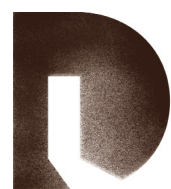


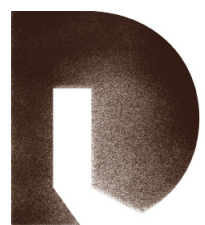


Into Treatment, Not Prison

*How To Save Taxpayer
Dollars and Keep RI
Families Together by
Expanding Drug Courts*



OPENDOORS



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INTRODUCTION

Rhode Island incarcerates approximately 360 individuals a year that are suffering from drug addiction, have no history of violent felony or drug dealing convictions, and were charged with nonviolent crimes. Arrest can provide an opportunity to initiate a supervised rehabilitation program designed to reduce relapse and recidivism. The current response, incarceration for an average of almost one year, results in reconviction rates over two times higher than diversion into treatment.

Incarceration is also very expensive. **This report estimates that the state could save a quarter of a million dollars by the end of the year through an initial expansion of drug court of 120 clients a year.** Ultimately, this report estimates the state could fully expand the court by 360 clients, potentially saving millions of dollars in incarceration costs.

The current Rhode Island Adult Drug Court could already be diverting these 360 individuals into court supervised treatment under current law, but it is limited to a small number of clients by funding and procedural restrictions. The program currently supervises 150 clients a year and achieves recidivism rates 61% lower than incarceration.¹

Drug courts are recommended by the Federal Government Office of Budget Accountability as safe and cost-effective criminal justice programs, estimated to save between \$1,000 and \$15,000 per defendant.²

The Rhode Island Drug Court has strict eligibility criteria and does not accept defendants with any history of violent felonies or drug dealing. This ensures that the program protects the public and actually decreases crime by dealing with the source of previous criminal activity-- addiction. Over 70% of individuals who currently qualify but are not receiving diversion to treatment state that they know they have a problem and want help. An expanded drug court would save the state money, improve public safety, and help treat individuals who are suffering from addiction and want treatment.

[1] See the section on Diversion and Addiction for methodology.

[2] Drug Court Effectiveness. Government Accountability Office-05-219, 2005

TREATMENT & ADDICTION

Addiction is a Disease

Drug addiction is a chronic disease with substantial effects on human health and behavior, and huge costs to both the individual and society. Addiction is caused by a combination of environmental and biological risk factors including genetics (40%-60% of addiction risk), parental drug use, and poverty.³ Relapse is caused in part by continued cravings in the brain from an absence of the substance.

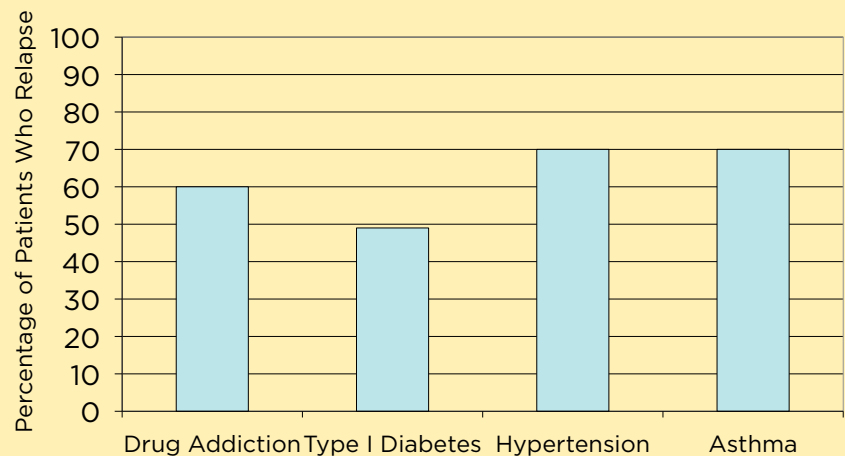
As shown in Figure 1, relapse rates for addiction are similar to or lower than other chronic diseases.⁴ Once an individual is addicted, physical and chemical differences in the brain cause actions to become in part involuntary responses to the brain's demand for the substance. While behavior is not entirely explainable by drug use, it becomes highly influenced by the disease of addiction.

There are substantial crime consequences to untreated addiction. Individuals addicted to drugs and involved in crime have high rates of recidivism. Individuals incarcerated for drug possession in Rhode Island that were seriously addicted to drugs had a history of 2-3 felonies more on average than those not seriously addicted (see Section 2: *Treatment & Incarceration* for details).



The average daily heroin user commits one hundred to three hundred crimes against persons or property each year⁵. The frequency of crime also increases as the intensity of drug misuse increases. Heroin users commit two to six times as much crime when they use drugs daily as when they use less frequently.⁶

Figure 1:
Relapse Rates of Chronic Disease⁶



[3] National Institute of Drug Abuse (2007). *Drugs, Brains, and Behavior: The Science of Addiction*. US Department of Health and Human Services. NIH Pub No. 07-5605.

[4] McLellan et al, 2000. Drug dependence, a chronic medical illness: implications for treatment, insurance, and outcome evaluation. *JAMA* 283, 1689-95.

[5] Johnson et al., 1985. *Taking Care of Business: The economics of crime by heroin users*. National Development and Research Institute.

[6] Ball et al., 1986. *Criminality of Heroin Addicts: When Addicted and When Off Opiates*. Inciardi, James, *Drugs-Crime Connection*; G Speckart and MD Anglin, 1986. *Narcotics use and crime*. *Contemporary Drug Problems* 741.

Treatment Works

The science of addiction treatment has proven successful in controlling addiction and providing benefits to society. A study conducted by the Center for Substance Abuse Treatment from 1992-1997 found that treatment cut drug use by 50%, reduced criminal activity by 80%, and reduced arrests by 64% (See the *Treatment Research Review* section for more evidence from specific studies).⁷ A review of the economic benefits of treatment found that the average net benefit per client was \$42,905, with 98% of the savings in crime reduction.⁸

Levels of Care

Several different levels of treatment are available, and appropriate treatment should be determined by a professional with the use of a standardized assessment tool. The state categorizes treatment into six levels of care:

- Detoxification and Day Treatment:* Generally one week or less of supervised abstinence from drug use focusing on dealing with the side-effects of detoxification.
- Narcotic Maintenance or Narcotic Outpatient Treatment:* Supervised medically assisted recovery, most commonly consisting of administering methadone to individuals addicted to heroin and providing treatment therapy.
- Outpatient:* Individual or group therapy
- Outpatient Intensive:* Individual or group therapy at least three times per week.
- Residential:* Residency that provides supervision and treatment services.
- Recovery Support:* Ongoing support to remain drug-free, such as recovery coaching, Narcotics Anonymous, or other support groups.

Medically Assisted Treatment

Pharmaceuticals such as methadone and suboxone can provide essential assistance to individuals in recovery. Pharmacological treatment decreases cravings, and allows individuals to overcome physiological causes of use while they participate in other forms of therapy to address the social or behavioral causes of their drug use.

Behavioral Therapies

There are a range of behavioral therapies used at all levels of care. In general, behavioral therapies try to provide individuals with skills to avoid drug use and deal with the psychological and social causes of drug use. For example, cognitive-behavioral therapy teaches skills to identify and avoid cues and behaviors that lead to relapse. The Community Reinforcement Approach uses social, recreational, familial, and vocational reinforcement to support recovery. Drug use associated with post-traumatic stress requires therapy that treats the effects of the trauma.



[7] Center for Substance Abuse Treatment, 2004. National Treatment Improvement Evaluation Study, 1992-1997. U.S. Department of Health and Human Services.

[8] McCollister and French, 2003. The relative contribution of outcome domains in the total economic benefit of addiction interventions: a review of first findings. *Addiction* 99, 1647-1659.

Treatment Research Review

Many studies demonstrate that participation in treatment programs correlates with a decline in reported drug use and behavioral problems. Several major national studies indicate that substance abuse treatment proves successful for significant numbers of clients. These include the Drug Abuse Reporting Program (DARP), the Treatment Outcome Prospective Study (TOPS), the Drug Abuse Treatment Outcome Study (DATOS), and the Services Research Outcomes Study (SROS). (See Appendix A for a complete review of these studies.)

Several major national studies indicate that substance abuse treatment proves successful for significant numbers of clients.

RI Has Highest Need In The US

Rhode Island has the highest rate of illicit drug dependence and the highest rate of people needing but not receiving treatment for illicit drug use of any state. Illicit drug addiction in Rhode Island is largely associated with cocaine, crack, marijuana, and heroin. In 2007, 32.6% of 18-25 year olds and 8.69% of those older than 26 indicated they had used an illicit drug in the past month.⁹ Rhode Island has by far the highest rate of cocaine use in the country, 32% higher than the next highest state.¹⁰

[9] National Survey on Drug Use and Health, 2007, SAMHSA.

[10] 4.32% of Rhode Island used cocaine in the previous year. 3.27% of Colorado had used cocaine in the past year, the next highest state. National Survey on Drug Use and Health, 2007.

[11] Warner, Margaret, et. al. September 2009. "Increase in Fatal Poisonings Involving Opioid Analgesics in the United States, 1999-2006." National Center for Health Statistics, Center for Disease Control and Prevention. NCHS Data Brief No. 22.

[12] Department of Mental Health, Retardation &

Additionally, drug overdose is the most common accident related form of death in Rhode Island: more people die from drug overdoses than homicide and car fatalities combined.¹¹ Addiction rates are on the rise in Rhode Island: illicit drug use increased from 24.9% in 1999 to 32.6% in 2007 for 18-25 year olds.

Addiction and Crime

High addiction rates are a significant cause of crime in Rhode Island. According to a study of 128 individuals incarcerated for drug possession, 8% reported abusing prescription opiates, 15% heroin, 25% cocaine, and 25% crack in the month prior to incarceration. Only 2/128 reported methamphetamine use.¹²

Chart 1. RI Discharge Types in 2007 for all Licensed Providers, Across all Treatment Modalities

Discharge Type	% Across All Modalities
Completed	41%
Left Voluntarily	28%
Discharged For Noncompliance	13%
Incarcerated	2%
Transfer	16%

Data provided by the RI Department of Mental Health, Retardation & Hospitals

Hospitals FY 2007 data on clients served.

[13] In 1999, Rhode Island allocated 19 million dollars (inflation adjusted to 2009 dollars) to the Substance Abuse Department of the Rhode Island Department of Mental Health, Retardation and Hospitals from General Revenues. In 2009 14.3 million was allocated.

The Northeast in general has relatively low crime rates (crime rates in the Northeast are considerably lower than in the West and South).¹³ However, Rhode Island has the highest rate of property crimes in the Northeast, including crimes that are often associated with addiction, such as larceny and shoplifting. In 2008, the property crime rate in Rhode Island was 33% higher than in New York.¹⁴

Funding

Treatment services in Rhode Island are generally at capacity.¹⁵ As a result, Rhode Island continues to struggle to provide addiction treatment to those who need it. While Rhode Island does dedicate state resources to addiction recovery, these funds have decreased by 25% since 1999.¹⁶

Funding sources for state subsidized treatment have changed dramatically from year-to-year. Since 2008, the state has relied largely on federal funding in the form of the Access to Recovery (ATR) grant to fund treatment. ATR funds allow qualifying clients to choose services from a host of providers, forcing providers to compete for clients. Individuals leaving prison that have drug addiction problems currently can apply to receive treatment services; however, the continuation of this program is uncertain.

Statewide Treatment at Capacity

Drug Treatment and Recovery services in Rhode Island are provided by a network of private treatment providers and hospitals and made possible through a combination of insurance and state-funded treatment slots. Licensed treatment providers are tracked and funded through the Department of Mental Health, Retardation, and Hospitals. In 2007, there were 255 licensed residential treatment beds in the state, which were at 97% capacity.¹⁷ There were 18,664 clients treated in 2007, including 8,475 individuals provided with outpatient services.¹⁸ Overall, these providers reported relatively successful outcomes, as shown in Chart 1. Only 2.2% of clients were reincarcerated during treatment, and only 13% were discharged for noncompliance.

“We have a very active waiting list—the minute someone leaves we are trying to get someone else in. [The wait] would probably be at least a month.”

—Phoenix House Residential Program in Exeter

[14] Unreleased study, Principal Investigators was Dr. Nick Zaller, Assistant Professor of Medicine at Brown Medical School and The Miriam Hospital.

[15] In 2004, there were 480 violent offenses per 100,000 people in the West, 540 in the South, and 390 in the Northeast. FBI Uniform Crime Report 2004.

[16] FBI Uniform Crime Report, 2008.

[17] This does not include unlicensed sober house beds; the 97% capacity reflects the turnover time that is sometimes required before a bed is refilled. This number indicates that residential slots are being used to capacity. No data was available on the length of waiting lists, but as described in the focus group section, anecdotal evidence indicates a lack of available residential beds.

[18] 18,664 individuals were either discharged or still receiving treatment from state licensed treatment providers in 2007.

Focus Groups Outline Obstacles to Treatment

OpenDoors, in conjunction with researchers from Miriam Hospital, completed five focus groups with direct service staff at treatment agencies across the state. These included: Phoenix House Residential Program in Exeter, STARR Detoxification, Providence Center outpatient services, Gateway Mental Health, and Discovery House methadone maintenance. The following results are not intended to be a comprehensive assessment of treatment systems across the state; however, they do indicate some of the obstacles that exist in treating addiction.

Capacity:

Most staff agreed that capacity was an issue. Although no organizations were able to provide records of waiting lists for analysis, intake staff stated that it can be difficult for clients to get into treatment, even if they have insurance. They described waiting periods ranging from a week to three months.

Payment:

Paying for treatment is generally a challenge, even for clients with insurance. Insurance often requires co-payment, and companies often resist paying for residential treatment or other services. Clients without insurance are sometimes only able to access treatment that is not the most appropriate for their situation. For example, sometimes only residential placement will be subsidized, when the client would be better served by outpatient treatment.

No Detoxification for Cocaine and Crack:

Detoxification services are available for alcohol and heroin withdrawal, but are not available for cocaine and crack withdrawal. This is an obstacle for individuals with cocaine and crack addictions that are interested in beginning the treatment process.

Medicine Availability: Clients are sometimes denied entry into programs if they do not have sufficient access to medication that has been prescribed to them. This causes clients to be denied necessary treatment services because they are also lacking other medical resources.

Treatment History: Although service providers emphasized the importance of recommending the appropriate level of care, they felt that sometimes clients were denied entry into an appropriate level of care just because they did not have sufficient treatment history in lower levels of care.

Financial Criteria: State funding can only subsidize treatment for individuals that meet financial criteria. Clients not meeting these financial criteria sometimes still cannot afford treatment, or go through periods of time when they cannot afford treatment, and have to be discharged due to nonpayment. This was identified as a problem by methadone maintenance programs, which sometimes see clients for long stretches of time in which their financial situation can change dramatically.

Problematic Delays in Access:

All programs identified the goal of quick intakes when spots are available in order to ensure that clients interested in treatment are not lost. However, some programs described intake processes that made it very difficult for them to transfer clients into other programs in time.

Inappropriate Court Mandated Treatment:

Some programs described working with clients mandated to a certain type of treatment who were not medically appropriate for that treatment. Programs described clients that were denied access to a certain level of care because they did not meet the programs medical criteria for that program, even though a judge had mandated that level of care.

INCARCERATION & ADDICTION

Rhode Island's addiction response has relied largely on arrest and incarceration. Between 1977 and 2005, the rate of incarceration for drug-related charges has increased by 1400%, from 5 per 100,000 people to 77 per 100,000 people.¹⁹

The cost of incarceration for these drug offenses has also increased by \$26 million, from \$2 million to \$28 million, not including judiciary and police costs.²⁰ Overall, one study provides the basis for an estimate of \$330 million in addiction costs in Rhode Island per year, including criminal justice, health, and loss of productivity.²¹

This report estimates that in 2008, approximately 360 people who were clinically addicted and interested in receiving treatment were put in prison for property or drug-related charges.²² The large majority of these prisoners frequently used cocaine or opiates prior to incarceration, most daily. It costs \$5.7 million per year to incarcerate only the subset that are charged specifically with drug possession.²³ Appendix B provides a thorough examination of who is incarcerated as a result of addiction.

Incarceration does not deal directly with the roots of addiction. Individuals suffering from addiction detoxify and stay clean while in prison. However, if they return to old environments without first learning how to deal with the root causes of their addiction, they are likely to relapse.²⁴

[19] National Survey on Drug Use and Health, 2007, SAMHSA. The 1977 estimate is based on the DOC report, RI Correctional Population FY1976 - FY2005.

[20] This cost estimate uses the FY 2010 Revised Institutional Correction Budget of \$163,885,224 divided by the FY 2010 average inmate population of 3,659 and multiplied by 620, an estimate for the number of inmates incarcerated at one time for drug charges. The historical figure is based on the Report on the Rhode Island Correctional Population 1976-2005 from the Department of Corrections, which states that 7% of the population in 1977 was incarcerated for drug offenses, or approximately 50 individuals. The cost estimate uses the figure of 8.5

Case Studies

Chris

Chris was using crack daily and occasionally using heroin when he was arrested for possession of one-half gram of crack. He reported having been suicidal and was taking psychological medication at the time of his arrest. Chris had nine previous nonviolent felony convictions, including possession of cocaine and larceny, but no violent felony or drug delivery convictions. He stated he was 'extremely' interested in treatment, specifically residential treatment, and he stated his addiction was an 'extreme' problem. He had been working as an auto technician at the time of his arrest and had been clean for two months prior to a relapse a month prior. He was sentenced to prison for one year.

Dan

Dan stated he had been clean for five months when he relapsed on the day of his arrest because of the death of his parents. He was arrested with five dollars worth of crack cocaine. He had previously been living in a residential treatment facility. He admitted to previously attempting suicide. He was sentenced to prison for 18 months.

million for the 1977 Correctional budget, based on the 1977 Rhode Island State Budget, inflation adjusted.

[21] Belenko, 2005. Economic benefits of drug treatment: A critical review of the evidence for policy makers. Philadelphia: Treatment Research Institute, University of Pennsylvania.

[22] This reflects the most immediate offense that caused the incarceration. Most of these individuals were serving probation for previous offenses and so the prison sentence was due to the previous charge and the new charge. For example, if someone was on probation for drug delivery, arrested for shoplifting, and then incarcerated as a probation violator of the drug delivery charge, this analysis counts them as being incarcerated for shoplifting. The Department of Corrections Population Reports show breakdowns of prison sentences by offense type using the original offense type. This graph also reflects the total number of sentences in one year. It is not a breakdown of the prison population at one time.

[23] See methodology section for details.

[24] McLellan, et. al, 2000. Drug dependence, a chronic medical illness: implications for treatment, insurance, and outcomes evaluation. JAMA 284: 1689-95.

Drug Court and Prostitution

Current Rhode Island policy towards prostitution focuses on arrest and incarceration. Drug Court would be a more humane, helpful, and cost effective response.

In 2009, the policy of criminalizing people working in prostitution was expanded by further criminalizing prostitution indoors. This policy has led to the additional arrests of women for indoor prostitution, added to the already ongoing arrests for outdoor prostitution.

As discussed in detail in the OpenDoors report, *Rethinking Arrest: Street Prostitution and Public Policy* (available at opendoorsri.org/prostitution) many of those engaging in prostitution are victims of abuse, addiction, and poverty. In 2009, there were 436 incarcerations for loitering for indecent purposes. 108 different women were sentenced to prison for an average of 100 days for loitering for indecent purposes. 78% of these women already qualified for the current drug court program—they had no history of violent felonies or drug delivery.



Drug Court could serve as an excellent model for diverting these women into treatment and providing support and supervision for their recovery. In addition to addiction treatment, supportive services including culturally competent case management, therapy for post-traumatic stress syndrome, and health and STI prevention classes would effectively support women attempting to recover from prostitution and addiction.

During the decision to criminalize indoor prostitution in Rhode Island in 2009, there was considerable discussion about pursuing next steps that would provide supportive services to those arrested for prostitution. Drug Court would provide an effective model for diverting these individuals into treatment instead of prison.

A More Effective Response to Addiction

Addiction to drugs is a serious public health problem with substantial human and financial costs. While addiction treatment has become more and more successful and widely accepted, Rhode Island continues to struggle to provide addiction treatment to those who need it.

Many states are successfully diverting those with addiction to treatment rather than prison. By doing this, they substantially reduce incarceration costs while improving outcomes. For example, in 2007 the Texas legislature expanded drug diversion by 9,000 slots, including an expanded drug court. According to a 2009 evaluation, the prison population was reduced by 4,612 beds, and the reforms already saved the state \$282 million in prison construction costs.²⁵

Rhode Island has already implemented successful programs that divert individuals with addiction issues into community supervision instead of prison, and the potential exists to expand these programs.

DIVERSION & ADDICTION

Diversion Works

Diverting addicted, low-risk individuals from prison into treatment is a successful and widely recommended criminal justice model. Rhode Island currently diverts people both at the front-end through the Rhode Island Drug Court and at the back-end through parole into treatment.

Clients from both programs have low recidivism rates similar to or lower than comparable rates for those who are incarcerated. This section includes background information about both programs.

Both RI Drug Court and parole into treatment currently provide a low cost, effective alternative to incarceration.

The *Recommendations* section offers a detailed blueprint for expanding drug diversion along a Reentry Court Model that combines the best of these two current programs. The program would serve between 100 and 400 clients per year and save the state between \$200,000 and \$2.43 million per year.



Many states are successfully diverting individuals with addiction problems to treatment rather than sending them to prison.



[25] Reduction based on number of projected needed beds. Assessing the Impact of the 2007 Justice Reinvestment Initiative. January, 2009. Council of State Governments. Available at http://justicereinvestment.org/files/Texas_Bulletin.pdf.

[26] GAO, 2005

[27] Finigan, 1998; Goldkamp and Weiland 1993; Gottfredson and Exum 2002; Harrell and Roman 2002; Jameson and Peterson 1995; Peters and Murrin 2000; Wilson et al. 2006. Brooklyn: Harrell et al. 2001; Baltimore: Gottfredson et al. 2003

[28] Gottfredson, Denise. "The Baltimore City Drug Treatment Court: One-Year Results From a Randomized Study." *Journal of Research in Crime and Delinquency*.

[29] Marr, John. Review of the Adult Drug Court Program in the Eleventh Judicial Circuit (Miami-Dade County) of Florida with Special Focus on Treatment Related Services. 2002, Office of Justice Programs Drug Court Clearinghouse and Technical Assistance Project.

Drug Courts Work

After two decades of experience and research, it is clear that drug courts are an effective way to respond to and reduce drug use and associated criminal activity.

A 2005 review of 117 drug courts around the country by the Federal Government Accountability Office concluded that “drug court programs can reduce recidivism compared to criminal justice alternatives, such as probation.”

Drug Courts decrease drug relapse, reduce re-arrest, reconviction and recidivism by 10-30%, and save \$1000-\$15,000 per participant.²⁶

These results have been repeated numerous times in other studies over the last two decades.²⁷ For example, 235 clients were randomly assigned to a drug court or ‘treatment as usual’ in the Baltimore City

The Rhode Island Drug Court has demonstrated consistent success.

Chart 2: Drug Court Client Flow

Year	Entered	Graduated	Terminated
2004	40	65%	30%
2005	69	59%	32%
2006	44	80%	11%
2007	36	--	--
2008	59	--	--
2009	70	--	--
Total	318		

Data provided by the RI Adult Drug Court

Drug Treatment Court study, which found a 66% reduction in rearrest for individuals in drug court.²⁸

The longest running drug court in the country, in Dade County, Florida, enrolls over 1,500 participants annually and achieves the remarkably low recidivism rate of 5% amongst graduates.²⁹



New Supervision Methods Can Reduce Incarceration by 70%

In the past several years, new and improved supervision methods have been proven to be highly effective. This report recommends incorporating these methods into the drug court model to ensure maximum effectiveness, decrease re-offending rates of participants, and increase savings.

Two highly successful models implemented in Hawaii and Georgia have demonstrated the effectiveness of “swift and certain sanctions” in improving outcomes for supervision of probationers. These models use frequent, random drug testing; clear guidelines; immediate, incremental sanctions; and outcomes analysis to create a well-structured supervision model. Program evaluations demonstrated a 60% decrease in incarceration time, 79% decrease in drug use, and 80% reduction in missed supervision appointments.³⁰

The current RI Drug Court incorporates some of these methods; however, funding has never been available for an outside assessment and evaluation of the court, which could provide the feedback necessary to guarantee that the court is utilizing these methods to operate at maximum effectiveness.

Rhode Island Drug Court is Well-Established

The Rhode Island Adult Drug Court (RIADC) was created in 2001 by Judicial Administrative Order to provide court supervised treatment to nonviolent felony offenders. The court has consistently maintained a case-load of approximately 150 clients per year and is currently funded through a combination of federal and state money.

The Rhode Island Drug Court has demonstrated consistent success. The court graduates 70% of participants and only 12% of clients recidivate within one year of participation, 61% lower than the average prison recidivism rate.³¹

In 2009, the Rhode Island Drug Court was determined to be the most effective program amongst all programs proposed by public safety.³² Appendix D details the current personnel costs of the program, which total approximately \$462,000 a year and entail 8 part-time or full-time staff positions.

[30] Hawken, A. & Kleiman, M., 2009. Managing Drug Involved Probationers with Swift and Certain Sanctions: Evaluating Hawaii’s HOPE. US Department of Justice; An Evaluation of Georgia’s Probation Options Management Act, 2007. Applied Research Services.

[31] The overall prison recidivism rate is 32%, according to the DOC report 2004 Recidivism Study: Two-year Follow Up. The recidivism comparison is meant to be an informal comparison only. The DOC report uses a more conservative definition of recidivism that only includes reincarceration, and not conviction. In addition, the two samples are not identical sets of individuals and this is in now way meant to imply that diverting individuals into drug court will decrease their likelihood of recidivating by 61%.

[32] The DOC, State Police, Attorney General’s Office, Judiciary, and Office of the Public Defender all submitted proposals for funding from the Federal Department of Justice Byrne Grant. The proposals were scored according to a rubric by an objective panel, and the Judiciary’s Drug Court Proposal scored the highest of all proposals.

[33] Gottfredson, Denise. “The Baltimore City Drug Treatment Court: One-Year Results From a Randomized Study.” *Journal of Research in Crime and Delinquency*.

Court Protocol

The RIADC was created through Administrative Order 2001-4 by the Rhode Island Judiciary, which has overall responsibility for the program. According to the order, the Rhode Island Department of the Attorney General will screen all Providence and Bristol County cases for cases that meet drug court criteria:

1. Adult residing in Providence/ Bristol county
2. Charged with alcohol or drug charge or another nonviolent offense
3. Exhibits a history of alcohol or drug dependency or abuse
4. No prior or pending convictions involving a crime of violence
5. A willingness to enter a plea of nolo contendere

Clients are then assessed by Drug Court staff to determine if they meet all criteria using an appropriate medical assessment tool. After a meeting involving the defense attorney, prosecutor, and drug court staff, the client may be offered entry into the

While in the program, the client must complete the court-ordered treatment, report to their probation officer as directed, and appear in front of the court on a regular basis.



program. Clients must plea to the charge and sign the drug court contract, which establishes the conditions and sanctions of the program.

The RIADC is a post-adjudication drug court, meaning clients are then placed on bail prior to sentencing. If they violate the conditions of the contract, they can be incarcerated for up to 90 days. While in the program, the client must complete the court-ordered treatment, report to their probation officer as directed, and appear in front of the court on a regular basis. The frequency of appearances decreases as the client's performance improves.

In order to graduate, a client must stay drug-free for one year, and upon graduation, the conviction is annulled prior to sentencing. If a client is terminated from the program for noncompliance, he or she can be convicted and sentenced for the charge per the normal criminal procedure.

Program Evaluation

OpenDoors conducted an analysis of Drug Court outcomes using available client data. Data was provided on all 312 clients admitted and tracked between 2004 and 2009

Rhode Island Drug Court has a high graduation rate.

The Rhode Island Drug Court has graduated 70% of clients. This is a high graduation rate. The completion rate varied nationally between 27% and 66% for the 16 programs reviewed in detail by the Federal Government Accounting Office. Completion rates represent the individuals who completed or were favorably discharged from a drug court program as a percentage of the total number admitted and not still enrolled. Although differences in programs make comparisons between programs difficult, the Rhode Island rate is certainly high.

In comparison to the individuals interviewed in prison, drug court clients were less likely to be on probation and had fewer prior felonies and misdemeanors. As required by the criteria, they do not have previous violent felonies or drug delivery convictions.

- Averaged 1.1 felony and 2.3 misdemeanors prior to entering drug court.
- Only 16% had more than two felonies
- 14% had a violent misdemeanor on their record.
- 23% had a possession conviction, 69% had a property crime on their record.
- Terminated clients had slightly worse criminal records:
 - Terminated clients averaged 1.4 felonies and 2.6 misdemeanors.
 - 19% had more than two felonies.
- 12% recidivism rates of clients was low in comparison to other drug courts and similar released inmates in Rhode Island.

Only 16% of clients were reconvicted within one year of beginning drug court. In contrast, 41% of individuals that met drug court criteria but were sentenced to prison were reconvicted within one year. However, these two groups are not directly comparable because the group sent to prison had longer criminal backgrounds.

It is possible that a large amount of the difference is due to the fact that drug court is dealing with lower-risk clients. However, even in comparison to other drug courts this recidivism rate is low. For example, 30.6% of Baltimore City Drug Court participants were reconvicted within one year.³³

Clients that were terminated from the drug court had higher rates of recidivism: 32% of clients eventually terminated from the program were reconvicted within one year of beginning drug court.

Intake and funding barriers limit program efficiency.

The drug court currently has the administrative capacity to serve more clients and operate more efficiently, however it is hampered by funding and intake limitations. As shown in Chart 2, client flow into the drug court program has been relatively moderate, with 70 new clients added in 2009. This is partially due to funding restrictions—the Drug Court has struggled every year to maintain funding to pay for client treatment and supervision. The current probation officer works part-time with the court and is not able to supervise additional clients. Without the capacity to serve more clients, the court is less likely to expand outreach. Currently, there is no outreach to many clients that would meet court criteria. According to the administrative order that created drug court, the Department of the Attorney General is responsible for screening all defendants that could potentially meet criteria; however, this goal is not currently being met.

Recommendations for Expanding Diversion into Treatment through Enhanced Drug Court

There are currently over 360 inmates that meet criteria for diversion but are currently incarcerated, including those who are seriously addicted to drugs (as defined in the Data Analysis section), the vast majority of whom are interested in treatment. Current law and court policy already provides the Drug Court with jurisdiction over all 360 of these cases.

This report recommends expanding the Adult Drug Court to serve these individuals by increasing supervision and treatment resources and designing a protocol to specifically target these individuals.

Program Design

Resources for addiction and recovery treatment

Currently, the Drug Court spends \$3,500 per client on average for substance abuse treatment services. These services are subcontracted out to providers across the state that provide a variety of modalities of treatment. Treatment is determined based on the clinical assessment of the defendant.³⁴

Two more probation officers to provide community supervision

The current drug court serves approximately 100 clients at a time with a probation officer that works with drug court for 80% of their time. The probation officer provides ongoing supervision between court visits to ensure clients are meeting court-ordered conditions and to provide case management to help rehabilitate clients.

The fully expanded court would require increased Department of Corrections funding for the current officer at full-time plus an additional two officers. Because the court will replace incarceration time with community supervision time, there is an increased amount of supervision required. However, the clients would have been placed on probation anyway at the end of their incarceration had they not been diverted into drug court.

Clinical coordinator to oversee client screening and assessment

The clinical coordinator conducts intake screenings, coordinates clients' treatment needs, and helps assign and monitor treatment. This position was created as part of the initial Rhode Island Drug Court in 2001 but has occasionally disappeared due to lack of funding. This position is necessary to conduct the increased number of intakes and help manage the increased number of clients. Currently, this staff position is provided through the Department of Mental Health, Retardation & Hospitals. However, future funding is not secured. The expanded Drug Court would secure permanent funding for this full-time position.

Screening protocol to identify and screen eligible clients

Client identification and screening is essential to ensure consistent and appropriate client participation. With the correct protocol, it will be possible to cost-effectively identify clients from the thousands of new cases every year and screen only the appropriate clients to be assessed. In addition, to be budget neutral in the FY 2012 budget, the expanded drug court must specifically serve clients that would otherwise go to prison. The current program is available to all clients, but tends to serve clients less likely to be incarcerated. Part of the reason for this tendency is the increased aversion by other courts and Attorney General staff to refer clients with longer criminal histories, even though according to research, these are the individuals most likely to benefit from supervised treatment.³⁵

There are two recommended routes for diversion into the program:

- Pre-disposition: Clients are identified by attorney and judges and screened by Drug Court staff. In particular, probation courts are targeted for client referrals.
- Sentence Modification: inmate self-referrals and screening information from DOC is used to identify clients who are referred back to their hearing judge for sentence modification into drug court.

[34] This is well within the guidelines recommended by the Federal Government. The Department of Justice, in the most recent drug court grant application, recommended a per client cost of between \$3,000 and \$5,000.

[35] Lowenkamp, Latessa, Holsinger, 2006. The Risk Principle in Action: What We Have Learned From 13, 676 Offenders and 97 Correctional Programs. Crime and Delinquency, 52: 1.

COSTS & SAVINGS

Program Costs

The drug court could be expanded to different scales, and depending on the size the costs for the court will vary. Serving all people eligible would require an expansion of around \$2.4 million. Appendix E shows a breakdown of costs for the minimally expanded model, with a cost of \$420,000.

The current drug court has considerable capacity to expand. The court could serve over 100 more clients a year with more probation officers and more treatment dollars. The current annual budget is \$812,000 most of which is provided through Federal Department of Justice funds (see Appendix D for budget breakdown and sources of funding).

Expansion beyond another 100 clients could also require more court staff assigned to a drug court calendar. The courts could potentially provide these resources by transferring them from other calendars.

According to research, drug court supervision actually requires fewer resources than traditional adjudication. This is because of the non-adversarial nature of the proceedings, which encourages defendants to plead no contest and speeds disposition. An expanded drug court more effectively uses current court resources by using court resources on supervision instead of contesting and prosecuting criminal charges.

Criminal Justice Savings

Expanding the drug court by 120 clients in FY 2012 would save the state a quarter of a million dollars. As shown in Appendix E, the savings are from per-diem savings on food and medicine as well as the possible eventual reduction of one supervision post.

The state currently spends an average of \$11 million per year incarcerating the 360 potential drug court clients. It is very difficult to estimate the actual potential savings associated with diverting these individuals, but one possible estimate is an average of \$10,000 per bed saved (see methodology).

To be budget neutral in the FY 2012 budget, the expanded drug court must specifically serve clients that would otherwise go to prison.

Appendix A: Treatment Research Review

Texas Christian University's Institute for Behavioral Research conducted the **Drug Abuse Reporting Program (DARP)**. The study entailed intake and bimonthly interviews with over 44,000 clients in 52 federally funded treatment programs between 1969 and 1974. Clients were also interviewed during follow-up, at six and twelve years after treatment admission. The survey was conducted across three treatment modalities: methadone maintenance, therapeutic community, and outpatient drug-free.

The DARP results demonstrate that drug abuse treatment was effective in reducing or eliminating drug use and criminal activity. Across the three treatment modalities, at a one-year post-treatment follow-up, 26% of clients showed no substance use and no criminal activity, and 38% of clients showed no daily substance use and no major criminal activity.³⁶

The Research Triangle Institute performed the **Treatment Outcome Prospective Study (TOPS)**. TOPS researchers observed more than 11,000 clients in 41 federally-funded drug abuse treatment programs from 1979 to 1981 at intake, one-month post-admission, every three months during treatment, and post-treatment at three months, one year, and three to five years post-discharge.

This study, like the DARP, illustrates the effectiveness of treatment in eliminating or reducing illegal substance use. Across the specified treatment modalities (methadone maintenance, TC, outpatient drug-free), near 89% of heroin users, 87% of cocaine users, 84% of nonmedical psychotherapeutic users, and 55% of marijuana users were no longer using their primary drug when interviewed one year after their discharge from treatment.³⁷

The **Drug Abuse Treatment Outcome Study (DATOS)** is the largest study of treatment outcomes conducted since the early 1980s. With funding from the National Institute on Drug Abuse, DATOS tracked 10,010 drug users entering treatment programs between 1991 and 1993. The study aimed to determine the outcomes of treatment delivered in stable, community-based programs by examining the role of treatment outcomes, program type, client characteristics, treatment received, therapeutic approaches, and provision of aftercare. DATOS surveyed outpatient methadone, short-term inpatient, long-term residential, and outpatient drug-free modalities. Alan Leshner, former director of the National Institute on Drug Abuse, proclaimed, "DATOS overwhelmingly confirms the effectiveness of drug abuse treatment. [...] Among the patients that DATOS studied, drug use dropped significantly from the 12 months before treatment to the 12 months after treatment began."³⁸

The **Services Research Outcomes Study (SROS)** was a survey of 3,047 clients in a random sample of 99 drug treatment facilities nationwide. The study sample represents approximately 950,000 clients who sought treatment in one of the four treatment modalities nationwide from September 1989 to August 31, 1990. Study results indicate that inpatient, outpatient, and residential treatment for substance use disorders effectively reduce use of alcohol, marijuana, cocaine, crack, heroin, and other illicit substances. The SROS provides a comparison of inpatient, residential, outpatient detox-methadone, and outpatient drug-free treatment modalities. This study also shows that treatment reduces criminal activity and arrests (except for parole violations). However, there was no observed improvement in employment outcomes.³⁹

Appendix B: Survey Results: Who is Addicted and Incarcerated?

Below are the results of our survey of 128 inmates incarcerated at the ACI during 2007 and 2008. All participants in the survey were incarcerated as a result of drug possession charges.

- In 2008, an average 300 people were incarcerated at one time for drug possession.⁴⁰
- The 128 person sample had an average sentence of 585 days.⁴¹
- 98% of individuals surveyed were sentenced as probation violators.
- 50% are highly addicted to drugs and want treatment.
- They report significant hard drug use, with the vast majority using predominantly crack and cocaine.
- 81% of individuals surveyed use crack, cocaine, and/or heroin everyday:
 - Heroin 22%
 - Crack 45%
 - Cocaine 33%
- 19% report occasional cocaine use.
- Highly addicted ASI score is .25, vs .1 for rest of sample.

Highly Addicted

- The 50% Highly Addicted have significant barriers to recovery, including mental health, housing, employment, and histories of addiction. However, they are good candidates for treatment.
- 50% of this sub-group reported frequent, serious depression prior to arrest.
- 15% had had thoughts of suicide.
- 21% were on psychological medicine.
- 30% had been in some sort of mental health treatment or substance abuse treatment in prior month.
- Many had relatively non-serious criminal histories:
 - 25% met strict criteria of no convictions for felony violent crimes or drug distribution charges.
 - 47% had no history of drug distribution charges.
 - 45% had no history of misdemeanor or felony violent crimes.
 - 63% had no history of felony violent crimes.

- Overall high levels of unemployment and low housing stability, however many hard drug users actually had moderate levels of economic and social resources:
 - 50% lived in their own apartment, with 23% living in the street.
 - 43% had legitimate income.
 - 56% had high school diploma, GED, or post-high school education.
- Interest in treatment is high amongst hard-drug users:
 - 75% extremely or considerably bothered by drug use.
 - 78% extremely (71%) or considerably interested in treatment.

Less Addicted

- The 50% that are less addicted are less good candidates for treatment and they have been more involved in drug dealing.
- Interest in treatment is very low:
 - 78% not bothered or only slightly bothered by drug use.
 - 74% not interested or only slightly interested in treatment.
- Criminal record shows greater history of drug distribution, less history of violent crimes:
 - 68% had no history of drug distribution.
 - 80% had no history of violent felonies.
- Greater employment and housing stability:
 - 60% had some employment before being incarcerated.
 - 60% had high school diploma, GED, or greater.
 - 67% lived in their own apartment, and almost all the rest lived with a friend or relative.
- Recidivism rates of sample were low:
 - 20% were reconvicted for some offense within one year of release.
 - 16% were reconvicted for a felony within one year of release.
 - One individual out of a possible 98 was reconvicted of a violent felony within one year.
 - Recidivism rate of Highly Addicted was 19% within one year (10/52).

Appendix C: Methodology

Estimate of Target Population

This report estimates that approximately 360 people are incarcerated annually that meet drug court criteria.

- This estimate was calculated by first analyzing raw DOC population data to calculate the total number of inmates sentenced for nonviolent property and drug crimes with no prior convictions for violent felonies or drug delivery.
- Secondly, a study of 128 inmates was conducted to estimate that 50% of this population are addicted to cocaine, heroin, or crack cocaine.

Estimating the 360 Inmates: Who fits drug court criteria?

A Department of Corrections data-set including all individuals sentenced to prison from 2004-2009 was combined with public court data in order to conduct the analysis.

- The analysis only included people sentenced for drug or property offenses.
- These offenses were chosen because offenders are most likely to be associated with drug addiction and also to traditionally be served by drug court.
- These offenses include: possession of controlled substances, possession of controlled substances with intent to deliver, larceny, check and credit card fraud, breaking and entering, loitering for indecent purposes, shoplifting, driving a motor vehicle without consent, burglary, and possession of stolen property.
- Other nonviolent offenses such as driving on a suspended license, driving while intoxicated, vandalism, and violation of a no-contact order were not included in the analysis because they are not as frequently associated with drug addiction.
- There were 722 inmates sentenced for these offenses in 2008 but they took up only a total of 640 beds. Using the

50% estimate for addiction, as discussed below, that equates to 360 clients and 320 beds.

- The bed estimate uses the estimate that inmates serve 75% of their sentence. This estimate was generated by looking at the percentage of time served by individuals released for these offenses in 2008.

Estimating the 50% rate of addiction

A study of 128 inmates incarcerated in the ACI for drug possession was conducted in association with Miriam Hospital in 2008 and 2009.

- The survey included the ASI addiction questions, which were used to compute a relative ASI score and determine level of addiction.
- 50% of the sample were categorized as addicted. This sub-sample had an average ASI score of .25 as compared to .1. They all used cocaine, heroin, or crack cocaine, and 81% reported using these drugs daily.
- This 50% estimate was applied to a larger sample of offenses for this analysis; however, similar rates of addiction have been found in other studies, justifying a broader use of this estimate.⁴²

Recidivism Analysis

All recidivism analyses in this report were conducted using the following methodology:

- The analysis uses a time-period that begins with program initiation and lasts for one year. Individuals accepted into the program are immediately exposed to the possibility of recidivating, so in terms of public safety considerations, the potential for recidivism begins immediately. An alternative method is used just for graduates, using the date of graduation instead of the date of program initiation. Individuals who had not been in the program for at least one year were removed.

- Recidivism is any new conviction or reincarceration.
- The data provided considers any new conviction or reincarceration as a recidivism event. This includes incidents in which the defendant fails to fulfill drug court obligations and is incarcerated or convicted, even if this was due to non-criminal activity such as failing to attend treatment.
- Recidivism rates do not include failing to meet conditions that do not result in conviction or incarceration. Because drug court supervision provides for a varying level of discretion, an individual could re-offend or fail to meet conditions without being terminated or convicted.
- Reconviction begins at complaint date.
- The time of the reconviction is calculated using the complaint date for the criminal case. This is more accurate than using the reconviction date because the conviction process can be lengthy.

Disclaimer About Causality

None of these recidivism rates should be interpreted as demonstrating any causal relationships between drug court and recidivism.

- Drug Court recidivism rates could be lower than recidivism rates for incarcerated individuals because of differences in the individuals, not the type of punishment.
- Recidivism rates for graduates could be lower because the more responsible people graduate, not because drug court supervision reduced recidivism.

Savings and Cost Calculations

- In order to estimate costs, this report uses an estimate of \$33,000 annual cost per bed in minimum security, where most potential drug court clients are incarcerated.
- Reducing the DOC population by 320 beds does not necessarily allow

the state to save on many of the costs associated with incarceration. This report uses a very conservative per-bed estimate based directly on the FY 2012 DOC budget. The Department of Corrections saved \$1.3 million in 2010 by reducing the inmate population by 124 individuals. This cost includes only the per-diem food and medical costs associated with each inmate. On average, the DOC saved \$9,972 per bed in one year, or about 25% of the total cost of the bed. This report uses an even more conservative per-diem estimate of \$10.4 (\$3,800 per year) as recommended by the DOC budget office.

Treatment Review Appendix

[36] Simpson, Dwayne, S.B. Sells; Effectiveness of Treatment for Drug Abuse: An overview of DARP Research Program. *Advances in Alcohol and Substance Abuse*, Volume 2, Issue 1 December 1982.

[37] Hubbard, RL, Rachel JV, Craddock, SG, 1984. Treatment Outcome Prospective Study (TOPS): Client Characteristics and Behaviors Before, During, and After Treatment. National Institute on Drug Abuse.

[38] Leshner, Alan, 1997. Introduction to the special issue: The National Institute on Drug Abuse's (NIDA's) Drug Abuse Treatment Outcome Study (DATOS). *Psychology of Addictive Behaviors*. Vol 11(4)

[39] Meara, E and Richard, F, 2006. Spending on Treatment: how much is enough? *Addiction*, 100 (9); Mojtabai, R and Zivin, J, 2003. Effectiveness and Cost-effectiveness of Four Treatment Modalities for Substance Disorders: A Propensity Score Analysis. *Health Services Research*, 38.

Survey Appendix

[40] Average calculated by averaging the total number of people sentenced for drug possession on one specific day, across 365 days.

[41] This sentence is longer than the average sentence for drug possession offenders, because the sample represents people in prison at one time, not all people newly sentences. The sample includes more people with long sentences and fewer people with short sentences.

Methodology

[42] Peters and Murrin 2000; Wilson et al. (2006)

Appendix D: Annual Rhode Island Drug Court Budget

	Total Salary	Percentage of FTE	Cost
Judiciary			
Special Magistrate	\$141,515	60%	\$84,909
Court Reporter	\$63,662	25%	\$15,915.5
Coordinator Special Projects	\$65,942	100%	\$65,942
Clinical Coordinator	\$45,772	25%	\$11,443
Project Manager	\$71,896	100%	\$71,896
Administration			
Sheriff	\$50,000	25%	\$12,500
Department of Corrections			
Probation Officer	\$68,015	80%	\$54,412
Attorney General's Office			
Staff Attorney	\$65,192	60%	\$39,115
Public Defender's Office			
Staff Attorney	\$63,978	60%	\$38,387

Total Costs			
		Salary	\$404,519
		Approximate Benefits (30%)	\$121,356
		Subcontracted Treatment Services	\$350,000
		TOTAL	\$997,231
Funding Sources			
		State	\$460,864
		Federal Byrne Grant	\$536,363
		TOTAL	\$997,231

Appendix E:**Minimally Expanded Court: Clients, Beds, Costs and Savings**

Treatment Costs	Clients	Beds	Cost
Men	100	100	\$350,000
Women	20	20	\$70,000
Total	120	120	\$420,000

Institutional Costs			Cost
Probation Officer (1)			\$100,000

Savings			
Per-Diem X 120 Beds			\$456,000
One Post in Minimum Security at \$37/hr			\$316,128
Total			\$772,128

SUMMARY			
		Total Cost	\$520,000
		Total Estimated Savings	\$772,128
		Maximum Net Savings	\$252,128