The author(s) shown below used Federal funds provided by the U.S. Department of Justice and prepared the following final report:

Document Title: Managing Drug-Involved Offenders

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Document No.: 247315

Date Received: July 2014

Award Number: 2011-IJ-CX-K059

This report has not been published by the U.S. Department of Justice. To provide better customer service, NCJRS has made this Federally-funded grant report available electronically.

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Managing Drug-Involved Offenders

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This project was supported by Grant No. 2011-IJ-CX-K059 awarded by the National Institute of Justice, Office of Justice Programs, U.S. Department of Justice. Points of view in this document are those of the authors and do not necessarily represent the official position or policies of the U.S. Department of Justice.

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Introduction

Effectively managing drug-involved offenders is an essential step to reduce crime and drug abuse. Many of the most active criminals and heaviest-using drug abusers are supervised by the criminal justice system; conversely, drug-using parolees and probationers are disproportionately responsible for both crime and drug abuse in America. Finally, since crime and drugs are at least somewhat synergistic — criminal behavior can lead to drug abuse, and visa versa — resolving the drug habits of the most chronic criminal offenders and the criminal habits of the most habitual drug abusers may be an integral element of a successful approach to either problem. Fortunately, many of these individuals are already supervised by probation or parole programs, subjecting them to additional monitoring and discipline.

Yet for decades, probation and parole programs have largely failed to wean participants off of either crime or drugs. In a nutshell, current programs have attempted to stretch insufficient resources across overwhelming numbers of parolees and probationers. Since identifying and punishing violations is a heavy drain on program resources, most supervision programs have eventually mutated into relatively lax and ineffective systems of control. Petersilia and Turner's (1991) classic experiment of Intensive Supervision Probation (ISP) revealed that in Los Angeles County, for example, probationers in the ISP condition were tested on average only once every two months (not necessarily randomly), with sanctions for positive tests being administered inconsistently.

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The result catalyzes a vicious cycle. Programs are unable to discipline minor violations. Offenders perceive that they can commit minor violations without consequence, and in turn stop trying to avoid them. The resulting uptick in minor violations further inundates the resources of the supervisory program, compounding the original problem. This general pattern can consume entire supervisory systems, such that only the most egregious violations or chronic offenders merit increasingly precious enforcement resources. Moreover, court and prison resources are so over-committed that the little punishment that these programs manage to dole out comes only after such a long delay that they have lost their maximum corrective effect on the violator.

However, innovations based on the Swift and Certain testing-and-discipline paradigm (SAC) as successfully implemented in Hawaii's HOPE project can break this pattern (Hawken and Kleiman, 2009). A phenomenon called "behavioral triage" allows program resources to be allocated to the offenders whose poor behavior most requires them (Hawken 2010). The quick and efficient identification of egregious offenders — rather than the slow and conventional process of waiting until they compile an extensive list of violations — is combined with swift and consistent punishments. When punishments follow within days of the violation, they have much greater correctional effect on the offender. There is some evidence that these programs introduce predictable consequences into the lives of offenders and increase their capacities for self-control (Hawken and Kleiman, 2009).

The promise of these programs creates optimism that drug use and incarceration, among even heavily-drug involved offenders, can be reduced.

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Mainland replications of the SAC model will show the local conditions that are required to successfully implement the model. These studies will also help to identify the characteristics of offenders who respond to the threat of credible sanctions alone, and those who do not. The latter night need more-intensive resources (such as the ancillary services offered by drug courts or long-term residential treatment), or may not be amenable to supervision in the community. The implementation challenges of SAC are non-trivial, but the promise is enormous. If enough departments are able to reconfigure their operations to deliver sanctions swiftly and with certainty, the effort could yield dramatic reductions in drug use and criminal activity.

The Overlapping Drug-Abusing, Criminal, and Supervised Populations

Data from ADAM II and the National Survey on Drug Use and Health (NSDUH) illustrate that individuals under criminal supervision are disproportionately likely to suffer from habits of drug abuse, and that drug abusers face similarly high risks of ending up under criminal supervision. In most big cities half or more of felony arrestees — even excluding those arrested on drug charges — have used one or more illicit drugs in the days before their arrest (National Institute of Justice, 2000). A majority of state and federal prisoners report that they were under the influence of drugs or alcohol (or both) at the time of their current offense (U.S. Department of Justice, 1999).

Chronic users dominate the consumption of illicit drugs, representing respectively 87%, 96%, and 95% of the cocaine, heroin, and methamphetamine sold

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in the United States (WAUSID, 2011). This heavily skewed distribution of consumption demonstrates the heuristic principle known as "Pareto's Law:" 80% of the volume of any activity is accounted for by 20% of the participants. The distribution of alcohol consumption, for instance, reflects the same pattern (Johnson, 1937).

A large majority of these chronic drug users pass through criminal supervision. However, the lack of a single authoritative data source tracking the criminal outcomes of drug abusers requires scientists to resort to secondary calculations. Post-arrest drug testing is limited to the few large cities selected as ADAM sites, and many of the worst drug offenders are invisible to household-based surveys such as the NSDUH.) One estimate using predecessors of those surveys — and in need of an update and further examination — estimated that about 75 percent of all more-than-weekly cocaine users had been arrested for a nondrug felony in the previous year (Kleiman et al., 2012). The implication is clear: reducing total volume of use requires reducing targeting the heaviest users, even though they constitute a small minority of total users.

Costs of Drug Abuse Among Supervised Populations

Bolstering Illicit Markets

The reverse implication is also true: a small minority of heavy users provide the bulk of profits for illicit drug dealers and organizations, thereby bolstering illicit markets. If it were possible to eliminate the drug demand of chronic users, the vast majority of illicit drug markets would grind to a halt. If half of all heavy users pass

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through criminal justice supervision within the past year, eliminating their demand could shrink these markets by approximately 45%. More realistic success rates still generate radical outcomes. Even a 25% reduction in the illicit drug demand of chronic drug users passing through the criminal justice system within a single year could reduce total illicit drug demand by more than 10%.

Any reduction in demand from the supervised population is likely to overflow to other populations. Illicit economies typically require a minimum economy of scale, regardless of whether the transactions are conducted flagrantly on the streets or inconspicuously behind closed doors. It is only after achieving sufficient scale that they can efficiently match buyers with sellers, all the while evading criminal prosecution. Once this minimum scale is achieved, controlling an illicit drug market is dramatically more difficult. The supplier price of drugs drops as distributors benefit from bulk discounts and can absorb lower per unit profit margins. Moreover, as the number of buyers and sellers increase, the amount of enforcement capacity required to raise the legal risk on these groups generically increases proportionally (Kleiman, 1993).. In other words, each unit of drug sold (or acquired) makes the next unit more likely. Drug buyers enjoy strength in numbers.

Accordingly, demand reductions from supervised populations can enable more effective drug control of non-supervised populations. If total demand falls, then legal risks, costs to suppliers, and acceptable profit margins may all rise, initiating a negative feedback loop decreasing the efficiency of drug markets near the minimal economy of scale. Illicit drugs may become more expensive, and in some cases, more difficult to acquire.

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Reductions in demand from supervised populations impact total drug demand with a multiplier effect. However, its magnitude is currently unknown and possibly unknowable; probably, it varies according to geography and size of existing illicit markets, among other circumstances. In either case, success in controlling chronic drug users is likely to bleed over to reducing the drug access of more moderate users.

Causing Drug-related Health Damage

Illicit drug use carries significant health costs. Nearly one million emergency room visits in the United States are associated with illicit drug misuse or abuse (SAMHSA, 2010). For many, drug use turns deadly. Nearly forty thousand people die of directly drug-induced causes in the United States each year (this excludes indirect causes such as accidents, homicides, and infectious disease) (Xu et al., 2010). Several reports have addressed some aspects of the health-related consequences of drug use disorders, revealing associations between stimulant use and cardiac arrhythmias and stroke, MDMA and kidney failure, and injection drug use with HIV and hepatitis B and C (see Khalsa et al., 2008 for a detailed review). Likewise, the risk of death among parolees during the first two weeks following release from prison is nearly 13 times greater than those of similar demographic background—with drug overdose being the leading cause (Binswanger et al., 2007). As dire as this finding is, it may be an underestimate of the problem. A study of newly released prisoners in England and Wales found that mortality rates among males were 29 times higher than the general population during the first two weeks

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of release. Female offenders' mortality rates were 69 times higher (Farrell & Marsden, 2007). Moreover, needles used for injecting drugs become disease vectors for HIV [injection drug use is a strong second to sex in the transmission of HIV (CDC, 1996)].

Preventing Cessation of Criminal Activity

Decreasing drug dependence can reduce criminal activity among current criminals (Sheerin et al, 2004), regardless of whether the decreases are voluntary or forced (Anglin & Hser, 1990; Anglin & Speckart, 1986; Nurco et al, 1988). (It is unclear if this effect extends to drug use rather than dependence for the same population or for reducing drug dependence among the non-criminal population; but since the drug-dependent, criminal population represents the bulk of our concern, this relatively narrow slice of the population deserves a targeted approach.)

Drug dependence obstructs an offender's ability to stop criminal activity. There is a strong negative association between criminal thinking and self-control. Spending on illicit drugs is associated with low self-control, and offenders who have low self-control as measured by self-control scales, have higher scores for criminal thinking (Packer et al., 2009). New research by a UK-based team shows that vulnerability to drug addiction may arise from pre-existing brain abnormalities that lead to self-control problems (Ersche et al., 2012), however it seems hard to believe that such problems are not aggravated by drug abuse

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Clearly, the problems created by the drug habits of the criminally supervised population are severe enough to warrant our focused attention. Their status as supervised individuals entails possibilities for behavior control that potentially make those problems easier to solve, or at least mitigate. However, progress on this front has been impeded by significant difficulties in managing offender populations.

Difficulties Inherent to Behavior Control Among Supervised Populations

The high failure rates of probation and parole programs demonstrate that they've failed to serve their primary purpose: chastising and monitoring criminal activity so participants can return to their lives without having to serve terms in prison. Roughly one-third of probationers and parolees fail the terms of their supervision programs (BJS, 2012), and are returned to prison, unless they manage to abscond entirely (Glaze & Bonczar, 2009). These failure rates have hardly changed over the past two decades, despite the broad variety of local, State, and Federal initiatives undertaken over the years to improve offender outcomes (Hawken & Grunert, 2010).

Indeed, strategies founded on the traditional prevention-enforcement-treatment triad have lost effectiveness along each of their three tactical avenues.

Prevention

Many of the traits that make an individual vulnerable to drug use (quality peer groups, drug-related norms, access to drugs, and lack of self-control) have long ago been set into place before a drug user enters the criminal population. An

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individual may only need to learn where and how to purchase drugs once in order to become a self-sufficient consumer. Similarly, trepidation and social taboos regarding drug use are much stronger before they've already been violated. In short, drug-involved offenders will have a difficult time reversing their momentum or changing habits in general, and particularly regarding drugs.

Even thinking decades ahead, prevention efforts face criticisms regarding the basic efficacy of their methods. Standard school and media based drug-prevention messages target the middle class kids whose parents' concerns drive the politics of anti-drug policy. There is little evidence that they are as effective on those most at risk of becoming future drug-involved offenders. (Caulkins et al, 1999). It is worth designing and testing an alternative campaign that focuses on preventing drug dealing, utilizing both messages aimed to change attitudes and policies to minimize opportunities for dealing drugs (Kleiman, 1996).

Enforcement

Though they have their opponents and are not universally successful, enforcement campaigns have certainly helped reduced drug availability. The decades-long policy of drug enforcement has clearly succeeded in making drugs more expensive and harder to obtain: illicit-market cocaine costs twenty times the price of the licit pharmaceutical product, for instance.

Nonetheless, it is not clear that increased enforcement can continue to drive prices to higher levels, or even mitigate structural factors that might drive overall price decreases. For instance, the 1980s and 1990s saw an explosion of drug law

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enforcement that failed to bring about symmetrical decreases in drug availability, particularly for hard-core users and offenders. Clearly, enforcement has diminishing returns and increasing marginal harms.

Any benefits of increased enforcement come with severe and negative unintended consequences, due to the consequences of a primary goal: increasing prices. Increasing prices of illicit drugs is a double-edged sword, strategically hurting the same population that it intends to benefit. It gives rise to both winners and losers. The winners are the drug users who respond by quitting or reducing consumption, as well as the potential future users who respond by never taking up the habit in the first place. The losers are those who fail to respond at all; they merely pay more money to their drug dealer, disempowering them further, exacerbating an already-severe financial drain, and crowding out socially desirable expenses and investments.

It is those users with the heaviest levels of consumption and the most stubborn habits that are most immune from the price-increasing and availability-reducing benefits of increased enforcement, and most vulnerable to the financial, criminal, and stigmatic costs of increased enforcement. Unfortunately, this very group engages in the drug use that is the most harmful for themselves and others, and who is most likely to resort to illegal methods to obtain money to continue using in the face of an increase in price.

Treatment

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Treatment programs are more benign but seriously constrained by inabilities to retain clients. A wide range of treatment programs have effectively reduced drug consumption and criminal activity as long as their clients actively participate in treatment programs, whether mandatory or voluntary (Leukefeld, 1994). Statistical reviews that only consider clients who complete treatment inflate programs' records of success, since those who drop out represent the population most resistant to persuasion and incapable of the discipline required for self-interested behavior.

Additionally, there is a lack of demand among those whom the programs are designed to help. Individuals dependent on drugs often deny their problem or lack the sustained will to commit themselves to treatment. In other words the saturation point for voluntary treatment programs is relatively low, and the bulk of substance abusers are out of reach of these programs' influence. This holds true regardless of improvements in affordability, effectiveness, and accessibility.

Opiate substitution marks the obvious exception. Substitution therapy, using either methadone or buprenorphine, provides addicts with a less-painful method to transition away from heroin addiction. It is not surprising that drop-out rates for substitution therapies are distinctly lower than other forms of treatment (Hawken and Anglin, 2007). Indeed, successfully lowering opioid use via methadone maintenance therapy (MMT) can precede decreases in criminal activity (Sheerin et al, 2004). The fact that only nine percent of drug treatment providers in the United States offer these substitution programs represents an important opportunity for crime reduction (SAMHSA, 2012).

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The marked contrast between treatment for opiates and for non-opiates demonstrates the fallacy of discussing both under the same “treatment” umbrella. The treatments for these types of drugs are radically different in important ways, and the source of these differences is pharmacological. The effective methods of opiate substitution therapy should not be seen as a pathway to success for non-opiate treatment programs. No amount of tweaking or funding increases will allow voluntary treatment for non-opiates the same pattern of success as demonstrated by substitution therapy, pending some unforeseen breakthrough.

Mandating Drug Treatment to Supervised Populations and its Difficulties

Since enforcement has been pushed past its marginal utility, prevention is logically impossible, and treatment programs are beset by failures to retain clients, one solution emerges: mandating participation in treatment programs. The case for mandatory treatment is obvious, especially considering the significant overlap between the egregious drug-abuse and criminal populations. Since a large number of drug-involved offenders will never voluntarily seek out and stay in treatment, the possibility arises that these individuals can be induced to seek and maintain treatment if their alternative is time in jail or prison.

This logic has already produced mandatory treatment programs — such as drug treatment “diversion” programs, where non-violent drug offenders are given the option of being sentenced to drug treatment in the community in lieu of a jail sanction. Most treatment diversion programs are limited to offenders charged with drug offenses, but some have expanded eligibility to include drug-involved

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offenders charged with other offenses. For the most part, these brands of mandated treatment are beset by the same three primary obstacles.

Weak Mandates

California's Proposition 36, the country's largest-ever diversion program, provides an example of a program that rarely held participants to their end of the bargain. According to Prop 36, certain drug offenders were given a choice between serving jail terms and enrolling in drug treatment; unsurprisingly, treatment was a popular alternative to incarceration. It was not as popular once participants were actually scheduled to attend sessions, however, and the law provided little authority to punish failures to attend.

Without the threat of discipline, program compliance suffered. Fewer than one-third of those mandated to Prop 36's treatment completed it (Longshore, Hawken, et al., 2006), and one quarter never even appeared for treatment.[1] Even 80 percent of treatment providers — hardly known for favoring a punitive approach — supported a change in the program to allow the use of short jail stays (Hawken & Poe, 2008).

It is not enough to intend to be tough on participants. Planned sanctions can fall through the cracks of a bureaucratic apparatus overwhelmed with offenders. Overworked probation officers are often too busy to file the paperwork leading to a revocation hearing; even when they prioritize the task, judges are often resistant to

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[1] Urada, et al. Evaluation of Proposition 36: The Substance Abuse and Crime Prevention Act of 2000. Available at http://www.uclaisap.org/prop36/documents/2008%20Final%20Report.pdf

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put someone behind bars for months or years for a violation as a mild as a dirty drug test.

Identifying violations in the first place is just as important and can be just as difficult. Drug violations will often go undetected, especially when drug tests are scheduled publicly and in advance. Whether an offender plans his drug use around scheduled tests or just gets lucky to not be tested the night after a binge, he learns the same message: "unbreakable" program rules are in fact somewhat voluntary in practice. In most cases, probation programs that allow continued drug use without consequence see their participants continuing to commit other crimes (Farabee & Hawken, 2009).

Low Quality and Mis-matched Treatment

The casualties of treatment-diversion programs include even compliant offenders — those who faithfully attend program sessions and refrain from violating their terms. In treatment-diversion programs, the sheer number of offenders who take a treatment referral — either through a desire to kick their drug habit, to avoid a harsher sentence behind bars, or a mixture of both, and with varying degrees of drug involvement and dependency — creates massive inflows to the drug treatment system. Meanwhile, the treatment centers receiving the patients are typically underfunded and overwhelmed. There is only so much staff time and so many beds in residence to go around, and treatment centers on a fixed budget react by watering down their services: requiring fewer days in treatments, reducing the intensity of programs, or mandating outpatient treatment to patients whose habits

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require residential treatment.

As a result, the patients with the worst drug habits — those who need the most supervision and most desperately require treatment — often fail to receive it. This is how programs such as Prop 36, which was designed to provide drug treatment to those in need, can counter-intuitively weaken our drug treatment systems. Because of the in-flow of patients referred by Prop 36 to treatment, many offenders with serious habits — methamphetamine or otherwise — received outpatient treatment. Probationers with serious drug-use problems were less likely to receive residential treatment after Prop 36 was implemented (Hawken, 2008). This has important consequences; probationers with addiction warranting intensive treatment completed the program twice as often when assigned to residential placement, compared to lower-intensity outpatient programs (Hawken, 2008). Yet in California, only 12 percent of clients admitted to care as a result of Prop 36 received a residential placement. Moreover, less than one in eight Prop 36 clients with opiate problems received substitution therapy (Hawken and Anglin, 2007). The ultimate result is a failure to help those who need it most, a less cost-effective treatment system, a waste of time for those who were referred to treatment who did not need it, and the release of potentially dangerous drug abusers onto the streets (Hawken & Anglin, 2007).

Drug courts, which also mandate drug treatment but under judicial supervision, have demonstrated better outcomes than standard treatment diversion programs. Drug courts are specialized courts that provide offenders with drug-possession charges the option between entering treatment and receiving straight

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jail time. The judge, prosecutor, public defender, probation officer, social-service providers, and treatment providers work together to provide comprehensive supervision and offer ancillary services that are not offered as a part of a standard treatment-diversion program. Participants then appear regularly before the court, where their drug tests and behavior are reviewed and either sanctioned or rewarded accordingly. Praise from the judge may pass as a positive incentive.

Indeed, the drug court movement has been very successful in managing offenders in the community (Belenko, 2001). There are now over 2,000 such (drug) courts across the country, serving about 70,000 clients nationwide (Huddleston, Marlowe & Casebolt, 2008).

Despite their differences, drug courts and treatment diversion programs are limited by what they share in common. Participation is voluntary (defendants can, and some do, choose routine sentencing instead) and restricted to defendants whom the court and the prosecution are prepared not to incarcerate if the defendants will just clean up their acts. By their nature as "alternatives to incarceration," they cannot apply to those whose crimes have been especially severe. That excludes most violent crimes, and the federal law providing funding for drug courts specifies that defendants admitted to drug-court treatment have no prior violent offenses either. This feature has dual disadvantages. Foremost, it limits the potential breadth of the program. For instance, very few of those entering state prison in 2004 or jail in 2002 would have been eligible for drug diversion through state drug courts (Pollack, Reuter et al., 2011). Additionally, many of the most troublesome offenders, whose

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drug consumption it would be most valuable to influence, are excluded from the beginning.

In the past few years, a number of drug court judges have recognized that there are better returns to focusing their efforts on higher-risk offenders and sought to address this challenge. Increasingly, we are seeing drug courts supervising higher-risk subjects, who five years ago would have been deemed ineligible for supervision under a drug court. However, there is still the critical limiting factor of resource costs.

Excessive Reliance on Justice Personnel

Even if drug courts were seen as the best available option, expanding their coverage from 70,000 clients to the more than two million drug-involved offenders (Huddleston et al., 2005) entails a thirty-fold expansion, which would require more judges than the nation could possibly provide. Since the participants require constant and intense supervision by a judge, of the typical drug court caseload is limited to 75 clients, moving the entire population of drug-involved offenders into drug courts would require every judge in the country to staff a drug court, leaving no judges left over for criminal cases. So even though drug courts and diversion programs, with all their weaknesses, can outperform incarceration in managing so many non-violent drug-abusing offenders, they seem unlikely to substantially reduce the drug abuse or non-drug crime created by drug-involved offenders, because of limitations on their scale.

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Mandating Abstinence, Rather Than Treatment

Unfortunately coerced drug treatment has been hamstrung by misapplication. If the treatment "alternative" is presented as a choice with jail or prison as the other option, drug abusers quite rationally choose not to go to jail or prison they do not in fact "choose" to undergo treatment. So long as this false choice is presented, a critical opportunity and elegant solution has been missed — mandate abstinence. Order the individual to stay drug free, and allow those who truly do choose it to seek treatment. Such abstinence-mandate programs have been examined in the relevant research literature and demonstrated some successful experimental and small-scale interventions.

Development and Previous Implementations

Mandated abstinence — the idea that drug rehabilitation can be brought out solely through consistent and appropriate sanctions, and with little behavioral counseling or pharmacological therapy — dates back to the heroin epidemic in the midst of the 1970s. The combination of swathes of Vietnam veterans returning home with a new kind of drug habit and skyrocketing rates of crime brought the pressure for a solution to heroin abuse to a peak.

In 1971 the nation's first drug czar, Jerome Jaffe, suggested requiring a clean urine test for heroin to all returning soldiers as a condition for release at home. Informally called "Operation Golden Flow," the effort succeeded in reducing the inflows of heroin-addicted veterans, even though it could not stop the epidemic entirely.

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In 1977, then-NIDA director Bob DuPont adapted that strategy for probationers and parolees, rather than veterans, announcing "Operation Tripwire." Tripwire would require clean urine tests and physicals of all parolees and probationers, regardless of drug and criminal history, as a condition for release from criminal justice supervision. At the bare minimum, all participants were required to undergo one or two, unannounced urine tests; those identified as having a history of drug abuse would begin instead with monthly screening. One failed drug test would transfer a participant to weekly urine tests, a second would mandate treatment, and further violations led to swiftly-assigned three-to-six month stints of incarceration; even after release from prison, a participant would be released only with intensive supervision and regular unannounced tests. In this manner, DuPont designed the sanctions and levels of scrutiny to escalate for participants whose habits would require greater discipline to break.

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However, political controversies prevented Operation Tripwire from ever getting a chance to test its effectiveness. Some criticized the program as a threat to civil liberties. Others attacked the program for using criminal-justice methods to treat what was viewed as a health problem. Others still doubted that heroin use led to criminal activity. Instead, the program was rebooted abortively as a scaled-back research study titled "Paroled Addicts in a Treatment for Heroin."

Instead, Project Sentry of Lansing, Michigan, is the oldest example of a true testing-and-sanction program. Originally designed in the 1970's as a supervision tool for released, county jail inmates in forced treatment, the Project Sentry drug testing program has grown to become Michigan's largest, single point-of-service testing clinic. Participants are tested three times weekly, and tests return clean nearly 90% of the time.

The next innovation in mandated abstinence programs was the Washington, DC Drug Court experiment, started in 1993. The experiment randomly assigned drug felony defendants into three dockets: a conventional docket involving twice-weekly drug tests and judicial monitoring; a treatment docket intended to transition defendants away from criminal lifestyles, offering community resources and programs to increase self-esteem and relevant skills; and a sanctions docket intending to directly incentivize abstinence from drugs, by way of swift and certain sanctions for failed drug tests and referrals to treatment as a last resort.

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Although both experimental dockets succeeded in reducing drug use during pretrial release, the sanctions docket also reduced arrests within one year of release and in a more cost-effective manner, resulting in savings of about $2 for every $1 in program costs (Harrell, Cavanagh, and Roman, 2000). A key element of the sanction docket's cost-effectiveness relied on limiting treatment referrals only to defendants who demonstrated they were unable to abstain from drug use on their own, based on repeated failures of the twice-weekly drug tests.

In 1997, Maryland implemented a program called "Break The Cycle" (BTC) intending to target offenders on probation or parole with a "drug condition" and subject them to a testing-and-sanctions regime roughly similar to that used in the D.C. Drug Court's sanctions docket. Compared to the population offenders without drug conditions, the offenders subjected to the strict sanctions regime reported lower likelihood for future drug arrests. A cost-benefit analysis of BTC showed returns between $2.30 and $5.70 for each dollar invested.

Nonetheless, BTC implementations often failed to provide frequent testing or swift punishment, particularly in early stages — some jurisdictions succeeded in testing only five percent of the offender population with a month turnaround each, and early on program revocations followed identified violations by an average of 146 days (Taxman, Reedy, Moline, Ormand, and Yancey, 2003). Moreover, BTC was often implemented inconsistently across counties, both in terms of identification of "drug conditions" and application of sanctions. One avenue for inconsistent implementation was the requirement that, in order for an offender to be identified as having a "drug condition," a supervising officer had to place a recommendation to

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the court. (This stands in marked contrast to the D.C. Drug Court experiment, which utilized initial drug tests to identify drug conditions.) Another avenue for inconsistent implementation was the breadth of options given to judges, who utilized discretion in determining the frequency of testing and severity of sanctions applied to the offenders. Evaluations suggest that counties utilizing more frequent drug testing and imposing more sanctions per supervised offender produced greater reductions in arrests for drug and non-drug offenses (Harrell et al., 2003).

In 1993, Oregon implemented "structured sanctions," introducing a grid prescribing appropriate sanctions based on the offender's risk level, crime of conviction, and seriousness of the violation (National Institute of Corrections, 2006). (The prescriptions also left room for officers to issue substance abuse and mental health treatment, employment assistance, and anger management classes.) In order to hasten and enforce consistency in the disciplinary process, Oregon delegated disciplinary authority away from formal judicial processes and toward community supervision agencies. The program initially targeted felony probation, but was later expanded to parole and post-prison supervision, and finally extended to misdemeanor probation (Salvo, 2001).

Although the program was implemented inconsistently, similar to Maryland's BTC program, the "structured sanctions" regime produced more swift and certain punishments: time between violation behavior and response was reduced by 38 days; offenders were 23% more likely to have violations detected and acted on. As a result, probation offenders experienced about 50% lower felony convictions rate and were less likely to be convicted for new offenses. Drug use declined as

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dramatically as 56% in counties where implementation most closely resembled the planned sanctions complete with frequent drug testing and repeated short jail stays (Baird et al, 1995).

Hawaii's HOPE program, which started in 2004, was the first successful large-scale implementation of swift-and-certain sanctions. HOPE was designed by Judge Steven Alm, in response to what he considered to be a failure of the status quo to effectively change the behavior of their primarily methamphetamine-using probationers.

Compared to its predecessors, the HOPE program dramatically improved the swiftness and certainty of sanctions: regular random drug tests (six times a month during the first few months of the program) removed any "safe window" for undetected drug use. Sanctions, when delivered, were meted out within days of the detected violation, and jail terms were as brief as three days.

The program relied on streamlined judicial processes and careful coordination among all the agencies involved (courts, probation, law enforcement, and treatment providers). The program minimized delays within the court system, expediting the reporting of dirty tests, the scheduling of court hearings, and the issuance of bench warrants to absconders. Cooperation with law enforcement agencies ensured that bench warrants were prioritized (whereas probation warrants are typically considered "low priority").

Another of HOPE's innovations was the "warning hearing," designed to ensure proper messaging, including creating perceptions of fairness and a clear and credible threat of sanctions. Upon a probationer's enrollment in the HOPE program,

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each receives a formal warning in open court to put him on notice that his violations will be punished. The warning explains to the participant the basics of the testing and sanctions structure, that the program is designed for the participant's path to success, and that his success is entirely within his own control. In this fashion, the warning demonstrated the program's capacity and commitment to follow-through on threatened sanctions. Theory and evaluations suggest that this initial warning is key to minimizing initial violation rates, which could otherwise potentially flood the court's resources, since probation officer time, court time, police officer time and jail space are all scarce resources (Kleiman, 1993; Kleiman & Kilmer, 2009; Hawken & Kleiman, 2009).

HOPE reserved treatment mandates for participants who consistently failed or missed drug tests, a la Operation Tripwire. This screening mechanism, in combination with overall low violation rates ensured by the program's demonstrated ability to identify and sanction violations, successfully minimized the number of participants referred to treatment. Consequently, the program can afford to use intensive treatment services, including long-term residential treatment, rather than relying primarily on outpatient drug-free counseling as most diversion programs do for most of their clients. This result might be called "behavioral triage" (Hawken, 2010).

Although HOPE's reliance on judicial processes draws comparisons to a drug court, it is different in important ways. Under drug courts, the judge is central to the supervision process (even for offenders who are fully compliant with the terms of probation), and probationers are required to appear regularly before the judge for

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Implementation problems, however, can prove crippling; a program that makes threats but delivers on them only sporadically could easily under-perform probation-as-usual.

Compared to the costs of incarceration, the costs of even very tight community supervision are almost certainly modest. But those costs — especially the costs of enhanced monitoring, drug treatment, and of law enforcement operations to bring in absconders — have yet to be comprehensively measured. Likewise, the benefits observed in the Honolulu Randomized Controlled Trial are extraordinarily large, but the feasibility of achieving comparable results in other institutional settings needs to be determined on a case-by-case basis. The sustainability of the model is also brought into question if there are slippages from initial fidelity. Program fidelity will need to be monitored vigilantly to ensure that sanctions continue to be delivered swiftly and with certainty when an exciting new program degenerates into one more organizational routine. Tools are now being developed to help program administrators monitor the many moving parts required to deliver SAC well.

So the case for transforming the entire community-corrections system to embody the principles of swift and certain sanctioning remains theoretically strong but empirically unproven. In principle, however, SAC-style programs are economical, and therefore scalable, by contrast with more service-intensive approaches such as drug courts.

Unlike drug courts, SAC programs spend little time and resources managing compliant clients. A SAC probationer who has been “clean” for 6 months is tested

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