"A Prescription for Effective Treatment

of

Illegal Drug Users"

By

Senior Judge Arthur L. Burnett, Sr.
National Executive Director,
National African American Drug Policy Coalition, Inc.

At

Symposium Sponsored by Senator Jim Webb
& the George Mason University Administration of Justice Department

"Drugs in America:

Trafficking, Policy, & Sentencing"

George Mason University Law School

October 15, 2008

It is an honor and privilege to appear here today to share with you, Senator Jim Webb, your staff and members of the audience my insights and perspectives from the experience I have had serving as a judge in the District of Columbia since June 26, 1969, except for a period slightly over four (4) years when I served as Assistant General Counsel (Legal Adviser) for the United States Civil Service System and as a principal legal adviser to President Jimmy Carter in reorganization matters and civil service reform from December 1975 – January 1980. During that judicial service in the United States District Court as one of its United States Magistrates (now called Magistrate Judges) for over fourteen (14) years and in the Superior Court of the District of Columbia since November 1987, I have literally handled several thousand drug cases, in setting bail and

pretrial release conditions, including conditions to deal with their drug problems, in conducting preliminary hearings, in hearing and deciding pretrial motions, and finally in presiding at trials of drug cases for both adults and juveniles, and in imposing sentences and dispositions in those cases.

Thus, I have had the judicial experience of dealing with such cases in the criminal context for more than thirty (30) years and in the family law context from 1987-2004 in dealing with parents of children in the neglect and abuse system in the Superior Court for the District of Columbia, and for the last four (4) years I have been on Sabbatical from my Senior Judge role in the Superior Court serving as the National Executive Director of the National African American Drug Policy Coalition, Inc. since August 1, 2004, where I have focused exclusively on drug law and policy issues, including promoting the expansion of a public health and medical approach to deal with the problem of drug abuse and addiction as a disease rather than as a voluntary act justifying incarceration in prison within the criminal justice system for non-violent offenders. It is the policy position of the National African American Drug Policy Coalition, Inc. to urge the alternative of drug treatment in a pretrial diversion program in lieu of criminal prosecution and incarceration, or in the alternative, therapeutic sentencing to probation with conditions requiring drug treatment, with the condition that if the person successfully completes drug treatment as a condition of probation, he or she would be allowed to withdraw a plea of guilty and seek to have the criminal charge dismissed. Such an approach would ameliorate the adverse consequences to employment and stabilization in the community that would otherwise result from a criminal conviction. We wish to emphasize however that we do support strongly significant criminal sanctions

and sentences for those individuals who are not drug addicts and who sell and distribute illegal drugs to profit at the expense of those who have become addicted to the use of illegal drugs and who thus take advantage of their disease. Indeed, we advocate that the federal government should primarily focus on the major traffickers of illegal drugs who procure them and make them available in our inner urban cities creating the drug crisis we have in America, and that the federal government should leave to the States to deal with small time drug pushers, who may be selling drugs to support their own habits and to make a little profit on the side, and to cope with the health and welfare implications of drug usage and substance abuse disorders by the large numbers of poor individuals living in circumstances below the poverty line and others who may be engaged in recreational use of illegal drugs. Where we draw the line between the addict who may be selling drugs to get his or her own supply and the one who may be doing so to make a profit on the side in addition should be left to state authorities and their local prosecutors and government officials under standards to be applied equally without racial, ethnicity or national origin bias by local prosecutors, so that there is equality of treatment in prosecutorial decisions in deciding who to prosecute in the traditional criminal manner, and who to allow to participate in a drug treatment program, either through pretrial diversion or through therapeutic sentencing under a probation program, allowing setting aside the guilty determination, if the individual successfully completes a drug treatment program.

We start from the premise set forth in *Robinson v. California,* 370 U.S. 660 (1962), that it is cruel and unusual punishment under the Eighth Amendment of the United States Constitution to punish one for the status of being a narcotic addict.

Building on that concept, we have urged that when an individual possesses illegal drugs as a result of the compulsion or craving to use drugs as a result of the disease of drug addiction, or even sell some illegal drugs simply to get his or her own supply of drugs to use to ameliorate his or her craving or compulsion to use drugs, like the insanity defense, the criminal offense should be viewed as a product of the disease of drug abuse and addiction, and not as an act permitting a criminal sanction. By analogous reasoning, the drug addict should be subjected to a treatment protocol just as we would treat one recovering from a mental illness who had been found not guilty due to an insanity defense. Indeed, it is significant to note that the majority in the 6-2 opinion in *Robinson, supra,* cogently likened the law in California involved in that case to one making it a criminal offense "to be mentally ill, or a leper, or to be afflicted with a venereal disease." The Physicians and Lawyers for National Drug Policy publication, *Alcohol and Other Drug Problems: A Public Health and Public Safety Priority – A Resource Guide for the Justice System on Evidence-Based Approaches,* published in April 2008[1] cogently observed at p. 14, "Though the initial use of substances is

[1] This publication was published by Physicians and Lawyers for National Drug Policy in partnership with The National Judicial College in Reno, Nevada, and was funded by the Justice, Equality, Humanity, and Tolerance (JEHT) Foundation, the National Highway Traffic Safety Administration (NHTSA) and The Hanley Family Foundation.

Physicians and Lawyers for National Drug Policy (PLNDP) was created in 2004 to unite leaders from law and medicine to promote the need for evidence-based policy and practice in handling alcohol and other drug problems in medical and legal settings. PLNDP was formed as an outgrowth of Physician Leadership on National Drug Policy, an earlier medical initiative started in 1997. In the Spring of 2004, PLNDP medical leadership decided that in order to have a meaningful and lasting impact on alcohol and other drug policies it was imperative to bring in leaders of law to work with medicine on this public health concern – in response, Physicians and Lawyers for National Drug Policy was created.

Subsequently, PLNDP created a Judges Advisory Council, Chaired by Chief Justice Shirley S. Abrahamson of the Wisconsin Supreme Court. Other members are Judge Barbara J. Rothstein, Director, Federal Judicial Center, Judge William F. Dressel, President, The National Judicial College, Martha P. Grace, Chief Justice, Juvenile Court, Boston, Massachusetts and Senior Judge Arthur L. Burnett, Sr., National Executive Director, National African American Drug Policy Coalition, with headquarters at Howard University School of Law.

voluntary, continued heavy use can lead to dependence (or addiction), which is a chronic brain disease that causes physical changes in areas of the brain that are critical to judgment, decision-making, learning, memory, and behavior control. Once an individual becomes addicted to a particular substance, their actions become in part involuntary in response to their brain's demand or craving for increased use despite medical and legal consequences."[2]

As a preliminary matter, I would like to focus on the circumstances involved in many case histories which have come before me in my judicial capacity, which are not discussed in media presentation of the problem of the drug scourge in America. I have had individuals come before me who related that they were coerced into drug use initially. Young boys excellent in math in the 4th and 5th grade were targeted by drug pushers who recruited gang members to beat up the youngster daily until he joined the gang for protection and then the youngster would be forced to act as a "stash" and to insure that the youngster would not become a police informant or snitch, a drug lieutenant would force the youngster to smoke a cigarette laced with cocaine powder or phencyclidine (PCP) at the point of a gun. These individuals claim that was how they were introduced to illegal drug usage.

Both in the criminal law context and in family law cases, many mothers facing termination of parental rights and having their children put up for adoption have testified before me in court proceedings that at 11, 12 or 13 years of age they were raped by their mothers' live-in boyfriend or by an uncle or cousin and started drinking alcohol to cope

[2] Physicians and Lawyers for National Drug Policy (PLNDP) mission is to align policy, practice and public understanding with the scientific evidence that addiction is a preventable and treatable disease; to support the use of evidence-based, cost-effective approaches toward prevention and treatment; and to enable lawyers and physicians to provide effective and sustained leadership in this effort.

with their depression, especially when their mothers' would not believe them, and then start smoking marijuana and graduate to using cocaine. Thus, sexual abuse of young girls entering their early teens have so emotionally traumatized them that to numb their memories and to cope they turned to alcohol and drugs. Finally, I have heard many cases of young women "falling in love" with a guy they later learn is pushing drugs after they become pregnant by him and have moved in to live with him just to have shelter for herself and her expected child. Frequently, these women are not initially drug users, but they are the victims of domestic violence and are forced to become aiders and abettors in the drug operation and to prove their loyalty and to prevent them from snitching to the police, they are forced to start using drugs. Thus, countless numbers of individuals are initially introduced to illegal drugs not through voluntary action and immoral culpability but as a result of coercion, duress and domestic violence, and when we see them in the judicial system, they frequently have co-occurring mental and emotional disorders which we must also treat.

For many such individuals and others living in poverty, in socio-economic circumstances where there is no stable employment or income for anyone in the household, nor is there health insurance coverage, providing meaningful drug treatment to them is an extraordinary challenge. First of all they fear authority and they distrust the system. When brought before the court with a criminal charge, or in the neglect and abuse system, they want to have as little as possible contact with the court system – they want to know how quickly they can get their case over with. They fear that the more contact they have with the court system, the more "bad things" the court will learn about them and the more severe consequences they will suffer. When it comes to considering

entering Drug Court to get help with their drug problem, they think it is a "trap" and will result in only harsher consequences for them. Even their benevolent lawyers may confirm their beliefs and distrusts by agreeing with them that their lives have been so unstable that they can not make it in drug court and comply with all of its conditions, and as a result they will ultimately end up going to jail. Drug court personnel may not relate well to such individuals in an interview to determine eligibility and the prospects of such an individual complying with the conditions and requirements of a drug court regimen prescribed.

Thus, our initial hurdle is to train drug court personnel to be culturally sensitive and to teach new approaches to the socio-economic poor to reassure them that drug courts are really there to help them if they want help and are willing to cooperate and put forth their best efforts in good faith to recover from their drug addiction.[3] Judges must also be trained and sensitized to these factors and also to the neuroscience and medical aspects of recovering from drug abuse and addiction, and appreciate that stress and traumatic incidents in life may lead to one or more relapses in the recovery process, as a matter of human frailty, and not as a sign of bad faith or an endeavor to manipulate the system, or

[3] The National Institute on Drug Abuse (2006) has developed 13 principles of effective treatment for addiction for criminal justice populations: (1) Drug addiction is a brain disease that affects behavior. (2) Recovery from drug addiction requires effective treatment, followed by management of the problem over time. (3) Treatment must last long enough to produce stable behavioral changes. (4) Assessment is the first step in treatment. (5) Tailoring services to fit the needs of the individual is an important part of effective drug abuse treatment for criminal justice populations. (6) Drug use during treatment should be carefully monitored. (7) Treatment should target factors that are associated with criminal behavior. (8) Criminal justice supervision should incorporate treatment planning for drug abusing offenders, and treatment providers should be aware of correctional supervision requirements. (9) Continuity of care is essential for drug abusers re-entering the community. (10) A balance of rewards and sanctions encourages prosocial behavior and treatment participation. (11) Offenders with co-occurring drug abuse and mental health problems often require an integrated treatment approach. (12) Medications are an important part of treatment for many drug abusing offenders. (13) Treatment planning for drug abusing offenders who are living in or re-entering the community should include strategies to prevent and treat serious, chronic medical conditions, such as HIV/AIDS, hepatitis B and C, and tuberculosis. *Alcohol and Other Drug Problems: A Public Health and Public Safety Priority, supra at p. 32.*

to show contemptuous disregard for the court mandated requirements.[4] Once a person is in a drug court treatment program, it should be individualized and tailored to the needs of that individual, including psychological and/or psychiatric counseling where mental health issues are indicated. The extent and frequency of monitoring must be such as to meet the needs of the individual, and a drug court judge must be willing to schedule hearings with the frequency need to meet the intense supervision some persons may require, even once, twice or three times a week where the person may be going through a difficult time of stress in his or her life. Frequent and random drug testing of individuals can enhance treatment adherence and protect public safety by preventing behaviors like driving under the influence of alcohol or other drugs or committing crimes such as shoplifting when inhibitions are relaxed and the person may be subject more to impulsive behavior. It is noted that a judicial system could develop a system of magistrate judges, court masters, or other entry level judicial officers appointed by the judges who could perform these functions on a full-time bases, which in the long run may be far more economical than sentencing the individual to prison with the aggregate costs of imprisonment of $25,000, $30,000 or $35,000 per year per inmate.[5] The length of time

---

[4] It is absolutely essential for all personnel connected with drug treatment to fully understand that alcohol and other drugs have specific and long-lasting effects on the brain. Introducing alcohol and other substances during adolescence has lasting consequences because the brain is still developing. *Alcohol and Other Drug Problems: A Public Health and Public Safety Priority, supra at 15.* Alcohol and other drugs stimulate the reward circuit in our brains, teaching the brain to remember and desire feelings of euphoria and pleasure. These substances over-stimulate this natural system – that can release 2 to 10 times the amount of dopamine that natural rewards do. The resulting effects on the brain's pleasure circuit dwarfs those produced by naturally rewarding behaviors such as eating and sex. The powerful reward produced by alcohol and other drugs strongly motivates people to continue use. *Id.*

[5] The authors of the publication, *Alcohol and Other Drug Problems: A Public Health and Public Safety Priority,* observed: "If treatment saves lives and money, why aren't more people being treated? Some believe that it costs too much to provide treatment. But research on the economic impact of treatment consistently illustrates that the economic benefits of treatment outweigh the cost. A review of the economic benefits of treatment found the average net benefit per client was $42,905 with 98% of that net benefit - $42,151 – was a result of crime reduction. …. Treating alcohol and other drug problems also

in a drug treatment program should not be arbitrarily limited to a fixed period, but rather the person should remain in the drug treatment program for the length of time sufficient to effect the cure, just as one would remain in treatment for a heart attack, recovery from cancer, or some other physical ailment. The National Institute of Drug Abuse, NIH, recommends treatment for a minimum of 3 months for individuals involved in the criminal justice system with substance use disorders. Individuals with severe alcohol and other drug problems and co-occurring disorders typically need longer treatment and more comprehensive services. For them, treatment must be provided long enough to produce consistent behavioral changes. *Alcohol and Other Drug Problems: A Public Health and Public Safety Priority, supra at 32.* Effective treatment for substance use disorders is not a one size-fits-all approach. Treatment should be modified to meet the individual's specific needs, based on the severity of the alcohol or other drug problems, criminal history, gender, culture, socio-economic status, ethnicity, language, literacy, and physical or cognitive ability, as all of these affect how an individual will respond to treatment and should be considered during the clinical assessment and throughout the treatment. Individuals with substance use disorders should be placed in treatment programs with the appropriate structure and level of intensity based on the severity of their problems, not based on their criminal charge. Taxman, F. S., Perdoni, M. L. and Harrison, L.D. *Drug treatment services for adult offenders: The state of the state. J. Subst. Abuse Treat 32, 239-54* (2007).

---

reduces other public health concerns such as HIV and hepatitis B and C." *Supra at p. 31.* An accompanying chart reflected that the National Treatment Improvement Evaluation Study conducted by the Center for Substance Abuse Treatment between 1992 and 1997 found that the effects of drug treatment are manifold and last. Treatment can cut drug use by 50%, reduce criminal activity by 80%, and reduce arrests up to 64%. *Id.*

The most difficult challenge facing a person in drug treatment and the healthcare and court personnel working with that individual is the influence of neighbors and associates of the individual in the vicinity where she or he lives. Where the individual is in an outpatient program and sees daily the very persons who were her cronies in drug usage, the temptations of returning to drug usage are great. Putting the person back into the same environment in which the drug usage and addiction occurred is an invitation for disaster. Thus, finding affordable housing, relocation and change of environment are critical factors to be considered in order to achieve success. If one in drug recovery goes home every night to a block where there are several crack houses and all of her friends are using drugs, what can we expect? In my experience, relapse is inevitable. We need to find the means of relocation of such persons to a different neighborhood and a different environment, and we need a residence which is safe and secure for such individual while they are endeavoring to overcome their addiction.

We must then focus on the post-recovery – post treatment period as to what we must do to prevent a return to drug usage and addiction. We must develop a safety net for the individual, i.e. provide job training, employment with the potential for advancement and moving up the ladder as an incentive to not returning to one's old ways, and a reasonable floor of basic healthcare and monitoring to assure that there is not a relapse and return to drug usage and abuse. It might even be wise to develop a Support Group System for such individuals so that they have others they can turn to even during the post-treatment period, who will fortify them and help them over the rough bumps of daily living and help them to cope with their frustrations and disappointments. That Support Group could be a Club of Recovered Drug Users, A Church Social Action

Group, or a Social Service Group helping others to overcome their problems, which would strengthen the resolve of our individual person.

One of the issues with which we are frequently confronted is the absence of drug treatment on demand. The question is presented, "Why must one be charged with a crime, or brought into court for neglect and abuse of children in order to get drug treatment?" A closely related question is whether drug treatment can work without the coercive effect of it being court mandated and supervised. We strongly support the concept of drug courts and urge that funds be found in our governmental budgets through reallocations, using funds which would have gone to incarceration and imprisonment and reallocated them to drug court treatment programs, to increase greatly the number of such courts in this Nation, even to the point of having a drug court in every county and city of this Nation where there are sufficient number of people with drug problems to warrant the existence of the court. We have to shift our priorities if we are to solve one of the major domestic crisis facing this nation with a prison population greater than any other Nation in the world and with healthcare costs escalating with respect to hepatitis and HIV/AIDS and other medical problems due to the extensive usage of illegal drugs in our society. According to a SAMHSA Report of 2007 only about 18% (4 million of the 22.6 million Americans with substance use problems – this includes alcohol, illicit drugs and prescription drug abuse – received treatment. We have to reach more people.

I note that only last Friday, October 10, 2008 The Washington Post, contained an article reporting that Governor Timothy M. Kaine of the Commonwealth of Virginia expects a serious budget shortfall which will necessitate cutting hundred of Virginia government jobs, and that article reported that he was contemplating closing several

prison facilities with the prisoners being transferred to other locations. The thought occurred to me, why not use reentry drug courts as contemplated by the Second Chance Act. What if 500 non-violent offenders were released from prison early but on condition that they participate in a drug treatment program in a drug court nearest their home of residence for the next two (2) years, with once a week reporting until a judge decides that less frequent reporting is sufficient to protect the public safety? As a general matter, studies of drug courts during the past decade indicates that 3-4 individuals can be closely monitored in a drug court program for the cost of one inmate in prison, and if that prisoner becomes employed and pays taxes, he or she would be contributing to the revenues of the State. A cost analysis and projection for the Commonwealth of Virginia by economists and budget personnel may be most interesting and could end up with net savings to the Commonwealth of Virginia. It may well be worthwhile for the Commonwealth of Virginia to explore this option.[6]

While the constitutionality of random drug tests of adults receiving public welfare benefits has not been definitively determined, *Marchwinski v. Howard,* 6th Circuit. – the full court of appeals with 12 judges evenly split upheld Judge Victoria Roberts's opinion issued in 2003 holding random drug testing to be unconstitutional, it appears to me that there is another basis for drug testing recipients of welfare benefits as well as drug testing of public housing residents, and requiring drug treatment if the tests confirm drug usage and addiction, which would past constitutional muster. Using a *Terry v. Ohio,* 392 U.S. 1 (1968) standard of "articulable suspicion" welfare recipients and public housing

[6] It is noted that one study showed in costs in 2004 dollars $4,524 for treatment in drug courts while treatment in prison while incarcerated, including the costs of incarceration, could run between $28,288 - $38,844 on an average. Belenko, S, Patapis, N., & French, M.T., *Economic Benefits of Drug Treatment: A Critical Review of the Evidence for Policy Makers,* (Philadelphia: Treatment Research Institute, University of Pennsylvania 2005).

residents, could be required to participate in drug treatment programs as a condition of continuing to receive their benefits. Thus, if a repairman went to a resident's public housing unit and while there repairing a leaking pipe in the bathroom notice syringes and drug paraphernalia lying around and reported it to the manager of the Public Housing complex, the Housing Authority could require the resident to submit to drug testing and if positive, require good faith participation in drug treatment as a condition of remaining in the premises. The same approach could be employed in dealing with the public welfare recipient. Where agents of the government or private citizens learn of facts establishing "articulable suspicion" and reports it to the welfare agency, it would appear to me to be reasonable under the Fourth Amendment to require that individual to be drug tested and if positive, to participate in good faith in a drug treatment program. Should a person fail in bad faith to comply with the regimen of a treatment program, it appears to me that it would be sound public policy to terminate that individual's public welfare benefits, especially if it appears that it could be factually established that that individual is purposefully manipulating the system and not even trying to comply and quit using illegal drugs.

With reference to public housing, such an approach would ameliorate the impact of *United States Department of Housing and Urban Development v. Rucker,* 535 U.S. 125 (2002) which upheld statutory provisions in 42 U.S. Code, Section 1437(D)(1)(6) as not violating due process in authorizing Public Housing Authorities and giving them discretion to evict a tenant, even when a relative or guest used drugs on the premises, and even when the tenant did not actually know of the drug usage, but should have known of it. Such an approach in public housing may indeed be more humane and more

reasonable than the absolute discretion under a strict liability standard which the Supreme Court gave housing authorities in *Rucker, supra.* Furthermore, such an intermediary approach to compelling drug treatment may influence law enforcement officers not to intercede in the occupant's case with getting a search warrant and pursuing criminal prosecution of that individual, thus reducing the costs of law enforcement and criminal processes in court by having this legal procedure available in dealing with the drug abuse problems of public housing and public welfare benefits available.

Finally, we would urge that a pilot program be established for strictly volunteers to participate in a drug treatment program under the auspices of SAMHSA, U.S. Department of Health and Human Services, perhaps in 5 or 10 urban areas, using evidence-based treatment requirements, with a tracking and evaluation system to establish outcomes over a 3 – 5 year period. We will never know if volunteer treatment program for poor people will work or not. We applaud the passage of The Paul Wellstone and Peter Domenici Mental Health Parity and Addiction Act as part of The Emergency Economic Stabilization Act of 2008 providing for parity in healthcare insurance coverage for mental illness and substance abuse issues. We expect and hope that it will provide far more services for people who want help with their substance abuse issues, to the same extent as if they were dealing with a physical illness, but this Act provisions will only apply to employers of 50 or more persons who provide a healthcare insurance package. It does not mandate that the employer provide healthcare insurance and it does not cover people employed by employers of less than 50 persons. It is a small step in the right direction, but it will not resolve the problems of people who are not employed and the great majority of people living below the poverty line and without

healthcare insurance coverage at all. Thus, we need these pilot programs to test the hypothesis that drug addicts who simply volunteer for drug treatment will not follow through and their treatment programs will not be successful. Physicians and Lawyers for National Drug Policy has noted that research has established that clinical screening for alcohol and other drug problems should be a standard of care in a variety of settings, including emergency departments of hospitals, trauma centers, and primary care, pediatrics, family practices as well as in the justice system. *Alcohol and Other Drug Problems: A Public Health and Public Safety Priority, supra at 21.* Putting aside the justice system, the other sources could be a major referral resource to encourage individuals to participate in such pilot programs on a volunteer basis. The 2006 National Survey on Drug Use and Health reported that 3.8 million people 12 years of age and older had problems with illicit drugs but not alcohol and that 3.2 million had problems with both, for a total of 7.0 million individuals. We must find some additional ways to deal with this large a population.

In dealing with illegal drug users, I think it is important to consider the problems of people on probation and on parole or supervised release. We need to provide more effective training for our probation and parole officers as to the nature of the disease status of being a drug addict and instill in them the concept that relapse will happen from time to time.[7] We need to get them to focus on the objective of aiding an ex-offender to

[7] Many in the justice system tends to view relapse as a voluntary violation of the law. However, relapse frequently occurs when an individual is trying to stop using a substance, but finds it to be difficult for their altered brain to resist craving. The medical system, however, does not regard relapse as a failure of treatment. Relapse to addiction occurs at similar rates to other chronic medical conditions such as diabetes, hypertension, and asthma. Like other chronic relapsing disorders, addiction to substances may require a change in treatment until abstinence is achieved. This is similar to when a diabetic does not take their medications or fails to exercise as outlined by their physician; their non-compliance and relapse are not seen as a failure but their treatment is altered to more effectively address their problems. *Alcohol and Other Drug Problems: A Public Health and Public Safety Priority, supra at p. 16.*

return to the community successfully and fully stabilized and not looking for an excuse to violate the offender and have him or her sent back to prison. The hallmark of success for such an officer should be how many ex-offenders he or she can get through probation, parole or supervised release without seriously re-offending and in the community and not how many persons he or she can violate and send back to prison. Technical violations should be dealt with in the community by more intense monitoring, supervision and counseling, and not by moving to requiring further prison incarceration. Prison should be reserved for the violent offenders, for those who are convicted of new offenses back in the community, or for those who show contemptuous disregard for orders of a court or for requirements of the system. I note an innovation that I used as a judge setting in criminal court in sentencing offenders with drug problems to probation, was the device of two-stage probation, i.e. imposing a sentence, suspending the execution and putting the person on probation for the maximum period of five (5) years, but providing at the time of sentencing in the Judgment and Probation Order that probation shall terminate in 3 years or 2 years, if the offender participated in drug treatment successfully, got his or her GED, and remained arrest free for the 2 years or 3 years initial period of time. This rewards system was most effective and I found that many offenders worked towards the goal of early termination of probation and were successful in finishing probation early, and in some instances they were so successful, I would reward them with a bonus, I would terminate probation following one of my periodic probation review hearings set at staggered intervals just to monitor the probationer's progress and when it was extraordinary, I would terminate probation even earlier than the 3 years or 2 years limitation initially set. My recollection is that this process reduced tremendously

the number of offenders I had to end up revoking and sending to prison, at least by one half if not more than in the traditional approach of waiting until there is a probation violation to intercede and to determine whether to continue the probationer on probation with stricter probation conditions or revoking probation and sending the individual to prison.

In conclusion, we wish to emphasize that we fully understand that developing these programs as outlined herein, and increasing the number of drug courts and expanding their reach as to the number of people served, will cost money and in these tight economic times, with the economic crisis facing this country now and perhaps for the next several years, finding money to do so will be difficult. But we wish to stress that funds to do what we recommend should not end up increasing the overall budgets of the federal and state governments, for if we take money away from our corrections and imprisonment complex and reallocated it to these programs, it would result in a net savings to government at both levels. Over the past decade, almost every study of drug courts shows that they work effectively, and they save substantial funds which would have otherwise been expended on imprisonment costs. Just take a portion of the prison budget and transfer it to the drug court budget, and the government will realize a net gain and savings, which money could be dedicated to meeting the other essential services of government, such as providing for education, healthcare, and meeting our infrastructure needs for essential services to our citizens. Further, this does not take into consideration the reduction in law enforcement arrests, the costs of criminal prosecutions, the costs of criminal trials and adjudications, the costs of recidivism and the negative impact on public safety. According to a recent publication by Physicians and Lawyers for

National Drug Policy (PLNDP), *Alcohol and Other Drug Problems: A Public Health and Public Safety Priority supra,* p. 4: "According to several conservative estimates, every $1 investment in treatment yields a return of between $4 and $7 in reduced drug-related crime and criminal justice costs. After including health care-related savings, the benefits exceed the costs by a ratio of 12:1." What we recommend here should reduce all of these costs and at the same time make all of our communities far safer than they are now under the manner we now operate and how we now deal with the problems of drug abuse and addiction in America.