999. *See* ADAM, *supra* note 14, at 64.

24. *See* Dana E. Hunt, *Drugs and Consensual Crimes: Drug Dealing and Prostitution, in* DRUGS AND CRIME, *supra* note 21, at 193 (finding that approximately 50% of prostitutes reported engaging in intravenous drug use and 72% reported frequent use of "crack" cocaine). In Philadelphia, during 1999, two-thirds of males (67%) and virtually all females (99%) arrested for prostitution tested positive for illicit drugs at booking. *See* ADAM, *supra* note 14, at 64.

25. *See* Hunt, *supra* note 24, at 166 (reporting that ethnographic research reveals that drug dealing is pervasive and enduring in drug world). "At some time in their drug careers, persons at almost all levels of drug use distribute drugs; that is, sell or share them." *Id.*

26. The National Household Survey on Drug Abuse administers structured interviews and self-report questionnaires to a nationally representative sample of U.S. citizens at their place of residence. *See* OFFICE OF APPLIED STUDIES, SUBSTANCE

lated to the likelihood of engagement in both predatory (violent) crimes and property crimes.[27]

These correlations do not, of course, prove causality. It is possible that substance involvement and crime are, themselves, influenced by a common predisposing factor[28] such as deviance,[29] psychiatric illness[30] or

ABUSE AND MENTAL HEALTH SERV. ADMIN., SUMMARY OF FINDINGS FROM THE 1998 NATIONAL HOUSEHOLD SURVEY ON DRUG ABUSE 5 (1999). It employs probability sampling to statistically represent the drug use patterns of residents of U.S. households, non-institutional group quarters and civilians living on military bases. *See id.*

27. *See* Michael T. French et al., *Chronic Drug Use and Crime*, 21 SUBSTANCE ABUSE 95, 105 (2000) (analyzing data from the 1993 and 1995 National Household Surveys on Drug Abuse). Weekly drug use was associated with a 10% to 30% increase in the probability of committing a violent crime or property offense. *See id.*

28. *See, e.g.*, Marlowe et al., *Voluntary*, *supra* note 9, at 207 (stating that link between substance use and crime might be moderated by another independent variable such as socioeconomic status or antisociality); George Speckart & M. Douglas Anglin, *Narcotics and Crime: A Causal Modeling Approach*, 2 J. QUANTITATIVE CRIMINOLOGY 3, 4 (1986) (stating that narcotics use and crime may be spuriously related as consequence of common predisposing factors such as socio-cultural or personality determinants).

29. *See, e.g.*, Blair Carlson, *Addiction and Treatment in the Criminal Justice System*, *in* PRINCIPLES OF ADDICTION MEDICINE 406 (Allan W. Graham & Terry K. Schultz eds., 2d ed. 1998) (concluding that deviant environment likely responsible for both drug abuse and criminal behavior where these behaviors coexist); HOWARD B. KAPLAN, PREFACE TO DRUGS, CRIME, AND OTHER DEVIANT ADAPTATIONS: LONGITUDINAL STUDIES ix (Howard B. Kaplan ed., 1995) (noting that trend in contemporary research is recognition of association among various forms of deviance such as violence, drug abuse and theft); LEE N. ROBINS & MICHAEL RUTTER, STRAIGHT AND DEVIOUS PATHWAYS FROM CHILDHOOD TO ADULTHOOD xiii (1990) (finding that crime and substance abuse in adulthood is clearly predicted by deviant antisocial or non-cooperative behavior in childhood); Nagalakshmi D. Kasarabada et al., *Cocaine, Crime, Family History of Deviance—Are Psychosocial Correlates Related to These Phenomena in Male Cocaine Abusers?*, 21 SUBSTANCE ABUSE 67, 67 (2000) (finding that cocaine use, aggression, sensation-seeking behavior and criminal arrests are part of common statistical factors).

30. There is a substantial co-occurrence between substance abuse or dependence and various psychiatric disorders. *See* David R. Gastfriend & Patrick Lillard, *Anxiety Disorders*, *in* PRINCIPLES OF ADDICTION MED., *supra* note 29, at 993 (concluding that co-occurrence of substance use disorders in individuals with anxiety disorders is approximately 50% higher than in general population); Bridget F. Grant & Thomas C. Harford, *Comorbidity Between DSM-IV Alcohol Use Disorders and Major Depression: Results of a National Survey*, 39 DRUG & ALCOHOL DEPENDENCE 197, 197 (1995) (finding that co-occurrence of alcohol use disorders and major depression is pervasive in general population); Denise B. Kandel et al., *Comorbidity Between Patterns of Substance Use Dependence and Psychiatric Syndromes*, 64 DRUG & ALCOHOL DEPENDENCE 233, 233 (2001) (finding that in nationally representative sample of U.S. citizens, drug dependent individuals have higher rates of psychiatric syndromes); Nong Lin et al., *The Influence of Familial and Non-Familial Factors on the Association Between Major Depression and Substance Abuse/Dependence in 1874 Monozygotic Male Twin Pairs*, 43 DRUG & ALCOHOL DEPENDENCE 49, 49 (1996) (concluding that co-occurrence of substance abuse or dependence and major depression is pervasive in general population); Douglas B. Marlowe et al., *Psychiatric Comorbidity in Cocaine Dependence: Diverging Trends, Axis II Spectrum, and Gender Differentials*, 4 AMER. J. ADDICTIONS 70, 71-73 (1995) (reviewing rates of psychiatric co-

poverty.[31] Yet, regardless of the root cause of the problems, it is clear that continued involvement with drugs or alcohol substantially increases the likelihood of further involvement in other forms of crime and violence.[32] More importantly, reducing drug or alcohol use substantially decreases the risk of future crime or violence.[33]

The White House Office of National Drug Control Policy (ONDCP) conceptualizes this relationship between drugs and crime as being cyclical in nature and has made "breaking the cycle" of drugs and crime its second-most urgent national priority.[34] From the perspective of demand reduction (namely, treatment and prevention), efforts have generally been multi-pronged, involving expansion of pre-trial diversion programs, intensive supervised probation and parole programs, drug courts, and in-prison

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morbidity in alcohol dependence, opiate dependence and cocaine dependence in treatment settings).

31. *See, e.g.*, BELENKO, *supra* note 10, at 95 (reporting that 40% of state prison inmates who are regular drug users are below the poverty level compared to only 12% of adult U.S. citizens).

32. *See, e.g.*, Chaiken & Chaiken, *supra* note 21, at 219-20 (concluding that in "self-reinforcing relationship," predatory crime increases probability of serious drug use which, in turn, enhances continuation and seriousness of predatory crime); Michael D. Newcomb et al., *The Drug-Crime Nexus in a Community Sample of Adults*, 15 PSYCHOL. ADDICTIVE BEHAV. 185, 189 (2001) (finding that in longitudinal study of large community sample of adult citizens, drug problems generally predated and predicted subsequent involvement in offenses against persons, theft and property damage).

33. *See, e.g.*, Adele Harrell & John Roman, *Reducing Drug Use and Crime Among Offenders: The Impact of Graduated Sanctions*, 31 J. DRUG ISSUES 207, 207-08 (2001) (noting that during periods of active narcotic use, addicts commit crimes four to six times more often than when not using drugs and criminal activity declines in direct proportion to decrease in drug use); Nurco et al., *supra* note 20, at 76 (reporting 40% to 75% reduction in crime-days for narcotic addicts during periods of abstinence). There is consistent evidence from clinical and laboratory studies that drug or alcohol use can precipitate subsequent violent or aggressive behavior. *See* Jeffrey Fagan, *Intoxication and Aggression*, *in* DRUGS AND CRIME, *supra* note 21, at 241, 248-70 (reviewing "pervasive evidence" of association between intoxication and aggression and noting that this association may be substance-specific and moderated by cognitive and emotional states); Terry J. Allen et al., *Subjects with a History of Drug Dependence Are More Aggressive than Subjects with No Drug Use History*, 46 DRUG & ALCOHOL DEPENDENCE 95, 100 (1997) (finding that subjects with history of drug dependence emitted more aggressive responses in laboratory paradigm); Charles M. Cychosz, *Alcohol and Interpersonal Violence: Implications for Educators*, 27 J. HEALTH EDUC. 73, 75 (1996) (noting that alcohol use may increase aggression by disrupting serotonin neurotransmitter system, disinhibiting impulses, restricting perception and inferential cognitive processes, and permitting disavowal of personal responsibility while under the influence); Marlowe et al., *Voluntary*, *supra* note 9, at 207-08 (reviewing characteristic effects of alcohol and other drugs and their likelihood of precipitating violent or criminal conduct).

34. *See* OFFICE OF NAT'L DRUG CONTROL POL'Y, NAT'L DRUG CONTROL STRATEGY: 2001 ANNUAL REPORT 6, 75-82 (2001) [hereinafter ONDCP 2001 REPORT] (listing five primary goals of ONDCP and outlining accomplishments towards second goal of breaking the cycle of drugs and crime).

treatment programs.[35] What has been lacking, however, is an empirically supported framework for structuring the programs and the content of the interventions. What, if anything, does history teach us about the best ways to intervene with drug-abusing offenders?

III. A BRIEF HISTORY OF "SOBERING" EFFORTS

Drug policy in this country can be analogized to the physical action of a pendulum, in which drug abuse has been alternatively viewed as being a *public safety* concern requiring a punitive correctional response or a *public health* concern requiring a treatment-oriented response. Both of these single-minded approaches have, for the most part, failed to rehabilitate drug-abusing offenders or reduce criminal recidivism. The only approach that has produced consistent or meaningful gains has been an *integrated public health/public safety* strategy that combines community-based substance abuse treatment with on-going criminal justice supervision and immediate and consistent consequences for clients' performance in treatment. In this next section, I will briefly review the unitary public safety and public health strategies that have produced disappointing results.

A. *Prison*

What if we put drug abusers in prison? Drug abuse is, after all, illegal and drug abusers commit a disproportionate amount of crime and violence.[36] Should not these individuals be confined, therefore, to protect the public? Moreover, would not we expect them to reduce or eliminate their drug use if imprisonment was a likely result of using drugs?

Regardless of what value incarceration may have for incapacitating serious offenders, it provides little benefit in terms of rehabilitating offenders or reducing recidivism. In the absence of additional treatment interventions, slightly more than one-half (55%) of all offenders, on average, recidivate within three years of their release from incarceration.[37] Substantially higher rates of recidivism are reported for drug-abusing of-

35. *See id.* (emphasizing dual goals of decreasing addiction and reducing crime/incarceration through "education, job training and social skills instruction").

36. For a discussion of the relationship between substance use and crime, see *supra* notes 9-35 and accompanying text.

37. *See* Donald A. Andrews et al., *Does Correctional Treatment Work? A Clinically Relevant and Psychologically Informed Meta-Analysis*, 28 CRIMINOLOGY 369, 400-04 (1990) (reporting recidivism rates for untreated control group subjects in 154 correctional treatment studies); *see also* Paul Gendreau et al., *Treatment Programs in Corrections*, *in* CORRECTIONS IN CANADA: SOCIAL REACTIONS TO CRIME 246 (J. Winterdyk ed., 2001) (reporting that large-scale reviews of correctional studies reveal that, on average, 50% to 55% of untreated offenders in control groups recidivate) (citing generally Mark W. Lipsey, *Juvenile Delinquency Treatment: A Meta-Analytic Inquiry into the Variability of Effects*, *in* META-ANALYSIS FOR EXPLORATION (T.D. Cook et al. eds., 1992); Friedrich Lösel, *The Efficacy of Correctional Treatment: A Review and Synthesis of Meta-Evaluations*, *in* WHAT WORKS: REDUCING RE-OFFENDING (J. McGuire ed., 1995); Robert Martinson, *What Works?—Questions and Answers*

fenders. Approximately one-half of drug abusers recidivate within eighteen months of release from prison and roughly 70% recidivate within three years of release.[38] The data are even more discouraging concerning drug use. Approximately 85% of drug-abusing offenders return to drug use within one year after release from prison and approximately 95% return to drug use within three years.[39] Clearly, imprisonment does little to alter the trajectory of drug use or criminal recidivism.

B. *Treatment in Prison*

What if we provide drug-abusing offenders with substance abuse treatment while they are in prison? This should protect the public while also meeting the rehabilitative needs of these individuals.

The research evidence suggests that in-prison rehabilitation programs generally have a small impact on criminal recidivism and appear to have little or no impact on relapse to drug use. Reviews of hundreds of studies of in-prison rehabilitation programs reveal a small, but statistically reliable, effect of approximately a ten percentage-point reduction in recidivism, on average reducing recidivism from 55% to 45%.[40] Some "exemplary" pro-

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About Prison Reform, 35 PUB. INT. 22 (1974); Ted Palmer, *Martinson Revisited*, 12 J. RES. CRIME & DELINQ. 133 (1975)).

38. *See* Kevin Knight et al., *Three-Year Reincarceration Outcomes for In-Prison Therapeutic Community Treatment in Texas*, 79 PRISON J. 337, 344 (1999) (finding that 42% of untreated drug-abusing offenders returned to custody within three years following release from prison); Steven S. Martin et al., *Three-Year Outcomes of Therapeutic Community Treatment for Drug-Involved Offenders in Delaware: From Prison to Work Release to Aftercare*, 79 PRISON J. 294, 307, 310 (1999) (finding that 54% of untreated drug-abusing offenders rearrested within one year following release from prison and 70% rearrested within three years); Harry K. Wexler et al., *Three-Year Reincarceration Outcomes for Amity In-Prison Therapeutic Community and Aftercare in California*, 79 PRISON J. 321, 322, 330 (1999) (finding that 50% of untreated drug-abusing offenders returned to custody within one year following release from prison, 67% returned to custody within two years following release and 75% returned to custody within three years); *see also* PRISONERS IN 1999, *supra* note 18, at 11 (noting that drug offenders accounted for more than half of total increase in parole violators returned to state prison from 1990 to 1999); DRUG COURTS PROGRAM OFFICE, U.S. DEP'T OF JUSTICE, LOOKING AT A DECADE OF DRUG COURTS 4 (1998) (noting that at least 45% of defendants convicted of drug possession recidivate with similar offense within two to three years).

39. *See* Martin et al., *supra* note 38, at 305, 310 (finding that 84% of untreated drug-abusing offenders returned to drug use within one year following release from prison and 94% returned to drug use within three years).

40. *See* Paul Gendreau, *The Principles of Effective Intervention with Offenders*, *in* CHOOSING CORRECTIONAL OPTIONS THAT WORK: DEFINING THE DEMAND AND EVALUATING THE SUPPLY 117-18 (Alan T. Harland ed., 1996) (charting in-prison rehabilitation programs' effect on recidivism); Gendreau et al., *supra* note 37, at 246 (concluding that in hundreds of correctional rehabilitation studies, average recidivism rates for treatment groups and untreated control groups were 45% and 55%, respectively) (citing generally Mark W. Lipsey, *Juvenile Delinquency Treatment: A Meta-Analytic Inquiry into the Variability of Effects*, *in* META-ANALYSIS FOR EXPLANATION, *supra* note 37); Clive R. Hollin, *Treatment Programs for Offenders: Meta-Analysis, "What Works," and Beyond*, 22 INT'L J. LAW & PSYCHIATRY 361, 363 (1999) (concluding that

grams have been reported to reduce recidivism by up to twenty-five to thirty percentage points.[41] These exemplary programs employ professionally trained staff, serve higher-risk offenders, provide structured behavioral or cognitive-behavioral treatments and focus on the specific attributes of offenders that bear directly on their risk for recidivism, such as antisocial attitudes, impulsivity, sensation-seeking behaviors and negative peer group associations.[42] Unfortunately, very few correctional programs (10% to 20% of programs) come close to satisfying these criteria for being "exemplary."[43] Worse, less than 25% of substance-involved inmates receive *any* in-prison drug or alcohol treatment at all.[44]

In-prison programs targeted specifically to drug-abusing offenders similarly yield discouraging effects on recidivism. A recent analysis of over 1,600 program evaluations conducted between 1968 and 1996 found *no* appreciable effect of drug-focused group counseling interventions or boot

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overall effect of correctional programs taken to be in region of 10% reduction in offending) (citing generally Mark. W. Lipsey, *Juvenile Delinquency Treatment: A Meta-Analytic Inquiry into the Variability of Effects, in* META-ANALYSIS FOR EXPLANATION: A CASEBOOK (T.D. Cook et al. eds., 1992); Lösel, *supra* note 37).

41. *See* Gendreau et al., *supra* note 37, at 249 (reporting that programs that provide "appropriate" interventions reduce recidivism by 25% to 30%) (citing Andrews et al., *supra* note 37; Donald A. Andrews et al., *Clinically Relevant and Psychologically Informed Approaches to Reducing Re-Offending: A Meta-Analytic Study of Human Service, Risk, Need, Responsivity, and Other Concerns in Justice Contexts* (unpublished manuscript, 1999)); Hollin, *supra* note 40, at 363 (noting that exemplary programs can decrease recidivism in excess of 20%).

42. *See, e.g.*, Gendreau, *supra* note 40, at 119-29 (detailing effective components of exemplary correctional treatment programs); Gendreau et al., *supra* note 37, at 243-44, 247-48 (same); Hollin, *supra* note 40, at 363 (same). Targeting symptoms of anxiety, depression or low self-esteem among offenders has been shown to have *no* effect on recidivism or to slightly *increase* rates of recidivism. *See, e.g.*, Gendreau et al., *supra* note 37, at 247.

43. *See* Gendreau et al., *supra* note 37, at 252 (reporting that as few as 10% to 20% of correctional programs adhere to guidelines for effective treatment) (citing generally Paul Gendreau & Claire Goggin, *Correctional Treatment: Accomplishments and Realities, in* CORRECTIONAL COUNSELING AND REHABILITATION (P. Van Voorhis et al. eds., 1997)). "In short, there has been a dearth of therapeutic integrity in too many correctional programs." *Id.* at 252-53.

44. *See* BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, CORRECTIONAL POPULATIONS IN THE UNITED STATES, 1997, at 72 (2000) (finding that less than 25% of drug-using state and federal inmates participated in drug treatment during 1997). "In state and federal prisons, the gap between available substance abuse treatment—and inmate participation—and the need for such treatment and participation is enormous and widening." BELENKO, *supra* note 10, at 10 (noting that only 13% of state prison inmates, 10% of federal prison inmates and 8% of state jail inmates received substance abuse treatment during 1996) (analyzing data from BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, DRUG ENFORCEMENT AND TREATMENT IN PRISONS, 1990 (1992); G.M. CAMP ET AL., THE CORRECTIONS YEARBOOK, 1996 (Crim. Justice Instit. ed., 1996); U.S. GENERAL ACCOUNTING OFFICE, DRUG AND ALCOHOL ABUSE: BILLIONS SPENT ANNUALLY FOR TREATMENT AND PREVENTION ACTIVITIES: REPORT TO CONGRESSIONAL REQUESTERS (1996)).

camps on re-arrest rates or re-incarceration rates among drug abusers.[45] In-prison TCs[46] were found to have a small impact on recidivism (equivalent to approximately ten to fifteen percentage points), with the magnitude of the effect varying considerably by the quality of the program.[47] Results were potentially promising for in-prison methadone maintenance (for opiate-dependent individuals),[48] twelve-step programs such as Narcotics Anonymous or Alcohol Anonymous[49] and cognitive-be-

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45. *See* Frank S. Pearson & Douglas S. Lipton, *A Meta-Analytic Review of the Effectiveness of Corrections-Based Treatments for Drug Abuse*, 79 PRISON J. 384, 388-98 (1999) (reporting that meta-analysis of U.S. treatment programs targeted at reducing recidivism among drug-involved offenders revealed no effects of drug-focused group counseling or boot camps; "meta-analysis" combines data from many studies to increase statistical odds of detecting outcome effects); *see also* Douglas B. Marlowe et al., *Day Treatment for Cocaine Dependence: Incremental Utility Over Outpatient Counseling and Voucher Incentives*, 27 ADDICTIVE BEHAV. (forthcoming 2002) (manuscript at 9-10, on file with author) (finding that drug-focused group counseling provided no independent or incremental utility for initiating cocaine abstinence among urban, poor clients in outpatient treatment).

46. For a further discussion of correctional therapeutic communities, see *infra* notes 120-32 and accompanying text.

47. *See* Pearson & Lipton, *supra* note 45, at 397-98 ("[T]he effect sizes show a very slight positive linear relationship with the quality of research methods used."). In some of the studies, subjects may have received aftercare services following release from prison, which might account for the positive findings. Research suggests that in-prison TC treatment without aftercare generally has no effect on recidivism or drug use. For a further discussion of in-prison TC studies, see *infra* notes 123-27 and accompanying text.

48. *See id.* at 401-02 ("[B]ased on the eight studies of methadone maintenance that we were able to locate, we found that methadone maintenance has indeed been shown to be effective in reducing recidivism). Methadone is a long-acting opiate that can be taken orally which blocks the effects of heroin and other illicit opiates but does not have the same euphoric effects. *See* JEROME J. PLATT, HEROIN ADDICTION: THEORY, RESEARCH AND TREATMENT 64-65 (2d ed., 1986) [hereinafter PLATT, HEROIN]. Thirty years of research consistently demonstrates that, when properly administered, methadone maintenance treatment substantially increases treatment retention and reduces illicit opiate use, criminal activity, unemployment and health-risk behaviors (i.e., unprotected sex and syringe sharing) among opiate addicts. *See* Jerome J. Platt et al., *Methadone Maintenance Treatment: Its Development and Effectiveness After 30 Years*, *in* HEROIN IN THE AGE OF CRACK-COCAINE 160, 161-62, 172-77 (James A. Inciardi & Lana D. Harrison eds., 1998) [hereinafter Platt, *Methadone*].

49. Twelve step programs are self-help support groups that focus on the goal of abstinence rather than controlled or reduced substance use. *See, e.g.*, Douglas B. Marlowe, *Alcoholism: Symptoms, Causes & Treatments*, *in* STRESS MANAGEMENT FOR LAWYERS 111-12 (Amiram Elwork ed., 2d ed. 1997). Participants receive group support, repeated reminders about the consequences of alcohol and drug use and straightforward advice about maintaining abstinence. *See id.* Emphasis is placed on completion of successive "steps" towards recovery including acknowledgement of a problem, frank self-awareness and contrition to others. *See id.* Research on twelve step programs is still in its infancy; however, there is evidence that long-term involvement in twelve step groups is associated with reduced alcohol and drug use and improved psychological functioning among substance abusers. *See* Barbara S. McCrady, *Recent Research in Twelve Step Programs*, *in* PRINCIPLES OF ADDICTION MEDICINE, *supra* note 29, at 707, 716.

havioral programs.[50] There were, however, too few scientifically sound studies of these interventions to reach any definitive conclusions.[51]

In-prison treatment, by itself, also appears to have little effect on reducing drug use. In one long-term study, parolees who attended in-prison substance abuse treatment without follow-up aftercare in the community relapsed to drug use at the same rate as parolees who received no in-prison substance abuse treatment at all.[52] In sum, therefore, with a small impact on recidivism and at best a slight impact on drug use, it reliably can be concluded that imprisonment coupled with substance abuse treatment is not an efficient means for rehabilitating drug-abusing offenders.

C. *Civil Commitment*

What if we civilly commit drug-abusing offenders to long-term residential substance abuse treatment in isolated settings? This should protect the public by confining and segregating these individuals while also increasing offenders' exposure to treatment and decreasing the costs of prison.

Civil commitment schemes were implemented in this country during the 1930s and again during the 1960s, with largely discouraging results.[53] The Public Health Service established federal "narcotics farms" in 1935 in Lexington, Kentucky, and in 1938 in Fort Worth, Texas.[54] These were rural, secure residential facilities where narcotic (mostly opiate) addicts were voluntarily treated, or involuntarily committed following a federal conviction, for up to a year of residential substance abuse treatment fol-

50. *See, e.g.*, AARON T. BECK ET AL., COGNITIVE THERAPY OF SUBSTANCE ABUSE 25 (1993) (noting that cognitive-behavioral therapy focuses on correcting clients' irrational or dysfunctional beliefs concerning drug or alcohol use such as "I can't be happy unless I can use drugs").

51. *See* Pearson & Lipton, *supra* note 45, at 401-05 (noting "the quality of the research is uniformly poor").

52. *See* Martin et al., *supra* note 38, at 306-07, 309-10 (finding no difference in drug use one year following release from prison between parolees who attended in-prison treatment only and those who received no treatment; small effect on drug use after three years). When, however, in-prison treatment is combined with subsequent aftercare treatment while parolees are on work release, the effects of the work release program may be enhanced. For a further discussion of in-prison and work-release treatment studies, see *infra* notes 123-27 and accompanying text.

53. For reviews of civil commitment programs for drug abusers, see generally M. Douglas Anglin, *The Efficacy of Civil Commitment in Treating Narcotic Addiction*, *in* COMPULSORY TREATMENT OF DRUG ABUSE: RESEARCH AND CLINICAL PRACTICE (Carl G. Leukefeld & Frank M. Tims eds., 1988); M. Douglas Anglin & Yih-Ing Hser, *Legal Coercion and Drug Abuse Treatment: Research Findings and Social Policy Implications*, *in* HANDBOOK OF DRUG CONTROL IN THE UNITED STATES, *supra* note 20, at 151, 152-62; PLATT, HEROIN, *supra* note 48, at 245-49; Douglas B. Marlowe et al., *Efficacy of Coercion in Substance Abuse Treatment*, *in* RELAPSE AND RECOVERY IN ADDICTIONS 208, 209-10 (Frank M. Tims et al. eds., 2001) [hereinafter Marlowe et al., *Efficacy*]; SALLY L. SATEL, DRUG TREATMENT: THE CASE FOR COERCION 5-6, 12-14 (Am. Enterprise Inst., Stud. in Soc. Welfare Pol'y Series, 1999).

54. *See* Platt, *Methadone*, *supra* note 48, at 245-46 (discussing drug use studies conducted at Fort Worth and Lexington sites).

lowed by long-term community-based aftercare, under parole supervision where appropriate.[55] Approximately 70% of the voluntary patients signed themselves out of treatment prematurely[56] and 90% of all patients relapsed to drug use within one to two years.[57] Although the outcomes were very poor in the aggregate, the data did suggest that patients who were under a legal mandate to remain in treatment tended to stay in treatment longer and to have significantly better outcomes.[58]

Formal civil commitment programs were implemented in the 1960s in New York and California as well as in the federal system pursuant to the Narcotic Addict Rehabilitation Act (NARA).[59] The New York program was a major failure,[60] with clients signing out or absconding from treatment in droves[61] and with large numbers of clients being re-arrested within a relatively brief period of time.[62] The primary problem with the New York program was that it was essentially voluntary in nature and there was a lack of adverse consequences if clients dropped out of the program.[63] Moreover, the costs of maintaining the residential facilities were viewed as prohibitive

55. *See id.*

56. *See* SATEL, *supra* note 53, at 5-6 (reporting that 70% of voluntary patients signed out against medical advice before completing treatment); PLATT, HEROIN, *supra* note 48, at 246 (reporting that more than half of voluntary admissions unwilling to stay in treatment for one month and only one fifth continued treatment for recommended time to be considered cured) (citing generally J. C. Ball et al., *Readmission Rates at Lexington Hospital for 43,215 Narcotic Drug Addicts*, 85 PUB. HEALTH REP. 610 (1970)).

57. *See* PLATT, HEROIN, *supra* note 48, at 246-47 (reporting that 45% of patients in narcotics farms used opiates within first month of release and 86% relapsed to opiates within six months of release); SATEL, *supra* note 53, at 6 (reporting that 90% relapsed within a few years).

58. *See, e.g.*, SATEL, *supra* note 53, at 6 (noting that addicts under continuing legal supervision following residential treatment in narcotics farms had better outcomes).

59. *See* PLATT, HEROIN, *supra* note 48, at 247-49 (discussing California Civil Commitment Program).

60. *See* James A. Inciardi, *Some Considerations on the Clinical Efficacy of Compulsory Treatment: Reviewing the New York Experience*, *in* COMPULSORY TREATMENT OF DRUG ABUSE, *supra* note 53, at 135, 135 (noting "overwhelming failure" of New York civil commitment program); Anglin, *supra* note 53, at 25 (stating that "general consensus of several authors is that New York [civil commitment] program was pretty much a failure").

61. *See* Anglin & Hser, *supra* note 53, at 158 (noting that many eligible addicts preferred shorter prison sentences to long period of supervision in New York civil commitment program).

62. *See id.* at 158-59 (noting that studies reported high rate of re-arrest and absconding; almost half of subjects reported engaging in criminal activity within first year and additional 26% reported engaging in criminal activity within three years).

63. *See id.* at 158 (stating that program's chief flaw thought to be its essentially voluntary nature); SATEL, *supra* note 53, at 14 (noting that supervision was loose and high proportion of patients went AWOL); Marlowe et al., *Efficacy*, *supra* note 53, at 210 (stating that because there was no provision for mandatory aftercare, few clients completed program).

by policymakers, and the program therefore was effectively abolished.[64] The federal NARA commitment program was similarly a failure due to an unwieldy administrative procedure in which clients' movement in and out of the program as well as through all phases of treatment required new court hearings.[65] The burden and time delays associated with holding multiple court hearings reduced the program's ability to provide meaningful consequences for clients dropping out of treatment and also greatly increased the costs of the program.

In contrast, the California Civil Addict Program (CAP) has been described as a relatively more successful civil commitment scheme. In the CAP program, narcotic addicts were diverted from the criminal justice system to a *seven-year* intervention, which included a substantial period of residential treatment at a minimum security facility[66] followed by a community aftercare component with intensive parole supervision.[67] The CAP program reduced the criminal activity of offenders by approximately twelve percentage points,[68] similar to what is commonly obtained from in-prison rehabilitation programs, and also reduced daily narcotics use by approximately fifteen percentage points.[69] Due in part, however, to the high cost of maintaining the program, CAP was substantially decreased in scope and size by the late 1970s and has since been abandoned.[70]

In sum, civil commitment to residential treatment facilities may be too prohibitively expensive to implement effectively. To have a meaningful impact, these programs required a year or more of secure residential treatment followed by long-term intensive probation or parole, with a realistic threat of re-incarceration for absconding from the program or for serious instances of relapse.[71] As such, the programs were viewed as untenable by policymakers and were abandoned. These programs did establish, however, that legally mandated substance abuse treatment *could* be

64. *See* Anglin & Hser, *supra* note 53, at 159 ("The residential treatment centers were thought to be too expensive and not effective enough in the fight against drug addiction.").

65. *See id.* at 159-61 (stating that because of these problems, NARA was underutilized and never served large number of addicts for which it was designed).

66. *See, e.g.*, SATEL, *supra* note 53, at 12 (noting that CAP protocol included eighteen to twenty-four months of residential treatment provided by specifically recruited and specially trained corrections staff).

67. *See id.* (noting that residential treatment in CAP was followed by up to five years of close supervision by specially trained parole officers with small caseloads who monitored patients closely and administered weekly urine toxicology tests).

68. *See* Anglin & Hser, *supra* note 53, at 153 (reporting that during seven years of commitment program, CAP clients reduced criminal activity by 18.6% versus 6.7% for comparison offenders).

69. *See id.* (reporting that CAP clients reduced daily narcotics use by 21.8% versus 6.8% for comparison offenders).

70. *See id.* at 155.

71. *See, e.g.*, Anglin, *Efficacy*, *supra* note 53, at 19 (concluding that most effective civil commitment approach for narcotic addicts is few months of inpatient treatment followed by five to ten years of parole monitoring of drug use and other behaviors).

effective if clients were appropriately supervised and, as a result, received appropriate dosages of treatment.[72]

D. *Intermediate Community Sanctions*

What if we reduced our emphasis on expensive residential treatment and provided increased surveillance of drug-abusing offenders in the community? It would be cheaper and potentially more effective, for example, to use trained probation and parole officers with light caseloads who could monitor offenders' compliance with treatment, make surprise home visits, demand spot-check urine samples, phone-monitor compliance with home curfews or house arrest and interview employers, friends and relatives about offenders' behavior. Most importantly, offenders could be immediately sanctioned, including being sent to prison, for violations of their conditions of probation or parole.

In practice, intermediate community sanction programs typically have been administered apart from treatment, with an emphasis on their monitoring and sanctioning functions at the expense of their potential rehabilitative functions.[73] Possibly as a result of this, these programs have failed to demonstrate significant effects in reducing criminal recidivism or drug abuse.[74] In fact, intensive supervised probation and parole programs have tended to produce seemingly *worse* outcomes in terms of more technical violations and returns to custody.[75] This is likely an artifact of more intensive monitoring of offenders in these programs, leading to a greater detection of infractions.[76] Reviews of dozens of evaluations have similarly

72. *See* SATEL, *supra* note 53, at 12 (stating that compelled treatment showed its potential in California Civil Addict Program).

73. *See, e.g.*, Paul Gendreau et al., *Intensive Rehabilitation Supervision: The Next Generation in Community Corrections?*, 58 FED. PROBATION 72, 72 (1994) (stating that more intrusive control of offenders and abandonment of treatment was believed to optimize protection of public safety and alleviate prison overcrowding).

74. *See, e.g.*, *id.* at 73 (reporting that recidivism rates for clients in intermediate sanction programs not significantly different from those of regular probationers).

75. *See* Joan Petersilia & Susan Turner, *Intensive Probation and Parole*, *in* CRIME AND JUSTICE: A REVIEW OF RESEARCH 306-08 (Michael Tonry ed., 1993) [hereinafter Petersilia & Turner, *Intensive Probation*] (finding that offenders on intensive supervised probation were more likely to incur technical violations and be incarcerated in study of fourteen sites in nine states); Joan Petersilia & Susan Turner, *Comparing Intensive and Regular Supervision for High-Risk Probationers: Early Results from an Experiment in California*, 36 CRIME & DELINQ. 87, 105 (1990) [hereinafter Petersilia & Turner, *Comparing*] (finding that offenders on intensive supervised probation were more likely to incur technical violations during first six months of program in California); Susan Turner et al., *Evaluating Intensive Supervision Probation/Parole (ISP) for Drug Offenders*, 38 CRIME & DELINQ. 539, 552-53 (1992) (finding that offenders on intensive supervised probation were more likely to incur technical violations and be incarcerated during first year of program in study of five different jurisdictions).

76. *See, e.g.*, Petersilia & Turner, *Intensive Probation*, *supra* note 75, at 303 (concluding that strict monitoring and enforcement of conditions of intensive super-

concluded that shock incarceration programs, electronic monitoring and "Scared Straight" programs are associated with a slight increase in recidivism (between two and seven percentage points), possibly due to increased monitoring of offenders, and boot camps and house arrest are associated with no appreciable change in recidivism.[77] Restitution programs, in which offenders are required to compensate their victims or society for their actions, are associated with only a slight decrease in recidivism of approximately four to eight percentage points.[78]

As noted, intermediate sanctions are often applied apart from treatment. When, however, they have been used to enforce compliance in treatment, they have produced an average of a ten percentage-point decrease in recidivism,[79] equivalent to what is commonly obtained in in-prison programs.[80]

E. *Referral to Treatment*

Perhaps a correctional approach is wrong-headed. Drug abuse or dependence may be a "disease"[81] that requires treatment rather than con-

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vised probation can result in higher proportion of probationers and parolees being returned to prison or jail).

77. *See generally* Ted Palmer, *Programmatic and Nonprogrammatic Aspects of Successful Intervention, in* CHOOSING CORRECTIONAL OPTIONS THAT WORK, *supra* note 40 (reporting that Scared Straight and shock probation consistently considered unsuccessful by reviewers and analysts); *see also* Gendreau et al., *supra* note 37, at 251-52 (reporting that best experimental and quasi-experimental studies reveal virtually no influence of electronic monitoring, boot camps, house arrest or Scared Straight on recidivism); Paul Gendreau et al., *The Effects of Community Sanctions and Incarceration on Recidivism*, 12 CORRECTIONS RES. 10, 11 (2000) (concluding that average effects of intensive supervised probation, boot camps, Scared Straight and electronic monitoring are zero or close to zero); Pearson & Lipton, *supra* note 45, at 397 (finding no effect of boot camp on recidivism among drug offenders); Faye S. Taxman, *Unraveling "What Works" for Offenders in Substance Abuse Treatment Services*, 2 NAT'L DRUG CT. INSTIT. REV. 93, 99-100 (1999) (concluding that intensive supervised probation, boot camps and home confinement are unsuccessful).

78. *See* Gendreau et al., *supra* note 37, at 252 (reporting that restitution is associated with slight decrease in recidivism of four percentage points); Gendreau et al., *supra* note 77, at 11 (concluding that restitution is associated with one percentage point decrease in recidivism); Palmer, *supra* note 77, at 137 (concluding that restitution had average effect of eight percentage point decrease in recidivism).

79. *See* Gendreau et al., *supra* note 77, at 12 (concluding that addition of treatment component to intermediate sanctions produced 10% reduction in recidivism). "On this evidence, one can tentatively conclude that the effectiveness of intermediate sanctions is mediated solely through the provision of treatment." *Id.*

80. *See supra* notes 37-39 and accompanying text.

81. *See* A. Thomas McLellan et al., *Drug Dependence, A Chronic Medical Illness: Implications for Treatment, Insurance, and Outcomes Evaluation*, 284 JAMA 1689, 1689-90 (2000) (concluding that drug dependence is highly comparable to chronic relapsing medical conditions such as diabetes, hypertension and asthma in terms of its genetic heritability, relapse rates and rates of treatment noncompliance). The "disease concept" of addiction originally gained sway among medical professionals in this country during the 1950s and early 1960s. *See* E. M. JELLINEK, THE DISEASE

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finement or punishment. What if we identified drug abuse problems among offenders and referred those individuals to treatment where they could be helped?

It is self-evident that treatment cannot be effective if clients do not attend the sessions or participate in the interventions. Unfortunately, attrition in substance abuse treatment is unacceptably high.[82] Approximately one-half to two-thirds of individuals who schedule an initial intake appointment for drug abuse treatment fail to show up for their first intake session.[83] Of those who do attend an initial intake, between 40% and 80% drop out of treatment within one to three months[84] and 80% to 90% drop

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CONCEPT OF ALCOHOLISM 10-12 (1960). This concept was readily embraced by the Alcoholics Anonymous (AA) movement of the time, which gravitated toward its deemphasis on personal blame and immorality. *See* ALCOHOLICS ANONYMOUS, THE BIG BOOK: BASIC TEXT FOR ALCOHOLICS ANONYMOUS 18 (1976). More recently, however, the disease concept has come under attack from cognitive-behavioral psychologists who are concerned that it might lead clients to feel hopeless in the face of an uncontrollable illness and might have the effect of relieving them of personal responsibility for their recovery. *See, e.g.*, ALBERT ELLIS ET AL., RATIONAL-EMOTIVE THERAPY WITH ALCOHOLICS AND SUBSTANCE ABUSERS 14 (1988) (stating that disease model is merely metaphorical and "[i]t is probably equally as inaccurate to view alcoholics as the helpless victims of an insidious disease as it is to view them as the unenlightened and sometimes uncooperative sufferers of deficits in moral character."); G. ALAN MARLATT & JUDITH R. GORDON, RELAPSE PREVENTION: MAINTENANCE STRATEGIES IN THE TREATMENT OF ADDICTIVE BEHAVIORS 7 (1985) (stating that if alcoholics come to view their drinking as result of disease, they may be more likely to assume passive role of victim).

82. *See, e.g.*, Lisa Simon Onken et al., *Treatment for Drug Addiction: It Won't Work If They Don't Receive it*, *in* BEYOND THE THERAPEUTIC ALLIANCE: KEEPING THE DRUG-DEPENDENT INDIVIDUAL IN TREATMENT (Lisa Simon Onken et al. eds., 1997) (noting that in drug treatment, issue of patient dropout is always present).

83. *See* David S. Festinger et al., *From Telephone to Office: Intake Attendance As a Function of Appointment Delay*, 27 ADDICTIVE BEHAVIORS 131, 135-36 (2002) (finding that 52% of clients failed to show for intake appointment for cocaine treatment and 28% of clients offered immediate intake appointment failed to show); David S. Festinger et al., *The Accelerated Intake: A Method for Increasing Initial Attendance to Outpatient Cocaine Treatment*, 29 J. APPLIED BEHAV. ANALYSIS 387, 388 (1996) (finding that 67% of clients failed to show for standard intake appointment for cocaine treatment and 41% of clients offered immediate intake appointment failed to show); David S. Festinger et al., *Pretreatment Dropout as a Function of Treatment Delay and Client Variables*, 20 ADDICTIVE BEHAVIORS 111, 112 (1995) (finding that 58% of clients failed to show for initial intake appointment for cocaine treatment).

84. *See* Randy R. Gainy et al., *Predicting Treatment Retention Among Cocaine Abusers*, 28 INT'L J. ADDICTIONS 487, 495-96 (1993) (reporting that 56% of cocaine clients attended less than eight sessions and 29% did not attend a single session); Ted D. Nirenberg et al., *Effective and Inexpensive Procedures for Decreasing Client Attrition in an Outpatient Alcohol Treatment Program*, 7 AM. J. DRUG & ALCOHOL ABUSE 73, 74 (1980) (reporting that 28% to 80% of clients discontinue alcohol treatment after attending one to four sessions); D. Dwayne Simpson et al., *Treatment Retention and Follow-Up Outcomes in the Drug Abuse Treatment Outcome Study (DATOS)*, 11 PSYCHOL. ADDICTIVE BEHAV. 294, 300-01 (1997) (reporting that 42% of clients nationally drop out of treatment within 90 days); Michael J. Stark, *Dropping Out of Substance Abuse Treatment: A Clinically Oriented Review*, 12 CLINICAL PSYCHOL. REV. 93, 94 (1992) (concluding that majority of investigators report over 50% attrition within first month of drug abuse treatment, 52% to 75% attrition in outpatient

out within a year.[85] Without additional supervision by criminal justice authorities, comparable attrition is found for drug-abusing offenders. In one study, 70% of parolees referred to substance abuse treatment dropped out or were irregularly attending treatment within two to six months.[86]

Research evidence suggests that three months of substance abuse treatment may be the minimum threshold for detecting dose-response effects for the interventions and twelve months may be the minimum threshold for observing meaningful reductions in drug use.[87] Given that roughly 90% of drug abusers drop out of treatment in less than twelve months,[88] this bodes very poorly for relying on substance abuse treatment, by itself, to modify offenders' behaviors. Moreover, of the small proportion of substance abusers that complete twelve months or more of treatment, about one-half (40% to 60%) of those remain abstinent for a year following discharge from treatment.[89] While perhaps showing some promise for treatment, these figures may be inadequate for serving public safety and public health objectives and are unlikely to sit well with policymakers or the public at large.

F. *Monitoring Compliance with Treatment*

What if agents of the criminal justice system continuously monitored offenders' attendance in counseling, received progress reports from their counselors or case managers and took random urine samples to confirm

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alcoholism treatment by fourth session and 80% attrition for heroin addicts by fourth session of drug-free treatment).

85. *See* SATEL, *supra* note 53, at 2 (concluding that 80% to 90% of addicts leave treatment by end of first year). "Among such dropouts, relapse within a year is the rule." *Id.*

86. *See* DOUGLAS YOUNG ET AL., ALCOHOL, DRUGS, AND CRIME: VERA'S FINAL REPORT ON NEW YORK'S INTERAGENCY INITIATIVE 42-45 (Vera Instit. of Justice ed., 1991); *see also* Jason Blankenship et al., *Cognitive Enhancements of Readiness for Corrections-Based Treatment for Drug Abuse,* 79 PRISON J. 431, 431 (1999) (noting that low motivation for engaging in substance abuse treatment is common problem among probationers); Matthew L. Hiller et al., *Risk Factors that Predict Dropout from Corrections-Based Treatment for Drug Abuse,* 79 PRISON J. 411, 411 (1999) ("[E]arly dropout or failure to engage in drug abuse treatment is a common problem in correctional settings."); Urvashi Pitre et al., *Residential Drug Abuse Treatment for Probationers: Use of Node-Link Mapping to Enhance Participation and Progress,* 15 J. SUBSTANCE ABUSE TREATMENT 535, 542 (1998) (same).

87. *See* Simpson et al., *supra* note 84, at 304 (finding that in nationally representative sample of drug abuse treatment programs, clients remaining in treatment three months or longer had better outcomes in all areas of functioning and clients who stayed one year or longer had significantly greater reductions in drug use); Robert L. Hubbard et al., *Overview of 1-Year Follow-Up Outcomes in the Drug Abuse Treatment Outcome Study (DATOS),* 11 PSYCHOL. ADDICTIVE BEHAV. 261, 268 (1997) (same).

88. *See supra* notes 84-85 and accompanying text.

89. *See* McLellan et al., *supra* note 81, at 1693 (concluding that one-year post-discharge follow-up studies typically show that only about 40% to 60% of patients are continuously abstinent, although additional 15% to 30% have not resumed dependent use).

drug abstinence? This might ensure that offenders received adequate dosages of treatment and could reserve costly prison resources for those individuals who were unwilling or unable to make use of the available interventions.

In the 1970s, under the rubric of what was originally termed Treatment Alternatives to Street Crime (TASC)—now renamed Treatment Accountability for Safer Communities[90]—hundreds of agencies were founded across the country[91] to identify, evaluate and refer drug-using offenders to community-based treatment as an alternative or supplement to criminal justice sanctions, to monitor offenders' progress in treatment and to report compliance information to appropriate criminal justice authorities.[92] Because TASC programs operate very differently across jurisdictions,[93] it is difficult to reach conclusions about their aggregate effects. Early evaluations concluded that these programs were generally quite effective at identifying substance abuse problems among offenders and making appropriate treatment referrals.[94] Moreover, clients involved with the criminal justice system tended to remain in treatment significantly longer when they were under TASC supervision.[95] A recent evaluation of five exemplary TASC programs concluded, however, that effects on drug use and criminal recidivism were mixed.[96] Drug use was significantly lower for

90. *See* ONDCP 2001 REPORT, *supra* note 34, at 79 (noting TASC acronym changed to Treatment Accountability for Safer Communities).

91. *See, e.g.*, Beth A. Weinman, *Treatment Alternatives to Street Crime (TASC), in* HANDBOOK OF DRUG CONTROL IN THE UNITED STATES, *supra* note 20, at 139, 140 (before federal funding was withdrawn in 1982, TASC projects were developed in 130 sites in thirty-nine states and Puerto Rico); M. Douglas Anglin et al., *Treatment Alternatives to Street Crime: An Evaluation of Five Programs*, 26 CRIM. JUST. & BEHAV. 168, 171 (1999) [hereinafter Anglin et al., *Five Programs*] (reporting that as of 1996, there were estimated 300 TASC programs in thirty states) (citing generally M. Douglas Anglin et al., *Studies of the Functioning and Effectiveness of Treatment Alternatives to Street Crime (TASC) Programs* (UCLA Drug Abuse Research Center, 1996)). Federal funding for these programs substantially diminished or became less stable in the 1980s and 1990s and now these programs generally rely on patchworks of local and federal funds for their continued existence. Anglin et al., *Five Programs*, *supra*, at 192.

92. *See, e.g.*, Anglin et al., *Five Programs*, *supra* note 91, at 170 (describing TASC functions); Weinman, *supra* note 91, at 141 (same).

93. The Bureau of Justice Assistance established criteria for the core components of a TASC program, entitled the "Ten Critical Program Elements and Performance Standards." BUREAU OF JUSTICE ASSISTANCE, TREATMENT ALTERNATIVES TO STREET CRIME: TASC PROGRAMS: PROGRAM BRIEF (1992). Relatively few programs, however, can document their compliance with these criteria. *See, e.g.*, Anglin et al., *Five Programs*, *supra* note 91, at 172-73 (noting lack of current data for some programs).

94. *See, e.g.*, Anglin et al., *Five Programs*, *supra* note 91, at 171 (citing generally M. A. TOBORG ET AL., TREATMENT ALTERNATIVES TO STREET CRIME (TASC) PROJECTS: NATIONAL EVALUATION PROGRAM, PHASE I SUMMARY REPORT (1976)).

95. *See id.* (citing generally Robert L. Hubbard et al., *The Criminal Justice Client in Drug Abuse Treatment, in* COMPULSORY TREATMENT OF DRUG ABUSE, *supra* note 53).

96. *See id.* at 183-91.

TASC clients in three of the five sites,[97] and criminal activity was lower in two of the sites.[98] Moreover, the magnitudes of the positive findings were generally modest and confined to high-risk offenders.[99] These data suggest, not surprisingly, that the effects of TASC programs vary considerably depending upon how well the programs carry out their supervisory responsibilities.

Recently, ONDCP and the National Institute of Justice sponsored "Breaking The Cycle" (BTC)[100] demonstration initiatives in four U.S. cities.[101] Although BTC was originally conceived as an extension of drug courts,[102] it has actually functioned as an extension of TASC, providing additional resources to augment urinalysis testing and case management services for pre-trial supervisees. Outcome data available from the first BTC demonstration site in Birmingham, Alabama indicate that BTC produced significant reductions in re-arrest rates and self-reported drug use and criminal activity among pre-trial supervisees.[103] Because the results from that study are expressed in terms of "predicted probabilities" of drug use or re-offending, it is difficult to estimate the practical impact or true magnitude of the effects. At a minimum, one can say that community-based monitoring of treatment compliance by drug-abusing offenders has the *potential* to reduce criminal recidivism and drug use if conducted properly. There is, however, no reliable basis at present for concluding

97. *See id.* at 183.

98. *See id.* at 191. It is possible that increased monitoring of offenders in TASC programs may be partly responsible for the seemingly worse outcomes in some jurisdictions because transgressions are more likely to be detected, resulting in greater rates of technical violations and returns to custody. *See id.* at 188 (citing Joan Petersilia & Susan Turner, *Intensive Supervised Probation for High-Risk Offenders: Findings From Three California Experiments* (RAND Criminal Justice ed., 1990); Petersilia & Turner, *supra* note 75, at 281).

99. *See* Anglin et al., *Five Programs, supra* note 91, at 191. TASC programs would not necessarily be expected, by themselves, to produce positive outcomes. These programs typically function primarily as assessment and referral sources, occasionally having an additional limited role in case management and drug testing. *See, e.g.*, Suzanne L. Wenzel et al., *Drug Courts: A Bridge Between Criminal Justice and Health Services*, 29 J. OF CRIM. JUST. 241, 243 (2001). As such, they often cannot ensure that clients' service needs are actually being met and they may have too many cases to supervise with too few resources to provide comprehensive services. *See id.*

100. "Breaking the cycle" of drugs and crime is the second-most urgent priority of ONDCP in its national drug control strategy. *See supra* notes 34-35 and accompanying text.

101. Adult BTC demonstration projects were initiated in 1997 in Jefferson County (Birmingham), Alabama and in 1999 in Duvall County (Jacksonville), Florida and Pierce County (Tacoma), Washington. A juvenile BTC demonstration project was initiated in 2000 in Eugene, Oregon.

102. For a discussion of drug courts, see *infra* notes 107-19 and accompanying text.

103. *See* ADELE HARRELL ET AL., EVALUATION OF THE BREAKING THE CYCLE DEMONSTRATION IN BIRMINGHAM, ALABAMA: FINAL REPORT 48 (Urban Inst. ed., Apr. 2001).

whether TASC programs, in the aggregate, are sufficiently effective to serve public safety or rehabilitative goals.[104]

IV. A MEASURE OF SUCCESS

It is often quipped that a pessimist is merely an optimist confronted with data, and it is easy to become jaded when decades worth of outcome data have consistently frustrated efforts to reduce drug use and criminal recidivism among offenders. In the past few years, however, encouraging findings have been reported for correctional programs targeted at various stages in the criminal justice process. In particular, drug courts show promise for reducing criminal recidivism, drug use and unemployment among offenders at the pre-trial or pre-sentencing stage,[105] and therapeutic community (TC) programs show promise for reducing criminal recidivism and drug use among parolees.[106]

A. *Drug Courts*

Drug courts are separately identified criminal court dockets that provide judicially supervised treatment and case management services for drug offenders in lieu of criminal prosecution or incarceration.[107] The core components of a drug court include: (1) on-going judicial supervision of offenders through regular status hearings, (2) random weekly urinalysis testing, (3) mandatory completion of a prescribed regimen of substance abuse treatment and case management services and (4) the imposition of progressive negative sanctions for program infractions and positive rewards for program accomplishments.[108] Clients who satisfactorily complete the prescribed regimen typically have their current criminal charges expunged in the case of a pre-plea drug court or avoid a sentence of incarceration in the case of a post-plea drug court.[109] Defendants are typically required to enter a guilty plea or plea of nolo contendere or to stipulate to the facts in the arrest report as a pre-condition of entry into drug court.[110] Therefore, termination from the program for non-compliance ordinarily results in a conviction and sentencing to an intensive level of probationary supervision or incarceration.

104. *Cf.* Steven Belenko, *The Challenges of Integrating Drug Treatment into the Criminal Justice Process*, 63 ALB. L. REV. 833, 852 (2000) (concluding that independent effects of TASC on client outcomes have not been determined).

105. For a discussion of drug courts, see *infra* notes 107-19 and accompanying text.

106. For a discussion of TC programs, see *infra* notes 120-32 and accompanying text.

107. *See generally* NATIONAL ASSOCIATION OF DRUG COURT PROFESSIONALS, DEFINING DRUG COURTS: THE KEY COMPONENTS (Office of Justice Programs, U.S. Dep't of Justice, 1997) [hereinafter KEY COMPONENTS] (defining what is drug court).

108. *See id.* at 9-38 (describing ten "Key Components" of drug court).

109. *See id.* at 7.

110. *See id.*

A trilogy of papers reviewing approximately one hundred evaluations of drug court programs[111] concluded that drug courts provide significantly more community supervision, judicial oversight and substance abuse treatment than standard or intensive pre-trial supervision or probation programs.[112] Moreover, drug court clients remain in treatment substantially longer than individuals in pre-trial supervision or probation,[113] and they demonstrate superior reductions in drug use (approximately twenty percentage points),[114] criminal recidivism (commonly ranging from ten to thirty percentage points)[115] and unemployment.[116] Most studies that have tracked criminal recidivism following graduation or termination from drug court have reported significantly lower rates for drug court clients at one-year follow-up,[117] and at least one study has reported

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111. *See generally* STEVEN BELENKO, RESEARCH ON DRUG COURTS: A CRITICAL REVIEW: 2001 UPDATE (Nat'l Ctr. on Addiction & Substance Abuse at Columbia University, 2001) [hereinafter BELENKO, 2001 DRUG COURT REVIEW] (reviewing thirty-seven drug court evaluations conducted between 1998 and 2001); Steven Belenko, *Research on Drug Courts: A Critical Review: 1999 Update,* 2 NAT'L DRUG CT. INST. REV. 1 (1999) [hereinafter Belenko, *1999 Drug Court Review*] (reviewing twenty-nine drug court evaluations conducted between 1998 and 1999); Steven Belenko, *Research on Drug Courts: A Critical Review,* 1 NAT'L DRUG CT. INST. REV. 1 (1998) [hereinafter Belenko, *1998 Drug Court Review*] (reviewing thirty drug court program evaluations conducted between 1993 and 1998).

112. *See* Belenko, *1998 Drug Court Review, supra* note 111, at 17-18, 21-23.

113. *See* BELENKO, 2001 DRUG COURT REVIEW, *supra* note 111, at 25-26 (finding 47% graduation rate, ranging from 36% to 60% across eight programs); Belenko, *1999 Drug Court Review, supra* note 111, at 26-27 (reporting that program retention rates were high in recent drug court evaluations); Belenko, *1998 Drug Court Review, supra* note 111, at 19 (finding that 60% of drug court clients were still in treatment after one year and minimum of 48% of clients graduated from program). These figures compare highly favorably to retention rates reported in community-based treatment programs, in which half of the clients typically drop out of outpatient services within three months of admission and 70% to 90% of clients drop out of residential treatment within one year. *See* Belenko, *1998 Drug Court Review, supra* note 111, at 19-20. For a discussion of attrition from drug abuse treatment, see *supra* notes 82-89 and accompanying text.

114. *See* Belenko, *1999 Drug Court Review, supra* note 111, at 24-25 (reporting that 10% of urine tests are positive for drugs among drug court participants versus 31% of urine tests for comparable non-drug court participants); Belenko, *1998 Drug Court Review, supra* note 111, at 26 (finding that drug use substantially reduced while drug offenders are in drug court program).

115. *See* BELENKO, 2001 DRUG COURT REVIEW, *supra* note 111, at 28-31 (finding that four of six studies reported lower post-program recidivism for drug court participants, with effects ranging from 6 to 38 percentage points); Belenko, *1999 Drug Court Review, supra* note 111, at 30-33 (finding that drug court participants had lower post-program recidivism than comparison groups in seven of twelve studies, with effects ranging from zero to twenty-seven percentage points); Belenko, *1998 Drug Court Review, supra* note 111, at 26-31 (reporting that most evaluations found criminal recidivism reduced during participation in drug court, with effects ranging from three to twenty percentage points).

116. *See* Belenko, *1998 Drug Court Review, supra* note 111, at 28 (reporting that 79% of drug court graduates were employed versus 62% of non-graduates).

117. *See* BELENKO, 2001 DRUG COURT REVIEW, *supra* note 111, at 30-34 (finding that three of six studies reported lower recidivism for drug court clients following

reductions in drug use for drug court clients at three-year follow-up.[118] Drug courts also appear to achieve superior cost savings to traditional probation or pre-trial supervision in terms of reduced jail time, reduced demands on the probation department and reduced prosecution and law enforcement costs related to court appearances.[119]

B. *Correctional Therapeutic Communities*

Encouraging results have also been reported in TC programs for parolees. TCs are residential treatment programs that isolate clients from drugs, drug paraphernalia and negative peer group affiliations.[120] Clients are involved in all aspects of the TC program's administrative and clinical functions. Peers exert substantial influence over each other by confronting negative personality attributes, punishing inappropriate behaviors, rewarding positive behaviors and providing mentorship and positive camaraderie.[121] Clinical interventions commonly include confrontational encounter groups, process groups, community meetings and altruistic volunteer activities.[122]

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termination of monitoring; two studies did not report comparative statistics); Belenko, *1999 Drug Court Review*, *supra* note 111, at 33 (finding that drug court participants had lower post-program recidivism in seven of twelve studies); Steven Belenko, *Diversion Programs: Providing Treatment-Based Alternatives to Incarceration for Drug-Involved Criminal Offenders*, CONNECTION NEWSL. (Acad. for Health Servs. Res. & Health Pol'y, Wash., D.C.), Dec. 2000, at 1, 2 (finding that fifteen of twenty-one studies reported lower recidivism for drug court clients following termination of monitoring).

118. *See generally* Elizabeth P. Deschenes et al., *Drug Court or Probation? An Experimental Evaluation of Maricopa County's Drug Court* (1995) (discussing effects of drug courts).

119. *See* BELENKO, 2001 DRUG COURT REVIEW, *supra* note 111, at 40-43 (reviewing results of cost savings analyses); Belenko, *1999 Drug Court Review*, *supra* note 111, at 38-41 (same); Belenko, *1998 Drug Court Review*, *supra* note 111, at 23-25 (same). A 1997 survey of ninety-three drug court programs estimated cost savings ranging from $85,000 to over $500,000 annually. *See* Caroline S. Cooper, *1997 Drug Court Survey Report: Executive Summary* (Drug Court Clearinghouse & Technical Assistance Project, U.S. Dep't of Justice, 1997), *at* http://gurukul.ucc.american.edu/spa/justice/publications/execl.htm. One study in Oregon concluded that a drug court program produced over $2 million in cost savings. *See* Michael W. Finigan, *Assessing Cost Off-Sets in a Drug Court Setting*, 2 NAT'L DRUG CT. INSTIT. REV. 59, 89 (1999). In that study, every dollar spent on drug court was estimated to produce $2.50 in direct cost savings for taxpayers and $10.00 in cost savings when broader costs were considered such as victimization and theft. *See id.*

120. For a detailed discussion of the history, philosophy and structure of TC programs, see generally GEORGE DE LEON, THE THERAPEUTIC COMMUNITY: THEORY, MODEL, AND METHOD (2000); MARTIEN KOOYMAN, THE THERAPEUTIC COMMUNITY FOR ADDICTS: INTIMACY, PARENT INVOLVEMENT, AND TREATMENT SUCCESS (1993).

121. *See* DE LEON, *supra* note 120, at 165-72 (describing peer roles and functions in TCs).

122. *See id.* at 249-305 (describing community meetings, process groups and encounter groups in TCs).

Comprehensive evaluations of three geographically diverse TC programs for parolees[123] indicate that, to be maximally effective, TC services should be provided along the full "prisoner reentry" continuum, ranging from in-prison treatment, through work-release treatment, to continuing outpatient treatment.[124] In virtually all studies, in-prison TC treatment without aftercare had *no* appreciable effect on drug use or return-to-custody rates.[125] Parolees, however, who completed a work release TC exhibited significant reductions of roughly ten to twenty percentage points in return-to-custody rates and drug use.[126] Moreover, these effects were enhanced for individuals who completed a continuum of services from in-prison through work release TC treatment. Completion of both in-prison and work-release services was associated with a reduction of thirty to fifty percentage points in new arrests and returns to custody.[127]

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123. *See* James A. Inciardi et al., *An Effective Model of Prison-Based Treatment For Drug-Involved Offenders*, 27 J. DRUG ISSUES 261, 269-73 (1997) (reporting one-year outcomes for KEY and CREST TC programs in Delaware); Martin et al., *supra* note 38 (reporting three-year outcomes for KEY and CREST TC programs in Delaware); Knight et al., *supra* note 38, at 347-49 (reporting three-year outcomes for in-prison TC in Kyle, Texas); Harry K. Wexler et al., *The Amity Prison TC Evaluation: Reincarceration Outcomes*, 26 CRIM. JUST. & BEHAV. 147, 158-59 (1999) [hereinafter Wexler et al., *Amity Prison*] (reporting one-year and two-year outcomes for Amity in-prison TC in California); Wexler et al., *supra* note 38, at 332-33 (reporting three-year outcomes for Amity in-prison TC in California).

124. *See* Wexler et al., *Amity Prison*, *supra* note 123, at 148-49 (reporting most effective correctional TC treatment methods).

125. *See* Knight et al., *supra* note 38, at 344 (finding return-to-custody rates for in-prison TC graduates without aftercare did not differ from comparison sample); Martin et al., *supra* note 38, at 306-07 (finding that outcomes for in-prison TC graduates without aftercare did not differ from those of comparison sample in conventional work-release program); Wexler et al., *Aftercare*, *supra* note 38, at 327, 331 (finding no effects for in-prison TC treatment alone at three-year follow-up). Importantly, in-prison TC treatment may still be desirable because it increases the likelihood that a parolee will complete a subsequent work-release TC program and enroll in continuing aftercare treatment. *See* Martin et al., *supra* note 38, at 311 (finding that coming from in-prison TC was predictive of retention in TC continuum of treatment). It is possible that in-prison TC treatment may serve to engage the offender in the treatment process and prepare him or her to make use of a TC regimen.

126. *See* Knight et al., *supra* note 38, at 344, 347 (finding seventeen percentage-point reduction in return-to-custody rate and thirteen percentage-point reduction in rate of new convictions for work-release TC completers); Martin et al., *supra* note 38, at 306-07, 309-10 (finding at one-year follow-up, eleven percentage-point reduction in new arrests and fifteen percentage-point reduction in return to drug use for work-release TC completers; at three-year follow-up, seventeen percentage reduction in relapse to drug use for work-release TC completers).

127. *See* Martin et al., *supra* note 38, at 306-07 (finding thirty-one percentage-point reduction in both new arrests and relapse to drug use for work-release TC completers who also completed an in-prison TC program); Wexler et al., *supra* note 38, at 322, 326 (finding forty-two percentage-point reduction in return-to-custody rate at one year, fifty-three percentage-point reduction in return-to-custody rate at two years and over fifty percentage-point reduction in return-to-custody rate at three years for in-prison TC completers who also completed aftercare). Notably, in some instances, positive effects on recidivism were no longer detectable

The positive findings reported for drug courts and correctional TCs demand explanation. On the one hand, the data are far from incontrovertible.[128] A majority of the studies suffered from serious research design limitations, including the use of systematically biased comparison samples such as offenders who refused, were deemed ineligible for or dropped out of the interventions.[129] Further, many studies failed to perform "intent-to-treat" analyses on the entire original sample, excluding offenders who absconded or were terminated from the program and instead focusing on outcomes for individuals who had the motivation or inclination to complete the entire regimen.[130] These errors are quite likely to have overestimated positive outcomes for the interventions because they restricted the analyses, *a posteriori,* to the most successful cases. It should also be noted that there is a range of outcomes across studies, with some evaluations reporting only small or insignificant effects.[131]

These caveats aside, one cannot ignore the predominance of positive findings. In multiple studies, impressive results from drug courts and, to a lesser extent, TC programs, have been reported in different jurisdictions serving different clients and providing different treatment services.[132] In prior decades, biased research designs did not hint at this level of success with any initiative. The results are at least sufficiently interesting to warrant further investigation into the operative ingredients of these interventions and to stimulate efforts to understand what might be going right.

V. ELEMENTS OF SUCCESS

The most commonly offered explanation for the success of these programs invokes principles of "therapeutic jurisprudence," in which the

at three-year follow-up. *See* Martin et al., *supra* note 38, at 310 (finding no effects on re-arrest rates at three years); Wexler et al., *supra* note 38, at 331 (finding no continuing effects for in-prison TC completers at three years). Given that drug abuse characteristically follows a chronic, relapsing course, it is not surprising that treatment effects would dissipate over long time intervals without appropriate long-term booster interventions. *See, e.g.,* McLellan et al., *supra* note 81, at 1694 (arguing that continuing care is essential for effective treatment for drug dependence).

128. *See* Douglas B. Marlowe & David S. Festinger, *Research on Drug Courts: Do the N's Justify the Means?,* CONNECTION NEWSL. (Acad. for Health Services Res. & Health Pol'y, Wash. D.C.), Dec. 2000, at 4-5 (describing study design limitations).

129. *See id.* at 4.

130. *See id.*; *see also* BELENKO, 2001 DRUG COURT REVIEW, *supra* note 111, at 52-53 (noting that many evaluations still focus only on program graduates rather than analyzing data for all participants).

131. *See* BELENKO, 2001 DRUG COURT REVIEW, *supra* note 111, at 34 (finding that one drug court study reported reduction of only four percentage points); Belenko, *1999 Drug Court Review, supra* note 111, at 30-32 (finding that some drug court studies reported reductions of zero to seven percentage points); Belenko, *1998 Drug Court Review, supra* note 111, at 29-31 (finding that some drug court studies reported reductions of only three to five percentage points).

132. *See* Marlowe & Festinger, *supra* note 128, at 4 ("Clearly, *something* is happening and there *is* room for optimism.") (emphasis in original).

criminal justice system is believed to be assuming a fundamentally new therapeutic role vis-à-vis offenders.[133] Grounded in the legal realism or consequentialist tradition,[134] therapeutic jurisprudence posits that laws, legal decision-making and legal processes should be evaluated, at least in part, by their empirically-determined effects on the psychological well-being of citizens.[135] Restricted until very recently to law school academic circles, therapeutic jurisprudence has now been wholly adopted by drug court practitioners looking for a legitimizing frame for their activities.[136]

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133. *See* Peggy Fulton Hora et al., *Therapeutic Jurisprudence and the Drug Treatment Court Movement: Revolutionizing the Criminal Justice System's Response to Drug Abuse and Crime in America*, 74 NOTRE DAME L. REV. 439, 440 (1999) ("[W]e propose to establish therapeutic jurisprudence as the DTC [drug treatment court] movement's jurisprudential foundation"); Peggy Fulton Hora & William G. Schma, *Therapeutic Jurisprudence*, 82 JUDICATURE 9, 10 (1998) ("Drug treatment courts . . . are the most recent and widespread example of the application of therapeutic jurisprudence in the criminal justice system.").

134. *See* Hora et al., *supra* note 133, at 446, 447 (stating that therapeutic jurisprudence "can be seen as one of a number of heirs to the legal realism movement" and is "essentially a consequentialist approach to law"); David B. Wexler, *Therapeutic Jurisprudence and Changing Conceptions of Legal Scholarship*, 11 BEHAV. SCI. & LAW 17, 18-19 (1993) (noting that traditional legal scholarship extracted principles from precedent, policy and reason, whereas "new" concept of law relies on data).

135. *See, e.g.*, David B. Wexler & Bruce J. Winick, *Therapeutic Jurisprudence and Criminal Justice Mental Health Issues*, 16 MENTAL & PHYSICAL DISABILITY L. REP. 225, 225 (1992) (arguing that legal decision-making should consider not only economic factors, public safety and citizen's rights, but should also take into account therapeutic implications of rule and its alternatives).

136. *See, e.g.*, Hora et al., *supra* note 133, at 449. As one drug court scholar observed:

> With their focus of effort aimed squarely at preventing the collapse of local court systems under the weight of drug cases, few early DTC [drug treatment court] practitioners worried about the jurisprudential theory behind the DTC movement. DTCs seemed to work, and the absence of analysis or debate coming from the "ivory towers" of academia about the efficacy of drug treatment in a criminal justice setting did not much matter. However, as DTCs spread across the country and the variation among DTCs grew, individuals in the legal community began to question and hypothesize about the legal and jurisprudential foundations of this new criminal justice concept. What legal theory could provide DTCs with the requisite formula so that the orientation, structure, and procedures of new and extant DTCs could provide court-ordered, effective treatment programs for their participants? Therapeutic jurisprudence provides the fundamental answer to these questions.

Id. It is actually ironic that therapeutic jurisprudence has been adopted as the chief explanation for the success of legally mandated treatment for offenders and that it is serving as the philosophical basis for extending the courts' influence over citizens. Traditionally, therapeutic jurisprudence was invoked as a rationale for why coerced treatment is likely to be psychologically counterproductive and, therefore, poor public policy. *See, e.g.*, BRUCE J. WINICK, THE RIGHT TO REFUSE MENTAL HEALTH TREATMENT 327-44 (1997) (providing therapeutic jurisprudence rationale for right to refuse mental health treatment).

Whatever value it may have as a normative legal philosophy,[137] therapeutic jurisprudence, without more, does not provide a very satisfying explanation for the success of drug courts or comparable initiatives. It also provides little guidance for developing new programs or defining a policy agenda. Therapeutic jurisprudence, as currently conceptualized, makes little effort to explain *why* past initiatives may have failed or succeeded and offers few predictions about the likely effects of future endeavors. In tautological fashion, therapeutic jurisprudence favors strategies that are therapeutic. It is necessary, therefore, to turn to the clinical and research data to effectuate therapeutic jurisprudence.

For decades, unitary public health and public safety strategies have failed to produce meaningful reductions in drug use or criminal recidivism among offenders. What is it about drug courts or work release TCs that could explain their promising results against this backdrop of disappointment?

A. *Treatment in the Community*

Drug courts and work release TCs treat offenders in the community rather than in isolated prison or hospital settings. Incarceration can have unfortunate consequences for individuals, including removing them from their family and social support systems, preventing them from obtaining or maintaining gainful employment or education and exposing them to antisocial peer influences.[138] Moreover, with few exceptions, treatment gains in institutional settings fail to generalize to the community at-large and may be lost within a relatively brief time in the absence of transitional aftercare.[139]

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137. Therapeutic jurisprudence has been criticized on a number of jurisprudential grounds. In particular, it offers little guidance for evaluating laws that have therapeutic effects for some citizens but anti-therapeutic effects for others. *See, e.g.*, Christopher Slobogin, *Therapeutic Jurisprudence: Five Dilemmas to Ponder*, 1 PSYCHOL. PUB. POL'Y & L. 193, 208 (1995) ("[T]he studied rule or practice will probably turn out to be neither wholly therapeutic nor antitherapeutic (i.e., it will benefit some and harm some)."). Moreover, it offers no guidance for determining how or when to balance the therapeutic effects of a law against other desirable effects such as improvements in business practices or public safety. *See id.* at 210-18.

138. *See, e.g.*, Gendreau et al., *supra* note 77, at 13 (noting widely endorsed view in some correctional circles that prisons may act as "schools of crime").

139. *See, e.g.*, Palmer, *supra* note 77, at 145-46 (concluding that research since 1970s indicates that community-based correctional treatment is equally or more effective than institutional treatment); Arthur J. Lurigio, *Drug Treatment Availability and Effectiveness: Studies of the General and Criminal Justice Populations*, 27 CRIM. JUST. & BEHAV. 495, 517-18 (2000) (concluding that without aftercare services, gains offenders make in prison or jail treatment programs diminished or lost altogether). "An important and consistent observation is that better results are obtained if offenders enter community-based treatment during a period of transition [from prison] back into the community." Peter J. Delany et al., *Drug Abuse Treatment in Correctional Settings: A Stage-Based Approach to Intervening with Chronic Drug Abusers, in*

It is true that segregated housing can serve important functions during the early stages of substance abuse treatment, such as detoxifying clients from drugs and alcohol, reducing environmental stressors and isolating clients from drugs, drug-related stimuli and negative peer group associations.[140] It appears to be necessary, however, for clients to practice new skills in their "real world" social environments in order to maintain treatment gains over the longer term.[141] Clients may learn in treatment, for example, to plan their daily activities to avoid drugs and drug-related stimuli, to distract themselves from cravings and to employ drug-refusal strategies when drugs are offered to them. These skills cannot simply be taught in a classroom or in a counselor's office. They must be applied and rehearsed in the real world, giving clients a chance to try out new strategies, to report their experiences back in counseling and to discuss how and why various strategies may have succeeded or failed. Community-based follow-up treatment may be essential, therefore, for transitioning offenders back into their communities and for forestalling criminal recidivism and relapse to drug use.[142]

B. *Opportunity to Avoid a Criminal Record or Incarceration*

Drug courts provide offenders with a tangible opportunity to avoid a criminal record or a sentence of incarceration contingent upon completion of a prescribed regimen of substance abuse treatment, case management, urinalyses and judicial status hearings. Similarly, TC programs provide inmates with an opportunity for early parole contingent upon completion of in-prison and work release treatment components. This provides substantial incentives to offenders to satisfy the monitoring conditions of these programs and to receive adequate dosages of treatment.[143] Rather than simply punishing offenders for engaging in drug

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AMERICAN SOCIETY OF ADDICTION MEDICINE, PRINCIPLES OF ADDICTION MEDICINE (3d ed.) (forthcoming 2002) (manuscript at 25, on file with author).

140. *See* A. Thomas McLellan & James R. McKay, *Components of Successful Treatment Programs: Lessons from the Research Literature, in* PRINCIPLES OF ADDICTION MEDICINE, *supra* note 29, at 327, 329-30 (reporting that virtually all studies showed greater engagement and retention of patients in inpatient settings as opposed to outpatient settings; however, effects on outcomes vary across studies); *see also* DE LEON, *supra* note 120, at 102 (noting that TCs seek to maintain social and psychological separateness from surroundings previously associated with addict's dysfunctional, negative lifestyle).

141. *See, e.g.*, BECK ET AL., *supra* note 50, at 108-10 (discussing importance of "homework assignments" in which clients practice skills taught in therapy sessions and receive feedback from therapist in subsequent sessions).

142. *See, e.g.*, BELENKO, *supra* note 10, at 128 (stating that community aftercare services are crucial to helping drug and alcohol-involved inmates avoid relapse after release from prison).

143. It was traditionally assumed that substance abusers could not be coerced into treatment with effective results. *See, e.g.*, Richard S. Schottenfeld, *Involuntary Treatment of Substance Abuse Disorders—Impediments to Success*, 52 PSYCHIATRY 164, 169-71 (1989) (discussing presumed negative effects of legally mandated treatment on therapeutic relationship, client's willingness to disclose important information

use, these programs meaningfully reward offenders for engaging in desired behaviors such as completing treatment and demonstrating drug abstinence.[144]

C. *Close Criminal Justice Supervision*

Unlike traditional TASC or probation programs, drug courts and TCs do not refer clients out to community treatment programs and relinquish control over the case.[145] Rather, the criminal justice system serves as the primary locus for the intervention with designated criminal justice professionals (usually a judge or probation or parole officer) functioning like the "head of the treatment team."[146] Treatment personnel may, for exam-

and client's self-esteem). The research evidence suggests, however, that legally mandated clients perform as well or better than voluntary clients in substance abuse treatment. *See, e.g.*, SATEL, *supra* note 53, at 45 (concluding that addicts need not be internally motivated at outset of treatment to benefit from it); Mary-Lynn Brecht et al., *Treatment Effectiveness for Legally Coerced Versus Voluntary Methadone Maintenance Clients*, 19 AM. J. DRUG & ALCOHOL ABUSE 89, 102 (1993) (finding that legally mandated clients in methadone maintenance treatment performed as well or better than voluntary methadone clients); James J. Collins & Margaret Allison, *Legal Coercion and Retention in Drug Abuse Treatment*, 34 HOSP. & COMMUNITY PSYCHIATRY 1145, 1148 (1983) (finding that in nationally representative sample of substance abuse treatment programs, legally mandated clients performed as well or better than voluntary clients); Hiller et al., *supra* note 9, at 475 (finding that in nationally representative sample of substance abuse treatment programs, clients under legal pressure stayed in treatment longer); Marlowe, *Coercive*, *supra* note 9, at 67 ("[C]ontrary to expectations, [a] substantial body of evidence reveals legally mandated substance abuse clients perform as well or better than non-mandated clients on various indices of treatment retention, abstinence and psychosocial functioning"). In fact, research suggests that the large majority of substance abusers enter treatment under some form of coercion stemming from various sources including family members, friends, employers, creditors, health care providers, the legal system or welfare caseworkers. *See, e.g.*, Marlowe et al., *Efficacy*, *supra* note 53, at 219-24 (finding that substantial proportion of substance abuse clients reported entering treatment due to coercive social, legal and financial pressures); Douglas B. Marlowe et al., *Multidimensional Assessment of Perceived Treatment-Entry Pressures Among Substance Abusers*, 15 PSYCHOL. ADDICTIVE BEHAV. 97, 98 (2001) (same); Douglas B. Marlowe et al., *Assessment of Coercive and Noncoercive Pressures to Enter Drug Abuse Treatment*, 42 DRUG & ALCOHOL DEPENDENCE 77, 78 (1996) (same).

144. *See* Douglas B. Marlowe & Kimberly C. Kirby, *Effective Use of Sanctions in Drug Courts: Lessons From Behavioral Research*, 2 NAT'L DRUG CT. INST. REV. 1, 21-23 (1999) (discussing use of "negative reinforcement" in drug courts, in which clients are rewarded for productive behaviors by removing criminal justice sanctions).

145. *See* John S. Goldkamp, *The Drug Court Response: Issues and Implications for Justice Change*, 63 ALB. L. REV. 923, 935-36 (2000) (discussing shift from "hands off" judicial approach of "referring out" drug offenders to treatment programs to more recent "hands on" judicial approach exemplified in drug courts).

146. *See* KEY COMPONENTS, *supra* note 107, at 27 (noting that judge is leader of drug court team). As one commentator put it:

> The courtroom was conceived as a therapeutic vehicle (a theatre in the "square") with the [drug court] judge at the center leading the treatment process. Under this model, it was widely believed that the role of the judge, with its symbolism and authority, would serve to galvanize the treatment process into a more powerful and accountable form of rehabil-

ple, no longer make the sole or ultimate decision about whether to admit or discharge a client, what level or term of care a client will receive or what adjunctive services will be provided.[147] More importantly, no longer cloaked under a veil of confidentiality,[148] clinical staff make routine, timely progress reports to appropriate supervisory officials[149] and, in the case of drug courts, may even accompany their clients to status hearings.[150] Criminal justice authorities are, therefore, kept continually apprised of clients' progress or lack thereof in treatment and can apply sanctions and rewards immediately and consistently in response to this information.

Drug courts and TCs also employ random and spot-check urinalysis testing to confirm clients' drug abstinence throughout their enrollment in the program[151] and may require clients to attend status conferences in court or with a parole officer.[152] These stringent supervisory requirements prevent clients from "falling through the cracks" and make it possible for criminal justice staff to respond quickly and consistently to infractions.

D. *Immediate, Consistent and Certain Consequences*

It is axiomatic that, to change behavior, negative sanctions and positive rewards must be administered in an immediate, consistent and certain manner.[153] The more often behavioral infractions or achievements go un-

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itation than previously (or recently) available in the criminal justice setting.

John S. Goldkamp et al., *Do Drug Courts Work? Getting Inside the Drug Court Black Box,* 31 J. DRUG ISSUES 27, 29 (2001).

147. *See, e.g.*, Goldkamp, *supra* note 146, at 936 (noting that drug court judge, rather than treatment staff, controls admissions to and terminations from treatment).

148. *See, e.g.*, Marlowe, *Coercive, supra* note 9, at 70 (stating that many treatment providers misunderstand their legal and ethical responsibilities when it comes to confidentiality issues for offenders; federal and state laws specifically authorize disclosure of certain types of information to supervising or referring criminal justice authorities) (citing 42 C.F.R. § 2.35; 4 PA. CODE § 255.5[b]).

149. *See id.* at 69-70 (arguing that for legally mandated treatment to be effective, it is essential for clinicians to share information and coordinate functions with responsible correctional officials).

150. *See id.* at 70 (stating that substance abuse treatment service providers are allowed to disclose information about their clients to judges).

151. *See* DE LEON, *supra* note 120, at 243-47 (discussing urinalysis testing and responses to positive results in TCs); KEY COMPONENTS, *supra* note 107, at 21-22 (noting that abstinence in drug court monitored is by frequent alcohol and other drug testing).

152. *See* KEY COMPONENTS, *supra* note 107, at 27 (stating that on-going judicial interaction with each participant is essential component of drug court).

153. *See generally* GARRY MARTIN & JOSEPH PEAR, BEHAVIOR MODIFICATION: WHAT IT IS AND HOW TO DO IT 36 (4th ed. 1992) (stating that for maximum effectiveness, positive rewards should be given immediately after desired response); Harrell & Roman, *supra* note 33, at 209 (stating that sanctions must be administered swiftly and certainly); Marlowe & Kirby, *supra* note 144, at 10-14 (stating that

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detected, the longer it takes to administer a sanction or reward, and the less certain it is that a sanction or reward will be applied, the less effective will be the intervention. Indeed, the effectiveness of a negative sanction declines precipitously within only a few hours or days following an infraction.[154]

Although procedural due process is a cornerstone of our legal system, it can have vexing consequences for improving offenders' behavior. The time delays involved in prosecuting criminal cases and in convening violation of probation or parole hearings[155] substantially curtail the effects of most criminal justice sanctions. Weeks, months or even years may go by before a sanction can be applied, making the intervention potentially useless from the standpoint of behavior modification.

In drug courts, clients are generally required to plead guilty or nolo contendere to the charges or to stipulate to the facts in the arresting police report as a precondition of entry into the program.[156] Therefore, if a client is terminated from drug court for non-compliance with treatment or unremitting drug use, conviction and disposition are relatively pro forma and are not subject to the usual panoply of procedural due process rights that are available in traditional violation of probation hearings.

In addition, entry criteria for drug courts typically require clients to stipulate to specified slates of interim sanctions and rewards that may be applied in response to infractions and accomplishments in the program.[157] For example, failure to attend a counseling session or the provi-

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infractions must be reliably detected and negative sanctions must be delivered immediately and for each infraction); Maxine L. Stitzer & Mary E. McCaul, *Criminal Justice Interventions with Drug and Alcohol Abusers: The Role of Compulsory Treatment*, *in* BEHAVIORAL APPROACHES TO CRIME AND DELINQUENCY 331, 356 (Edward K. Morris & Curtis J. Braukmann eds., 1987) (concluding that efficacy of legal sanctions depends upon how consistently and immediately the sanctions are imposed); Faye S. Taxman et al., *Graduated Sanctions: Stepping Into Accountable Systems and Offenders*, 79 PRISON J. 182, 190 (1999) (stating that sanctions should be delivered with certainty, celerity and consistency); Taxman, *supra* note 77, at 124-25 (stating that sanctions must be swift and certain).

154. *See* N.H. Azrin & W.C. Holz, *Punishment*, *in* OPERANT BEHAVIOR: AREAS OF RESEARCH AND APPLICATION 389, 394-95 (Werner K. Honig ed., 1966) (reporting that effectiveness of negative sanction begins to decline within one hour of target behavior); Taxman, *supra* note 77, at 124-25 (stating that as a rule, it is important to have negative sanctions occur within twenty-four hours of target behavior).

155. *See, e.g.*, Goldkamp, *supra* note 145, at 932-33 (discussing "non-relevance" of probation due to inability to respond meaningfully to offenders' infractions and clinical service needs); Taxman et al., *supra* note 153, at 182-83 (noting that inability of probation and community corrections to respond quickly and decisively to problems of noncompliance raised doubts about probation as viable sentencing option).

156. For a discussion of drug courts, see *supra* notes 107-19 and accompanying text.

157. *See* KEY COMPONENTS, *supra* note 107, at 24-25 (listing list of negative sanctions and positive rewards commonly used in drug courts); William M. Burdon et al., *Drug Courts and Contingency Management*, 31 J. DRUG ISSUES 73, 78-79 (2001) (same).

sion of a drug-positive urine specimen might be met with increased counseling requirements, fines, community service or a brief interval of detention. Because drug court clients agree in advance to these interim sanctions after being informed of the requirements of drug court and after waiving their rights on the record, the imposition of negative sanctions is streamlined and not subject to the usual adversarial proceedings.

In a similar way, TC programs require clients to observe a written Code of Conduct[158] and to agree to pre-specified sanctions and privileges based upon their behavior in the program.[159] Sanctions may include such things as loss of privileges, demotions, room restrictions, group confrontation, speaking bans or expulsion.[160] Peers and staff generally mete out these sanctions without meaningful due process constraints. These programmatic arrangements permit punitive sanctions and positive rewards to be applied readily and consistently, thus greatly enhancing the efficacy of the interventions.

In summary, drug courts and correctional TCs have the potential to combine the best elements of substance abuse treatment and criminal justice system monitoring. Substance abuse treatment assumes a central role in these interventions rather than being viewed as peripheral to punitive ends. Clients can be treated in their community-of-origin where they can maintain family and social contacts and seek or continue in gainful education or employment. The responsibility for ensuring offenders' adherence to treatment and avoidance of drug use and criminal activity is not, however, delegated to treatment personnel who may be unprepared or disinclined to deal with such matters and who may have very limited power to intervene. The criminal justice system maintains substantial supervisory control over offenders and has enhanced authority through plea agreements to intervene rapidly and consistently in response to infractions.

VI. POST-SCRIPT: CALIFORNIA PROPOSITION 36

It is understandable why policymakers, practitioners, researchers and the public would be excited about the promising reports emerging from drug courts and work release TC programs. After decades of frustration, who would not wish to spread the word and extend the practice to new contexts? This zeal, however, can have serious untoward effects if future initiatives fail to discern the important lessons of history.

In an effort to expand upon the early success of drug courts, California's "Proposition 36"[161]—and comparable initiatives in other jurisdic-

158. *See* DE LEON, *supra* note 120, at 224-25 (describing "Cardinal Rules," "Major Rules" and "House Rules" of TCs).

159. *See id.* at 211-33 (discussing of sanctions and privileges in TCs).

160. *See id.* at 225-28 (describing of sanctions commonly used in TCs).

161. California Substance Abuse and Crime Prevention Act of 2000, 2000 Cal. Legis. Serv. Prop. 36 (West) [hereinafter Proposition 36]. California's Proposition 36 was approved by a referendum vote of approximately two thirds of California

tions such as Arizona[162]—seek to extend substance abuse treatment to a larger class of drug offenders *in lieu of* judicial supervision and intensive criminal justice monitoring. The goal of Proposition 36 is to divert all nonviolent[163] defendants, probationers and parolees who are charged with drug possession or drug use from the criminal justice system into community-based substance abuse treatment.[164] Proposition 36 requires that offenders convicted of such offenses must be sentenced to probation with drug abuse treatment as a mandatory condition of probation.[165] Upon successful completion of treatment and substantial compliance with probation, the offender is entitled to have his or her arrest record and conviction record expunged.[166] Furthermore, under Proposition 36, parole may generally not be revoked due to the commission of a nonviolent drug offense or for violating a drug-related condition of parole.[167]

There is no provision in Proposition 36 for on-going judicial status hearings; rather, court hearings are held only in the event of a formal petition for revocation of probation or parole.[168] At such hearings, a violation must be proved by a preponderance of the evidence[169] with traditional procedural due process requirements. Offenders essentially get "three chances" for drug-related violations of probation and "two chances" for drug-related violations of parole.[170] In the case of a first drug-related violation of probation, in addition to proving the violation itself, the state must prove by a preponderance of the evidence that the offender is a danger to the safety of others to accomplish a revocation.[171] For a second drug-related violation of probation, the state must prove both the violation and that the offender is either a danger to the safety of others or is unamenable to treatment.[172] Finally, for a first drug-related violation of

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voters on November 7, 2000 and was scheduled to take effect on July 1, 2001. *See id.* § 8.

162. Arizona Drug Medicalization, Prevention, and Control Act of 1996, 1997 Ariz. Legis. Serv. Prop. 200 (West).

163. Proposition 36 specifically excludes individuals charged with or convicted of the sale, production or manufacturing of drugs, as well as individuals charged with or convicted of a serious felony or violent offense unless the prior conviction was at least five years old and the individual remained free from incarceration or conviction of a non-drug possession offense during that five-year period. *See* Proposition 36, *supra* note 161, §§ 4(a), 5(b)(1).

164. *See id.* § 3(a).

165. *See id.* § 5(a). The judge may impose additional treatment conditions for probation including vocational training, family counseling, literacy training or community service and the offender may be required to bear some of the costs of treatment. *See id.*

166. *See id.* § 5(d).

167. *See id.* § 6(a).

168. *See id.* § 5(e)(2)-(3) (regarding probation); § 6(d)(2)-(3) (regarding parole).

169. *See id.*

170. *See id.* §§ 5(e)(3)(F), 6(d)(3)(D).

171. *See id.* § 5(e)(3)(A).

172. *See id.* § 5(e)(3)(B).

parole, the state must prove both the violation and that the offender is a danger to the safety of others to accomplish a revocation.[173]

Needless to say, the stringent due process requirements imposed, the multiple burdens of proof placed on the state and the normal time delays associated with convening formal court hearings could greatly reduce, if not effectively eliminate, meaningful correctional supervision of these offenders. It is also important to note that, as presently written, Proposition 36 prohibits the use of appropriated funds for drug testing services (namely, urinalyses),[174] which are essential in most instances for establishing that a drug-related violation has occurred.

Apart from what value it may have for public policy in terms of reducing prison costs or effectively decriminalizing drug possession, it is questionable whether the research evidence supports Proposition 36.[175] On the positive side, Proposition 36 does emphasize treatment in the community and provides a meaningful opportunity for offenders to avoid a criminal record contingent upon successful completion of treatment. On the other hand, Proposition 36 erects multiple barriers to effective criminal justice supervision of drug offenders and prevents the timely and consistent imposition of consequences based upon their performance in treatment. The criminal justice system is not the primary locus of the intervention. For example, treatment providers are not required to coordinate their activities with criminal justice authorities, there are no judicial status hearings, it is unclear whether there will be sufficient resources for urinalysis testing, there are no interim sanctions or rewards, and dispositions require multiple due process court hearings.

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173. *See id.* at § 6(d)(3)(A).

174. *See id.* § 7. However, in response to severe criticism on this point, efforts are underway in the California legislature to appropriate additional monies to cover some of the costs of drug testing services. *See How Will Proposition 36 Affect the Drug Treatment and Criminal Justice Systems in California*, DRUG POL'Y RES. CENTER NEWSL. (RAND Criminal Justice, Santa Monica, CA), June 2001, at 2. *See generally* K. JACK RILEY ET AL., DRUG OFFENDERS AND THE CRIMINAL JUSTICE SYSTEM: WILL PROPOSITION 36 TREAT OR CREATE PROBLEMS? (RAND Criminal Justice, 2000).

175. Proposition 36 has been criticized on numerous grounds, particularly in terms of its predicted effects on the substance abuse treatment system in California. *See* JACK RILEY ET AL., *supra* note 174, at 5-6. The legislative enactment is likely to bring a substantial influx of difficult-to-serve clients into existing treatment programs that are already overburdened, understaffed and unable to adjust readily to census fluctuations. *See id.* at 18-19. Many of these new clients will have relatively lower levels of motivation for treatment, greater involvement with newer classes of drugs such as methamphetamine and "crack" cocaine, an earlier age of onset of drug use, lesser education, more drug-related problems and fewer prior treatment episodes. *See id.* at 17-18. There are also serious concerns about whether the funding appropriations for Proposition 36 are sufficient for meeting the increased demands on the substance abuse treatment and criminal justice systems. *See id.* at 23 (reporting that economic cost models "suggest that claims for probation and court costs, in combination with treatment costs, could well exceed the available funding"); *see also How Will Proposition 36 Affect the Drug Treatment and Criminal Justice Systems in California?*, *supra* note 174, at 2 (discussing of predicted effects of Proposition 36 on substance abuse treatment system in California).

Whatever the ultimate effects of Proposition 36, it is essential to place this strategy within the context of other public health and public safety approaches that have been attempted in the past. Proposition 36 is a public health strategy similar to TASC that bears little resemblance to the integrated public health/public safety strategies exemplified in drug courts and work release TCs. If successful, Proposition 36 might raise important questions about whether some of the monitoring components of drug courts may be unnecessary or even counterproductive in some instances. On the other hand, if it is relatively unsuccessful, the results should not be taken as an indication that "treatment doesn't work" for offenders. Rather, additional monitoring and contingencies might be required to ensure that offenders receive adequate dosages of treatment.

VII. CONCLUSION

Historically, drug policy in the United States has been guided by deeply held belief systems concerning the "true nature" of drug involvement and its relationship to criminal activity. At varying times, a public health perspective or a public safety perspective has gained sway among policymakers and the public and served as the basis for various uni-dimensional strategies designed to address a serious and complicated social problem. When the research evidence characteristically failed to support these single-minded approaches, the resulting disillusionment typically precipitated another "new" reactionary policy to address the problem of drugs and crime.

This pendulum-like process has been further influenced by the fact that the criminal justice system and substance abuse treatment system evolved as separate service entities in this country with highly divergent philosophies and practice standards. As such, they cannot be readily called upon to coordinate their functions or to share information. It has, therefore, often appeared to policymakers as more practical and cost-effective, at least in the short term, to emphasize the functions of either one of these systems as opposed to funding the creation of new integrative service mechanisms.

Research evidence suggests, however, that integrated public health/public safety strategies can reduce recidivism and drug use by twenty to thirty percentage points.[176] Although far from ideal, these outcomes are two to three times greater in magnitude than those obtained from unitary public safety or public health approaches. There appears to be less justification for revisiting empirically discredited unitary strategies than for pinpointing the operative components of successful integrated programs. More research is needed, for example, to identify the most effective and cost-efficient methods for scheduling status hearings, assessing and reporting on clients' progress in treatment and administering contingent sanc-

176. For a discussion of the effects of integrated public health/public safety strategies, see *supra* notes 106-19, 120-32.

tions and rewards. History points to the most fruitful areas to focus future research and policy efforts. Failing to study history, however, may lead us to repeat its mistakes.