Approved: April 4, 2008
Date

MINUTES OF THE SENATE JUDICIARY COMMITTEE

The meeting was called to order by Chairman John Vratil at 9:36 A.M. on February 6, 2008, in Room 123-S of the Capitol.

All members were present.
David Haley, excused
Greta Goodwin, excused
Donald Betts, excused

Committee staff present:
Athena Andaya, Kansas Legislative Research Department
Bruce Kinzie, Office of Revisor of Statutes
Karen Clowers, Committee Assistant

Conferees appearing before the committee:
Tom Stanton, Kansas County and District Attorneys Association
Robert Sanders, Kansas Parole Board
Rep. Peggy Mast
Teresa Walters, Emporians for Drug Awareness
Judy Moler, General Counsel, Kansas Association of Counties
Craig Murphy, Butler County Sheriff's Office
Peter Ninemire, Families Against Mandatory Minimums

Others attending:
See attached list.

The Chairman opened the hearing on **SB 479– Post release supervision for certain offenders convicted under K.S.A. 21-4628.**

Tom Stanton testified in favor, indicating **SB 479** will correct an anomaly in the law which currently acts to free persons who have been convicted of crimes for which the sentence is life from post-release supervision (Attachment 1). Currently a prisoner serving a life term can shorten his or her parole/post release supervision term by committing a felony while in prison

Robert Sanders spoke as a proponent, stating enactment of **SB 479** is a positive step toward introducing greater parity in sentencing (Attachment 2). The Board requested the provisions of **SB 479** be expanded so that offenders serve the longest term of post incarceration supervision carried by any of the offenses, determinate or indeterminate, for which they have been convicted ans sentenced. The Chairman suggested they provide a balloon amendment with the requested changes.

There being no further conferees, the hearing on **SB 479** was closed.

The hearing on **SB 481–Controlled substance, schedule I. salvia and gypsum weed** was opened.

Tom Stanton appeared in support as author of the bill (Attachment 3). Mr. Stanton provided background on the effects of the drugs, trafficking as an uncontrolled substance, and increased use among Kansas teenagers. Enactment of the bill will take a proactive stance in the fight against harmful drugs and protect the children of Kansas.

Written testimony in support of **SB 481** was submitted by:
Rep. Peggy Mast (Attachment 4)
Teresa Walters, Emporians for Drug Awareness (Attachment 5)

There being no further conferees, the hearing on **SB 481** was closed.

The Chairman opened the hearing on **SB 482–Substance abuse treatment for certain offenders**.

Senator Derek Schmidt testified in support, indicating this bill is one of three intended to provide an additional

treatment option for offenders with substance abuse problems (Attachment 6). **SB 482** is not intended to disrupt the existing treatment regime established by 2003 SB 123 but will provide the courts with the additional option of incarceration based treatment for third time offenders sentenced pursuant to 2003 SB 123.

Craig Murphy appeared in support, stating that state drug treatment programs outlined in **SB 482** will set the stage for an offenders successful reentry into society while addressing one of the major public health and safety issues of our time (Attachment 7).

Peter Ninemire spoke in a neutral capacity, indicating he supported the bill with some reservations (Attachment 8). Mr. Ninemire stated jails and prisons do not cure addiction but are a necessary element of change. They remove offenders from their lifestyle, environment, association and addiction forcing them to some level of accountability. However, the approach that has shown consistent promise for reducing substance abuse and criminal recidivism combines community-based drug treatment with ongoing criminal supervision in the respective communities of origin of the offenders.

Written testimony in support of **SB 482** was submitted by:

Judy Moler, General Counsel, Kansas Association of Counties (Attachment 9)
Ed Klumpp, Kansas Association of Chiefs of Police (Attachment 10)
Ed Klumpp, Kansas Peace Officers (Attachment 11)

Written testimony in opposition to **SB 482** was submitted by:

Helen Pedigo, Kansas Sentencing Commission (Attachment 12)
Roger Werholtz, Secretary, Kansas Department of Corrections (Attachment 13)

The Chairman called for final action on **SB 433–Uniform prudent management of institutional funds act.** Chairman Vratil reviewed the bill and a minor amendment recommended by the Uniform Law Commissioners and the Kansas Judicial Council amending page 1, line 32.

Senator Bruce moved, Senator Donovan seconded, to amend **SB 433** on page 1, line 32, changing the word "and" to "or". Motion carried.

Senator Donovan moved, Senator Schmidt seconded, to recommend **SB 433** as amended, favorably for passage. Motion carried.

The Chairman called for final action on **SB 434–Code of civil procedure, electronically stored information** and reviewed the bill.

Senator Journey moved, Senator Schmidt seconded, to recommend **SB 434** favorably for passage

The Chairman called for final action on **SB 435– Amendments to revised Kansas juvenile justice code and revised Kansas code for care of children.** The Chairman reviewed the bill indicating most of the changes to the code are technical in nature with one substantive change which defines the term *infectious diseases* and replaces inconsistencies with references to *infectious diseases*. The Chairman reviewed several technical amendments proposed by the Judicial Council in a balloon amendment during testimony heard January 30.

Senator Bruce moved, Senator Donovan seconded, to amend **SB 435** as reflected in the balloon amendment distributed January 30 by the Kansas Judicial Council. Motion carried.

Senator Donovan moved, Senator Betts seconded, to recommend **SB 435** as amended, favorably for passage. Motion carried.

Approval of Minutes
Senator Bruce moved, Senator Schmidt seconded, to approve the committee minutes of January 17 and January 24. Motion carried.

The meeting adjourned at 10:19 A.M. The next scheduled meeting is February 7, 2008.

PLEASE CONTINUE TO ROUTE TO NEXT GUEST

SENATE JUDICIARY COMMITTEE GUEST LIST

DATE: February 6, 2008

NAME	REPRESENTING
Randy Hearrell	Judicial Council
Jeff Bottenberg	KS Sheriffs Assn
Craig Murphy	Butler Co. Sheriff
Roberta Sue McKenna	SRS
Deb Stidham	SRS
Judy Moler	KAC
Mark Gleeson	Judicial Branch
Peter Ninemire	FAMM
Bill Brady	[illegible]
Richard Samaniego	Kearney & Assoc.

Kansas County & District Attorneys Association
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(785) 232-5822 Fax: (785) 234-2433
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TO: The Honorable Senators of the Judiciary Committee

FROM: Thomas R. Stanton
Deputy Reno County District Attorney
President, KCDAA

RE: Senate Bill 479

Chairman Vratil and members of the Committee:

Thank you for consideration of Senate Bill 479, and for giving me the opportunity to testify regarding this legislation. This legislation is intended to correct an anomaly in the law which currently acts to free persons who have been convicted of crimes for which the sentence is life from post-release supervision.

The current language of K.S.A. 21-4608 fails to take into consideration the effect of a prisoner who has been sentenced to life in prison and who commits another crime while incarcerated. For example, John Doe has been convicted of first degree murder, and is sentenced pursuant to the law to life in prison. After serving the mandatory twenty-five years in the system, he is eligible for parole subject to supervision for life. However, if Mr. Doe commits a felony while in prison, he completes the twenty-five year sentence and begins serving the sentence for that felony as mandated by the Kansas Sentencing Guidelines Act (hereinafter referred to as "KSGA"). Under the current law, the defendant would serve that sentence, then be released on the term of post-release supervision commensurate with the sentence for the new crime. The post-release supervision would never be more than thirty-six months. Upon completion of the term of post-release supervision mandated by the KSGA for the new crime, Mr. Doe would then be released from supervision, with the prior term of parole supervision being null and void. In other words, a prisoner serving a life term can shorten his or her parole/post-release supervision term by committing a felony while in prison. This legislation would correct this problem and require the prisoner to serve the original term of parole supervision for life.

This legislation is designed to protect the community from those who have no regard for human life. I ask you to support this bill.

Respectfully submitted,

Thomas R. Stanton
Deputy Reno County District Attorney

KANSAS
PAROLE BOARD

Kathleen Sebelius, Governor
Libby Scott, Administrator
and ReEntry Liaison
www.dc.state.ks.us

Paul Feleciano, Chairperson
Robert Sanders, Member
Patricia Biggs, Member

MEMORANDUM

TO: SENATE JUDICIARY COMMITTEE, SENATOR VRATIL, CHAIRMAN

FROM: KANSAS PAROLE BOARD

DATE: FEBRUARY 6, 2008

RE: 2008-SB 479

INTRODUCTION

2008-SB 479 relates to the term of post-incarceration supervision required of certain offenders. The Kansas Parole Board strongly supports this proposed policy change.

ANALYSIS AND CONSIDERATION

Presently, incarcerated offenders with a life sentence imposed by the Court who are convicted subsequently of a guidelines-level crime for an offense committed during his/her incarceration, upon achieving parole suitability on the non-guidelines crime, the term of post-incarceration supervision for that offender is tied to the guidelines-level crime and the life sentence is completed.

An example would be an offender serving a 20 to life sentence for kidnapping and aggravated robbery who, while incarcerated, is convicted of introduction of contraband to a correctional facility (K.S.A. 21-3826(a)). This severity level 5 crime carries with it a term of post release supervision of 24 months which, with the application of earnable goodtime credits while on supervision may be reduced to 12 months. Under current law, this post-release supervision term is the duration for which the offender must be supervised in the community. Absent the subsequent conviction for trafficking in contraband, the offender would serve a term of post incarceration supervision of life. In essence, current law rewards additional anti-social criminal behavior within the confines of our correctional facilities.

SB 479 remedies this situation and allows retention of the life term of post incarceration supervision for an offender in this scenario.

ANTICIPATED IMPACT

When considering the parole suitability of offenders who present with cases such as that described in the example above, the current Parole Board has been reluctant to issue a positive finding in terms of parole suitability knowing that the severity of the initial offense, the degree of victim harm, and the truncated term of post incarceration supervision would apply. The enactment of SB 479 is viewed as remedying the disparity imposed by additional bad acts and felony convictions within the confines of correctional facilities. Anecdotally, there have been some offenders who have admitted during a parole hearing that they committed additional offenses while incarcerated to "get out from under" the life sentence.

ADDITIONAL CONSIDERATION: AMENDMENT REQUEST

While the Parole Board supports SB 479, we feel that the policy stops short of achieving true parity in this domain of sentencing. In particular, if an offender is sentenced to an indeterminate term of incarceration less than "life" (e.g., 20-80 years) and s/he is convicted of a new sentence determinate sentence while incarcerated, this offender is still "rewarded" by the elimination of the indeterminate maximum sentence date in lieu of the new guidelines sentence with its term of post incarceration supervision.

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TO: The Honorable Senators of the Judiciary Committee

FROM: Thomas R. Stanton
Deputy Reno County District Attorney
President, KCDAA

RE: Senate Bill 481

Chairman Vratil and members of the Committee:

Thank you for consideration of Senate Bill 481, and for giving me the opportunity to testify regarding this legislation. Two insidious hallucinogenic drugs have appeared in communities across this nation. Those drugs are salvia divinorum, also known as salvinorum A, and datura stramonium, also known as gypsum weed or jimsom weed. This bill would criminalize the possession, use and sale of these drugs by listing them as controlled substances pursuant to K.S.A. 65-4105(d).

Salvia divinorum is a powerful psychoactive herb grown primarily in South America. Videos of teenagers using the drug have appeared on You Tube. These videos show children using the drug and entering a state in which neither the body nor the emotions can be controlled. According to the information I have gathered, many of these "trips" result in horrifying, depressing hallucinations. Use of the drug has been linked to the suicide of one Delaware teenager, Brett Chidester. Brett was a well adjusted, bright, high school student who began purchasing the drug over the internet. He ultimately committed suicide when the "insight" he received during the use of this drug resulted in his conclusion that his life was not worth living. The tragedy led to the Delaware legislature taking the action I am asking you to take today.

The DEA reports that the drug has been added to the schedule I list of controlled substances in Delaware and Missouri. Controls on the drug were passed in Tennessee, Oklahoma, Maine and North Dakota in 2006. As of July 2007, the following states have proposed legislation to control the drug: Alabama, Alaska, California, Florida, Illinois, Iowa,

New Jersey, New York, Ohio, Oregon, Pennsylvania, Texas, and Kansas. While there have been no salvia-related deaths reported in Kansas, the fact that this substance is not controlled makes it difficult to track its current effects in our State.

Datura stramonium is a weed found in many parts of this country. Its use has been promoted in the recent past by, again, videos available by internet which depict teenagers "getting high" using the drug. The high has been described as a "living dream," with hallucinogenic effects that can last for days. A major concern with this drug is the fact that dosages which result in the desired "high" and dosages that can result in death are extremely close. If a person uses this drug and does not experience the expected result, a second dose can then kill the user.

There are times in life when the prudent action to be taken is to wait until a particular situation occurs before taking action. This type of reactive response is sometimes preferable to alternative courses of action. There are other times when the prudent course to follow is a proactive course of action. When it comes to these substances, the prudent action is to pass this legislation now. We should not wait for the death of a child in Kansas to take steps to control these drugs.

Respectfully submitted,

Thomas R. Stanton
Deputy Reno County District Attorney

STATE OF KANSAS

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REPRESENTATIVE, 76TH DISTRICT
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TOPEKA, KS 66612
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TOPEKA

HOUSE OF REPRESENTATIVES

COMMITTEE ASSIGNMENTS

VICE-CHAIR: HEALTH & HUMAN SERVICES
UTILITIES
SOCIAL SERVICES BUDGET

Testimony for SB481
February 6th 2008

Members of the Committee, thank you for the opportunity to speak a few words about the merit of this piece of legislation. We all desire to protect our young people from unnecessary harm. This important bill will help to move toward that goal. The active chemical - Salvinorin A, which is found in Salvia, is the strongest naturally occurring psychoactive drug known to date. There are several ways of ingesting this drug and the youth culture has caught on to the hallucinogenic effects of its use.

Salvia is an extremely potent drug and the effects of taking it becomes stronger with each use. For this reason, I join with law enforcement, parents, and organizations across Kansas and ask you to pass this legislation to help keep our children safe.

Respectfully,

Peggy Mast

Peggy Mast, State Representative
76th District

Senate Judiciary
2-6-08
Attachment 4

Emporians for Drug Awareness, Inc.
Working for a Safer Community

PO Box 2015 Emporia KS 66801

620.341.2450 voice
620.341.2331 fax

February 6, 2008

Honorable Senator Vratil, Chair, and
Distinguished Members of the Judiciary Committee:

The changes proposed by Senate Bill No. 481 related to controlled substances in the State of Kansas represent a significant effort to prevent the use of two hallucinogens that are, as yet, unscheduled on a national basis and, therefore, considered legal for use, purchase or cultivation. Several individual states have already taken the step to address the dangers of Salvia Divinorum or Salvinorum A. Datura Stramonium, commonly known as jimson weed, grows wild in Kansas making it particularly relevant to try to control.

Internet sites abound proclaiming the purported benefits and "mind-expanding" properties of both of these plants. Not only can the information on these sites be misleading in regards to health benefits, but because the two are "plants", potential users may have the impression that they are "natural" substances and, thus, much safer than is actually the case.

By adopting legislation that adds salvia and jimson weed to other controlled substances, our state can be proactive in helping to raise awareness and possibly prevent many injuries or deaths.

Respecfully,

Teresa Walters

Teresa Walters, Certified Prevention Specialist
Executive Director

Visit our website at www.emporiansfordrugawareness.com

Senate Judiciary
2-6-08
Attachment 5

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Senator Derek Schmidt
Majority Leader

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Chair: Confirmation Oversight
Vice Chair: Assessment & Taxation
Organization Calendar & Rules
Member: Judiciary
Agriculture
Legislative Post Audit

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Testimony in Support of Senate Bill 482
Presented to the Senate Judiciary Committee
by Senator Derek Schmidt

February 6, 2008

Mr. Chairman, members of the committee, thank you for the opportunity to testify today in support of Senate Bill 482.

This legislation is one of three bills -- Senate bills 482, 483 and 484 -- that taken together are intended to provide an additional treatment option to help break the cycle of addiction for certain drug offenders. They would provide a third option, available to courts on a discretionary basis, to provide in appropriate cases both treatment and incarceration instead of forcing courts to choose between treatment or incarceration.

In developing this legislation, I have worked with the Department of Corrections and with others to ensure this approach would be workable within our overall corrections system.

We have been careful not to disturb the existing treatment regime established by Senate Bill 123, and with respect to the felon DUI bill (Senate Bill 484) we have been cautious not to unduly disrupt the community-based treatment regime put in place several years ago by Senate Bill 67. But the additional option of incarceration-based treatment is important in helping give courts a full range of options to tailor the appropriate combination of punishment and treatment intervention for individual offenders.

The individual approach of these bills is as follows: Senate Bill 482 focuses on providing this additional treatment option for third-time offenders sentenced pursuant to Senate Bill 123. Under current law, these third-time offenders would simply be incarcerated in a traditional facility and would not receive community-based treatment. This new approach would provide an additional, intermediate treatment option before a person is sentenced to traditional incarceration for subsequent offenses. In short, it gives one more chance -- a third chance -- for treatment to work before traditional incarceration is substituted for treatment, but it does so by trying a different, more-intensive form of treatment than the community-based treatment offered for first- and second-time offenders.

Senate Bill 483 focuses on condition violators whose violation is that they used drugs or alcohol while on parole or probation. Under this proposal, judges would have an option to revoke a person's parole or probation only for the period of time needed for that person to serve a term of intensive drug-treatment in a state drug rehabilitation prison (probably 120 or 180 days). This is a middle-ground option between, in effect, ignoring the violation and a complete revocation of parole or probation.

Senate Bill 484 focuses on felons convicted of a third or subsequent DUI. Of the three bills, this is the one that has the greatest possibility of producing a short-term, quantifiable savings of taxpayer funds by relieving county jails of the costly burden of housing felon DUI offenders. Under this proposal, certain of these offenders could be sentenced by a court to serve their time in a state drug-treatment facility instead of in the county jail. It is likely that significant jail expansion projects could be delayed or, possibly, eliminated as a result of this approach -- and, of course, the offender would receive better, more-intensive treatment that would increase the likelihood of breaking the cycle of addiction and preventing future offenses.

Thank you, Mr. Chairman, for considering these measures. I would stand for questions.

Kansas Sheriffs Association

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Before the Kansas Senate Judiciary Committee
Testimony of Sheriff Craig Murphy, Butler County, Kansas
Regarding SB 482, An ACT amending KSA 21-4705

Chairperson Vratil, Vice Chairperson Bruce, and distinguished members of the Committee:

My name is Craig Murphy, Sheriff of Butler County, Kansas appearing before you today in support of the proposed changes set out in Senate Bill 482.

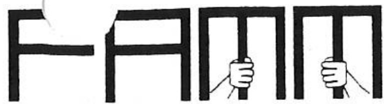
I support the presumption that drug offenders will be sentenced to state drug treatment programs. This approach will produce no negative impact on County Jail inmate populations, and is intended to set the stage for the successful reentry of these offenders into society.

Bed space in all of the county jails in Kansas is in short supply, and any initiative with the primary focus of reducing that pressure while addressing one of the major public health and safety issues of our time will always have my strong support.

Sheriff Craig Murphy
Butler County Sheriff

Executive Director Darrell Wilson Officer Manager Carol Wilson Legal Counsel Bob Stephan

Home Page: ks-sheriff.org



Families Against Mandatory Minimums

FOUNDATION

February 6, 2008

RE: SB482 – SB483 – SB484

Senator Vratil and Honorable Members of this Committee:

Thank you again for this opportunity to testify before this committee, especially on this bill, which I support, but with reservations. While I am testifying on behalf of Families Against Mandatory Minimums, some of my comments are relative to my position as the supervisor of substance abuse services for the Wichita and Sedgwick County Day reporting centers. In that capacity, I can tell you that jails and prisons do not cure or even treat addiction, but they are almost always a necessary element of change. They remove the offender from their lifestyle, environment, associates and addiction, and force them to take some level of accountability. As a student and practitioner of the "neuroscience of addiction" I can also tell you that incapacitation provides the person an opportunity to begin restoring the chemical imbalance caused by the prolonged use of drugs and alcohol.

However, this reaches the point of diminishing returns relatively soon. Real and effective treatment must take place in these offenders respective communities of origin, "where the rubber meets the road." This is where the person gains the tools and skills to manage their cravings and obstacles with the support of intensive ongoing cognitive-based treatment in conjunction with incentive-based graduated sanctions that allow the offender to slowly integrate back into their community. I have attached a research article on Integrating Substance Abuse Treatment and Criminal Justice Supervision based on science and practice perspectives by Dr. Douglas Marlowe, a lawyer and clinical psychologist by background. This research illustrates the importance of community-based intermediate sanctions which create much stronger incentives, and generally produce an average 10 percent reduction in recidivism when delivered in conjunction with treatment, than can be delivered in a prison setting.

This research article concisely, but yet comprehensively, outlines best practices related to this bill. Integrated public health – public safety strategies blend the functions of the criminal justice system and the drug abuse prevention system in an effort to optimize outcomes for offenders. Substance abuse treatment assumes a central role in these programs, rather than being peripheral to punitive ends, and is provided in the client's community of origin, enabling clients to maintain family and social contacts and seek or continue in gainful education or employment. The attributes they share are treatment, avoiding incarceration (and related effects), close supervision and swift and certain consequences.

Both the National Institutes of Drug Abuse and Treatment Research Institute where Marlowe worked prior to becoming Chief of Science, Law and Policy at the National Association of Drug Court Professionals, validates that comprehensive and holistic community-based treatment is two, and in some cases, three times as effective as treatment based in prison treatment facilities. Providing drug abuse treatment with prison typically reduces criminal recidivism rates by only about 10 percent, but if follow-up is absent in the community the results are indistinguishable. Effectiveness of treatment becomes all the more significant when we know that sustained abstinence from narcotics is associated with a 40 – 75 percent reduction in crime.

Senate Judiciary
2-6-08
Attachment 8

1612 K Street, NW • Suite 700 • Washington, D.C. 20006 • (202) 822-6700 • fax (202) 822-6704 • FAMM@famm.org • h

A 2006, NIDA report tells us that 95% of those in prison for drug related offenses who do not receive drug treatment in or outside of prison upon their release, end up relapsing into drugs, and 70% of them return to prison. The addiction lies dormant in prison, and cannot be as effectively treated there as it can be in the community where the offender is reintegrating. While incapacitation is an earned and necessary element to treating compulsively addicted drug and alcohol abusers, treatment is all about seamless continuity of services in the in the community in conjunction with graduated sanctions that slowly integrate the offender back into the community, (or jail or prison) with the support of ongoing therapy, family, employment, housing and quite possibly social services, such as mental health treatment. Recovery is a process that has to be holistic. Many, if not all, of these essential elements to recovery would be missing in a prison treatment setting, especially if it is in an isolated location.

These bills are long overdue and most worthy endeavors, but we have to utilize the approach that has shown to be the most effective, and efficient. The approach that has shown consistent promise for reducing drug use and criminal recidivism is an integrated public health-public safety strategy that combines community-based drug treatment with ongoing criminal supervision in the respective communities of origin of the offenders. What a wonderful opportunity this is to contribute to what all of the folks here today for the Kansas Association of Addiction Professionals Lobby Day know is the most vital and essential missing element from our communities for those who need recovery, which is some type of in-patient treatment beds. We can save all the monies all the monies for bricks, mortar and bars and build from existing structures or programs in the community by changing the configuration and approach to the therapeutic model, while incorporating the vital criminal justice perspectives of incapacitation and accountability.

People don't go to treatment because they want to. It is because they have to." It is in large part because the addiction has become part of the limbic, or survival system of the brain and the drug or alcohol becomes as or more paramount to that person than food. The only hope of changing this dynamic is constantly engaging and training the logical, rational, but weaker neo or prefrontal cortex to override those cravings in the environment drug and alcohol addicted persons face on a daily basis. While I fully support these endeavors, we have to look at the most effective and efficient means of delivering substance abuse services. To do this, we need only look at investing into and beefing up our treatment capacity in many of the cities and counties across Kansas with the provisions in these most worthy bills. In closing, I would like to commend Sen. Schmidt in his efforts toward treating drug and alcohol addicted offenders, restoring lives, families and communities across Kansas.

Sincerely

Peter Ninemire, LMSW,SAPTR
Midwest Regional Organizer/Trainer
Families Against Mandatory Minimums
1926 S. Estelle – Wichita, KS 67211
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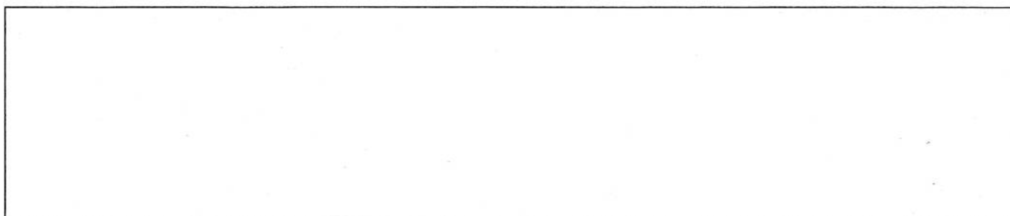
For those that might be interested to learn more about addiction, this is a Post-script about addiction that was edited out of my published article "Treatment, not prison" that I attached to testimony in opposition to SB409 on 1/24/08.

People do not practice behaviors that are outside of societal norms, or incongruent with family and/or personal values, without creating belief systems to justify them. The larger the discrepancy between our values and our behaviors, the greater the belief system must be to manage the internal conflict. In this fashion, marijuana and other drugs work in much the same way as the cigarette smoker creates the reason, or justification for smoking to satisfy the internal conflict, or cognitive dissonance, of knowing the multitude of negative effects. The addiction is created because of the reward pleasure action, where the reward is part of the relief from the intense physical discomfort caused by the chemical imbalance created by nicotine. This is reinforced by psychological and habitual aspects, such as the social interaction of co-workers having a cigarette during a planned break at work. Most psychoactive drugs are not as physically addictive as nicotine, but create a mental or psychological addiction to the reward of the associated feeling. Over time, the chemical make-up of the brain is altered, and the person becomes a "stimulus response machine." They get stimulus, (feelings -both good and bad) and the brain is now programmed to respond by seeking or doing the drug.

People do drugs because they like them. This also has to do with the reward pleasure center. Research strongly suggests that the action that caused the reward is more deeply imprinted. The more intense the reward, the more ingrained the memory and so the more likely the action will be repeated (Wicklegreen, 1998). Refined psychoactive drugs are so strong that they can imprint the emotion associated with the subsequent euphoria or pain relief more deeply than most natural memories (Inaba & Cohen, 2000). The brain short-circuits the rational, logical neocortex and the addict becomes a stimulus response machine. Dr. Nora Volkow, Director of the National Institutes of Drug Abuse, believes that becoming an addict is more a matter of chance than anything, largely due to the mix of the right combination of life experience and genetics. High levels of certain neurotransmitters, especially dopamine receptors associated with pleasure, seem to protect against addiction, where low levels make one more susceptible. Volkow's research, and others, suggests that receptor space decreases with high levels of stress, and increases when that it is relieved. This helps explain the correlation between life crisis events sending some off into a "tailspin" that makes them more susceptible to addiction at these times.

Addiction is also relative to the substance and the individual. Merrel Norton, a Georgia pharmacist, turned addictions specialist at the University of Georgia, has become a national expert on the neurobiology and pharmacology of the brain as it relates to addiction. He explains that the reason some of us like white over dark chocolate, or methamphetamine over marijuana, can be found in the nucleus accumbens region of our brain that determines which experiences we like best. This combined with neurotransmitter/receptor site levels and life experiences, may explain in large part why I became addicted to marijuana and not alcohol. Once the addiction cycle has begun, the combination of biopsychosocial effects, and inability to resolve past or present life experiences, can make the wheel of addiction difficult to escape.



The National Association of Drug Court Professionals (NADCP) is pleased to announce that **Douglas B. Marlowe, J.D., Ph.D.** has joined our organization as **Chief of Science, Law and Policy**.
In his new role, Dr. Marlowe will be responsible for translating the latest scientific findings into useful and understandable practice and national policy, addressing legal issues facing the drug court model and expanding NADCP's role in the full problem-solving court arena.

More About Dr. Marlowe:
Dr. Marlowe is an Adjunct Associate Professor of Psychiatry at the University of Pennsylvania School of Medicine and former Director of the Division of Law & Ethics Research at the Treatment Research Institute (TRI). A lawyer and clinical psychologist by background, Dr. Marlowe has received numerous state and federal research grants to study the role of coercion in drug abuse treatment, the effects of drug courts and other specialized programs for drug-abusing offenders, and behavioral treatments for drug abusers and criminal offenders. He is a Fellow of the American Psychological Association (APA) and has received proficiency certification in the treatment of psychoactive substance use disorders from the APA College of Professional Psychology. He has published over 100 professional articles and chapters on the topics of crime and drug abuse and is on the editorial boards of the journals, the Drug Court Review and Criminal Justice & Behavior. From 2004 through 2007, Dr. Marlowe was a member of NADCP's Board of Directors on which he served as Chair of the Research Committee and the Drug Policy Reform Committee.
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Integrating Substance Abuse Treatment and Criminal Justice Supervision

Proponents of a pure public safety perspective on the drug problem hold that drug-involved offenders require consistent and intensive supervision by criminal justice authorities in order to stay off drugs and out of trouble. In contrast, proponents of a thoroughgoing public health perspective commonly argue that clients perform better if they are left alone to develop an effective therapeutic alliance with counselors. Both may be correct, but with respect to different groups of offenders. One approach has shown consistent promise for reducing drug use and criminal recidivism: an integrated public health-public safety strategy that combines community-based drug abuse treatment with ongoing criminal justice supervision. This article presents promising findings from programs implementing this strategy and discusses best treatment practices to meet the needs of both low-risk and high-risk clients.

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The drug abuse treatment and criminal justice systems in this country deal with many of the same individuals. Approximately two-thirds of clients in long-term residential drug abuse treatment, one-half of clients in outpatient drug abuse treatment, and one-quarter of clients in methadone maintenance treatment are currently awaiting a criminal trial or sentencing, have been sentenced to community supervision on probation, or were conditionally released from prison on parole (Craddock et al., 1997). Conversely, 60 to 80 percent of prison and jail inmates, parolees, probationers, and arrestees were under the influence of drugs or alcohol during the commission of their offense, committed the offense to support a drug addiction, were charged with a drug- or alcohol-related crime, or are regular substance users (Belenko and Peugh, 1998).

The co-occurrence of drug abuse and crime is not simply an artifact of criminalizing drug possession. Drug use significantly increases the likelihood that an individual will engage in serious criminal conduct. More than 50 percent of violent crimes, including domestic violence, 60 to 80 percent of child abuse and neglect cases, 50 to 70 percent of theft and property crimes, and 75 percent of drug dealing or manufacturing offenses involve drug use on the part of the perpetrator—and sometimes the victim as well (e.g., Belenko and Peugh, 1998; National Institute of Justice, 1999). Sustained abstinence from narcotics is associated with a 40- to 75-percent reduction in crime (e.g., Harrell and Roman, 2001).

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In dealing with drug abusers who are criminal justice offenders, many clinicians and service providers support a public health perspective, contending that clients are best served through a focus on treatment, with only minimal involvement of the criminal justice system. They sometimes find themselves at odds with public safety proponents who say that criminal offenders require constant supervision to succeed. Both views are valid, but neither is adequate in itself. Research has shown that neither the pure public safety nor an exclusively public health approach to the problem works fully; instead, it supports an integrated approach that has very specific implications for best practices (see Marlowe, 2002, for review). This article briefly reviews results obtained from one-dimensional public safety and public health strategies and presents promising findings from integrated public health-public safety programs. Finally, the implications for best treatment practices and client-program matching are discussed.

PUBLIC SAFETY STRATEGIES

Drug abuse is illegal and drug abusers are responsible for a disproportionate amount of crime and violence. Society often imprisons drug abusers to protect the public and deter further drug use. Yet, within 3 years of release from prison, approximately two-thirds of all offenders, including drug offenders, are rearrested for a new offense, one-half are convicted of a new crime, and one-half are reincarcerated for a new crime or a parole violation (Langan and Levin, 2002). In some studies, 85 percent of drug-abusing offenders returned to drug use within 1 year of release from prison, and 95 percent returned to drug use within 3 years (e.g., Martin et al., 1999). Providing drug abuse treatment within prison typically reduces criminal recidivism rates by only about 10 percentage points (e.g., Gendreau et al., 2001; Pearson and Lipton, 1999). Moreover, in the absence of followup treatment in the community, drug use outcomes are often indistinguishable between offenders who attended in-prison drug abuse treatment and those who received no treatment in prison (e.g., Marlowe, 2002; Martin et al., 1999).

Drug abuse treatment in prison does, however, confer limited, short-term benefits. Studies indicate that in-prison treatment is associated with fewer disciplinary infractions by inmates and reduced absenteeism by correctional staff (Prendergast et al., 2001). More importantly, it increases the likelihood that an inmate will enter drug abuse treatment after release from prison (Martin et al., 1999). Possibly, in-prison services enhance inmates' motivation for change or prepare them to use drug abuse treatment services once they are in the community or in a transitional-release setting.

Intermediate-sanction programs attempt to reduce drug use and criminal activity, as well as reduce costs, by reducing the emphasis on incarceration and instituting close surveillance of drug-abusing offenders in the community. In these programs, specially trained probation or parole officers with light caseloads typically monitor offenders' compliance with treatment, make surprise home visits, demand spot-check urine samples, phone-monitor compliance with home curfews or house arrest, or interview employers, friends, and relatives about offenders' behavior.

The co-occurrence of drug abuse and crime is not simply an artifact of criminalizing drug possession.

Unfortunately, community-based intermediate-sanction programs have had little impact. Approximately 50 to 70 percent of probationers and parolees fail to comply with their release conditions, including drug testing, attendance at drug treatment, and avoidance of criminal activity (e.g., Taxman, 1999*a*). Moreover, no incremental benefits are obtained from intensive supervised probation and parole programs, electronic monitoring, boot camps, or house arrest (e.g., Gendreau et al., 2001; Taxman, 1999*b*). Enhanced monitoring of offenders in these programs often leads to a greater detection of infractions and therefore, paradoxically, to seemingly worse outcomes.

In practice, intermediate sanctions typically have been administered in isolation from treatment, with an emphasis on monitoring and sanctioning at the expense of potential rehabilitative functions. When they have been administered in conjunction with treatment, they have generally produced an average of a 10 percentage-point reduction in recidivism (e.g., Gendreau et al., 2001), equivalent to what is commonly obtained from prison-based treatment programs.

PUBLIC HEALTH STRATEGIES

In a pure public health approach to drug-involved offenders, drug abuse or dependence is viewed as a disease that requires treatment rather than confinement or punishment. Accordingly, identifying drug abuse problems among offenders and referring those individuals to treatment in the community is con-

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Drug abuse treatment in prison increases the likelihood that an inmate will enter drug abuse treatment after release.

sidered to be potentially the most effective way to turn them away from drug abuse and repeated crime. Case management to facilitate referral and coordinate ancillary services for the offender-patients also is believed to influence the success of a public health strategy.

Referral to Treatment

To benefit from treatment, clients must attend the sessions and participate in the interventions. Evidence from the Drug Abuse Treatment Outcome Study, which included an evaluation of a nationally representative sample of outpatient and long-term residential drug treatment programs, suggests that 3 months of participation in drug treatment may be a minimum threshold for detecting dose-response effects for the interventions (Simpson et al., 1997). That is, with less than 3 months of treatment, there may not be a significant correlation between time in treatment and outcomes. It also appears that 6 to 12 months of treatment may be a further threshold for observing lasting reductions in drug use. In fact, 12 months of drug abuse treatment may be a median point on the dose-response curve. Approximately 50 percent of clients who complete 12 months or more of drug abuse treatment remain abstinent for an additional year after completing treatment (McLellan et al., 2000).

Unfortunately, attrition in substance abuse treatment programs is unacceptably high. Approximately 70 percent of probationers and parolees drop out of drug treatment or attend irregularly prior to a 3-month threshold, and 90 percent drop out prior to 12 months (e.g., Marlowe, 2002; Taxman, 1999*a*; Young et al., 1991). Comparable attrition rates are found for drug abuse patients in general (e.g., Stark, 1992). These figures suggest that, on average, only about 10 to 30 percent of clients, in or out of the criminal justice system, receive a minimally adequate dosage of drug treatment. Perhaps as few as 5 to 15 percent achieve extended abstinence.

Of course, these figures are national averages for treatment-as-usual in community-based settings, and it is possible that particular regimens may be more successful at retaining offenders in treatment. Further research is needed to determine whether some treatment interventions may be more acceptable to offender populations or superior for retaining offenders in treatment in noninstitutional correctional settings.

Case Management

The use of specially trained case managers to continuously monitor offenders' attendance in counseling, take random urine samples to confirm drug abstinence, and provide progress reports to responsible criminal justice authorities is a strategy that seeks to ensure that offenders receive adequate dosages of treatment. Yet, adding case-management services to drug abuse treatment for offenders has produced mixed findings.

In the 1970s, under the rubric of Treatment Alternatives to Street Crime (TASC)–later renamed Treatment Accountability for Safer Communities–hundreds of case-management agencies were founded across the country to identify and refer drug-using offenders to a range of treatment services, monitor their progress in treatment, and report compliance information to appropriate criminal justice authorities. Federal seed funding for TASC was withdrawn in the early 1980s, and now these programs generally rely on a patchwork of local and Federal funds for their continued existence.

TASC agencies operate very differently across jurisdictions, with some programs providing treatment services directly, others developing contractual or formal referral arrangements with treatment programs, and still others making referrals with few formal agency linkages. Generally, there are no systematic sanctions in TASC programs for individuals who do not comply with their treatment regimens.

Early evaluations of TASC programs concluded they were generally effective at identifying substance abuse problems among offenders and making appropriate treatment referrals. Moreover, in a national study, TASC clients were more likely to complete a 3-month threshold of outpatient or residential treatment (48 percent and 57 percent, respectively) than were clients with no current legal involvement (30 percent and 41 percent, respectively) (Hubbard et al., 1988).

A recent evaluation of five large and representative TASC programs concluded, however, that effects on drug use and criminal recidivism were mixed (Anglin et al., 1999). Drug use was significantly lower for TASC clients in three of the five sites, and criminal activity was lower in only two of the sites. These data suggest that the effects of TASC programs vary considerably, depending upon how well the programs carry out their case-management responsibilities. It

is reasonable to hypothesize that TASC agencies will be most effective if they have moderate caseloads, meaningful control over the quality of the services their clients receive, and the ability to provide meaningful consequences if clients fail to attend treatment or continue to use drugs.

INTEGRATED PUBLIC HEALTH-PUBLIC SAFETY STRATEGIES

Integrated public health-public safety strategies blend the functions of the criminal justice system and the drug abuse treatment system in an effort to optimize outcomes for offenders (Marlowe, 2002). Substance abuse treatment assumes a central role in these programs, rather than being peripheral to punitive ends, and is provided in clients' community-of-origin, enabling clients to maintain family and social contacts and seek or continue in gainful education or employment. Responsibility for ensuring clients' attendance in 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 have limited power to coerce patients to attend. The criminal justice system maintains substantial supervisory control over offenders and has enhanced authority through plea agreements and similar arrangements to respond rapidly and consistently to infractions in the program.

Noteworthy examples of recent integrated public health-public safety strategies include drug courts and work-release therapeutic communities, which are described in the following sections. While these certainly are not the only conceivable models of integrated strategies, they are the only ones that studies have consistently found effective in reducing drug use and recidivism.

Programs that represent the public health-public safety integration strategy and that have demonstrated effectiveness share a core set of attributes:

- They provide treatment in the community.
- They offer the opportunity for clients to avoid incarceration or a criminal record.
- Clients are closely supervised to ensure compliance.
- The consequences for noncompliance are certain and immediate.

Drug Courts

Drug courts constitute a clear paradigm of an integrated public health-public safety strategy that has shown promise for reducing drug use and recidivism among probationers and pretrial defendants. Drug courts are separate criminal court dockets that provide judicially supervised treatment and case-management services for drug offenders in lieu of prosecution or incarceration. The core components of a drug court typically include regular status hearings in court, random weekly urinalyses, mandatory completion of a prescribed regimen of substance abuse treatment, progressive negative sanctions for program infractions, and rewards for program accomplishments.

Common examples of negative sanctions include verbal reprimands by the judge, writing assignments, and brief intervals of detention. Common examples of rewards include verbal praise, token gifts, and graduation certificates. Counseling requirements may also appropriately be decreased when the client complies well with treatment or increased if he or she has poor attendance or participation or other problems. Clients who satisfactorily complete the program may have their current criminal charges dropped or may be sentenced to time served in the drug court program. Defendants are generally required to plead guilty or "no contest" as a precondition of entry into drug court. Therefore, termination from the program for noncompliance ordinarily results in a criminal drug conviction and sentencing to supervised probation or incarceration.

The evidence is clear that drug courts can increase clients' exposure to treatment. Reviews of nearly 100 drug-court evaluations concluded that an average of 60 percent of drug court clients completed a year or more of treatment, and roughly 50 percent graduated from the program (Belenko, 1998, 1999, 2001). This compares favorably to typical retention rates in community-based drug treatment programs where, as noted, more than 70 percent of clients on probation and parole drop out of drug treatment or attend irregularly within 3 months, and 90 percent drop out in less than 1 year.

Promising, although less definitive, is the evidence with regard to the effects of drug courts on drug use and crime. Two experimental studies have compared outcomes between participants randomly assigned to either drug court or a comparable probationary condition. In one study, the Maricopa County (Arizona) Drug Court was found to have had no impact on re-arrest rates 12 months after admission to drug court

In a national study, TASC clients were more likely to complete a 3-month threshold of outpatient or residential treatment than were clients with no current legal involvement.

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Elements of Successful Programs

Effective programs such as drug courts and work-release therapeutic communities have the following elements in common:

- ***Treatment in the community.*** For treatment gains to generalize and be sustained, clients require opportunities to practice new skills in the community environment. In contrast, incarceration removes individuals from family and social supports, interferes with employment or education, and exposes them to antisocial peer influences.
- ***Opportunity to avoid a criminal record or incarceration.*** Treatment completion and drug abstinence are reinforced by removal of criminal justice sanctions, and clients can avoid the debilitating stigma of a criminal record.
- ***Close supervision.*** The programs include random weekly urinalyses, status hearings with criminal justice authorities, and monitoring of official rearrest records. Clinicians provide regular progress reports to supervising authorities and may provide testimony at status hearings. As a result, clients are less apt to drop out of the system through inattention and cannot exploit gaps in communication.
- ***Certain and immediate consequences.*** Clients agree to specified sanctions and rewards that can be readily applied without having to hold new formal hearings with the full range of due process protections. Termination for noncompliance or new infractions automatically results in a criminal conviction and criminal disposition.

To be maximally effective, therapeutic community services should be provided along the full continuum of reentry—in prison, during work-release, and continuing after the offender's return to the community.

(Deschenes et al., 1995). However, a significant "delayed effect" was detected at 36 months, at which time 33 percent of the drug court participants had been rearrested, compared to 47 percent of subjects in various probationary tracks (Turner et al., 1999).

Similarly, in a randomized study of the Baltimore City Drug Treatment Court, 48 percent of drug court clients and 64 percent of adjudication-as-usual control subjects were rearrested within 1 year of admission (Gottfredson and Exum, 2002). At 2 years post-admission, 66 percent of the Baltimore drug court participants and 81 percent of the controls had been rearrested for some offense, and 41 percent of the drug court participants and 54 percent of the controls had been rearrested for a drug-related offense (Gottfredson et al., 2003).

Nearly 100 quasi-experimental evaluations have compared outcomes between drug court participants and nonrandomized comparison groups. In the majority of these evaluations, drug court clients achieved significantly greater reductions—differences of approximately 20 to 30 percentage points during treatment and 10 to 20 percentage points after treatment—in drug use, criminal recidivism, and unemployment than did individuals on standard probation or intensive probation (Belenko, 1998, 1999, 2001). The magnitudes of the posttreatment effects are comparable to the 15 percentage-point reduction in recidivism obtained in the two experimental studies reviewed above.

It is important to note, however, that many drug court evaluations have used systematically biased comparison samples, such as offenders who refused, were deemed ineligible for, or dropped out of the interventions. This may have led to an overestimation of positive outcomes for drug court clients in some studies because the comparison subjects are likely to have had more severe criminal histories or lower motivation for drug abuse treatment from the outset. Further, most of the studies evaluated outcomes only during the course of drug court or up to 1 year postdischarge, and hardly any studies have assessed substance-use outcomes after discharge. Thus, we know little about how drug court clients generally fare after the criminal justice supervision ends.

These limitations in the extant research on drug courts led the congressional General Accounting Office (GAO) to conclude there are insufficient data available to gauge the effectiveness of federally funded drug court programs in this country (GAO, 2002). In response to the GAO report, the National Institute of Justice (NIJ) released a request for proposals for long-term client-impact evaluations of up to 10 drug courts that will include assessments of postprogram recidivism, drug use, employment, and psychosocial functioning and will include suitable comparison conditions. These evaluations are expected to shed further light on the long-term impact of drug courts.

Work-Release Therapeutic Communities

Encouraging results have been reported for therapeutic community (TC) programs targeted to individuals paroled from prison or conditionally transferred to a correctional work-release facility in the community. TCs are residential treatment programs that isolate clients from drugs, drug paraphernalia, and affiliations with drug-using associates. The peers in TCs influence each other by confronting negative personality traits, punishing inappropriate behaviors, rewarding positive behaviors, and providing mentorship and camaraderie. Clinical interventions commonly include confrontational encounter groups, process groups, community meetings, and altruistic volunteer activities.

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Three-year longitudinal evaluations of geographically diverse correctional TC programs (Knight et al., 1999; Martin, et al., 1999; Wexler et al., 1999) suggest that, to be maximally effective, TC services should be provided along the full continuum of reentry, ranging from in-prison treatment, through work-release treatment, to continuing outpatient treatment. In all studies, in-prison TC treatment without aftercare had no appreciable effect on drug use or rates of return to custody. However, offenders who completed a work-release TC exhibited significant reductions—of approximately 10 to 20 percentage points—in re-arrests, returns to custody, and drug use. Moreover, completion of both in-prison and work-release programs was associated with a reduction of 30 to 50 percentage points in new arrests or returns to custody.

As with drug courts, these TC studies made inherently biased comparisons, such as contrasting TC dropouts with graduates, and comparing offenders who voluntarily entered aftercare to those who did not. As a result, it is difficult to be confident of the actual magnitude of the effects. Nevertheless, the results underscore the importance of providing aftercare services to offenders once they are released from prison. It is not sufficient to provide inmates with referral to a community treatment program. It is essential to prepare them for what to expect, to facilitate the referral by transferring the relevant paperwork and clinical information to the referral source, and to follow up to ensure that the individual has completed the referral (Cornish and Marlowe, in press). Moreover, as noted earlier, providing in-prison TC treatment may increase the probability that an inmate will continue in aftercare services. It would seem optimal to begin the continuum of drug treatment, including initial assessments and motivational enhancement interventions, prior to the inmate's release.

Unfortunately, TCs are the only community-reentry programs that have been systematically studied. There are virtually no outcome data available on other types of postprison initiatives. Recently, NIDA released a request for applications to develop the Criminal Justice-Drug Abuse Treatment Services Research System, which is intended to, among other things, provide support for controlled studies of various community-reentry strategies for drug-involved offenders.

BEST PRACTICES

Proponents of a pure public health perspective commonly argue that the involvement of criminal justice authorities in treatment can be disruptive and potentially harmful for a number of reasons:

- Clients may mistrust treatment providers who are allied with law enforcement and may not confide important clinical information for fear it will be used against them.
- Treating sick people like criminals may breed countertherapeutic feelings of resentment, hostility, or hopelessness.
- Forcing clients to spend time in criminal justice settings may have the unintended consequence of socializing them into a milieu of antisocial behavior.
- Criminal justice supervision is expensive and time-consuming. Judges, bailiffs, and probation and parole officers cost money that may then not be available for formal drug abuse treatment.

Proponents of a pure public safety perspective contend instead that:

- Drug-involved offenders are characteristically impulsive and irresponsible.
- These offenders frequently fail to meet their obligations and often do not stay out of trouble unless they are closely monitored and face immediate, consistent, and severe consequences for their noncompliance.
- Such close monitoring may itself be therapeutic because it instills a sense of accountability and provides highly effective behavioral contingencies.

Neither the pure public health position nor the pure public safety position is often borne out by research. The available evidence suggests that both may be correct, but with reference to different clients. Some clients perform better if they are left alone to develop an effective therapeutic alliance with their counselor and to focus on their problems and recovery in treatment. Others require consistent and intensive supervision by criminal justice authorities in order to succeed.

The Risk Principle: A Foundation for Best Practices

Outcome studies indicate that intensive interventions are best suited to high-risk offenders who have relatively more severe criminal dispositions and drug-use histories, but may be ineffective or contraindicated for low-risk offenders (e.g., Gendreau et al., 2001). This is known as the "Risk Principle" in the crimi-

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nal justice literature and is attributed to the idea that low-risk offenders are less likely to be on a fixed antisocial trajectory and are more likely to adjust course readily after a run-in with the law. Therefore, intensive treatment and monitoring may offer little incremental benefit for these individuals, while the cost is substantial. High-risk offenders, on the other hand, are more likely to require intensive structure and monitoring to alter their entrenched negative behavioral patterns.

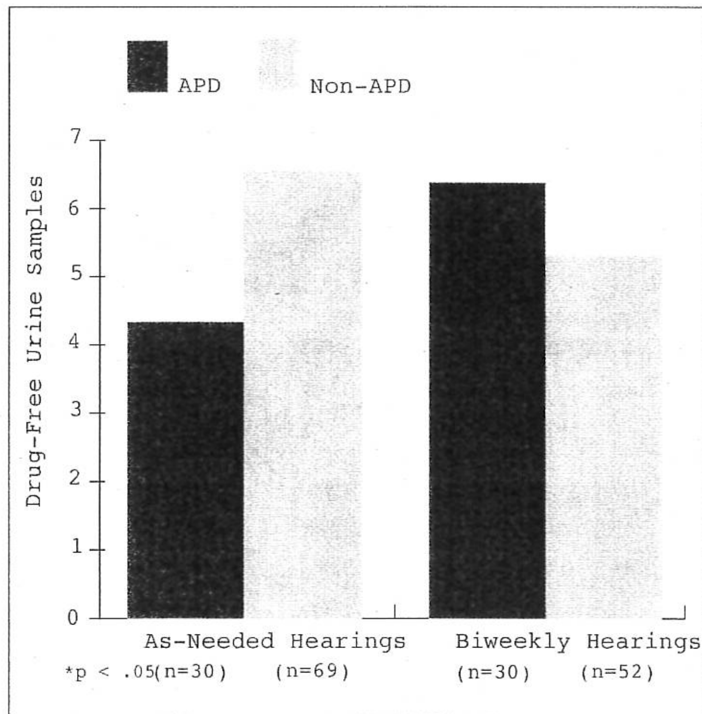
The greatest risk factors reported in the literature for failure in offender rehabilitation programs are a younger age during treatment (typically under age 25), an earlier age of involvement in crime (especially violent crime prior to age 16), an earlier age of beginning drug use (typically prior to age 14), a comorbid diagnosis of antisocial personality disorder (APD) or psychopathy, previous failed efforts in drug treatment or a criminal diversion program, and first-degree relatives with drug abuse problems or criminal histories (e.g., Gendreau, 1996). These risk factors are labeled "static" because they are historical in nature and are generally unaffected by clinical interventions. "Dynamic" risk factors, which can be targeted for change during treatment, include such things as antisocial attitudes, criminal associations, and gang membership.

The research program at the Treatment Research Institute (TRI) at the University of Pennsylvania has validated the Risk Principle among drug court clients. With funding from NIDA and the Center for Substance Abuse Treatment (CSAT), TRI randomly assigned misdemeanor drug court clients either to an intensive level of judicial supervision involving biweekly status hearings in court, or to a low level of supervision in which they were monitored by treatment personnel and had status hearings (see "A Basis for Matching Patients to Supervision Regimens") only as needed in response to sustained noncompliance or serious infractions. The results revealed no differences for participants as a whole in counseling attendance, urinalysis results, graduation rates, or self-reported substance use or criminal activity during treatment or at 6 months or 12 months postadmission (Marlowe et al., 2002; Marlowe et al., 2003*a*).

Importantly, however, the study showed a significant interaction effect, depending on participants' risk status. Participants who met DSM-IV diagnostic criteria for APD or had prior experiences in drug abuse treatment attained significantly greater drug abstinence and were significantly more likely to succeed in graduating from the drug court program when they were assigned to biweekly hearings. Conversely, clients without APD or a prior history in drug treatment performed better when they were assigned to as-needed hearings (Festinger et al., 2002). These same findings were replicated in two additional jurisdictions, in rural and urban communities and serving both misdemeanor and felony offenders (Marlowe et al., 2003*b*; Marlowe et al., in press).

In the replication studies, the magnitudes of the interaction effects were quite large. For instance, mis-

A Basis for Matching Patients to Supervision Regimens



During a 14-week misdemeanor drug court program, clients with antisocial personality disorder (APD) who were assigned to biweekly judicial status hearings turned in significantly more drug-free urine samples than similarly diagnosed offenders without a fixed schedule for hearings. Drug court clients without an APD diagnosis, conversely, did better when assigned to as-needed hearings.

Source: Festinger et al., Drug and Alcohol Dependence, 2002. *Copyright 2002 by D.S. Festinger, D.B. Marlowe, P.A. Lee, K.C. Kirby, G. Bovasso, A.T. McLellan, and Elsevier Press. Used with permission.*

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demeanor participants with a prior drug treatment history provided substantially more drug-free urine specimens during the first 3 months of drug court (11.50 versus 2.67) and were substantially more likely to graduate successfully from the program (83 percent versus 17 percent) when they were assigned to biweekly status hearings as opposed to as-needed hearings. Similarly, felony participants with APD reported engaging in substantially fewer days of alcohol intoxication when they were assigned to biweekly status hearings as opposed to as-needed hearings (0.50 versus 4.83).

The large magnitude of these effects made it ethically necessary to stop the studies and to institute remedial procedures for the high-risk participants assigned to the as-needed condition. The resulting small cell sizes (n=6 per cell in some analyses) do raise concerns about whether the study samples were adequately representative of drug court clients generally. Because the findings were reproduced in sequential experimental studies and are supported by a previously validated criminal justice theory (i.e., the Risk Principle), we have considerable confidence in their reliability. Nevertheless, it is essential to replicate this work in new settings with a larger number of participants.

It is also important that the interaction effects, although hypothesized in advance, were not under direct experimental control. TRI is currently conducting a prospective matching study in which drug court clients are randomly assigned to different schedules of judicial status hearings on the basis of an assessment of whether they have APD or a prior drug treatment history. The results of this work will permit an estimate of the effect size and relative costs and benefits of assigning drug offenders to different service tracks in drug court based upon their risk level.

Our finding that APD and drug treatment history were the most robust indicators of risk level among the drug court clients in our studies is quite consistent with prior research on the greatest risk factors for criminal reoffending (e.g., Gendreau, 1996). It is, however, possible that other risk factors will emerge in future matching studies and permit a more sensitive classification of high-risk and low-risk offenders. Further research is also needed to interpret the influence of prior drug treatment history. It is an open question whether this variable reflects the severity of participants' drug problems, past negative experiences with standard drug treatment, or some other, unknown influence. Further inquiry is needed to gain a definitive grasp of the nature of this interaction effect.

From Risk to Regimen

In the three jurisdictions TRI studied, approximately 50 percent of the felony and misdemeanor drug court clients met criteria for being at high risk, meaning they had APD, a prior drug treatment history, or both. These findings suggest that no more than half of drug offenders might reasonably be expected to perform adequately in the type of low-intensity, nonjudicially managed diversionary intervention exemplified in recent State policy initiatives such as Proposition 36 or Proposition 200 (see "States Move to Low-Intensity Intervention for Nonviolent Drug Offenders"). A substantial proportion of drug offenders could be at risk for failing in such an intervention, suggesting that criminal diversion statutes should incorporate some mechanism to permit poorly responding individuals to be readily transferred to a judicially managed program.

The findings have further implications for best treatment practices and for ethical guidelines for drug treatment providers (see "Confidentiality Guidelines for Integrated Approaches").

Ideally, there might be (at least) two tracks in treatment programs, involving different service arrangements with courts and probation and parole offices. Low-risk clients could be treated with the general client population. High-risk clients, however, might be treated separately in a track that provides routine progress reports to criminal justice authorities and has full-time court liaisons who can accompany clients to status hearings in court or to probation or parole offices. In practice, such court liaisons typically are professional case managers who may be employed either by the substance abuse treatment system or by the criminal justice system through law enforcement or substance abuse block grants or through specific drug court implementation grants.

Integrated approaches should incorporate the ability to readily transfer clients between tracks according to their actual conduct in treatment. Demonstrated success in the program could be rewarded with reduction of monitoring requirements, whereas evidence of poor performance could be met with an increase of treatment services or of supervisory obligations such as more frequent urinalyses or court hearings.

Intensive treatment and monitoring may offer little incremental benefit for low-risk offenders.

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States Move to Low-Intensity Intervention for Nonviolent Drug Offenders

A few States have passed referenda aimed at diverting drug-possession offenders into community-based treatment in lieu of judicial supervision. California's Proposition 36 and Arizona's Proposition 200 were each passed by approximately two-thirds of voters. These statutes require, among other things, that nonviolent offenders convicted of drug possession, drug use, or transportation for use be sentenced to probation with drug abuse treatment as a mandatory condition. 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. This would entitle the individual to truthfully respond on an employment application or similar document that he or she has not been arrested for a drug-related offense.

Many jurisdictions offer this form of diversion—sometimes called "Deferred Judgment" or "Probation Without Verdict"—to first- or second-time offenders charged with relatively minor crimes such as disturbing the peace, public intoxication, petty theft, or driving while intoxicated. However, Proposition 36 and Proposition 200 extend the opportunity, as a matter of right, to all nonviolent drug-possession offenders who are not currently charged with another felony or serious misdemeanor offense and who have not been convicted of or incarcerated for such an offense within the preceding 5 years. Moreover, Proposition 36 and Proposition 200 generally provide offenders with three chances to succeed in the program. If an offender violates a drug-related condition of probation or is charged with a new drug-possession offense, the statutes simply provide for a second and then a third opportunity at diversion unless, according to the statute, the State can make the difficult showing that the offender is a "danger to others" or is "unamenable to drug treatment."

A ballot initiative comparable to Propositions 36 and 200 was passed in the District of Columbia, and the Hawaii State Legislature enacted a similar law in 2002. Equivalent referenda were withdrawn from the 2002 elections in Florida and Michigan on technical, procedural grounds and are likely to be placed on the ballot again for the next elections. Kansas and several other State legislatures also are considering bills containing similar statutory provisions. Yet, despite their widespread and rapidly growing appeal, no reliable data are available on the efficacy of these types of diversionary programs in general or on specific initiatives such as Proposition 36 and Proposition 200.

Studies of Proposition 36 are currently under way in California. Various counties have been implementing Proposition 36 differently at the programmatic level. For instance, some counties are administering Proposition 36 through the existing drug court system using ongoing court hearings. Comparisons of client outcomes across different service models may reveal the best way to implement these types of initiatives.

In truly integrated programs, the criminal justice system retains ultimate jurisdiction or authority over clients; therefore, it is possible to increase the intensity of services readily in response to infractions without having to hold new court hearings with formal due-process requirements such as the right to notice, to counsel, and to present evidence.

The content of treatment might also be tailored to clients' risk levels. Highly structured behavioral or cognitive-behavioral interventions are ideally suited for many offenders, particularly those identified as "high risk" (e.g., Cornish and Marlowe, in press; Gendreau et al., 2001). In contrast, insight-oriented or group-process interventions have been associated with increased rates of drug use and recidivism among high-risk offenders, and educational or drug-awareness sessions have been shown to have no effect for any offenders (e.g., Pearson and Lipton, 1999; Taxman, 1999*b*). The worst outcomes have been seen with insight-oriented treatments that presume a wellspring of anxiety, depression, or low self-esteem underlies antisocial conduct. The best results have been obtained from programs that focused on restructuring clients' distorted antisocial cognitions, correcting their erroneous assumptions about the motives of others, and teaching adaptive problemsolving, communication, and coping skills. Of course, observable and diagnosable symptoms of depression or anxiety should also be targeted in conjunction with any treatment regimen.

Furthermore, in the most successful programs, staff members have been in a position to reliably detect clients' accomplishments and infractions in the program and to apply rewards for desired behaviors and negative sanctions for undesired behaviors (e.g., Harrell and Roman, 2001; Marlowe and Kirby, 1999; Taxman, 1999*b*). For instance, the most effective programs regularly monitor clients' substance use through random breathalyzer tests and urinalyses. Drug-free test results are met with rewards, such as reduced monitoring requirements, reduced criminal sanctions, or goods and services that support a productive lifestyle. Drug-positive results, on the other hand, are met with such sanctions as loss of privileges, increased counseling requirements, or a brief return to detention. If a particular program's philosophy or structure cannot easily accommodate such an approach, that program might consider having a separate, intensive,

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behavioral or cognitive-behavioral track for high-risk offenders or might consider not accepting referrals to treat such offenders.

Pharmacological interventions are seriously underutilized in the criminal justice system despite the fact that several medications have demonstrated success for reducing substance use and crime among offenders (e.g., Cornish and Marlowe, in press). Methadone maintenance treatment, in particular, has been consistently demonstrated in numerous experimental studies to reduce drug use and criminal activity among opiate addicts, with effects many times the size of hospital-based detoxification, drug-free outpatient treatment, and residential treatment (e.g., Platt et al., 1998). In a controlled experimental study, researchers at the University of Pennsylvania similarly found that Federal probationers who were randomized to receive naltrexone in combination with psychosocial counseling had lower rates of opioid-positive urines and were less likely to be reincarcerated for probation violations than those receiving psychosocial counseling alone without naltrexone (Cornish et al., 1997). Subsequent studies by the same investigators are examining the effects of oral and depot naltrexone among State parolees, probationers, and drug court clients. Preliminary data from those studies suggest that oral naltrexone may be more effective in retaining parolees in treatment than standard psychosocial treatment alone.

It is possible that opioid-antagonist medications such as naltrexone may be more palatable to policymakers and criminal justice practitioners because they are not perceived as substituting one addictive substance for another, as is commonly ascribed to methadone. Further research is needed to evaluate the acceptability and effects of these types of medications in correctional settings, and to identify and resolve barriers to the use of efficacious medications with criminal justice clients.

Confidentiality Guidelines for Integrated Approaches

Drug treatment providers are typically socialized to maintain strict confidentiality and nonporous professional boundaries between themselves and criminal justice authorities. The author's drug court studies suggest this might, indeed, be therapeutic for low-risk clients who may need a safe and discreet setting to focus on their problems. Such an approach, however, would appear to be contraindicated for high-risk clients who could deliberately evade detection of infractions or might exploit gaps in communication and monitoring.

Many clinicians misunderstand their ethical and legal obligations with regard to confidentiality for criminal justice clients. Federal law and most State laws expressly permit substance abuse treatment programs to disclose information about clients to criminal justice officials who have made program participation a condition of the disposition of a criminal proceeding, probation, parole, or conditional release from prison or jail (e.g., Marlowe, 2001). Disclosure must be limited to those individuals who need the information to meet their duty to monitor the client's progress. Notably, Federal law prohibits the use of such information to investigate or prosecute any new charge against the client. The information can be used only to monitor the client's progress during the immediate treatment episode.

The Health Insurance Portability and Accountability Act (HIPAA) does not add substantive restrictions on the sharing of health-related information in this context. Rather, HIPAA requires treatment providers to clearly inform clients about how their personal health information will be used and to give them an opportunity to object to such uses. Clinicians may share treatment information with criminal justice professionals so long as they provide clients with appropriate notice of their agency's privacy practices and the limitations on confidentiality, and they obtain specific authorizations from the client to disclose the information in that manner.

CONCLUSION

Research evidence suggests that public health proponents and public safety proponents may have different types of drug-involved offenders in mind. Certain offenders might be well suited to being diverted into treatment and given an opportunity to avoid the stigma of a criminal record. Others require intensive monitoring and consistent consequences for noncompliance in treatment. Just as clinical interventions should be targeted to the specific needs of each individual, the degree to which criminal justice authorities and drug treatment providers actively coordinate their functions for a particular client should be based upon a careful assessment of that client's risk status and ongoing monitoring of his or her progress in treatment. Programs that jointly allocate responsibility for clients to criminal justice and drug abuse treatment professionals are in the best position to respond readily by increasing or decreasing their coordination of efforts, depending upon clients' performance in the program. This provides maximum flexibility and access to resources for handling an impaired and potentially resistant population.

Highly structured behavioral or cognitive-behavioral interventions are ideally suited for many offenders, particularly those identified as "high risk."

ACKNOWLEDGMENTS

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of Justice (NIJ) and the Office of National Drug Control Policy (ONDCP). The views expressed are those of the author and do not represent the views of NIDA, CSAT, NIJ, or ONDCP.

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KANSAS
ASSOCIATION OF
COUNTIES

WRITTEN TESTIMONY
Before the Senate Judiciary Committee
In Support of
SB 482, SB 483, SB 484
By Judy A. Moler, General Counsel/Legislative Services Director

Thank you, Chairman Vratil and Members of the Committee for allowing the Kansas Association of Counties to provide written testimony in support of SB 482, SB 483, SB 484.

The Kansas Association of Counties is in support of these three bills. These bills allow for alternatives for substance abuse treatment for certain offenders. These alternatives are both humane and offer to the courts an alternative to commitment in county jail. That is a winning combination for counties. The counties, has you have heard in previous testimony, are dealing with jail overcrowding as well as budget shortfalls. These bills offer a venue that helps substance abusers while offering much needed relief to counties.

The Kansas Association of Counties, an instrumentality of member counties under K.S.A. 19-2690, provides legislative representation, education and technical services, and a wide range of informational services to its member counties. Inquiries concerning this testimony should be directed to Randy Allen or Judy Moler by calling (785) 272-2585.

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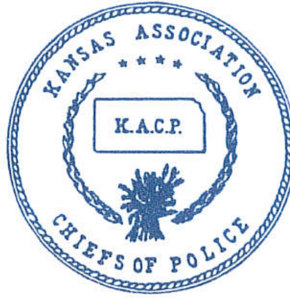

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TESTIMONY TO THE SENATE JUDICIARY COMMITTEE IN SUPPORT OF SB 482
Presented by Ed Klumpp

February 6, 2008

This testimony is in support of SB 482 which proposes to increase the treatment options for certain offenders of the illegal drug possession statutes. Our Association has long recognized the need for a combination of treatment and legal sanctions to address the illegal drug problem and the associated crimes.

This proposal combines those two approached in a reasonable manner. It is presumed that such offenders will have had the opportunity to seek treatment in their community after their first two convictions. By the time there is a third conviction it should be clear that community corrections and treatment is not being effective.

Under this bill the third conviction will result in treatment in a confined environment under the direction of the Department of Corrections. This will provide an excellent opportunity to drive home the seriousness of continued violations of these laws while affording a last chance for treatment of the abuse of drugs.

If that treatment fails, a fourth conviction will lead to a prison sentence. This should reduce the use of prison space for these offenders. But more importantly it provides an avenue to turn a person's life around and the opportunity to become a productive contributor to society instead of imposing a burden on the state. In addition, if we turn these offenders away from drug use and the resulting need for money to buy those drugs, it should reduce the victimization of our citizens through other crimes such as thefts and burglaries.

Ed Klumpp
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Senate Judiciary
2-6-08
Attachment 10

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Kansas Peace Officers' Association

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Testimony to the Senate Judiciary Committee
In Support of SB482

February 6, 2008

The Kansas Peace Officers Association supports the additional step SB482 provides for dealing with offenders of the drug possession laws. The first and second offenses will continue to provide the initial steps to encourage community treatment for drug abuse.

This bill will add a tougher approach to treatment by mandating an in custody treatment program under the direction of the Department of Corrections upon a third conviction. Hopefully there will be a positive response to this strong message and we can avoid these offenders coming back into the system on a fourth offense, thus avoiding imprisonment.

If this multi-step approach with increasing opportunities for treatment and increasing corrections sanctions succeeds we will see a multitude of positive results. We should see fewer persons in prison on these offenses. We should see more of these offenders overcoming their addictions and returning to a productive and contributing lifestyle. We should see a decrease in property crimes as the offenders free themselves of the economic costs of their addictions and improve their income capability reducing the need for them to commit crimes to support their drug addictions.

We encourage you to recommend this bill to pass.

Ed Klumpp
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Senate Judiciary
2-6-08
Attachment 11

In Unity There Is Strength

KANSAS SENTENCING COMMISSION
Honorable Ernest L. Johnson, Chairman
Helen Pedigo, Executive Director

KATHLEEN SEBELIUS, GOVERNOR

SENATE JUDICIARY COMMITTEE
The Honorable John Vratil, Chairman

WRITTEN TESTIMONY –AMENDMENT REQUEST
SENATE BILL 482
KDOC Treatment Facility – Drug Possession
Helen Pedigo, Executive Director
Wednesday, February 6, 2008

Mr. Chairman and Committee members, thank you for the opportunity to request an amendment in SB 482. On page 5, line 33, it appears that the word "*first*" should be stricken. Section 2 (b)(9), relates to the contents of the presentence investigation report for offenders who are eligible for the alternative sentencing substance abuse treatment program (2003-SB 123), who are those convicted of either a first or second felony possession. The drug abuse assessment is done presentence to determine whether the offender has a substance abuse problem, to determine the modality of treatment necessary, and to aid in finding a provider so as not to delay entry into treatment upon sentencing. The State of Kansas, through the Kansas Sentencing Commission, pays for the assessment as part of SB 123 treatment. The amendment is attached below.

31 services officer's professional assessment as to recommendations for con-
32 ditions to be mandated as part of the nonprison sanction.
33 (9) For defendants who are being sentenced for a ~~*first*~~ conviction of
34 a felony violation of K.S.A. 65-4160 or 65-4162, and amendments thereto,
35 and meet the requirements of K.S.A. 21-4729, and amendments thereto,
36 the drug abuse assessment as provided in K.S.A. 21-4729, and amend-
37 ments thereto.
38 *(10) For defendants who are being sentenced for a third conviction*
39 *of a felony violation of K.S.A. 65-4160 or 65-4162, and amendments*
40 *thereto, the drug abuse assessment as provided in K.S.A. 21-4729, and*
41 *amendments thereto.*

It also appears that Paragraph 10, and therefore Section 2, may be unnecessary, as the offender identified by this bill will be sentenced to a KDOC treatment facility where assessment may be done as well. A question may also arise regarding responsibility for payment with regard to a presentence assessment. I would be happy to answer any questions about this proposed amendment.

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Senate Judiciary
2-6-08
Attachment 12

KANSAS DEPARTMENT OF CORRECTIONS
ROGER WERHOLTZ, SECRETARY

KATHLEEN SEBELIUS, GOVERNOR

Testimony on SB 482
to
The Senate Judiciary Committee

By Roger Werholtz
Secretary
Kansas Department of Corrections
February 6, 2008

The Department greatly appreciates the opportunity to comment and make suggestions regarding the clarity and operational aspects of SB 482. The issues of clarity involve the length of the sentence to be served, whether the completion of the intensified substance abuse treatment program affects the release of the defendant from the incarceration obligation, where the offender is to serve any balance of the incarceration obligation, and the relationship between prior community based treatment and sentencing to the treatment facility. The operational issues concern the Department's authority to transfer an offender sentenced to a substance abuse treatment facility to another KDOC facility due to security, medical or other correctional needs and the availability of treatment resources and sentencing options to both male and female inmates.

The Department believes that SB 482 is not clear in setting out the length of the sentence to be imposed for a person convicted of a third felony possession of drugs in violation of either K.S.A. 65-4160 or 65-4162. (Page 4, lines 11-24). While SB 482 provides that the intensified substances abuse treatment program shall be determined by the secretary and that the length of the treatment program shall be at least 120 days, the Department does not believe that SB 482 clearly sets out whether the defendant will receive a specific determinate sentence, the length of which is determined by the number of months set out in the drug sentencing grid, or whether the offender will be incarcerated for only the length of time required to complete the treatment program as long as it does not exceed the length of a sentence that would otherwise be imposed. Additionally, if the defendant is sentenced to a term of months pursuant to the drug sentencing grid, would the defendant remain incarcerated at the substance abuse treatment facility after completion of the treatment program, be transferred to another prison for service of the balance of the sentence or be discharged to community supervision?

The Department believes that some clarity would be gained in regard to the references to "substance abuse treatment facility" and "prison" at page 4 lines 13-15 relative to the condition of whether the offender previously participated in or refused community based treatment

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Attachment 13

pursuant to K.S.A. 75-52,144. It is ambiguous as to whether "substance abuse treatment facility" and "prison" are used synonymously and thus if the defendant had prior community based treatment, he or she would be sentenced to the substance abuse treatment facility. On the other hand that section could be read as providing that if the defendant had a prior community treatment opportunity, he or she would not be sentenced to the substance abuse treatment facility but rather would be sentenced to prison. The Department also notes that some drug possession offenders are ineligible to participate in community drug treatment pursuant to K.S.A. 21-4729 and thus would not have previously completed, been discharged or refused community based treatment as defined as a precondition for the sentencing of third time possession offenders to a substance abuse treatment facility or fourth and subsequent offenders to prison in paragraphs (f)(1) and (f)(2) on page 4.

The operational concern of the Department is due to its understanding that a substance abuse treatment facility would be a minimum security facility with limited medical resources. Such a facility would not be suitable for an offender with increased security or medical needs. The Department has prepared a balloon amendment that would clearly provide the Department with the authority to transfer an inmate from a substance abuse treatment facility to any of the Department's other facilities.

Finally, the Department wishes to remind the committee that comparable treatment resources and sentencing options need to be made available to female offenders as well.

1 having such offender in custody to convey such offender immediately to
2 the department of corrections reception and diagnostic unit or if space is
3 not available at such facility, then to some other state correctional insti-
4 tution until space at the facility is available, except that, in the case of
5 first offenders who are conveyed to a state correctional institution other
6 than the reception and diagnostic unit, such offenders shall be segregated
7 from the inmates of such correctional institution who are not being held
8 in custody at such institution pending transfer to the reception and di-
9 agnostic unit when space is available therein. The expenses of any such
10 conveyance shall be charged against and paid out of the general fund of
11 the county whose sheriff conveys the offender to the institution as pro-
12 vided in this subsection.
13 (b) Any female offender sentenced according to the provisions of
14 K.S.A. 75-5229 and amendments thereto shall be conveyed by the sheriff
15 having such offender in custody directly to a correctional institution des-
16 ignated by the secretary of corrections, subject to the provisions of K.S.A.
17 75-52,134 and amendments thereto. The expenses of such conveyance to
18 the designated institution shall be charged against and paid out of the
19 general fund of the county whose sheriff conveys such female offender
20 to such institution.
21 (c) Each offender conveyed to a state correctional institution pursu-
22 ant to this section shall be accompanied by the record of the offender's
23 trial and conviction as prepared by the clerk of the district court in ac-
24 cordance with K.S.A. 75-5218 and amendments thereto.
25 (d) If the offender in the custody of the secretary is a juvenile, as
26 described in K.S.A. 2007 Supp. 38-2366, and amendments thereto, such
27 juvenile shall not be transferred to the state reception and diagnostic
28 center until such time as such juvenile is to be transferred from a juvenile
29 correctional facility to a department of corrections institution or facility.
30 *(e) Any offender sentenced to a state substance abuse treatment fa-*
31 *cility established by the department of corrections shall not be transferred*
32 *to the state reception and diagnostic center but directly to such state*
33 *substance abuse treatment facility.*
34 Sec. 5. K.S.A. 21-4705 and 21-4714 and K.S.A. 2007 Supp. 75-5210
35 and 75-5220 are hereby repealed.
36 Sec. 6. This act shall take effect and be in force on and after July 1,
37 2010, and its publication in the statute book.

The secretary may transfer the housing and confinement of any offender sentenced to a state substance abuse treatment facility to any institution or facility pursuant to K.S.A. 75-5206 and amendments thereto.