NEW YORK STATE SENATE STANDING COMMITTEE ON ALCOHOLISM & DRUG ABUSE

Senator Jeffrey D. Klein, Chair

Assessing the Effectiveness of
Substance Abuse Treatment Under
Rockefeller Drug Law Reform

February 2012

Introduction

On April 2, 2009, the State Legislature passed ground-breaking legislation that effectively swept away an entire era of notoriously harsh drug sentencing schemes known as the Rockefeller Drug Laws. The 2009 reform caused a major change in New York's drug policy, shifting it away from mass incarceration and toward a public health model. The two most fundamental pieces included in the legislation were an elimination of mandatory minimum sentences, and restoration of judicial discretion to order treatment and rehabilitation as an alternative to incarceration.

Two years have passed since these reforms were implemented, and the questions that need to be answered are: have they been successful? Are drug offenders truly being given the treatment they need, and is this treatment producing better outcomes than incarceration as the reforms intended? In order to determine the effectiveness of the 2009 Drug Law Reform (DLR), Senator Jeffrey Klein, Chair of the Senate Alcoholism and Substance Abuse Committee, gathered first-hand information from treatment providers across the State.

In collaboration with the New York Association of Substance Abuse Providers (ASAP), an online survey was circulated to ASAP's membership of 250+ alcoholism and drug treatment providers. The purpose of this survey was to determine whether treatment providers were seeing an increase in the number of patients referred from the criminal justice system, and if so, whether these providers have the capacity and resources to support all clients coming into their program for treatment to overcome their dependency and lead healthy and productive lives. ASAP providers' responses were also recognized as crucial in determining the need for further legislation and/or funding to maximize the effectiveness of drug law reform.

Background: The 2009 Rockefeller Drug Law Reform

In February 2009, after 18 months of studying the State's sentencing laws, the Commission on Sentencing Reform released its recommendations. Among its suggestions were to:

- expand judicial discretion in sentencing;
- remove prison mandates;
- offer alternatives to jail and probation; and
- create more judicial diversion programs, such as drug court.

Drug law reform became law in April 2009 and major provisions took effect on October 7, 2009. A summary of statutory changes and effective dates, published by the Division of Criminal Justice Services (DCJS), is highlighted below:

<u>April 2009</u>

- Eliminated mandatory minimum prison sentences for 1st B drug convictions (jail or probation now an option). Class B drug offenses include criminal sale or possession of a controlled substance in the 3rd degree, criminal sale of a controlled substance in or near school grounds, and unlawful manufacture of methamphetamine in the 1st degree.

- Reduced minimum prison sentence length for 2nd B drug convictions from 3½ years to 2 years.

- Eliminated mandatory minimum prison sentences for 2nd C, D, and E drug convictions (jail or probation now an option). There are many class C, D and E drug offenses. For complete descriptions, see New York Penal Law Sections 220 and 221.

- Expanded eligibility for participation in the Department of Correctional Services (DOCS) Shock Incarceration Program: age limit increased from 40 to 49; "aging in" from general confinement authorized; B 2nd drug offenders now eligible; judges may now "court-order" individuals to Shock.

- Expanded eligibility for a direct sentence to parole supervision, which requires 90 days at the Willard Drug Treatment Campus, to include those convicted of 1st felony B drug offenses, 2nd felony C drug offenses, and third degree burglary.

- Division of Parole authorized to discharge non-violent drug offenders prior to their maximum expiration date.

June 2009

- Conditional sealing provisions took effect. Upon successful completion of a judicial diversion program, the court may conditionally seal the instant offense and up to three prior misdemeanors. If the defendant is re-arrested, the records are unsealed.

October 2009

- Judicial diversion statute took effect. Individuals charged with felony level B, C, D, or E drug offenses and specified property offenses eligible. Specified property offenses are: Burglary 3rd, Criminal Mischief 2nd and 3rd, Grand Larceny 3rd and 4th (excluding firearms), Criminal Possession of Stolen Property 3rd and 4th (excluding firearms), Forgery 2nd, Possession of Forged Instrument 2nd, Unauthorized Use of a Motor Vehicle 2nd, Unlawfully Using Slugs 1st.

- Resentencing authorized for previously sentenced B felony drug offenders in State DOCS custody.[1] This only requires that the trial judge consider applications for reduced sentences.[2]

[1] NY CPL Section 440.46.

[2] Whether parole violators are eligible to seek a reduction of their sentences under the 2009 drug law reform will be reviewed during the week of May 31, 2011, by the Court of Appeals. A unanimous panel of the Appellate Division, Second Department, ruled in an Orange County case in March 2011 that parole violators are eligible in People v. Phillips, 4881/01, concluding that "nothing" in the 2009 reform law "supports a conclusion" that being a parole violator "renders a person ineligible to apply for resentencing in the first instance." The First Department concluded that to allow parole violators the chance to seek resentencing under the 2009 amendments is "contrary to the dictates of reason or leads to unreasonable results," People v. Pratts, 74 AD3d 536.

Cumulatively, the 2009 DLR created the need for greater capacity in drug courts to accommodate the rise in residential and outpatient treatment needs.

Drug Treatment Under the Judicial Diversion Program

Prior to drug law reform, the most widely used drug treatment models for felony drug offenders were judicially supervised drug courts and prosecutor-run programs, such as DTAP ("Drug Treatment Alternatives to Prison"). Drug courts in New York were established in the early 1990's and combine "a personalized approach to each defendant, constant judicial monitoring, and a graduated system of punishment and reward in order to rehabilitate the individual for successful re-entry into the community."[3] Before 2009, judges did not have the authority in drug cases to place defendants into alternatives to incarceration programs, like drug treatment, without the prosecutor's consent; however, that system changed when judicial discretion was restored to judges under drug law reform.

The Judicial Diversion Program (post-Rockefeller DLR) is a deferred-sentencing model in which the defendant must first plead guilty to the charged offense; the sentence is deferred while he or she undergoes a treatment program, and upon successful completion of the program will the original charges may be dropped.[4] DTAP, which is run by prosecutors, still exists, but the program has witnessed a slight drop in enrollments since judicial diversion was created.
In the twelve months following the passage of Rockefeller DLR, existing drug courts were expanded in all five boroughs of New York City, and new drug courts were established in Nassau, Suffolk, Westchester, Dutchess, Madison, and St. Lawrence counties.[5] At the same time, statewide, evaluations to determine eligibility for diversion grew to a total of 40% over the 2008 baseline of 4,621 to 6,478, although after peaking during the first quarter following implementation of Rockefeller DLR, they have declined each quarter. [6] However, screenings remain substantially higher than before drug law reform implementation.

In the 2010 report released by the Division of Criminal Justice Services regarding the Preliminary Impact of 2009 Drug Law Reform, an estimated 2,800 individuals entered a drug court for a class B, C, D, or E felony offense, or one of the property offenses specified in CPL Article 216, representing an increase of 1,750 from 2008. 73% of those drug court entrants were

[3] Peter A. Mancuso, "Resentencing After the "Fall" of Rockefeller: The Failure of the Drug Law Reform Acts of 2004 and 2005 to Remedy the Injustices of New York's Rockefeller Drug Laws and the Compromise of 2009," 73 Albany Law Review 1535, 2010, p.16.

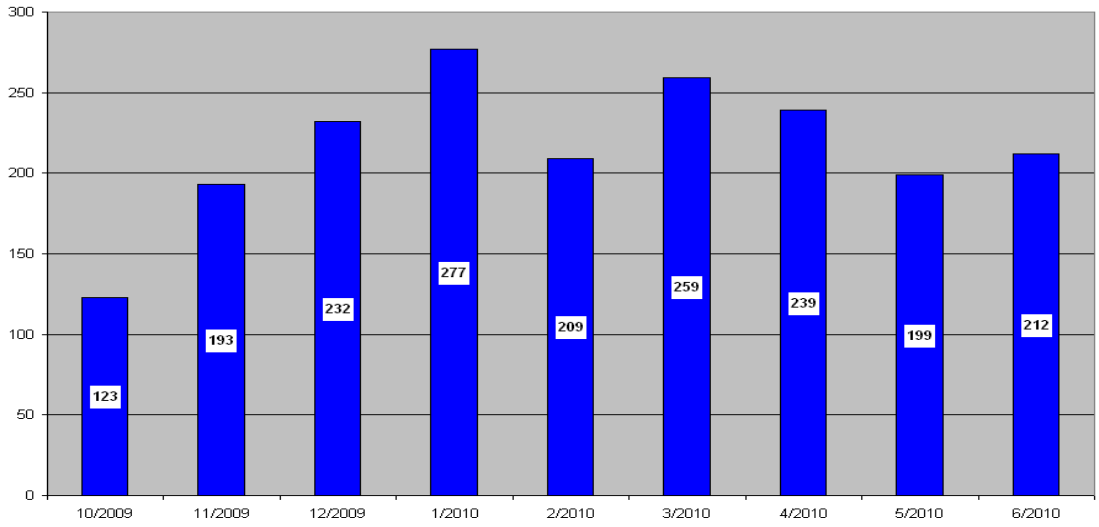
[4] Ibid.

[5] Division of Criminal Justice Services (DCJS), "Preliminary Impact of 2009 Drug Law Reform October 2009 – September 2010," published October 2010, p.5, retrieved 14 March 2011 from DCJS website, available at: http://www.criminaljustice.state.ny.us/drug-law-reform/documents/interim-drug-law-reform-update-10-07-2010.pdf.

[6] Division of Criminal Justice Services (DCJS), "Felony Drug Court Activity Among Offenders Eligible under 2009 Drug Law Changes 2008-2010," published November 2011, p.3, available at: http://www.criminaljustice.state.ny.us/drug-law-reform/documents/drug-court-activity-report.pdf.

drug offenders and 27% had been indicted for at least one Article 216 property crime.[7] In the 2011 report just released in November 2011, beginning in October 2010, 8,530 Article 216-eligible offenders, about 90% of them indicted on drug offenses, were screened in New York State and 41%, or 3,463, were admitted into drug court.[8]

New Article 216 Participants Statewide



Source: NYS OASAS

As the number of drug court entrants doubled, the number of Article 216-eligible offenders for DTAP declined by approximately 17%, from 900 in 2008 to 750 in the 12-month period following reform. These numbers continued to decline to only 495 for DTAP and related programs in 2010, of which 430 of those were in New York City.[9] "Program admissions in some jurisdictions, particularly those where new drug courts were established, [have] declined substantially."[10] Outside of New York State, DTAP and related program admissions have decreased 70%[11]

Despite an increase in individuals entering drug court and a decrease in individuals entering DTAP, the net increase in offenders diverted from State prisons since the law changed was 1,600. According to the 2010 DCJS report, approximately 700 (or 44%) of those 1,600 offenders, including 500 drug offenders and 200 property offenders, would have been sentenced to prison if they were not diverted. These 1,600, along with 150 fewer enrollees in programs

[7] Division of Criminal Justice Services (DCJS), "Preliminary Impact of 2009 Drug Law Reform October 2009 – September 2010," published October 2010, p.5, retrieved 14 March 2011 from DCJS website, available at: http://www.criminaljustice.state.ny.us/drug-law-reform/documents/interim-drug-law-reform-update-10-07-2010.pdf.

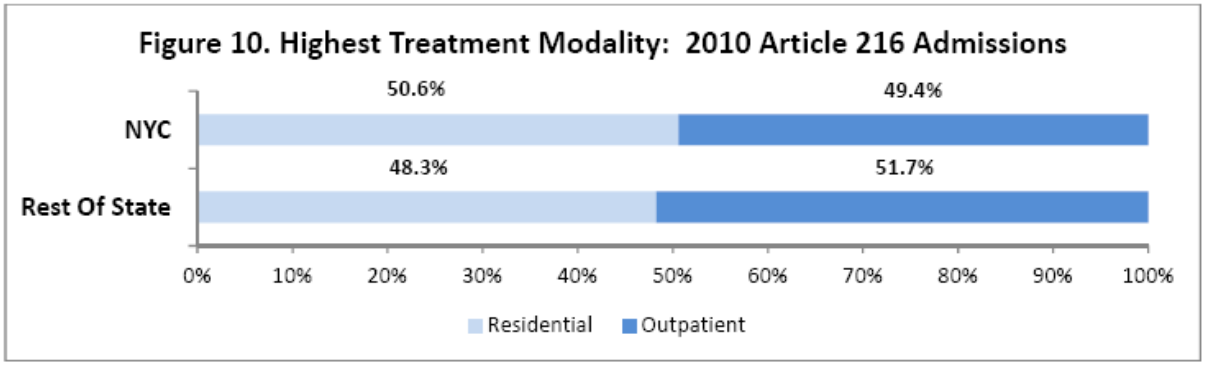
[8] "Felony Drug Court Activity" *supra* note 6, at 6, 11.

[9] Ibid. at 22.

[10] "Preliminary Impact of 2009 Drug Law Reform" *supra* note 5, at 5.

[11] "Felony Drug Court Activity" *supra* note 6, at 22.

such as DTAP, contributed an additional 1,750 Drug Court enrollments, which approximately total 2,800 enrollees reported in 2010. Of those, 46% of Drug Court participants were admitted into in-patient treatment, and 54% were admitted to outpatient programs.[12] This ratio of program admittance stayed consistent through 2010:[13]



Treatment Provider Survey

While these statistics and alternatives offer some encouraging news, it is unclear what happened to these offenders post-diversion. DCJS' data only captures offenders at the point of diversion, but it does not explain how the treatment system is coping with that influx in patients from the criminal justice system, or what resources are available to aid the treatment system in supporting reform implementation. Are there waiting list to get into treatment? How do treatment facilities handle patients who are uninsured? These questions have not yet been answered and form the basis for the research into monitoring drug law reform's impact.

Methodology[14]

In collaboration with the New York Association of Substance Abuse Providers (ASAP), Senator Klein and the Committee circulated an online survey to ASAP's membership of 250+ alcoholism and drug treatment providers.

In order to evaluate the impact of drug law reforms on the treatment system and the needs of treatment providers to support successful reform implementation, Senator Klein constructed an online survey comprising of 18 questions The survey was initially circulated, between April 7, 2011, and April 14, 2011, to all ASAP members throughout the State. To ensure a comprehensive and accurate picture of implementation during varied periods of the year, we circulated the survey a second time, between May 3, 2011, and May 9, 2011. A final third

[12] "Preliminary Impact of 2009 Drug Law Reform" *supra* note 5.

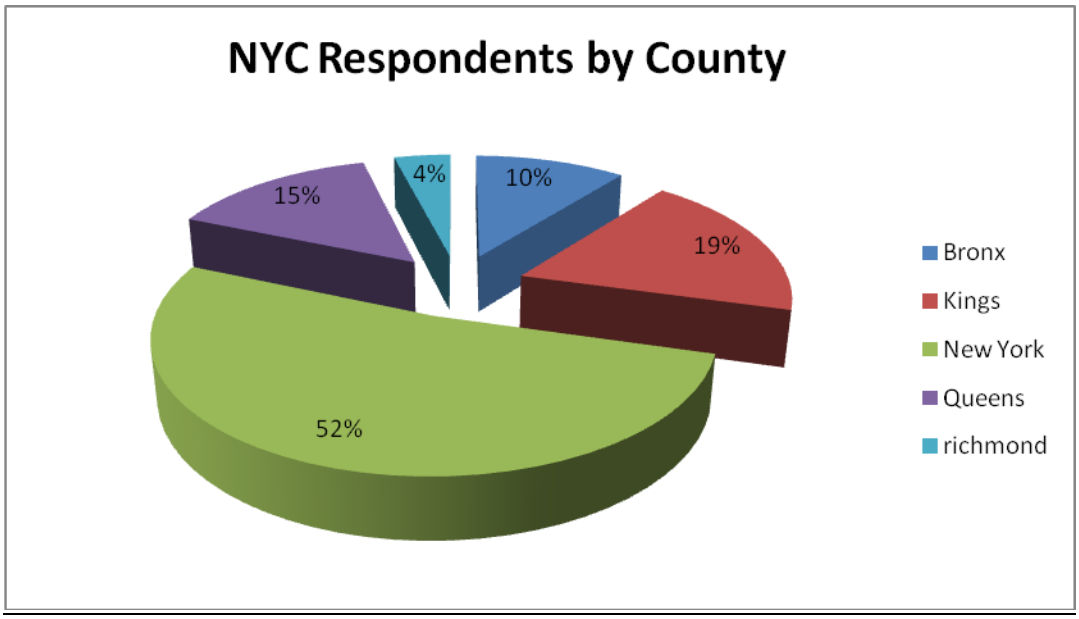
[13] "Felony Drug Court Activity" *supra* note 6, at 22.

[14] Throughout the survey analysis, numbers have been rounded to the nearest percent.

circulation occurred in late November 2011. In total, 156 responses were received from 37 counties, translating into a response rate of 63%.

Respondent Profile

Approximately 43% of the respondents operated treatment programs in New York City and the other 57% operated programs in the rest of the State. Thirteen respondents indicated that they served patients in more than one county, four respondents worked at a substance abuse facility that offered services nation-wide, and one respondent did not specify. Not counting three "nation-wide" answers, the survey marked a heavy presence of treatment providers in the downstate area: of which, slightly over half were in New York County (52%), more specifically 19% from Kings (Brooklyn), 15% from Queens, 10% from Bronx, and 4% from Richmond (Staten Island) County.

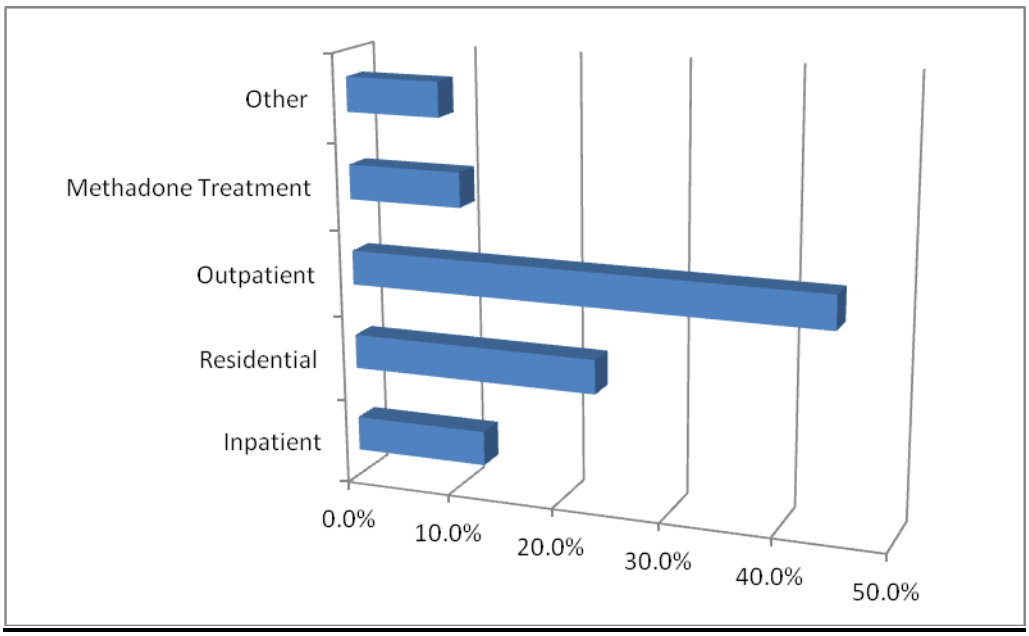


Of the respondents who reported operating facilities in the rest of the State, 19% were located in Westchester and 14% were in Suffolk. The rest were spread in 30 other counties through the State, over half of the 57 counties, not including the five comprising New York City, which make up New York State.

Treatment Program Type

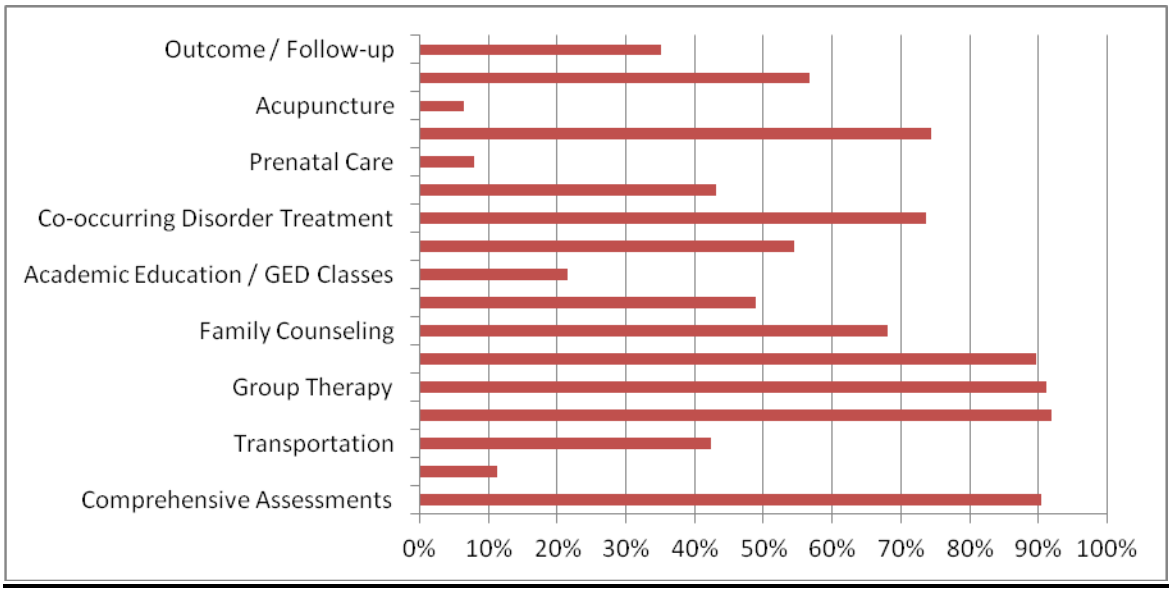
The respondents were asked to describe the treatment program type they provide out of precreated selections (see appendix): Inpatient, Outpatient, Residential, Methadone Clinic or Other. The 156 respondents provide an aggregate of 215 services, as many provide multiple

types of programs. 45% of survey respondents identified themselves as providers of outpatient treatment services, 23% were residential, 13% were inpatient, 11% offered methadone treatment, and 9% as "Other." The "Other" responses are predominantly self-described as "Prevention," but also included Crisis Centers, Halfway Houses, and Parole Services.



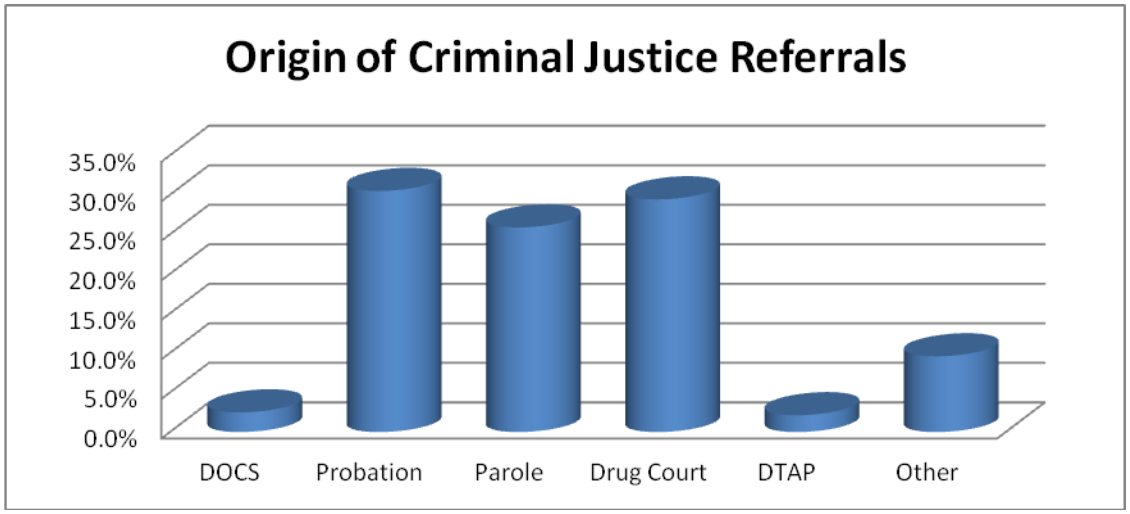
Services Provided

The services provided by these treatment facilities include predominantly comprehensive assessments and diagnosis, individual and group therapy, relapse prevention, smoking cessation, family counseling, treatment for co-occurring disorders, and to a lesser extent employment counseling, HIV/AIDS counseling, TB screening, academic training/education, and aftercare. Only very few offered child care, prenatal care, and acupuncture. Transportation to and from the treatment facility was provided by 42% of all respondents; and 35% engaged in outcome follow-up.

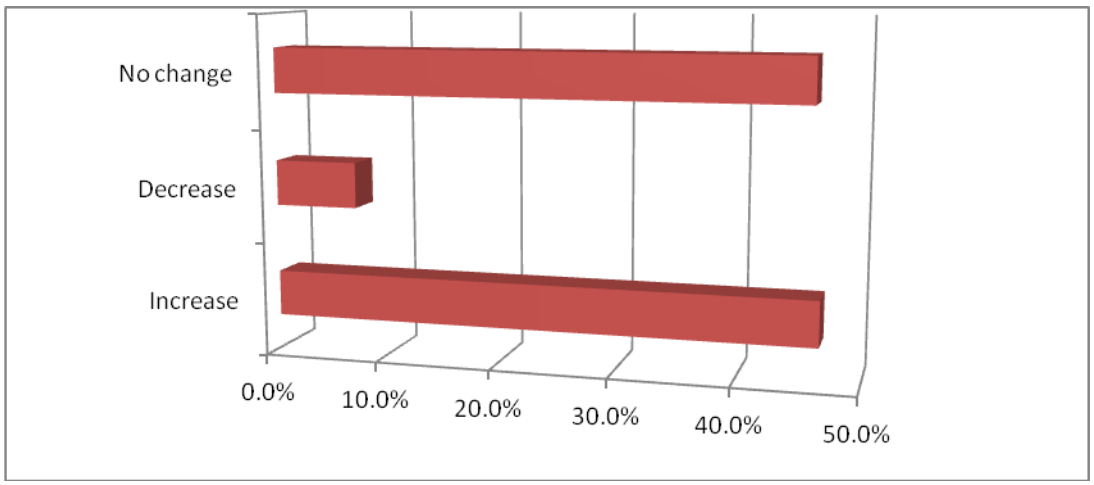


Criminal Justice Referrals

When asked where referrals to the respondents' programs came from, be it Department of Correctional Services (DOCS), DTAP, Parole, Probation, Drug Court, or Other, the answers were fairly even between Parole, Probation, and Drug Court. Referrals originated from Probation (31%) followed by Drug Courts (29%) and Parole (26%). Only very few providers indicated that their patients were referred through DTAP (2%) and DOCS (3%). The remaining 10% noted a variety of referral sources such as Treatment Alternatives for Safe Communities (TASC).



47% of the treatment providers surveyed witnessed an increase in the number of patients coming in from the criminal justice system since Rockefeller DLR was passed. 46% have seen no noticeable change, and 7% have seen a decrease in the number of patients referred.



While it is unclear what caused the drops of referrals reported by 7% of respondents, one explanation may be the decrease in DTAP enrollment reported by DCJS as well as a possible lack of drug courts in certain areas. One particular criticism of Rockefeller DLR has been the fact that there was no coordinated attempt to implement a statewide treatment program. As Peter Mancuso noted in his 2010 Albany Law Review article on *Resentencing After the "Fall" of Rockefeller*, "even though judicial diversion program permits a judge to redirect an offender into treatment rather than incarceration, this assumes that the particular county has a[n appropriate] drug treatment program."

However, the problem could also be reversed: it is likely that, even though drug courts have been expanded in certain parts of the State, they may be scarce or have inadequate resources in areas where treatment providers reported a decrease in criminal justice referrals since the implementation of Rockefeller DLR. If, overall, DTAP utilization decreased and drug court utilization has increased, it is only reasonable to assume that the facilities experiencing a drop in patient referrals are located in areas where DTAP is the traditional model used for drug treatment.

An alternative explanation is that the decrease is associated with an overall fall in the crime rate, as evidenced in DCJS' October 2010 and 2011 reports. According to Sean Byrne, Acting Commissioner of DCJS, "[d]rug offenders now make up only 15 percent of the state prison population and it continues to drop monthly."[15] As evidence of this, in 2011 DCJS reported a 21% decrease in felony drug arrests between 2008 and 2010, "from 28,764 in 2008 to 22,784 in 2010."[16] Part of that decrease is due to Rockefeller reform; however, much of it is also attributable to the overall drop in crime, which has been persistently falling since its peak of 1.14

[15] Sean M. Byrne, Acting Commissioner of DCJS, Testimony before the Assembly Standing Committees on Alcoholism and Drug Abuse, Codes, Corrections, and Judiciary, 20, December, 2010, p.4.

[16] "Felony Drug Court Activity" *supra* note 6, at 4.

million reported crimes in 1990.[17] While there are many probable explanations for the 7% drop in referrals, the fact that only half of all treatment providers have noticed an increase in the number of patients referred from the criminal justice system may be evidence that judicial diversion has not been consistently applied.

According to Derek Champagne, Franklin County DA and President of the District Attorneys Association, 25-30 out of the state's 62 counties have seen very little impact when it comes to drug treatment or the handling of dealers. Especially in rural areas, where judges and DAs have a close working relationship, judges are often reluctant to order a defendant to treatment over the objections of the prosecutor.[18] In other (urban) counties, where cooperation between judges and prosecutors is not as strong, however, judges tend to make use of their newly found discretion and divert more offenders to drug treatment programs than before.

Bill Gibney, Director of the Criminal Defense Practice Special Litigation Unit at the Legal Aid Society, confirms the perception that the general culture has not significantly changed but disagrees with the idea that the issue is largely a matter of rural vs. urban, or upstate vs. downstate. In a recent testimony, Gibney explained that in New York City, in particular, "prosecutors object to many requests for diversion and courts have then often offered DTAP (prosecutor-run drug treatment) but not a judicial diversion program."[19] And "whether a person is admitted to a prosecutor-controlled DTAP program or a court supervised diversion program makes a real difference."[20] This is because the judge is theoretically an impartial party exercising control over the defendant whereas the prosecutor is not. The judge will likely be more inclined to take a range of factors into account when deciding what to do with a defendant, from both the defense and the prosecution.

The cultural difference does not just exist between drug court and DTAP programs. Within New York City's DTAP program, implementation has also always heavily varied from borough to borough: Brooklyn, where DTAP was first established, has a generally very open culture to treatment. Many offenders get into the program, and it is recognized statewide as having a smoothly functioning referral system. By contrast, Manhattan has a DTAP that is very narrowly defined. DAs tend to be cautious in advising their clients because the likelihood of successfully completing DTAP is very slim.

[17] New York State Drug Law Reform," PowerPoint Presentation by Steve Hanson, Director of Treatment, NYS OASAS, published October 2010, slides 20 & 21.

[18] Noeleen G. Walder, "One-year-old reform saves 1,000 drug offenders from prison, according to preliminary estimates," *New York Law Journal*, published 14 October 2010, retrieved 13 March 2011 from Academic OneFile Database.

[19] Testimony of the Legal Aid Society of the City of New York at a Joint Public Hearing on Implementation and Funding of the Rockefeller Drug Law Reform, presented by Bill Gibney, Director of the Criminal Defense Practice Special Litigation Unit at the Legal Aid Society, 20 December 2010.

[20] Ibid.

The solution to this problem is not an easy one. As Alan Rosenthal, Co-Director of Justice Strategies at the Center for Community Alternatives, explained in his testimony before the Assembly in December 2010, "I think that some cultures die hard. […] I don't know how we go about undoing a culture of deferring to the prosecution. But over one thousand people by DCJS data have been left out judicial diversion because the prosecutor said no."[21] In some counties, judicial diversion is the default answer in most drug cases; "in other counties, there exists tremendous resistance."[22]

Funding

For those 47% of treatment providers who reported an increase in the number of patients referred from the criminal justice system, handling that influx of clients has not been an easy task. Most respondents explained they are trying to shift resources around to better manage existing capacities. Some of the statements are outlined below:

> *"We have had to change [our] intake process to accommodate the increased requests for evaluation and treatment, and to address the high rate of no-show appointments and recidivism. Clinical caseloads are high."*
>
> *"The additional increase in criminal justice clients is being served in our existing services."*
>
> *"We can handle the additional volume, but costs are rising."*
>
> *"We need funding from the criminal justice system to support that added time/work that is needed to provide services to them."*

Indeed, funding has been a serious issue for treatment providers who have tried to accommodate the rise in criminal justice referrals to their substance abuse programs. 97% of survey respondents stated that the increase in their number of patients was NOT matched with an increase in State or federal funding.

In fact, providers across the State have agreed that the full potential of the law is not being achieved because resources have not been distributed according to schedule. In 2009, the Legislature allocated over $65 million (in both state and federal stimulus funds) over two years to pay for the reforms. Included in the budget was funding for outpatient and residential substance abuse treatment services, an expansion of drug treatment courts, probation services, and alternative to incarceration (ATI) and reentry programs.[23]

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[21] Alan Rosenthal, Co-Director, Justice Strategies, Center for Community Alternatives, Public Hearing Transcript, "Implementation and Funding of the Rockefeller Drug Law Reform Legislation," 20 December 2010, p.117.

[22] Ibid at 127.

[23] New York State Assembly Committee on Correction, 2010 Annual Report, p.12.

According to ASAP, $40 million in state and federal funds were to be allocated to four major Rockefeller DLR initiatives:[24]

- $17.2 million to fund residential expansion (400 beds);
- $12 million in outpatient and assessment services to serve an estimated 750+ new clients coming in as a result of diversion;
- $1.7 million to fund targeted case management services; and
- $10 million to fund annual renovation, expansion, and new construction of residential treatment beds to meet the future needs of people diverted from incarceration.

In addition, Rockefeller DLR allocated $15 million in federal stimulus grants for re-entry programs through DOCS, [25] $5 million in State local assistance funds through DCJS, and $15 million in grants for the expansion of drug courts and the implementation of judicial diversion initiatives.[26]

Unfortunately, a significant amount of these resources have not yet been released, and it is unclear where that money is now. "If you try to find out where that money is now, you'll very likely get different answers from OASAS and DCJS depending on who you talk to and on what day."[27] According to ASAP, only very little has been transferred to Oneida, Queens, Schenectady, Brooklyn, and Onondoga Counties to support residential expansion; all other funds were indefinitely frozen and eventually cut from the OASAS budget. Many agencies also responded to RFPs issued by OASAS to increase their ability to provide clinical case management, treatment, and assessment services, "only to never learn why these critically important grants were never made."[28]

For FY 2011-12, the State's budget cut last year's funding level to $20 million for costs incurred by OASAS related to the 2009 drug law reforms. The money is intended to maintain the 250 residential beds that were opened in 2010-11; however, all other services must be supported within existing OASAS capacity by "enhanced performance and the prioritization of services."[29] This means that all of the additional offenders who have been and are continuing to be diverted

[24] Alcoholism and Substance Abuse Providers (ASAP) of New York State, Inc, March 18, 2011.

[25] Re-entry program providers receiving federal stimulus funding under Rockefeller DLR include: the Center for Employment Opportunities ($5 million), the Doe Fund ($3 million), the Fortune Society ($2 million), the Osborne Association ($2 million), and DOCS – all of them over a period of 2 years.

[26] Drug Policy Alliance, "Rockefeller Drug Law Reforms of 2009: Follow the Money," Fact Sheet, updated January 2010.

[27] Gabriel Sayegh, State Director of the Drug Policy Alliance, "Testimony before the Joint Public Hearing on Implementation and Funding of the Rockefeller Drug Law Reform Legislation," 20 December 2010, p.4.

[28] Glenn Martin, Vice President of Development and Public Affairs, The Fortune Society, Public Hearing Transcript, "Implementation of the Rockefeller Drug Law Reform Legislation," 20 December 2010, p.233.

[29] 2011-12 New York State Executive Budget, "Mental Hygiene," p.60.

since the passing of drug law reform are being absorbed within the pre-existing treatment system.

Treating the Uninsured

Adding to the strain of the funding issues is the fact that the money, which has not yet been released, was also intended to fund treatment for the uninsured. As Sandeep Varma, Chair of ASAP's Criminal Justice Committee, explained: "If someone went to an outpatient treatment program, and they didn't have insurance, and they didn't have the money to pay that, the state aid would in fact support that treatment slot that […] OASAS certifies and runs. And that hasn't happened yet."[30]

When questioned in the survey how they handle the influx of patients who cannot afford to pay for treatment, respondents answered the following:

> *"We take them and assist with applications for Medicaid but we are on our own with this process. There has been no local effort to prioritize or otherwise help providers to accommodate this increase."*
>
> *"Hardly anybody can afford the full treatment cost. We stitch together: p.a., m.a., food stamps, SSI, private pay, insurance pay, donations of money and consumables, OASAS and other contract funding."*
>
> *"We are pressed to handle uninsured patients because we receive so little net deficit financing from OASAS, less than 15% of our total funds. We require all eligible patients to apply for Medicaid and those who do not cooperate cannot be retained in treatment."*

When Rockefeller DLR was passed, the Legislature concurred that "access to Medicaid benefits for persons immediately upon their release from incarceration [was] essential in ensuring adequate medical care, drug treatment, and mental health services."[31] For a drug offender, the re-entry period into society is a crucial time "that may very well determine whether he or she will commit to leading a new life or recidivate. Without the proper healthcare, subsistence level income, and treatment, reintegration can be stressful and close to impossible."[32]

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[30] Sandeep Varma, Vice President of Stay'N Out & Chair of ASAP's Criminal Justice Committee, Public Hearing Transcript, "Implementation of the Rockefeller Drug Law Reform Legislation," 20 December 2010, p.155.

[31] Peter A. Mancuso, "Resentencing After the "Fall" of Rockefeller: The Failure of the Drug Law Reform Acts of 2004 and 2005 to Remedy the Injustices of New York's Rockefeller Drug Laws and the Compromise of 2009," 73 Albany Law Review 1535, 2010, p.22.

[32] Ibid at 17.

A pilot program for filing medical assistance applications for inmates prior to release from a correctional facility, not from a corresponding drug program, was established under Correction Law section 140-a. "[O]ffenders who were receiving Medicaid benefits prior to incarceration were allowed to maintain a suspended status, rather than being terminated." [33] Unfortunately, while this was a good first step, it is limited in its applicability to drug law reforms and "it did nothing for those who did not previously receive such benefits, leaving a window of opportunity for recidivism."[34]

For those not covered by Medicaid, the survey revealed that treatment providers accommodate uninsured patients by offering a sliding fee scale. One respondent explained:

> *"We use a patient advocate process and those patients who qualify for Medicaid are assisted with that application process. If a patient does not qualify for Medicaid, we assist them with Family Health Plus coverage. If they do not qualify for that coverage, we use our own sliding scale and payment programs."*

According to Jim Scordo of Credo Community Center in Jefferson County, the lowest fee on a sliding fee scale could entail as little as $5 per week, meaning a patient could attend as many as 2 or 3 group therapy sessions per week and only pay $5. Nevertheless, reduced funding has made offering a sliding fee scale increasingly difficult. One treatment provider stated:

> *"We historically have received some net-deficit funding, but the number of clients on sliding scale has increased dramatically while we have NOT received any additional funding. We still accommodate requests for service, but our revenues per unit of service have decreased. This population is often not eligible for Medicaid or other third party payments, and is sometimes resistant to payment for services.*

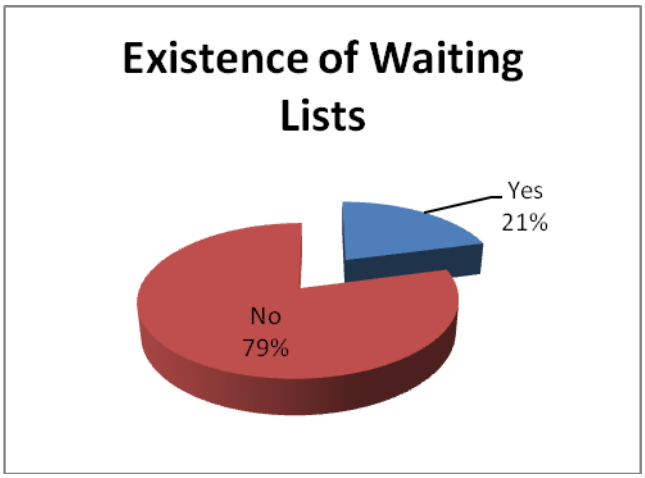
According to the survey, all of those who responded contended that they serve clients regardless of their ability to pay. Not a single patient is denied treatment: "if they cannot pay, then we treat them for free."

Waiting Lists

Meanwhile, as many as one quarter of the providers surveyed indicated that they have a waiting list for patients to get into treatment.

[33] Ibid at 22.

[34] Ibid.



Of the providers who specified, 11 had an average waiting list of 5 patients; 9 had an average waiting list of 10 patients; and the remaining 6 providers had waiting lists of over 30 patients. One provider reported 70-85 week-by-week. Another stated the treatment facility had as many as 112 patients waiting for treatment at the present time.

The waiting period for those on the list varied from 1-3 weeks to 1-3 months. One provider explained that the next available date for new patient entry was not for another 4 months.

Recent studies suggest that defendants must be placed into treatment within 30 days and stay a minimum of 90 days in order to successfully combat their addiction.[35] A 2003 study of drug courts in New York revealed that in 8 of 11 courts studied, the median time from drug court intake to treatment placement was less than one month; in the remaining three, it was less than 10 days.[36] Unfortunately, the current findings imply that this is no longer the case. Since the 2009 Rockefeller DLR, and possibly even since the 2004 and 2005 reforms before that, waiting lists have expanded and the waiting period to get into treatment has significantly increased, making a successful treatment outcome considerably less likely.

The existence of waiting lists and the extensive time period it takes for patients to be accepted into treatment is a serious concern. It highlights the need for resources to support expanded treatment capacity, and the retention of qualified employees to staff provider agencies. Besides making sure that drug offenders have the proper identification, Medicaid and other public benefits before they are released into society, it is crucial to reduce these waiting periods as much as possible, "because any breaks in the availability of treatment can lead to relapses and a negation of any gains made during incarceration."[37] While judicially-referred applicants may be

[35] Ryan S. King and Jill Pasquarella, "Drug Courts: A Review of the Evidence," The Sentencing Project, April 2009, pp.15-16.

[36] Michael Rempel et al., "The New York State Adult Drug Court Evaluation: Policies, Participants, and Impacts," October 2003, Executive Summary, p.6.

[37] Ibid at 18.

referred to other programs that may be able to expedite enrollment to an appropriate program, many observe that courts are not exploring the fill breath of treatment options for offenders due to a lack of knowledge of existing programs.

Alternatives to Drug Court Diversion

Drug Court diversion comprises the vast, and growing, majority of judicial diversion. However, Alternatives-to-Incarceration (ATI) are available by hearing, often at the request of the defense attorney, and have been available since before Drug Law Reform. Indeed, it is arguable that diversion to many of these programs may be more preferable in some ways than to Drug Court under the 2009 Drug Law Reform statute. However, they are seldom used and many judges continue to apply their personalized pre-Drug Law Reform practices and rely almost exclusively on Drug Courts. However, avenues for using an ATI exist and can be generally broken into four categories of treatment modality:

1- Probation with Monitoring

The principle behind this method is allowing for counseling-centered treatment, often through a gender-specific day program. The counselor becomes responsible for reporting to the court the progress of the enrollee.

2- Interim Probation

This option is most useful for "on-the-line" cases. A guilty plea is taken but the sentence is deferred. This allows for a test period for an ATI enrollee, but that individual is still under a guilty plea.

3- Conditional Discharge

This is designed for first-time offenders, mostly for the crime of possession. The idea is to not waste scarce resources on a low-risk case. Instead, an ATI is used to help educate and treat the offender.

4- Adjournment Plus Case Management

Under this method, a case is adjourned, or held, for a matter of months, often six. There is no plea, but after the adjournment period, the case is reevaluated. In the interim, reports are gathered and submitted by the ATI.

Under ATI's, treatment methods can be tailored after in-depth analysis, often by CASAC's (Credentialed Alcoholism and Substance Abuse Counselors); to fit the specific needs of an enrollee. However, resources for ATI programs are also scarce especially since they do not always receive funding directly from the State and instead operate as 501(c) (3) not-for-profits and instead track and obtain their own funding. This limits the range of these programs. Lack of

resources in the judiciary also limits access to court CASAC's and other necessary steps for properly matching providers with enrollees.

Funding Priorities

When asked how they would spend their money if provided with adequate funding to treat the criminal justice population and sustain their long-term recovery, treatment providers' responses were almost evenly split among the following three answer options:

Answer Options	First priority	Second priority	Third priority	Rating Average[38]	Response Count
To develop supported housing units	38	42	23	**35.01%**	132
To provide wraparound services like vocational and educational training/assistance	41	44	18	**31.29%**	118
To increase capacity (add service slots or beds)	42	29	29	**33.68%**	127
Other (please specify)					11
answered question					**136**
skipped question					**20**

Priority #1: Developing Supported Housing Units

Developing supported housing units rated second with a rating average of 33.68%. This entailed the development of housing units to support drug offender re-entry services. "[I]mproving employment and housing opportunities are extremely important for those who have been convicted of drug […] offenses. The stigma of conviction, coupled with employer screening, can lead to difficulty in obtaining employment. […] Also, housing upon re-entry can be an issue and therefore the public housing requirements need to be reevaluated to allow for non-violent ex-prisoners to gain admission."[39] One respondent explained:

[38] Rating average excludes respondents who answered "would not spend money on this" and "N/A."

[39] Peter A. Mancuso, "Resentencing After the "Fall" of Rockefeller: The Failure of the Drug Law Reform Acts of 2004 and 2005 to Remedy the Injustices of New York's Rockefeller Drug Laws and the Compromise of 2009," 73 Albany Law Review 1535, 2010, p.18.

"Certainly the success of DLR is that criminal behavior that stems from addiction is being addressed in a treatment setting. Challenges arise from the lack of transitional services offered to the newly released, such as housing, employment and general re-entry issues. There is a concern that, without services to assist in reentry, there is a higher risk of recidivism. Of course, additional funding in reentry, transitional services and treatment models which specifically address the criminal justice population."

Priority #2: Wraparound Services

The first priority, with a rating average of 35.01%, was to provide wrap-around services such as vocational and educational training and assistance. One respondent expressed the need for wraparound services as follows:

"[Those who are coming out of prison often] return homeless and this is a set-up for failure. When you talk about wrap-around services people being released from prison would be better served by half-way houses and work release programs. This would make a smoother transition back into the community and would provide better supervision. We have seen the release of offenders with more violent histories and who have been in prison a long time and, again, housing and jobs are an issue."

Priority #3: Increasing Treatment Capacity

And finally, the third priority—though very close to the other two at a rating average of 31.29%—is increasing Treatment Capacity. Related to this priority was the ability to attract and retain staff to service existing programs. As ASAP noted, "salaries and benefits are not competitive with other local programs and they are often able to hire our staff as soon as they become CASACs (Credentialed Alcoholism and Substance Abuse Counselors) and pay them $3,000 to $15,000 more." Two other providers suggested that increasing the availability of services for patients with co-occurring disorders was needed to accommodate "an ever growing population."

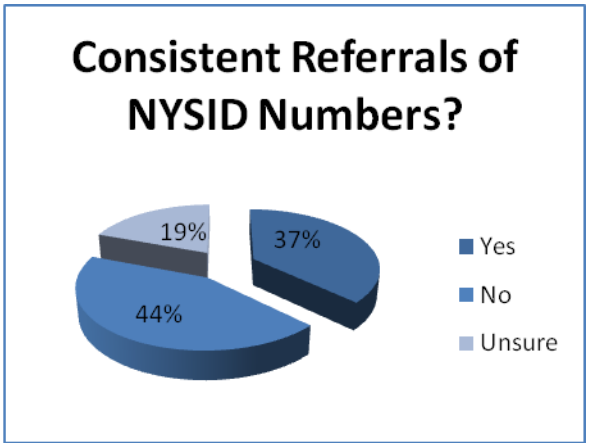
NYSID Numbers

In addition to their funding priorities, treatment providers were asked about their ability to obtain New York State Identification (NYSID) numbers from criminal justice agencies whenever a patient is referred from the CJ system to their program. In its testimony before the Assembly in December 2010, ASAP had revealed that providers had "difficulty in obtaining NYSID numbers for criminal justice referred clients, a piece of information that was mandated to be collected to help track all persons diverted into treatment because of changes to [New York's] drug laws."[40]

[40] New York Association of Alcoholism & Substance Abuse Providers (ASAP), Inc., "Drug Treatment Reform Implementation: Prevention, Treatment and Recovery are Keys to Success," Testimony by John J. Coppola, Executive Director, 20 December 2010.

The survey actually revealed an almost even split among those providers who were given NYSID numbers from referring criminal justice agencies on a regular basis and those who were not:

- 37% of respondents stated that they consistently received NYSID numbers;
- 44% stated they had difficulty in obtaining NYSID numbers; and
- 19% were unsure.



While evidence seems to be mixed, the ability to obtain NYSID numbers continues to be a contentious issue for many providers who rely on courts, probation, parole, and other criminal justice officials to provide them with that particular piece of information. The burden is on treatment staff to track down the numbers from referral sources that are sometimes reluctant to share it. One survey respondent explained:

> *"We cannot tell if there is an influx [in judicial diversion referrals] or not. Drug courts are not providing the enrollment/consent forms to us, and the pts know nothing about it. If we try to call the drug courts they often don't know anything about the form."*

Another stated:

> *"We seldom get ID numbers from any judicial program and residents claim they don't have one or don't know what it is."*

According to Sandeep Varma, Chair of ASAP's Criminal Justice Committee, "only one third of admissions into the treatment system that come from the criminal justice system have the adequate NYSID number."[41] General perception, specifically with regards to Probation, is that most officers are not aware that they even have to provide these numbers. "It appears that the

[41] Sandeep Varma, Vice President of Stay'N Out and Chair of ASAP's Criminal Justice Committee, Public Hearing Transcript, "Implementation of the Rockefeller Drug Law Reform Legislation," 20 December 2010, p.157.

mandate for the inclusion of the NYSID number on referral documents was not effectively communicated to criminal justice entities"—and that poses a problem, because "measuring the success of drug law reform and treatment as an alternative to incarceration hinges on the ability of state agencies to track outcomes and assess if diversion is having a positive impact."[42]

Drug Treatment Completion Through Judicial Diversion

Of the 156 treatment providers surveyed, 62 respondents estimated having treated anywhere between zero and 300 patients who were referred through drug court or another ATI program since October 2009.[43] Rates of successful treatment completion were self-reported to lie anywhere between 15% and 95%, the vast majority of which reported success rates above 50%, and many between 70% and 90% success—higher than the 40%-50% graduation rate reported in New York's drug courts and DTAP programs.[44]

Caution is advised in interpreting these statistics. Besides treatment design, many other factors have the ability to impact treatment outcomes, including gender, age, race, socioeconomic background, criminal history, and substance abuse history.[45] A 2003 study, for example, found that older defendants were more likely to graduate a drug treatment program and less likely to recidivate than young ones. "A primary drug of heroin made graduation less likely […] and prior criminal convictions were near universally predictive of future recidivism. Also participants entering on *property* charges were somewhat more likely to return to criminal activity than those entering on *drug* charges."[46] It is also important to note that addiction is recognized as a chronic disease which requires lifelong management and support, making "success" a concept defined more by ability to manage the symptoms of disease in the long-term, including relapse, than the complete absence of substance use.

One survey respondent explained that 62% of patients since October 2009 had successfully completed the program; the others were either referred to higher levels of treatment or incarcerated. The exact number of patients incarcerated for re-offending either throughout the course of treatment or after successful completion of treatment remains unclear. Even though

[42] New York Association of Alcoholism & Substance Abuse Providers (ASAP), Inc., "Drug Treatment Reform Implementation: Prevention, Treatment and Recovery are Keys to Success," Testimony by John J. Coppola, Executive Director, 20 December 2010.

[43] The remaining respondents either left that answer blank or indicated percentages, which unfortunately could not be used for the purpose of this analysis.

[44] As of January 4, 2010, 2,826 drug offenders have been accepted into the program. According to OASAS, 372 DTAP participants are still in treatment, and 1,203 have successfully completed the program. As of September 24, 2010, a total of 60,588 individuals participated in the State's drug court programs, and 24,423 have graduated (though it is unclear how many were still enrolled).

[45] Ryan S. King and Jill Pasquarella, "Drug Courts: A Review of the Evidence," The Sentencing Project, April 2009, p.6.

[46] Michael Rempel et al., "The New York State Adult Drug Court Evaluation: Policies, Participants, and Impacts," October 2003, Executive Summary, p.4.

31% of the 119 providers surveyed reported engaging in outcome follow-up, only 11 (or 9%) were knowledgeable of these statistics and estimated that between 1 and 8 of their post-Rockefeller DLR patients had been re-incarcerated. Three other survey respondents estimated that somewhere between 1 and 3% of their patients have returned to prison, and one survey respondent believed that as many as 30-35% of his patients have been re-incarcerated since being referred to treatment.

While these statistics give some indication of the effectiveness Rockefeller's judicial diversion program, much more needs to be done to determine how to boost success rates while minimizing recidivism rates, both in terms of crime and in terms of substance abuse. One major factor in determining the effectiveness of drug treatment under judicial diversion, for example, is whether offenders are properly matched with the right level of care

At times, the treatment programs conferred upon offenders either do not match their actual needs or are not the conclusions of a professional. Discussions with treatment providers and prosecutors reveal numerous instances in which people have been diverted into treatment for the wrong reasons. Without more input in the form of clinical assessments and treatment plans by individuals such as certified alcohol and substance abuse counselors (CASAC), many are not given the appropriate level of care. A system that diverts offenders into residential treatment without carefully examining their substance abuse history and other relevant factors is simply not effective. "Placing a defendant into an inappropriate level of care will often lead to a self-fulfilling prophecy of failure and increased punishment, potentially costing the state more than if the person had never been diverted."[47]

At the opposite end of the spectrum are all of those individuals who were eligible for drug court but still denied admission. According to testimony by Anita Marton, Vice President of the Legal Action Center, "40% of people who were appropriate for drug court, who were sent to drug court, [and] who wanted to participate in drug court, […] [ended up not] getting diverted, and [as a result were] sent to prison."[48] Allegedly, 18% of those drug court eligible individuals were excluded on account of DA objections, 2% were rejected based on Article 216 hearings, and the remaining 20% were barred from diversion for "other reasons."[49] Requirements generally differ by court but typically "defendants must be charged with drug possession or a non-violent offense and must have tested positive for drugs or have an established substance abuse problem for the time of arrest."[50] Given these general guidelines, it is questionable why 40% of drug-court eligible offenders were still prohibited the treatment they so desperately need.

[47] Glenn Martin, Vice President for Development and Public Affairs, The Fortune Society, Public Hearing Transcript, "Implementation of the Rockefeller Drug Law Reform Legislation," 20 December 2010, p.230.

[48] Public Hearing Transcript, "Implementation of the Rockefeller Drug Law Reform Legislation," 20 December 2010, p.209.

[49] Testimony of the Legal Action Center, Public Hearing on Implementation and Funding of Rockefeller Drug Law Reform Legislation, submitted by Anita R. Morton, Vice President, 20 December 2010.

[50] Ryan S. King and Jill Pasquarella, "Drug Courts: A Review of the Evidence," The Sentencing Project, April 2009, p.4.

According to Glenn Martin, Vice President for Development and Public Affairs at the Fortune Society, "the process and instruments that are currently being used to evaluate defendants allows people with addictions to fall through the cracks, and people who are clearly dependent are frequently rejected."[51] Their addiction is simply not deemed severe enough to warrant diversion, a sentiment echoed by the Drug Policy Alliance: "In county after county, we have learned of defendants who, while statutorily eligible for diversion, are instead deemed ineligible for diversion because they don't need drug treatment."[52]

Combined with the results of this survey, the message is clear: Better guidelines must be established to provide for more effective evaluation of drug offenders prior to diversion into drug treatment. The evaluation process alone should be able to accurately identify those in need of treatment services, those who may be in need of an ATI program, or those who are altogether ineligible for diversion.

Final Comments

Finally, respondents were given the opportunity to provide comments or feedback related to the implementation of Rockefeller Drug Law Reform. A large majority of them focused on the need for the criminal justice system to embrace the use of addiction medicine as part of a comprehensive treatment program. According to the Drug Policy Alliance, "the Manhattan judicial diversion courts automatically exclude people who are on methadone from participating in judicial diversion."[53] If methadone patients stop their treatment too soon as a requirement for participation in drug court, they may relapse and may eventually face re-incarceration.

As one respondent explained:

> *"The key problem has been the refusal of the criminal justice system to acknowledge and accept the efficacy of methadone as treatment modality. Pulling people out of treatment when they are doing well does not make sense. Refusing access to effective care is also not productive."*

Henry Bartlett, Executive Director of the Committee on Methadone Program Administrators (COMPA), agreed. "Too many judges, district attorneys, and other judicial officials have outdated views on treatment,"[54] he stated in a recent public hearing. Judicial diversion courts

[51] Public Hearing Transcript, "Implementation of the Rockefeller Drug Law Reform Legislation," 20 December 2010, p.229.

[52] Gabriel Sayegh, State Director, Drug Policy Alliance, Public Hearing Transcript, "Implementation of the Rockefeller Drug Law Reform Legislation," 20 December 2010, p.87.

[53] Gabriel Sayegh, State Director of the Drug Policy Alliance, "Testimony before the Joint Public Hearing on Implementation and Funding of the Rockefeller Drug Law Reform Legislation," 20 December 2010, p.3.

[54] Henry M. Bartlett, Executive Director of the Committee on Methadone Program Administrators (COMPA) of New York State, Testimony before the Assembly Hearing on Rockefeller Drug Law Reform, 20 December 2010, retrieved 23 March 2011 from COMPA website, available at: http://www.compa-ny.org/druglawreform.html.

need to be on the same page when it comes to drug treatment. A standardized assessment and placement instrument and protocol needs to be in place administered by qualified professionals such as certified CASAC counselors and the courts should accept the assessment and recommendations of those qualified professionals. "It is time to replace dogma with science and evidence."[55]

In addition to comments on drug therapy, survey participants provided feedback on other issues, including the following:

"People come in to treatment who may really have an untreated addiction problem.

"Lack of support services make re-integration very difficult for clients and agency efforts are thwarted by lack of sufficient funding."

"In starting our criminal thinking track, we expected a lot more resistance from this section of the population. We have found, however, that most of these particular clients are desperate to change their lifestyles and need to learn the tools and skills to do so."

"The need for services and manpower has increased without the requisite increase in funding."

"Over the years, we have been able to adapt our programs to meet the needs of CJ clients and have become increasingly successful with them. However, we could do even better with funds from the CJ system to fund the time that our staff spends at the various drug courts. In addition, we could using funding to assist our Supportive Living program which provides housing and case management services as individuals transition to independent living. OASAS has been trying to start a Supportive Housing program which would assist individuals who still need services past the Supportive Living level of care. Some of these individuals just need continued monitoring in order to be successful. Instead of putting so much money into to jails and prisons, it can be more effectively spent on providing treatment and transition back into the community as sober, responsible and productive individuals."

"The problems that have blocked DLR from achieving its full potential in my opinion is that it does not appear that everyone is on the same page. It seems that some interpret the law in different ways."

"There has been some added success with clients from the criminal justice system. We have found some drug courts to be very demanding. We really could use funding from the criminal justice system to help with the staff's time with reports and attending court on a weekly basis."

Conclusion & Recommendations

The responses obtained from treatment providers across the State lead to an important revelation: Rockefeller Drug reforms are working, but systematic problems remain and must be addressed.

[55] Ibid.

Two years have gone by since sweeping drug law reform was passed. Instead of responding to the symptoms and wasting valuable resources on correctional remedies to punish drug offenders, the Legislature shifted its approach to a health-based model that focuses on treating the underlying cause of drug-related crime. At least 2,800 drug offenders have since been diverted to drug treatment; incarceration numbers have decreased, as have overall crime rates. However, numerous problems still need to be addressed, and more can be done to maximize the effectiveness of drug law reform.

While, unfortunately, it was too difficult to gauge recidivism rates, the results of the survey highlight the importance of adequate funding to accommodate the rise in criminal justice referrals to the treatment system. Over 97% of providers indicated that lack of state and federal funding was putting them in a strong financial bind, inhibiting their ability to support services for all clients referred through the court system and other channels, who are seeking services. Waiting lists are long in some cases, sometimes extending to over 3 months, which increases the likelihood of recidivism, thereby negating any progress these offenders might have made while serving time in the correctional system. Therefore,

- Residential, inpatient, and outpatient capacity must be expanded;
- Treatment providers must be given enough funds to attract and retain quality staff, and to continue net-deficit funding for those patients who are uninsured and cannot afford to pay for treatment.
- At the same time, re-entry services must be better coordinated and improved, so that all offenders have the Medicaid benefits necessary to cover treatment expenses as needed.
- Housing and educational opportunities must be expanded to reduce the stigma associated with incarceration and provide ex-convicts with the opportunity to become productive and valued members of society.
- Better instruction must be given to court personnel on the availability and use of ATI programs outside of traditional judicial diversion.

The fact that only 47% of survey respondents have seen an increase in the number of patients since October 2009 is a clear indication that judicial diversion is not being consistently applied. Part of this finding is a direct result of cultural differences as well as general stubbornness to change.

- One way to ensure uniform implementation of Rockefeller DLR is to clarify the intent and purpose of the reform. This can be achieved by adding a memo of legislative intent "[which restates the Legislature's] commitment to developing a public health approach and utilizing a broad array of alternatives to incarceration."[56]

- Included in this memo, or in a separate section of the law, should be a clear and concise set of guidelines and protocols to set the course for uniform implementation and expanded access to alternatives to incarceration. If drug courts are used as the

[56] Gabriel Sayegh, State Director of the Drug Policy Alliance, "Testimony before the Joint Public Hearing on Implementation and Funding of the Rockefeller Drug Law Reform Legislation," 20 December 2010, p.3.

predominant model for judicial diversion, efforts must be made not only to expand them to all parts of the State but also to link them up with the appropriate treatment provider. Combined with training for criminal justice professionals, scientifically sound assessment instruments and evaluation procedures, a streamlined diversion system will allow for a much fairer assessment of drug offenders' eligibility for diversion, enabling due process and expanded access to drug treatment for all of those who truly need it.

Finally, the three C's – communication, coordination and cooperation – with State agencies must be improved to ensure that referral from the criminal justice system runs as smoothly as possible.

- All treatment providers must be given the NYSID numbers, case records, and other documents required to ensure continued care of criminal justice patients. Greater communication and compliance with procedures will also significantly enhance DCJS' ability to collect data, monitor judicial diversion participants as they circulate through the justice system, and assess the overall effectiveness of Rockefeller drug law reform, so that future adjustments can be made as necessary.