

COUNCIL OF THE CITY OF PHILADELPHIA
SPECIAL COMMITTEE ON CRIMINAL
JUSTICE REFORM

Room 400, City Hall
Philadelphia, Pennsylvania
Friday, May 13, 2016
10:15 a.m.

PRESENT:

KEVIN BETHEL, Philadelphia Police
Department (retired)/Stoneleigh
Foundation
WILLIAM COBB, representative of formerly
incarcerated person
ANN SCHWARTZMAN, PA Prison Society
JULIE WERTHEIMER, Managing Director's
Office
JASON COSLEY, Impact Services
GEORGE MOSEE, ESQUIRE, First Deputy
District Attorney
RICHARD McSORLEY, Deputy Court
Administrator, Criminal Trial
Division
COUNCILMAN KENYATTA JOHNSON
COUNCILWOMAN JANNIE L. BLACKWELL

RESOLUTION 160101 - Resolution appointing
members to the "Special Committee on Criminal
Justice Reform," who will conduct public
hearings examining the Philadelphia criminal
justice system for the impact of current
policies, and offer recommended strategies for
reform that are in the best interest of public
safety and the public good.

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DEPUTY COMMISSIONER BETHEL:

We're going to call this session to order. The Clerk will read the resolution.

THE CLERK: Resolution 160101, a resolution appointing members to the "Special Committee on Criminal Justice Reform," who will conduct public hearings examining the Philadelphia criminal justice system for the impact of current policies, and offer recommended strategies for reform that are in the best interest of public safety and the public good.

DEPUTY COMMISSIONER BETHEL:

First we're going to put forth the summer action plan and open that for discussions for anyone on the Committee.

I know, Julie, you have some questions about that.

MS. WERTHEIMER: Yes. If you turn to Page 4, the second recommendation down, the Committee recommends the 21st sign of realized savings to the City from

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2 the prison population reduction efforts
3 underway via the MacArthur grants be
4 dedicated to funding summer jobs and
5 youth mentoring programs beginning in
6 budget year 2017-2018 with dedicated
7 funding. Successful pilot programs that
8 begin in the summer can be carried
9 through and funded in subsequent years.

10 The recommendation -- I just
11 wanted to propose some change to the
12 language. I think it's important to
13 understand two things. One, while this
14 set of strategies that are being funded
15 by the MacArthur Foundation are distinct,
16 it's going to be difficult to discern
17 what savings and efficiencies seen in the
18 criminal justice system are specifically
19 because of MacArthur versus just overall
20 system efficiency. So it's hard to pull
21 out a certain number on that.

22 The second thing is, we don't
23 believe that we're going to see
24 significant savings that early. Speaking
25 in budget year 2017, Fiscal 2017 starts

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2 on July 1, which will be three months
3 into implementation of our work and
4 really no realized savings. We don't
5 anticipate actually seeing anything
6 substantial almost until Fiscal Year '19.
7 So I think it's important to understand
8 the timeline on this.

9 In addition, we have already,
10 as a criminal justice system, made some
11 assurances to the MacArthur Foundation in
12 terms of sustainability. For anyone who
13 has dealt with grants before, you know
14 that having a sustainability plan is key
15 to any application. And so we've made
16 some commitment to allocate savings
17 realized to sustaining programs that are
18 successful, specifically dealing with the
19 pretrial population.

20 So understanding those three
21 points, I'd like to propose new language
22 that removes the specificity of MacArthur
23 and just talks about when savings are
24 realized in general in the criminal
25 justice system that a certain portion is

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2 allocated towards youth programming.

3 DEPUTY COMMISSIONER BETHEL: So
4 I would be in agreement with that.

5 Anyone on the Committee have
6 any dissent on that?

7 MR. COSLEY: I agree as well.

8 DEPUTY COMMISSIONER BETHEL: So
9 we'll just make note of that in our
10 records and we'll follow up and change
11 the language.

12 MS. WERTHEIMER: Thank you.

13 DEPUTY COMMISSIONER BETHEL:
14 You got a win. There you go.

15 Anybody else in the report?

16 Yes, ma'am.

17 MS. SCHWARTZMAN: I had two
18 issues that I wanted to bring up. One,
19 on Page 1 of the Committee
20 recommendations, evidence-based
21 programming. A number of non-profits
22 strive for evidence-based programming,
23 but due to costs, due to fiscal issues,
24 due to restraints, it's very difficult to
25 do, and language that we could include

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2 that I would like the Committee to
3 consider is to include a phrase "research
4 informed" so that there is background,
5 there is substantive information that can
6 be used, but it's a little shy of the
7 actual evidence-based programming that
8 may be out of non-profits' reach.

9 DEPUTY COMMISSIONER BETHEL:

10 Any comments on that?

11 (No response.)

12 DEPUTY COMMISSIONER BETHEL:

13 All right. I mean, so clearly we're
14 trying to go down a path of being -- so
15 you're not saying going away from
16 evidence-based, you're just saying
17 adding?

18 MS. SCHWARTZMAN: Right.

19 DEPUTY COMMISSIONER BETHEL: So
20 I think -- I don't have any issues with
21 that, but, again, we'll take that back in
22 discussion and talk about that and see if
23 that's language we want to add to this
24 process.

25 MS. SCHWARTZMAN: And then

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2 there was one other potential. I believe
3 when the individual testified on behalf
4 of PCCD for the juvenile justice
5 programs, there are programs that we
6 could jump in on now or at least enroll
7 in that could have some impact either for
8 the summer or beyond, and I would just
9 like us to include that as a possibility.
10 I don't have the exact language, however,
11 with me.

12 DEPUTY COMMISSIONER BETHEL:

13 All right. Well, I know Mary, she's
14 worked hard to try to get some of the
15 recommendations from the Committee to
16 include in this report. I know we're on
17 a very short timeline trying to get this
18 completed, but I'm sure -- Mary, we can
19 talk offline to see if those additions
20 are acceptable and practical with such a
21 short timeline.

22 But, again, I think we just
23 have to be mindful that though we're on a
24 timeline to try to get this done very
25 quickly before the summer, this is a long

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2 process and the recommendations that
3 anyone puts forth has the potential to
4 have the effect next budgetary year as
5 well.

6 Mr. Mosee.

7 MR. MOSEE: So for the public,
8 it may not be significant, but for people
9 who are in the system, we recognize the
10 distinct difference between criminal
11 justice and juvenile justice. And so
12 throughout the Youth Action Plan, there
13 are references to criminal justice, but
14 it should in fact be juvenile
15 justice/criminal justice in recognition
16 that most of the people that we're
17 talking about in this plan would not be
18 within the jurisdiction of the criminal
19 justice system.

20 DEPUTY COMMISSIONER BETHEL:

21 Duly noted.

22 Anyone else?

23 (No response.)

24 DEPUTY COMMISSIONER BETHEL:

25 Okay. I think we're prepared to move on

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2 with the session.

3 THE CLERK: Panel 1 is David
4 DeMatteo, Arthur Evans, and Roland Lamb.
5 (Witnesses approached witness
6 table.)

7 DEPUTY COMMISSIONER BETHEL:
8 Just clarify, Professor DeMatteo from
9 Drexel University. So we're honored to
10 have a Professor from Drexel who is
11 really doing a lot of work and to help --
12 part of the role as we move forward is
13 trying to really use evidence-based, some
14 of the information, but I sat at a panel
15 and listened to Professor DeMatteo,
16 really helped me understand this cycle of
17 drugs and how it affects us and the
18 things we can do. So I was very honored
19 when he agreed to come and speak with us
20 today.

21 So I'm going to turn it over
22 and let him introduce himself in more
23 detail and who he is.

24 Let me back up. My first time
25 heading the Chair, so I'm out of order a

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2 little bit. So before we start, I need
3 to get everyone to introduce themselves
4 and put their name on record on the
5 Committee.

6 MS. SCHWARTZMAN: Hi. My name
7 is Ann Schwartzman. I'm the Executive
8 Director of the Pennsylvania Prison
9 Society.

10 MS. WERTHEIMER: Julie
11 Wertheimer, Chief of Staff, criminal
12 justice, Managing Director's Office.

13 MR. COSLEY: Jason Cosley,
14 Impact Services Corporation.

15 DEPUTY COMMISSIONER BETHEL:
16 Kevin Bethel, Stoneleigh Foundation.

17 MR. MOSEE: George Mosee, First
18 Assistant, District Attorney's Office.

19 MR. McSORLEY: Richard
20 McSorley, Deputy Court Administrator,
21 First Judicial District, Court of Common
22 Pleas.

23 MR. COBB: William Cobb,
24 Founder and Chief Executive Officer of
25 Redeemed.

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2 DEPUTY COMMISSIONER BETHEL:

3 Okay. We're good.

4 DR. DeMATTEO: Good morning.

5 Thank you very much to former Deputy
6 Commissioner Bethel for inviting me here
7 today. It's a real pleasure. It's a
8 pleasure to speak with distinguished
9 members of this Committee.

10 I'm very excited about this
11 topic. We're going to be talking about
12 criminal justice interventions for
13 drug-involved offenders. And this is a
14 topic I've been able to spend the past
15 15-plus years researching, fortunate to
16 get some support from federal and state
17 agencies.

18 So here's what we're going to
19 talk about today: The main question that
20 I'm here to address is what can we do
21 about the increasing numbers of
22 drug-involved criminal offenders. And
23 when I say what can we do, I mean as a
24 society and as a criminal justice system.

25 So the first thing we're going

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2 to do is, we're going to talk about the
3 scope of the problem, and by that we're
4 going to look at the relationship between
5 drug use and criminal behavior. I know
6 we're here primarily talking about
7 drug-involved offenders. I will
8 occasionally also talk about offenders
9 with mental illness. The overlap between
10 offenders with mental illness and drug
11 problems is so substantial that you can't
12 talk about one without the other.

13 Then we're going to look at the
14 historical responses to drug-involved
15 offenders. We're going to take a quick
16 look at the two major approaches that
17 have been taken to handle drug-involved
18 offenders over the past 40 years, and
19 these are competing paradigms. They
20 represent different ends of the
21 continuum. And a bit of a spoiler alert
22 here, both of these paradigms, both of
23 these approaches have failed miserably
24 when it comes to handling drug-involved
25 criminal offenders.

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2 That's the bad news. The good
3 news is that some of the current
4 approaches to handling drug-involved
5 criminal offenders are showing
6 outstanding effects in terms of reducing
7 recidivism and reducing drug use. So
8 we're going to end on a more positive
9 note.

10 So what do we know. Let's
11 start with what we know. We know a
12 couple of things. We know that over the
13 past few decades in the United States,
14 there has been mass incarceration, mostly
15 of drug-involved and/or mentally ill
16 offenders, and of those, most of those
17 are -- there's a disproportionate number
18 of minority offenders in those numbers.

19 We also know that the
20 historical responses to drug-involved
21 criminal offenders have failed. Put
22 simply, incarcerating drug users -- we're
23 talking about drug users. We're not
24 talking about drug dealers. We're not
25 talking about people who are violent.

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2 But incarcerating drug users, the war on
3 drugs, has been a massive failure from an
4 economic and a criminal justice
5 perspective. This is not a political
6 statement. I'm a scientist. My views
7 are based on data.

8 So what could work? What could
9 work is diversion, diverting
10 drug-involved offenders from standard
11 criminal justice processing into more
12 appropriate interventions that actually
13 address their needs. We're going to take
14 a look at a couple types of diversion.
15 We're going to look at drug courts and
16 we're also going to look at pre-arrest
17 diversion. These represent interventions
18 at different stages of the criminal
19 justice process. So pros and cons.

20 As we'll see, the key to
21 effectively handling drug-involved
22 criminal offenders is ongoing care and
23 cross-system collaboration. Those will
24 be the themes that you will see
25 throughout the data that I will present.

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2 So mass incarceration. United
3 States has 5 percent of the world's
4 population, yet we have 25 percent of the
5 world's incarcerated population. The
6 United States incarcerates more people
7 per capita than just about any nation on
8 earth.

9 So these are the current
10 numbers: Total correctional population,
11 we have 2.3 million people incarcerated
12 in jails and prisons in the United
13 States. If you do the math, that means
14 one out of every 130 people in the United
15 States is incarcerated. And this burden
16 falls heavier on racial minorities. The
17 most recent figure that I can find is
18 that one out of every 15 African American
19 men is incarcerated in a jail or prison
20 in the United States. When we add the
21 roughly 5 million people on probation or
22 parole, this gives us a figure that 3
23 percent of adults in the United States
24 are under some form of correctional
25 supervision. And what we know is that

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2 individuals with drug problems and/or
3 mental health problems are hugely
4 overrepresented in these numbers. This
5 is the criminalization of mental health
6 disorders.

7 So let's look at the scope of
8 the problem. Everyone knows that
9 drug-involved offenders are
10 overrepresented in the system, but take a
11 look at some of these numbers and I think
12 you might find them surprising. A lot of
13 times people talk about criminal
14 offenders and drug users as if they're
15 different populations, but the overlap is
16 so substantial that you're almost talking
17 about the same population.

18 So high rates of drug-involved
19 criminal offenders. As I mentioned,
20 drug-involved criminal offenders are
21 disproportionately represented in the
22 criminal justice system. A shorthand for
23 this is 80/40/20. Eighty percent of all
24 inmates in the United States have some
25 connection with drugs, broadly defined,

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2 80 percent, meaning that they committed
3 the offense to get money for drugs or
4 they were under the influence of drugs at
5 the time of the offense or they have a
6 drug problem.

7 Of those 80 percent, 40 percent
8 meet criteria for a clinical disorder
9 relating to their substance use. Of
10 those 40 percent, 20 percent, their
11 criminal activity was fueled primarily by
12 drugs.

13 We know from large
14 multi-samples across the United States
15 the most reliable statistic is that
16 two-thirds of offenders were under the
17 influence of drugs or alcohol at the time
18 they committed the offense. We also know
19 there's high levels of drug involvement
20 with probationers, parolees, and even
21 juvenile arrestees, where the number is
22 at roughly 30 percent.

23 And if you look at the
24 relationship between drug use and
25 crime -- and drug use is one of the most

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2 reliable and robust predictors of
3 criminal behavior that's been
4 investigated by social scientists. Take
5 a look at some of these figures. More
6 than 50 percent of all violent crimes
7 have some relationship with drug use or
8 alcohol use, meaning the perpetrator was
9 under the influence at the time of the
10 offense.

11 Two-thirds of domestic violence
12 cases, the perpetrator was drunk or high
13 at the time of the offense. Sixty to 80
14 percent of substantiated child abuse and
15 neglect cases, the perpetrator was under
16 the influence of drugs or alcohol. And
17 even non-violent crimes, theft and
18 property offenses, 50 to 75 percent the
19 offender was under the influence.

20 If we look specifically at drug
21 offenses, we look in the state and
22 federal system, what we see is that half
23 of federal inmates and about 18 percent
24 of state inmates are charged with a drug
25 offense. Forty percent, as I mentioned,

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2 of drug-involved offenders meet criteria
3 for a substance use disorder, yet look at
4 this figure, less than 33 percent
5 participate in drug treatment while
6 they're incarcerated. That's a small
7 number. Now, I would argue the number
8 should probably be even smaller. That
9 might be surprising, but we're going to
10 take a look at why I say that.

11 Now, if we switch gears for a
12 bit and I just touch briefly on the scope
13 of the problem when it comes to mental
14 illness and offending, the statistics
15 vary because many jurisdictions do not
16 routinely screen for mental health
17 disorders and there are differing
18 definitions of what counts. So these are
19 the most reliable data we have.

20 Prison inmates, 56 percent of
21 state prisoners and 45 percent of federal
22 prisoners have mental health disorders.
23 These are huge numbers. Now, this is
24 broadly defined. If we limit this to
25 serious mental health disorders, 10

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2 percent of prison inmates have a serious
3 mental health disorder. We see higher
4 numbers among jail inmates. Sixty-four
5 percent of jail inmates have mental
6 health disorders and 16 percent have
7 serious mental health disorders. The
8 best estimate is that roughly 15 percent
9 of inmates, jail and prison inmates, have
10 a serious mental health disorder. The
11 rate of serious mental health disorders
12 in the general population is about 2 and
13 a half percent. This is a staggering
14 increase in the number of people who have
15 mental health disorders who are
16 incarcerated.

17 If we broaden it a bit more and
18 include people who are intellectually
19 disabled, which used to be referred to as
20 mental retardation -- we no longer use
21 that term -- it's estimated that 8 to 10
22 percent of all inmates nationally meet
23 criteria for being intellectually
24 disabled. Compare that to about 1 and a
25 half percent in the general population.

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2 A bit more on mental health.

3 If we look at the largest mental health
4 facilities in the United States -- and by
5 "largest," I mean by the most people that
6 they serve, the number of people that
7 they serve -- here are the top three:
8 Number one is Riker's Island in New York;
9 number two, Cook County Jail in Chicago;
10 number three, Los Angeles County Jail.

11 Our citizens in the United
12 States who are mentally ill who get
13 involved in the criminal justice system
14 are largely being treated by the criminal
15 justice system. We can't talk about the
16 mental health and criminal justice system
17 as being separate entities.

18 We also know that for people
19 who are mentally ill, they are more
20 likely to be arrested than people who are
21 not mentally ill for the same behavior.
22 We know that people who are mentally ill
23 face more serious charges than people who
24 are not mentally ill for the same
25 behavior. We know that they get longer

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2 sentences.

3 A recent statistic, which I
4 place some stock in, suggests that
5 mentally ill offenders, their sentences
6 are two to five times longer than
7 non-mentally ill offenders for the same
8 offenses. Once they're incarcerated,
9 individuals with mental health disorders
10 are more likely to get in trouble, more
11 likely to fight, more likely to have
12 infractions, and -- this is important to
13 note too -- they are much more likely to
14 be victimized because of their mental
15 health problems.

16 Now, what happens when you
17 combine mental illness and drug use,
18 which unfortunately we see this
19 combination quite a bit among offenders.
20 Drug use, as I mentioned, is an extremely
21 strong risk factor for offending.
22 Contrary to what many people think, being
23 mentally ill does not increase your risk
24 of being an offender. Being mentally ill
25 does not increase the likelihood that

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2 someone will be violent, with very
3 limited exceptions, but when you combine
4 drug use and mental illness, now we have
5 a remarkably strong risk factor for
6 offending behavior.

7 So that's the scope of the
8 problem. I think we can admit that we're
9 seeing large numbers of drug-involved
10 offenders in our criminal justice system.
11 So how as a society and a criminal
12 justice system do we handle these
13 drug-involved offenders? Over the past
14 40 years, we've seen a paradigm shift in
15 how drug-involved offenders have been
16 treated, and the two major approaches --
17 and these are competing paradigms -- we
18 have the public safety approach and the
19 public health approach.

20 The public safety approach says
21 drug use is a criminal behavior. The
22 appropriate response to a criminal
23 behavior is punishment. That's one
24 approach. On the other end of the
25 continuum is the public health approach,

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2 which says drug use is a disease. We
3 don't punish people for having diabetes
4 or hypertension. We treat them. So
5 instead of punishing drug-involved
6 offenders, we should be treating them.
7 Let's take a look at both of these
8 approaches and see how they've worked in
9 terms of handling drug-involved
10 offenders.

11 So the public safety model. As
12 I mentioned, this is the one that deals
13 with punishment. This is the war on
14 drugs. This is the criminalization of
15 drug possession. And what we know about
16 the war on drugs, the war on drugs was
17 started by President Nixon, and it was
18 amped up in the 1980s, is that the inmate
19 population in the United States more than
20 quadrupled in the 30 years after the war
21 on drugs was started. It went from
22 500,000 to now over 2 million. Sixty
23 percent of the increase in federal
24 inmates is due to drug charges. Thirty
25 percent of the increase among state

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2 inmates is due to drug charges.

3 So what if we put them in
4 prison? And by "them," I mean
5 drug-involved offenders. We're not
6 talking about violent offenders or drug
7 dealers. Drug users. What if we put
8 them in prison? The two major outcomes
9 of interest to the criminal justice
10 system are relapse of drug use and
11 recidivism. So let's see. What happens
12 when you incarcerate drug-involved
13 offenders?

14 Now, what I've done, just to
15 let you know, is, there are hundreds of
16 studies out there on these issues and
17 I've taken the liberty of synthesizing
18 and summarizing these studies to be able
19 to present a more succinct snapshot of
20 where we are.

21 The reliable statistic is that
22 within a year of release, 85 percent of
23 people who went into incarceration having
24 a drug problem, 85 percent of those
25 people relapse and have a drug problem

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2 again. Let's extend it to three years.
3 Ninety-five percent relapsed to drug use
4 after three years. Clearly,
5 incarceration as a way to treat drug
6 problems is not effective.

7 Now, let's look at recidivism.
8 Within three years of release, two-thirds
9 are rearrested, roughly half are
10 reconvicted, and 44 percent return to
11 prison.

12 Now, what if we treat them in
13 prison? Because I get it, prison is not
14 always supposed to be rehabilitative.
15 There are, of course, programs in prison
16 which can be rehabilitative. So let's
17 take a look at the research. What does
18 the research show if we treat drug users
19 in prison? You see a small effect on
20 criminal recidivism, about a 10
21 percentage point drop. That's good. I
22 certainly would not discount that, but it
23 may not justify the cost. And there's no
24 effect on drug use. Now, let me explain
25 that for a second.

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2 There's a research method
3 approach used by social services called a
4 meta-analysis where you essentially take
5 a bunch of studies that look at the same
6 topic and you crunch it down to one
7 number, and that one number gives you an
8 indication of the size of the treatment
9 effect. It's called an effect size.

10 Current standards are that a
11 0.2 value is small, 0.5 is medium, and
12 0.8 is large. The higher, the better.
13 It means the treatment is more effective.

14 There was a meta-analysis done
15 of over 1,600 in-prison drug treatment
16 programs. The effect size for drug use
17 was 0.1. That's almost statistically
18 impossible to see that small of an
19 effect, and what it actually suggests is
20 that some of those programs were likely
21 making the people worse than when they
22 got there.

23 What about intermediate
24 sanctions? Because incarceration doesn't
25 seem to work. Let's look at some

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2 intermediate sanctions. Restitution has
3 been shown to have a slight effect on
4 decreasing recidivism. If you hit people
5 in their pocketbook, you hit people in
6 their wallet, then people are less likely
7 to recidivate.

8 Unfortunately, boot camp and
9 house arrest has been shown to have
10 almost no effect on recidivism. We can
11 talk more about that research, if you
12 would like. Now, it can't get worse than
13 no effect, can it? Well, it can. You
14 can have a worse effect. And
15 interventions such as scared straight and
16 in some jurisdictions intensive
17 supervised probation have actually been
18 shown to be associated with an increase
19 in the rate of criminal offending. I'll
20 talk more about that later. It's a bit
21 of an artifact there. If you watch
22 anyone closely enough, like with
23 intensive supervised probation, you're
24 likely going to find them doing something
25 wrong. That's called the surveillance

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2 effect. But there is some evidence that
3 programs like scared straight and other
4 programs are actually making some
5 offenders worse.

6 So that's the public safety
7 model. Let's switch gears, talk about
8 the public health model. So, again, this
9 is the idea you don't punish drug users,
10 you should treat drug users, because they
11 have a disease. So let's look at
12 attrition. Fifty to 67 percent -- so
13 it's half to two-thirds -- of the people
14 who make an appointment to talk about a
15 drug problem don't show up for their
16 intake. Forty to 80 percent of people
17 who start treatment drop out within three
18 months. Ninety percent drop out within
19 12 months. Why is 12 months an important
20 benchmark? There's something called the
21 dose response curve. It's the idea that
22 you need to be exposed to an intervention
23 for a certain amount of time for it to
24 have an effect. This idea of a dose
25 response curve is taken from the medical

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2 literature with medications.

3 So, for example, you need to
4 take a certain dose of a medication to
5 have a response. The research strongly
6 suggests that for people who have an
7 entrenched, severe addiction to drugs,
8 the dose response curve is one year of
9 treatment, meaning that if they don't get
10 one year of treatment, the odds of them
11 getting better are very, very slim. So
12 this one-year mark is very important. We
13 even see that among probationers and
14 parolees who are ordered to drug
15 treatment. Seventy percent will stop
16 going within two to six months. That's a
17 national statistic.

18 What about the effectiveness of
19 drug treatment? So forget the criminal
20 justice system for a second. If you had
21 a relative who had a drug problem, how
22 confident would you be that your relative
23 who goes into treatment is going to come
24 out without a drug problem? The best
25 evidence suggests that the best treatment

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2 programs we have, 50 percent of people
3 who receive those best treatments will
4 remain abstinent for one year after
5 treatment. That's the best that we can
6 do right now. That's not great.

7 So here's the summary so far:
8 Prison by itself does not work in curing
9 people of their drug problem. Treatment
10 in prison doesn't last. Intermediate
11 sanctions don't work and sometimes make
12 things worse. Treatment referrals don't
13 take, and treatment produces mixed
14 results.

15 So this brings us -- the bad
16 news part is over. That's the end of the
17 bad news for the presentation. We're
18 going to talk about some good news here,
19 and this brings us to this integrated
20 public health/public safety model. So
21 instead of taking an either/or approach
22 where we punish people or we treat them,
23 why don't we combine that approach, and
24 that approach, this combined approach, is
25 really captured by problem-solving

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2 courts, in particular drug courts.

3 So I'm sure most of you are
4 familiar with drug courts. I won't
5 belabor it, but drug courts are separate
6 court dockets. They're for non-violent
7 drug offenders. These are drug users.
8 They're not drug dealers ideally,
9 although drug dealers can get into drug
10 courts in some jurisdictions. And they
11 receive judicially supervised treatment
12 and case management. There are random
13 urine drug screens. They have judicial
14 status hearings in front of a judge, and
15 they get sanctioned and rewarded based on
16 their behavior.

17 A couple of things I want to
18 point out. In a series of studies that
19 we did in Delaware, we randomly assigned
20 criminal offenders to different doses of
21 seeing the judge in drug court. And this
22 is one of the first research teams in the
23 United States that allowed us -- we were
24 allowed by a court of law -- to randomly
25 assign actual criminal offenders. Some

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2 saw the judge once a month, which is
3 fairly standard. Some saw the judge not
4 at all, and some saw the judge twice a
5 month. So we had standard dose and low
6 and high.

7 What we found is that the
8 judge, not surprisingly, is a critical
9 component of drug courts. The judge is
10 one of the things that separates drug
11 courts from the things like probation and
12 parole. The judge has a lot of authority
13 to be able to do things in that context.
14 And what we also found -- and this is an
15 important result -- is that high-risk
16 offenders did better when they saw the
17 judge twice a month. The high-risk
18 offenders did better when they saw the
19 judge on that high dose. The low-risk
20 offenders did worse when they saw the
21 judge twice a month. Interesting effect.
22 The low-risk offenders actually did
23 better when they didn't see the judge at
24 all, and we can talk about that if anyone
25 has any questions.

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2 These drug courts range from
3 several months to two years. There's
4 misdemeanor and felony drug courts
5 depending on the jurisdiction.

6 Completion results in nolle prosequere. And
7 in some jurisdiction, the arrest record
8 can be expunged.

9 Drug courts are not new. Drug
10 courts have been around. The first one
11 was developed in 1989 in Dade County,
12 Florida. Janet Reno, who later became
13 the Attorney General of the United
14 States, was instrumental in developing
15 the drug court in Dade County. She
16 realized and the judges realized that the
17 docket was overwhelmed with drug
18 offenders, and so they developed this
19 separate docket.

20 There are nearly 3,000 drug
21 courts in the United States right now.
22 There's a drug court in -- multiple drug
23 courts in every state and every
24 jurisdiction and every territory, and
25 this model has been exported to over 13

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2 countries right now.

3 Given the success of drug
4 courts, which we'll talk about, other
5 problem-solving courts were developed.
6 So drug courts were first. Then mental
7 health courts were developed. Mental
8 health courts are for people where their
9 mental health issues are a catalyst for
10 criminal behavior. Family dependency
11 treatment courts. You can see the list.
12 Domestic violence courts, DUI courts, gun
13 courts, and prostitute courts.

14 The idea behind these courts --
15 and this sounds simple, folks. The idea
16 is, let's actually treat what it is
17 that's causing these people to come into
18 contact with the criminal justice system.
19 If it's a mental health problem, let's
20 treat that. If it's a drug problem,
21 let's treat that. Too often that was not
22 happening in standard criminal justice
23 processing. So it's targeted treatment
24 at criminogenic needs. The criminogenic
25 needs are the risk factors that can be

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2 addressed during intervention.

3 The idea behind these courts is
4 called therapeutic jurisprudence, meaning
5 the law can be a clinical agent to help
6 people. The law doesn't just have to
7 punish people. The law can help people.

8 So do drug courts work?

9 There's more research on drug courts than
10 there is on any criminal justice
11 intervention for drug-involved offenders.
12 There's more research supporting the
13 effectiveness of drug courts for
14 drug-involved offenders than there is
15 supporting the effectiveness of
16 anti-depressants for people with
17 depression. This is not hyperbole. This
18 is where we are with an extremely large
19 and well-developed body of research. Put
20 simply, drug courts are the most
21 effective intervention for drug-involved
22 offenders in terms of reducing drug use
23 and reducing recidivism.

24 There's a reason that drug
25 courts have received bipartisan support

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2 in the United States Congress. There's a
3 reason that President Obama has suggested
4 that drug courts be used more often.

5 So a couple statistics. Again,
6 these are summarized, synthesized from
7 multiple studies. Sixty percent of
8 people who go into drug court complete at
9 least one year of treatment. Remember
10 that one-year mark that we talked about
11 before where the statistic was only 10
12 percent complete a year of treatment? In
13 drug courts, it's a sixfold increase, 60
14 percent get to that dose response curve.

15 Drug courts reduce crime 45
16 percent more than other criminal justice
17 interventions, and we're seeing some
18 long-term effects with drug courts. So
19 75 percent of graduates remain arrest
20 free for at least two years. That is a
21 staggering statistic when you compare it
22 to standard criminal justice processing.
23 And long-term reductions, because drug
24 courts have been around since 1989,
25 longitudinal studies are suggesting that

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2 the criminal justice reduction effect is
3 lasting nearly 15 years. They seem to
4 have a long-term effect.

5 We also know that drug courts
6 are cost effective. There are several
7 studies on the cost analysis. One study
8 I'll point out, because I think it was a
9 particularly strong study, found that for
10 every dollar invested in drug courts,
11 drug courts were producing \$2.21 worth of
12 savings. And if you focus mostly on high
13 risk, that number actually goes up. So
14 they seem to be cost effective as well.

15 We also see some more specific
16 research on different subsets of
17 offenders. So, for example, lots of
18 jurisdictions are struggling with
19 methamphetamine, and there's some good
20 research about drug courts. So we know
21 that graduation rates are nearly 80
22 percent. It quadruples the length of
23 abstinence from methamphetamines, drug
24 courts versus not drug courts. And it
25 reduced methamphetamine use by more than

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2 50 percent compared to outpatient
3 treatment alone.

4 What about family drug courts?

5 This is the idea that the family dynamic
6 needs to be assessed. There needs to be
7 an intervention at the family level to
8 help even one individual who has a
9 problem. If any of you know someone who
10 has had a drug problem or if you've
11 experienced it in your family, you know
12 it's not limited to that individual.

13 There's a family dynamic that needs to be
14 addressed.

15 Here's what we see: Parents in
16 family drug courts are twice as likely to
17 begin treatments and complete treatment.
18 Children spend significantly less time in
19 out-of-home placements, less foster care,
20 and family reunification rates are 50
21 percent higher for families that go
22 through family drug courts versus
23 standard criminal justice processing.

24 We also have juvenile drug
25 courts. Now, I'll tell you now that the

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2 research on juvenile drug courts is much
3 more mixed and a little bit less
4 optimistic. Now, partially because a lot
5 of juvenile drug courts don't adhere to
6 the best practices that have been
7 outlined by the National Association of
8 Drug Court Professionals. There's more
9 variability in operations and practice,
10 so we're seeing more variability in
11 outcomes. Nevertheless, we see
12 significantly lower recidivism rates
13 versus standard probation. We see
14 significantly lower rates of drug use and
15 delinquency compared to juveniles who go
16 through Family Court. And the cost
17 savings -- and this is from several
18 studies -- \$1,000 to \$5,000 per juvenile
19 over a two-year period. Given the number
20 of juveniles that we have who are
21 involved in the criminal justice system
22 or juvenile justice system, particularly
23 in Philadelphia, this is something that
24 we cannot ignore.

25 Also, avoiding secured

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2 detention of low-risk juveniles is
3 extremely important, and this is, I
4 hope -- even though we're not focusing
5 entirely on juveniles, I hope this is a
6 takeaway point. The research is very
7 clear that if you mix low-risk juveniles
8 with high-risk juveniles, you get
9 high-risk juveniles. It's called
10 deviancy training, and this is a
11 phenomenon that has been demonstrated
12 over and over again. So programs like
13 Scared Straight or other in-prison
14 visitation programs have been shown
15 mostly to have no significant effect for
16 the high-risk adolescents, but they
17 actually have been shown to have an
18 iatrogenic effect for the low-risk
19 adolescents, meaning that the low-risk
20 adolescents, they actually do worse after
21 they go to a scared straight program.

22 So this brings me to sort of a
23 meta issue here about is it time for a
24 paradigm shift in how we are handling
25 people with drug problems in the United

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2 States? Because what we've been doing
3 for the past 40 years doesn't work. And
4 even the treatment model outside of the
5 criminal justice system doesn't work
6 particularly well. So here's what we
7 know about treating drug users, and I'm
8 not being cutesy. This is what we know.
9 Some treatments work for some types of
10 drug use for some individuals some of the
11 time under some conditions. That we
12 know.

13 So let me draw an analogy from
14 the medical literature. The treatment
15 for Type 1 diabetes is insulin. Does
16 insulin work? Does it keep your blood
17 sugar in check? Yes, if you take it.
18 Does insulin work if you don't take it?
19 No. Do we then conclude, well, insulin
20 doesn't work? No. Insulin works when
21 you take it.

22 What we know about drug
23 treatment is drug treatment works while
24 people are getting it, and then when they
25 stop getting it, it doesn't work anymore,

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2 and a bunch of smart people sit around
3 and say, I can't believe that person went
4 back and used drugs again.

5 This suggests drug problems
6 should be treated. They should be viewed
7 as a chronic relapsing condition, the
8 same way that we view hypertension and
9 diabetes. Hypertension and diabetes
10 require ongoing care or you relapse.
11 Drug use for most people requires ongoing
12 care or there's a relapse.

13 Now, I understand there are
14 fiscal implications here. I'm not an
15 expert on that, but what the research
16 does suggest is that people who have a
17 drug problem need a high dose of
18 treatment up front and then they need
19 continuing treatment after that ends.

20 So we're going to shift gears a
21 little bit. We're going to shift gears.
22 We've been talking about drug courts.
23 Drug courts are extremely effective, as
24 I've pointed out, but they reach a very
25 small number. Despite having nearly

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2 3,000 drug courts, drug courts treat a
3 very small number of drug-involved
4 offenders. Less than 5 percent of
5 drug-involved offenders go to a drug
6 court despite their effectiveness. Also,
7 drug courts are fairly deep in the
8 criminal justice process. The person has
9 penetrated the criminal justice system
10 fairly deep by the time you get to the
11 court stage. So perhaps it will be
12 better to intervene earlier, to have a
13 diversion effort earlier than the court
14 states. So this brings us to pre-arrest
15 diversion.

16 The Sequential Intercept Model,
17 which some of you may be familiar with,
18 is a useful way to illustrate points
19 along the criminal justice system at
20 which an intervention could be made to
21 take someone out of standard criminal
22 justice processing into a more
23 appropriate intervention. So the
24 Sequential Intercept Model was developed
25 by a community psychologist, Patty

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2 Griffin -- some of you may know her. She
3 does a lot of work for the City, for
4 DBH -- and a psychiatrist out in Ohio
5 named Mark Munetz, and these are the five
6 points that they identify. It's a
7 conceptual model. So you could see it
8 starts very early in the process at
9 pre-arrest. This is first responders.
10 These are law enforcement. These are
11 emergency services. That is the first
12 point at which, if there's proper
13 training, someone could be diverted from
14 the criminal justice system into
15 something more appropriate. That's the
16 first intercept.

17 The second intercept is
18 post-arrest. The third is post-initial
19 hearings. So here's where we're talking
20 about drug courts and other courts. The
21 fourth is reentry, and the fifth is
22 community corrections and support.

23 This is a visual depiction if
24 you're more -- I apologize, it's tough to
25 see. And this is another one that

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2 illustrates that funnel approach where
3 there's a lot of people at that initial
4 intercept of law enforcement contact and
5 there should be fewer people as you get
6 deeper into the criminal justice system.

7 So when it comes to pre-arrest
8 diversion, the ultimate intercept is
9 before someone enters the criminal
10 justice system. So this is the idea --
11 and I'll talk about this a little bit
12 more later -- of training first
13 responders, of training law enforcement
14 to recognize when someone needs to be
15 arrested versus when someone may not need
16 to be arrested and put into the system
17 and might need to be diverted into a
18 treatment of some sort.

19 There's a couple of ways to
20 reduce the number of people in the
21 criminal justice system at this early
22 stage. One way is to look at the
23 offenses. So maybe we reduce the
24 offenses from misdemeanors to summary
25 citations, which I know is something

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2 that's been taking place in Philadelphia.

3 Another approach would be to
4 divert subsets of offenders into
5 appropriate treatment. This is -- it
6 could be done at the point of arrest. If
7 there's appropriate training, if there's
8 appropriate measures in place, then it's
9 possible -- in fact, we are looking for a
10 grant to study this, but it's possible to
11 develop a measure that could be used by
12 police officers at the point of arrest to
13 help determine is this person appropriate
14 for a diversion program or do they need
15 to go into the system. Certainly
16 high-risk people, they're going to need
17 to go into the system. Someone who is
18 low-risk but who has high needs, maybe
19 they're appropriate for diversion. So
20 we're looking at developing a measure to
21 help move this along.

22 Why should we do this? Why
23 should we do pre-arrest diversion? Well,
24 some obvious reasons. One, it reduces
25 overcrowding in jails and prisons. Two,

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2 research suggests that it's less
3 expensive because it reduces the burden
4 on the system, and then the system can
5 focus on the people who actually really
6 need the services, and -- this is a big
7 one particularly for me as a scientist
8 because it works -- we have data
9 suggesting that pre-arrest diversion
10 programs work. And by "work," I mean
11 that does not put the community at any
12 increased risk. There's no risk to
13 public safety, and it is effective in
14 treating the problems that brought that
15 person into contact with the criminal
16 justice system.

17 So a popular program, which I
18 know has also been implemented in
19 Philadelphia, is specialized police
20 responding. A classic example would be
21 crisis intervention training. So this is
22 the idea that you train police officers,
23 you train emergency dispatchers on the
24 nature of mental illness and substance
25 use. You train police officers on

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2 available community behavioral health
3 services, and you train law enforcement
4 on crisis intervention techniques.

5 Now, one of the things -- I
6 have tremendous respect for law
7 enforcement. In many jurisdictions law
8 enforcement sometimes engage in what's
9 called the Handy Hammer Syndrome, which
10 is the idea that if you give someone a
11 hammer, everything looks like a nail.
12 And for law enforcement, when they
13 encounter someone engaging in deviant
14 behavior, their first response is to
15 arrest that person. That's
16 understandable, because that's how they
17 were trained. And so if we can broaden
18 the repertoire, educate police
19 officers -- and this is an effort that
20 we've actually been doing for quite some
21 time now -- educate police officers on
22 the available services in their
23 community, even give them a laminated
24 card so they know where they can take
25 someone who is presenting with a drug

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2 problem or erratic behavior or whatever
3 it may be, then we know it reduces the
4 number of people in the system and the
5 behavioral health outcomes and criminal
6 justice outcomes are much improved.

7 The goal of CIT training is to
8 reduce response time, to provide better
9 care to those who are in crisis and,
10 importantly, to protect the safety of
11 police officers who are responding to
12 these crises. And the research, it's
13 ongoing. This is not as set in stone as
14 it is with, say, drug courts. But the
15 research suggests that officers who go
16 through CIT training feel better prepared
17 to handle an individual who is in crisis
18 because of a drug problem or a mental
19 health problem. They are less likely to
20 use force in resolving the crisis
21 situation, and they are more likely to
22 divert individuals into treatment instead
23 of processing them through the criminal
24 justice system, which, as we've talked
25 about, doesn't work for people who have a

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2 drug use problem.

3 So this brings me to -- I
4 mentioned that one of the keys to
5 effective treatment of drug-involved
6 individuals is cross-systems
7 collaboration. This brings me to a
8 discussion of the Pennsylvania Mental
9 Health and Justice Center of Excellence.
10 The Center of Excellence was initially
11 funded in 2009 by PCCD and OMHSAS, and
12 it's directed by Drexel University here
13 in Philadelphia and the Western
14 Psychiatric Institute and Clinic in the
15 western part of the state. I'm one of
16 the senior consultants for the Center of
17 Excellence. And our goal, since we
18 started getting funding in 2009, is very
19 simple. It's a simple goal at least on
20 paper - to reduce justice involvement for
21 people with mental illness and/or drug
22 use problems, to decriminalize the
23 criminalization of mentally ill. And our
24 primary goal is diversion. And as I
25 talked about, the best diversion is to

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2 prevent someone from even entering the
3 system. So we want to prevent people
4 with mental health disorders and/or drug
5 use disorders from even entering the
6 criminal justice system.

7 So we do this in a couple ways.
8 One is, we offer trainings throughout the
9 Commonwealth. And actually you're going
10 to hear me talking in past tense language
11 occasionally, because we just lost our
12 funding for this project about two months
13 ago, unfortunately. We had continuous
14 funding from 2009, and we're very
15 disappointed to find out that it's not
16 going to be renewed. We've been, we
17 think, doing some outstanding work over
18 the past seven years.

19 One of the things we do is
20 provide ongoing training and technical
21 assistance at the county level and at the
22 Commonwealth level. So counties who are
23 developing a crisis intervention program,
24 counties who want to train their law
25 enforcement on an existing program, we go

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2 in there and we help them do that.
3 Counties that want to start a drug court
4 or evaluate their drug court, we go in
5 there and we help them do that. So it's
6 a variety of technical assistance and
7 research, and we also focus on all five
8 of the intercepts that we've talked about
9 so far. So we helped train law
10 enforcement on crisis intervention. And
11 crisis intervention has become more
12 specialized. So it's not just crisis
13 intervention. It's crisis intervention
14 for working with vets or people with
15 mental illness or drug problems or any
16 number of other conditions that might be
17 useful for police officers to have some
18 additional training.

19 We also worked very heavily in
20 Intercept 5. Housing, of course, is a
21 huge problem when people come out of
22 incarceration. So working with counties
23 to try to develop housing initiatives,
24 treatment opportunities and so on. The
25 point being that this Sequential

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2 Intercept Model shows the continuum of
3 care that someone needs if they have a
4 drug problem. The care should not stop
5 when someone is released from
6 incarceration. The care should not stop
7 when someone finishes a treatment
8 program.

9 We've also done what's called
10 cross-systems mappings, and we've done
11 this in 45 of Pennsylvania's 67 counties.
12 So we've done two-thirds of Pennsylvania
13 counties with these mappings. You can
14 take a look at the map here. You can see
15 that we've hit just about every area of
16 the state for these mappings. And for
17 those of you who are not familiar with a
18 mapping, let me tell you the basis of it
19 first. The basis of a mapping is that we
20 see many of the same people in the same
21 systems. We see the same people in the
22 mental health system, in the criminal
23 justice system, social services,
24 substance abuse, and this is expensive
25 because we have these high service users

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2 who cycle and recycle throughout the
3 system, and sometimes the substance use
4 system doesn't know what the criminal
5 justice system is doing with this person.

6 A potential answer to this is a
7 cross-systems collaboration. Let's
8 decrease some of the silos that we have.
9 Let's open a dialogue. It takes a
10 village, right? It takes a village for
11 someone to fall through the cracks and it
12 takes a village to bring that person
13 back. So this is the goal of
14 cross-system collaboration, to try to
15 provide -- and you can see that
16 intersection of mental health, substance
17 abuse, and criminal justice. To target
18 that circle in that Venn diagram and
19 provide those types of services.

20 Now, the goal with mapping is
21 you want to develop this cross-system
22 collaboration. So you map the local
23 system. I'm going to just very briefly
24 describe how it works if you're not
25 familiar with it. You inventory the

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2 gaps, the resources, the opportunities.
3 You agree on a priority plan, and then
4 you develop an action plan. And this is
5 a one-and-a-half-day process. The first
6 day is, you bring together key
7 stakeholders from various systems. So
8 you have representatives from law
9 enforcement, you have representatives
10 from the judiciary, you have
11 representatives from probation and
12 parole, you have representatives from
13 treatment. You bring together everyone
14 in the same room. It's not uncommon when
15 we do these mappings to have 20 or 30
16 different representatives in the same
17 room.

18 You visually depict how someone
19 with a drug problem goes through the
20 system, from the point of arrest all the
21 way to the point where they're released
22 and likely incarcerated again. You
23 depict it. By visually depicting it,
24 then you can identify the gaps in
25 services, where increased communication

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2 will be helpful and opportunities for
3 providing additional services.

4 The key, though, is to do this
5 in a specific locality. It's not good
6 enough to read a book about what would be
7 helpful in providing services in your
8 jurisdiction, because that book doesn't
9 know what's in your jurisdiction.

10 You've probably heard this
11 before. As I mentioned, there's 67
12 counties in Pennsylvania. The old saying
13 is if you've seen one county in
14 Pennsylvania, you've seen one county in
15 Pennsylvania, because they're all
16 different. So there's not one blueprint
17 that's going to work for every county.
18 So you do this in a specific locality to
19 try to provide people with prompt access
20 to treatment, opportunities for
21 diversion. You want to get them through
22 the criminal justice system as quickly as
23 possible if they're in the system and
24 then, importantly, you want to link them
25 to community resources. We're seeing

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2 that theme again, which is you need
3 ongoing care for drug-involved offenders.

4 You go over priorities for
5 change. You pull best practices from
6 other counties and other states and you
7 see if they would work in this county.
8 You determine areas where immediate
9 actions can have big impact, and then you
10 develop a local set of priorities for
11 change.

12 The second part of the mapping
13 is day two. It's a half-day activity
14 where you make a specific plan for taking
15 action, and the key here is
16 accountability. The key is assigning
17 oversight and tasks to specific people in
18 the system and having them be accountable
19 for doing what they're supposed to do,
20 whether it's addressing the gap or
21 securing more services or increasing
22 linkages. Accountability.

23 So through this local action
24 plan, which is based on all the data from
25 that community, you look at what are the

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2 problems that are impeding criminal
3 justice and diversion and service
4 delivery. Every county has problems.
5 You have to identify the problem first.
6 You look at the best practices that could
7 solve it, and then you establish action
8 steps. And then the result is, when we
9 would do these mappings, we would issue a
10 final report, a very thick final report
11 of all of our findings, and it is a
12 county-specific narrative. So imagine
13 you're in the county, we're giving a
14 narrative on each of the five intercepts,
15 what you're doing well, where there's
16 gaps, where there's opportunities for
17 community linkage and so on.

18 So I'm going to end, and before
19 I do, I just want to make sure that we
20 have these high points here in summary.
21 High rates of drug-involved offenders.
22 Incarceration, the traditional approach
23 that we've taken for the past 40 years in
24 the war on drugs, doesn't work, and it's
25 expensive. Fortunately, diversion, these

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2 efforts to divert people out of the
3 criminal justice system into appropriate
4 treatment, has been shown to effectively
5 reduce relapse and recidivism, and it's
6 cost effective and it does not put the
7 community at any increased risk in terms
8 of dangerous to public safety.

9 So I hope I'm leaving on a high
10 note here, on a positive note, because
11 there's a lot of research supporting the
12 effectiveness of diversion throughout the
13 United States, and given that it's
14 effective in terms of relapse and
15 recidivism and it's cost effective, I
16 think it's a good opportunity for the
17 future.

18 So thank you very much for your
19 time.

20 DEPUTY COMMISSIONER BETHEL:

21 Well, first, Dr. DeMatteo, let me first
22 thank you for a very extensive and very
23 clear -- when I was looking for you to
24 come, one of the things I wanted folks in
25 the room but, more importantly, the

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2 viewing public to really see what's
3 behind the scenes. As I mentioned to
4 you, my brother was addicted for many
5 years and he passed away, that whole
6 cycle. And arrest didn't work for him.
7 I could tell you that. I mean, I used to
8 feed him cheese sandwiches in the
9 cellblock. It didn't work.

10 And so I just really want to
11 first thank you for coming here and
12 really sharing with us a really strong
13 base of what we really need to be looking
14 at.

15 So if you were sitting in this
16 group and you're sitting as part of the
17 recommendations, am I hearing you
18 correctly that -- and I know the First
19 Assistant, who is sitting to my left, is
20 very much involved in the juvenile and
21 adult drug courts. So I'm assuming he's
22 glad to hear what he probably also knows
23 and studied the evidence that it works.

24 Is that the area that we should
25 be going in? Is the pre-arrest

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2 diversion, which is something to be
3 discussed in the MacArthur model that
4 we're move forward with, and the drug
5 courts is where we should be spending a
6 lot of our energy in as we move forward
7 in this process?

8 DR. DeMATTEO: I think for me
9 as a scientist, recommending drug courts
10 is easy for me to do, because there's a
11 large and strong, well-developed body of
12 literature suggesting that they're very
13 effective. We're not talking about some
14 of those other courts, and that's
15 probably good, because there's less
16 evidence that they're effective. One of
17 the worst things that can happen is for
18 something to become a movement, because
19 people stop asking the right questions.
20 They stop asking the hard questions.
21 They stop doing the research. So some of
22 these other courts the research is not
23 that strong, but for drug courts it's
24 extremely strong. It's the most
25 effective intervention we have for

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2 reducing relapse in drug use and
3 recidivism.

4 And pre-arrest diversion, the
5 research is emerging, but what we see is
6 extremely promising and suggests that it
7 can be very effective.

8 DEPUTY COMMISSIONER BETHEL:
9 Outstanding.

10 Any questions from the panel?

11 MR. MOSEE: Thank you very
12 much, Doctor. One of the things that I
13 think is sometimes confusing is the
14 definition of substance abuser,
15 especially in the criminal justice
16 context. The presenting problems and
17 whatever it was that brought them to the
18 attention of the justice system, they're
19 never mutually exclusive. So you don't
20 have just a user and you don't have just
21 someone who breaks into homes. You have
22 somebody who has done both. And so when
23 you talk about prison not benefiting a
24 substance abuser, what exactly are you
25 talking about? Who are you talking

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2 about? Are you talking about somebody
3 who was sent to prison simply because
4 they committed the crime of possession of
5 a controlled substance or are you talking
6 about other people?

7 DR. DeMATTEO: That's a
8 wonderfully inciteful question, and it
9 really points out some of the nuances and
10 subtleties in these data.

11 When I write about drug use and
12 crime, I try to make a distinction among
13 several things, one of them being there
14 are people who use drugs, there are
15 people who misuse drugs. There's people
16 who abuse drugs, and there's people who
17 are dependent on drugs. We're talking
18 about different populations there when
19 you cut it that thinly.

20 Drug use, as I mentioned, is a
21 major risk factor for criminal offending,
22 but it depends on what drug and in what
23 circumstance and in what setting. So
24 that's important and I don't want to
25 overstate it. But overall drug use is a

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2 risk factor.

3 To get to your specific
4 question, a lot of the research combines
5 those groups. So you take the person you
6 mentioned who is incarcerated simply for
7 drug possession versus the person who is
8 incarcerated for using drugs but they
9 committed some other offense. Some
10 research combines them and takes a look
11 at them in the aggregate, which I think
12 is going to cloud some of the
13 interpretation, because they are
14 different samples.

15 What we do know, though, for
16 both of those is that when you look at
17 rates of relapse, they're similar for
18 both of those groups, whether they were
19 in there just for the possession or the
20 possession and some other criminal
21 behavior.

22 MR. MOSEE: And not to harp on
23 the incarceration piece, but in terms of
24 research that examines a variable that I
25 believe is sometimes omitted from the

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2 research -- and the variable that I'm
3 talking about is reentry -- is there any
4 study that not only looks at the success
5 rate for someone who has been
6 incarcerated but the success rate for
7 someone who after they were released
8 received effective reentry and after-care
9 programming?

10 DR. DeMATTEO: Yes, there is
11 research on that, and the research,
12 perhaps not surprisingly given what I've
13 talked about in terms of ongoing care and
14 the continuum, suggests that when people
15 are released and they're released either
16 to a step-down facility or a halfway
17 house, if it's providing quality
18 treatment, those people are less likely
19 to recidivate, and if they do recidivate,
20 it takes them much longer to recidivate.

21 MR. MOSEE: And so to follow up
22 on Mr. Bethel's question to you about
23 what you would recommend, would you add
24 to your list of recommendations effective
25 after-care, especially when it comes to

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2 substance abuse treatment?

3 DR. DeMATTEO: That would be
4 one of my top recommendations. So if we
5 look at pre-arrest diversion as early in
6 the process, we look at drug courts in
7 the middle, and we look at reentry at the
8 end of that process, ongoing care --
9 again, using that analogy -- ongoing care
10 is one of the main things that separates
11 those who remain abstinent from those who
12 don't. There needs to be that ongoing
13 care to provide that person with what
14 they need so that they remain abstinent.

15 DEPUTY COMMISSIONER BETHEL:
16 I'm going to recognize Councilman
17 Kenyatta Johnson, who has been here once
18 we started, and he also has a question.

19 Sir.

20 COUNCILMAN JOHNSON: Thank you.
21 It's more of a statement. One, I want to
22 commend all the participants on the panel
23 for your commitment as we address the
24 issue of reforming our criminal justice
25 system and making sure that we're

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2 providing the best resources and the best
3 opportunities possible for those who
4 happen to go through our criminal justice
5 system, but particularly in this case
6 those who are returning to society.

7 I like the concept of the
8 paradigm shift and using treatment courts
9 as a way to address the drug abuse and
10 substance abuse role that it plays in
11 individuals committing crime. There's
12 already research and documented that in
13 our state prisons a significant
14 population, maybe between 80 to 85
15 percent -- you'll probably know the
16 numbers in more detail than I do, but
17 from doing this work since I was a State
18 Representative, a significant population
19 of individuals are in prison as a result
20 of not violent crimes, non-violent
21 crimes, but more than likely drug
22 related.

23 And so when we talk about the
24 paradigm shift from a public policy
25 standpoint, we have to begin putting more

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2 of an emphasis on everything that you're
3 already talking about, treating the
4 addiction. But not also just the
5 addiction, but the behavior from just
6 drug use, period, because -- and now I
7 speak more on a personal level. I talk
8 to young men that I see in my
9 neighborhood, and a lot of guys get high
10 just for the simple fact for the
11 environment, just to cope. But as a
12 result, a lot of the actions and the dumb
13 decisions come as a result of being high
14 on drugs.

15 And so when you talk about
16 juvenile reentry -- and we had a
17 presentation by individuals from Family
18 Court the other day, and they talked
19 about they have a model that deals with
20 the treatment of young people as it
21 relates to substance abuse. I just
22 wanted to reiterate -- and I like the
23 whole paradigm shift perspective -- that
24 if we're going to move away from just
25 housing individuals just for the simple

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2 sake of housing them, I think this is
3 probably one of the most effective models
4 that can be utilized, because if you have
5 a drug problem before you go to prison,
6 you got a drug problem when you come
7 home, real simple. If you're not
8 checking those same behaviors that got
9 you in prison as it relates to you
10 getting high while you're in prison, you
11 come home, as soon as the pressure hits,
12 you revert back to that same behavior.

13 So I really just want to
14 commend the presentation, because for me,
15 I recognize how important when we look at
16 the different alternatives, but really
17 when you talk about the treatment of drug
18 addiction, the substance abuse, that's
19 like probably the cornerstone of why
20 we're dealing with a lot -- and the law
21 enforcement officials will tell you in
22 some cases, you know, you just have
23 straight violent offenders, individuals
24 who just engage in crime, and I'll never
25 sit up publicly and say I don't know

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2 people who just like, this is what I do.
3 This is the type of things I like to get
4 involved in. But I've seen more people
5 more than not make a dumb decision
6 because you're high on drugs and don't
7 really know how to just cope with life.

8 And so to the panel, at least
9 from my perspective, I wanted to make
10 sure I was on the record reiterating as
11 we look at all the different ways to
12 address it - you talk about reentry, job
13 training, employment - this is a key
14 component, because at least -- we all
15 have our own personal experience because
16 everybody up there is a professional in
17 their own right. This is a significant
18 part of that puzzle that we have to look
19 at. And hopefully on the state level
20 they'll begin looking at a lot of the
21 sentence reform guidelines and
22 alternatives that are available to begin
23 looking at treatment court as a whole.

24 Thank you.

25 DEPUTY COMMISSIONER BETHEL:

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2 Thank you, Councilman.

3 Let me recognize -- I'm sorry.

4 You got a response. Go ahead.

5 DR. DeMATTEO: Thank you,
6 Councilman, for those comments. I really
7 appreciate that. And just one quick
8 follow-up to that. Drug use is a complex
9 phenomenon. It develops because of
10 multiple factors. There's not one reason
11 why drug use develops. What that means
12 is, the response to drug use has to be
13 complex. You can't just pluck a drug
14 user out and treat that drug user and
15 expect that person to get better, when
16 you put them back in the same
17 environment, with the same friends, the
18 same lack of resources, same lack of
19 opportunity. It has to be a multi-modal
20 intervention.

21 COUNCILMAN JOHNSON: And I do
22 want to follow up with one extra comment.
23 You did talk about mental health, right,
24 and they create these various different
25 courts off the model of treatment court,

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2 because we have about, what, 10, 15
3 different court models here in the City
4 of Philadelphia, but I know Judge
5 Presenza and the work that he's done, and
6 he's been very successful with that
7 particular court. But there's a mental
8 health component when you talk about
9 substance abuse and drug addiction as
10 well, because it's all about the brain
11 and coping and how you're going to go
12 about coping and looking at how do you
13 address both, because the addiction in
14 some cases is a mental health issue and
15 how you're coping with life under life's
16 terms.

17 And so hopefully as we move
18 forward, that can also be a part of the
19 conversation. Because I think you
20 separated the two. I know you said you
21 have mental health courts, but for the
22 most part, I'm sticking with what we have
23 results, and right now that's treatment
24 court model. Just elaborate on that just
25 a little bit more.

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2 DR. DeMATTEO: That's a great
3 comment, and it's -- from a clinical
4 perspective, it's very difficult to
5 address. I've worked with a lot of drug
6 users, and the rate of mental illness
7 among drug users is exceptionally high,
8 and sometimes you have a chicken and the
9 egg problem. Did they start using drugs
10 because of their mental illness? Did the
11 mental illness, was it exacerbated
12 because they used drugs? And as a
13 clinician -- I'm trained as a
14 psychologist clinician too -- when you
15 work with individuals in that, it's very
16 difficult to know what to address.

17 From a system perspective, I
18 imagine it's even more complex, because
19 the relationship between mental illness
20 and drug use can take lots of different
21 forms.

22 So I agree with you entirely
23 that we do have these boutique courts
24 that have been developed and we might be
25 cutting it too thin, because to separate

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2 mental illness and drug use is just not
3 supported by the research.

4 COUNCILMAN JOHNSON: I want to
5 pose a question to the Chairman. Do we
6 have a representative on here from Family
7 Court?

8 DEPUTY COMMISSIONER BETHEL: I
9 think in our Committee, but not here
10 today.

11 COUNCILMAN JOHNSON: On the
12 Committee.

13 So to Mr. Mosee, the District
14 Attorney's Office, I know you have a
15 background dealing with particularly the
16 issue of juvenile justice. So what are
17 we doing to increase our efforts working
18 in partnership with Family Court to deal
19 with drug abuse, substance abuse
20 addiction amongst juveniles? Like it's a
21 known fact -- and I'm quite sure you know
22 this doing this work -- most young men
23 that carry guns, they wet, PCP before
24 they go commit the crime or they take
25 pills before they go commit the crime.

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2 We just had a major homicide in Grays
3 Ferry. At the end of the day, it was
4 about a pill war on the streets, and when
5 I grew up, it was a crack war. Now
6 they're shooting each other over Xanaxes
7 and Percocets.

8 So what role is the District
9 Attorney and the Family Court doing in
10 terms of maybe bridging your efforts
11 specifically when these young men come
12 through the system? Okay, we're
13 addressing the specific drug addiction
14 component of why they're there. Are they
15 tested for urine when they come in, or
16 how does that work? I just wanted to
17 just ask you that question.

18 MR. MOSEE: So there was a
19 major impediment to actually determining
20 whether or not these young people were
21 abusing substances. Defense attorneys
22 would actually advise their clients not
23 to submit to any screening or evaluation.
24 So we changed the law, and the law now
25 prohibits us from using that information

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2 against a juvenile. So we get the
3 information up front.

4 Once we have the information,
5 then we try to expedite the determination
6 of whether or not they need inpatient,
7 outpatient, whatever the level of care
8 is. We try to take care of that early on
9 with our own Juvenile Treatment Court.

10 And so the treatment court is
11 precisely what the doctor was talking
12 about. It's an opportunity for the young
13 person to be diverted. Now, our
14 definition of diversion is different from
15 what the doctor said. We don't divert
16 away from the system. Diversion in
17 Pennsylvania means to avoid an
18 adjudication of delinquency or
19 conviction. So even though they're in
20 the system, they won't have that stigma.

21 COUNCILMAN JOHNSON: Thank you.

22 MS. WERTHEIMER: And I just
23 wanted to add, Councilman, that within
24 the Criminal Justice Advisory Board, the
25 Administrative Judge of Family Court,

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2 Judge Murphy, recently constituted a
3 juvenile subcommittee specifically
4 looking at issues within the juvenile
5 system since, as George pointed out, it's
6 separate from the adult system, the
7 criminal justice system, and actually
8 yesterday was the second meeting of this
9 esteemed committee, and that committee
10 has decided to focus on specific issues
11 to develop holistic responses so that all
12 of the partners and players understand
13 the same thing. So yesterday's focus was
14 on the drug K2 and making sure that
15 everyone from the Police Department
16 through the Defender through Juvenile
17 Probation and Parole had the same
18 understanding of what the problems are
19 with that specific.

20 COUNCILMAN JOHNSON: Is it
21 illegal -- and I want to make sure I
22 understood what George was saying,
23 Mr. Mosee. Is it illegal, at least from
24 the juvenile side, that the young men as
25 a part of their interaction with the

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2 system through Family Court that they're
3 tested for drug use to determine if they
4 need treatment?

5 MS. WERTHEIMER: I would defer
6 to Mr. Mosee on that question.

7 MR. MOSEE: So my point was
8 that we changed the law so that it
9 wouldn't be a legal impediment. When I
10 say defense attorneys would advise their
11 clients not to submit to that testing,
12 that's what they should do. If that
13 information was going to be used against
14 them, then, sure, that's problematic, but
15 it can't be used against them, so we've
16 removed that hurdle and now we get more
17 information.

18 COUNCILMAN JOHNSON: Thank you.

19 DEPUTY COMMISSIONER BETHEL:
20 One more final question, but before we
21 do, I'll recognize Councilwoman Jannie
22 Blackwell, who is in session.

23 COUNCILWOMAN BLACKWELL: Thank
24 you.

25 DEPUTY COMMISSIONER BETHEL:

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2 One final question and then we'll
3 continue with the panel.

4 MR. COBB: William Cobb.

5 Doctor, thank you very much for
6 that well-informed testimony. As you can
7 probably see from here, I wrote down a
8 slew of questions, and I'm going to
9 forward these questions to you, and then
10 I would ask that you provide answers, and
11 then we'll add them to the record for the
12 purposes of helping this Committee move
13 towards our goal.

14 But I want to point out
15 specifically that you used the term
16 "offender" repeatedly during your
17 presentation. Offender is defined as a
18 person who commits an illegal act. So
19 what I'm going to ask is from your
20 clinical perspective, because we're
21 receiving a lot of what you said as
22 truth, because you're a lot smarter than
23 all of us probably, so I want to make
24 sure that we don't inadvertently make
25 people believe that there's truth to the

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2 term "offender," because we know that
3 certain communities are over-policed. We
4 know that specific behaviors are
5 hyper-criminalized.

6 So could you please just speak
7 to that.

8 DR. DeMATTEO: That's a great
9 point, and I certainly didn't want to
10 convey that. That was probably -- it's
11 an artifact of the term that you see in
12 the literature. It doesn't make it right
13 that I use that term. But you're
14 absolutely correct. I think that there
15 is -- and I didn't mean it to sound this
16 way, but there is a judgment when you use
17 the word "offender." There's some
18 labeling and some things that go along
19 with that term.

20 So I thank you for that
21 comment, and as I do these presentations,
22 I'm going to try to think of a more
23 appropriate word moving forward.

24 MR. COBB: Just to piggyback on
25 that, I kind of sort of use the term

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2 "people."

3 DR. DeMATTEO: That's fair.

4 Okay. Thank you.

5 DEPUTY COMMISSIONER BETHEL:

6 Well, again, Dr. DeMatteo, we want to
7 thank you, but one of the things I want
8 people to understand, that one of the
9 reasons that the doctor is so effective
10 at his work, he's on the ground with the
11 men and women on the ground from day to
12 day, not sitting at 40,000 feet. He is
13 actually working in the field,
14 understanding what's going on in the
15 field to inform his work.

16 So, again, we hope to have you
17 back in another session, but, again,
18 thank you for your time this morning.

19 DR. DeMATTEO: Thank you all
20 for your time. Thank you.

21 DEPUTY COMMISSIONER BETHEL: SO
22 we're going to...

23 THE CLERK: The next witness is
24 Roland Lamb.

25 (Witness approached witness

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2 table.)

3 DEPUTY COMMISSIONER LAMB: Good
4 morning. My name is Roland Lamb. I am
5 the Deputy Commissioner for the
6 Department of Behavioral Health and
7 Intellectual disAbility Services and the
8 outgoing Director for the Office of
9 Addiction Services.

10 DEPUTY COMMISSIONER BETHEL:
11 So, Roland, I don't know if you had
12 testimony. I know it was trying to get
13 you here, so I don't know if you came
14 with -- and good morning.

15 DEPUTY COMMISSIONER LAMB: Good
16 morning.

17 DEPUTY COMMISSIONER BETHEL:
18 I'm not sure if you came with testimony.

19 DEPUTY COMMISSIONER LAMB: No.
20 In fact, I was a little bit caught off
21 guard in terms of I'm supposed to be
22 testifying next week with Councilman Oh's
23 hearings and didn't quite understand
24 whether or not specifically what was
25 being looked for at this hearing outside

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2 of addiction treatment issues in that
3 respect.

4 DEPUTY COMMISSIONER BETHEL: So
5 you're kind of behind curve on that. I
6 guess for the purpose of this, I guess we
7 should probably just move on to the next
8 panel, not to be disrespectful to you,
9 but I think we could probably bring you
10 back for one of the other panels and give
11 you more clarity on what we're doing,
12 unless anyone had specific questions.
13 And you didn't hear the prior session. I
14 know you just came in, so it would be
15 kind of hard to put you on the spot.

16 So I respect your work. I know
17 you do a lot of work -- and, George,
18 maybe did you have something?

19 MR. MOSEE: I don't think it's
20 possible to put Roland Lamb on the spot.
21 But I think that it would be helpful as a
22 follow-up to the presentation that we
23 just received for you to talk about the
24 work of the Office of Addiction Services
25 in conjunction with criminal justice and

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2 juvenile justice just to sort of lay the
3 foundation so we'll have a foundation for
4 our future discussions.

5 DEPUTY COMMISSIONER LAMB:

6 Well, I think that I take a great deal of
7 pride in the amount of collaboration that
8 we've had in the justice system. I'd
9 like to point out that the District
10 Attorney's Office, the Public Defender's
11 Office, Probation and Parole, the
12 Philadelphia Prison System all have been
13 collaborators and partners with us with
14 respect to diversion from incarceration,
15 early release from incarceration to get
16 people into treatment.

17 We operate the Forensic
18 Intensive Recovery program, the FIR
19 program, which literally serves thousands
20 of people each year and saves the City
21 hundreds and thousands of days of prison
22 days, in fact, in relationship to that.
23 We also have a great deal of involvement
24 in having a network of providers at the
25 ready to provide services to folks coming

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2 out of incarceration who have been
3 adjudicated. We also have a panel of
4 recovery houses that are outfitted so
5 that people who have, for instance,
6 bracelets or have tracking devices can be
7 released from incarceration and placed in
8 those kinds of facilities.

9 We are looking at actually
10 expanding the role that we have as far as
11 increasing the number of recovery houses,
12 because actually 70 percent of our
13 housing placements are out of the justice
14 system. So we have an extensive
15 involvement there.

16 We're also looking to enhance
17 our involvement with women who are in the
18 justice system. We see currently that
19 that is the most significant group that's
20 coming out of the justice system in need
21 for reunification and mentoring services
22 to reenter the community.

23 So we have a number of
24 different programs. We have a number of
25 different collaborations, and I'd like to

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2 think that we have our hands in pretty
3 much several courts in the City of
4 Philadelphia, from Treatment Court to
5 Community Court or AMP Court, Dawn Court,
6 Mental Health Court. We're able to
7 provide adjunctive services. We're able
8 to provide staffing. We're also able to
9 provide case management.

10 So I'm very, very positive
11 about that. In fact, I don't think we
12 have enough, if you ask me, because if
13 you look at what we do with the justice
14 system, it's only a microcosm of the
15 number of people that are in the justice
16 system.

17 DEPUTY COMMISSIONER BETHEL:

18 Anyone else have questions?

19 (No response.)

20 DEPUTY COMMISSIONER BETHEL:

21 So, Roland, I would just ask you one
22 question. So when you look at a
23 percentage, where is your gap? Knowing
24 that the individual is in need of
25 treatment and the services you can

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2 provide, how big is that gap? Huge,
3 right?

4 DEPUTY COMMISSIONER LAMB:

5 Well, right now it's pretty big. You
6 consider that Philadelphia is the only
7 city that has its own managed care
8 organization. So that allows us to bring
9 to bear a host of services, in-kind
10 services, all kinds of treatment services
11 across all levels of care. And so when
12 you include that, we're talking about a
13 huge number.

14 But the issue is this: We
15 estimate that there are between 122,000
16 and 155,000 people in Philadelphia that
17 need to be in treatment. God forbid if
18 all those folks showed up at the same
19 time, we would not have the services to
20 accommodate all of them.

21 DEPUTY COMMISSIONER BETHEL:

22 Very good. Well, thank you, Roland.

23 DEPUTY COMMISSIONER LAMB:

24 Thank you. And, again, whatever you guys
25 need for me to come up with, I will

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2 certainly hear from you all and then put
3 together a presentation.

4 DEPUTY COMMISSIONER BETHEL: We
5 all have a lot of respect for the work
6 you do. You know I do personally in my
7 contacts with you and I'm sure Mr. Mosee
8 as well. But we appreciate it.

9 DEPUTY COMMISSIONER LAMB:
10 Thank you all.

11 DEPUTY COMMISSIONER BETHEL:
12 Okay. We'll go to the next panel now.

13 THE CLERK: Panel 2, Noni West
14 and Sterling K. Johnson.

15 (Witnesses approached witness
16 table.)

17 MR. JOHNSON: Hello.

18 DEPUTY COMMISSIONER BETHEL:
19 Mr. Sterling, you'll start.

20 Ms. Noni, how are you?

21 MS. WEST: Sterling is going to
22 start.

23 MR. JOHNSON: We submitted
24 testimony and we're just going to just
25 deliver that, but just be here to answer

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2 questions.

3 DEPUTY COMMISSIONER BETHEL:

4 Can you pull that mic just a little bit
5 forward to you.

6 MR. JOHNSON: Great. So my
7 name is Sterling Johnson and I'm a lawyer
8 from Legal Science. It's a company in
9 the City. We track public laws and
10 specifically related to prescription drug
11 overdose. I'm working with PRO-ACT as a
12 research consultant and also under the
13 Open Society contract. I'm also a
14 recovering -- in recovery, a person in
15 recovery, for alcohol and prescription
16 pills.

17 So today we're going to talk
18 about the LEAD program, the Law
19 Enforcement Assisted Diversion program.
20 Right now LEAD has successfully been
21 launched in several cities around the
22 country, including Seattle; Santa Fe,
23 Mexico; Albany, New York; Canton, Ohio;
24 Huntingdon, West Virginia, and in the
25 final stages in Baltimore, San Francisco,

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2 and Atlanta. PRO-ACT is now the
3 recipient of an Open Society grant to
4 work with the Philadelphia Police, the
5 DA's Office, and the Department of
6 Behavioral Health and Intellectual
7 disAbilities to implement a LEAD model in
8 Police Districts 22 and 39, which is
9 where the Pennsylvania Recovery Community
10 Center resides. Philadelphia is one of
11 seven cities that has received one of
12 these grants.

13 So as I said, we're currently
14 working with the City at the time and
15 planning with them as they are the
16 recipients of the MacArthur Foundation
17 grant to reduce jail population and also
18 address racial disparities in the City,
19 and specifically working with panel
20 member Julie Wertheimer and Rachael
21 Eisenberg at the City, part of the DA, DA
22 Riker and also Captain Healy of the
23 Philadelphia Police Department.

24 So now I'm going to talk about
25 what LEAD is. To start, some of the

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2 principles of LEAD are reorient the
3 government's response to safety disorder
4 and health-related problems; improve
5 public safety and public health through
6 research-based, health-oriented, and
7 harm-reduction interventions; reduce the
8 number of people entering the criminal
9 justice system; undo racial disparities
10 at the front end of the criminal justice
11 system; and sustain funding for these
12 alternative interventions by capturing
13 and reinvesting justice system savings;
14 and then, lastly, strengthen the
15 relationship between the community and
16 all systems, including public health and
17 criminal justice in the City.

18 So I'll tell you what LEAD is.
19 So under LEAD, the police officer
20 exercises their discretion at the point
21 of contact to divert low-level offenders
22 into community-based, harm-reduction
23 interventions. Instead of booking an
24 individual into jail, the officer refers
25 the individual to a trauma-informed

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2 intensive case management system for
3 unmet behavioral needs and other general
4 person-based needs. So those can be drug
5 treatment, peer-supported services in the
6 community, counseling, job training,
7 mental health treatment, and healthcare,
8 physical healthcare. There's no booking,
9 detention, prosecution or conviction or
10 incarceration.

11 As a part of LEAD that has been
12 implemented in other places is this idea
13 of social referral. It's a recognition
14 that the police on the ground know and
15 the narcotics units on the ground have
16 more information about the community than
17 anybody else. So they are able to use
18 their discretion to divert the people
19 that may be successful in a LEAD program.

20 LEAD is more of a process than
21 a program, and it's been proven effective
22 in other places. It represents a
23 paradigm shift that integrates and
24 creates communication for all of these
25 systems, including the police, health,

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2 housing, business, political, and
3 community-based community leaders to
4 reduce the role of the criminal justice
5 system specifically in responding to
6 these low-level drug offenses, sales, and
7 possession.

8 LEAD's harm-reduction framework
9 makes it far less coercive than some
10 other models like a drug court that
11 relies on sanctions and other
12 punishments. These models often result
13 in the individual spending time entangled
14 in the system. LEAD bypasses these
15 entirely by diverting them directly to --
16 diverting them directly when they meet
17 the police.

18 Because of LEAD's
19 harm-reduction principles, which I am
20 repeating on purpose, it's to let us know
21 that abstinence is an option. It's not
22 the primary objective. Drug use is one
23 of many issues for the person that would
24 be contacted by the police at the time.
25 LEAD does not force anybody into

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2 sobriety, but rather helps individuals to
3 stabilize and make better choices.

4 Just quickly, the background on
5 harm reduction is that just three
6 principles are that harm-reduction
7 programs are non-coercive and
8 non-judgmental, and that the drug user or
9 the person who is using drugs at the time
10 is the primary person who has agencies to
11 control their own life.

12 Harm reduction incorporates the
13 spectrum of strategies from safer use to
14 managed use to abstinence and it meets
15 them where they're at at the time. It
16 addresses conditions of use along with
17 the use itself.

18 And harm reduction is a set of
19 practical strategies and ideas aimed at
20 reducing negative consequences associated
21 with the drug use. It's also a movement
22 for social justice and built on a belief
23 and respect for people and the right of
24 people who use drugs.

25 So to move on to how the

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2 determinations are made. Each
3 jurisdiction has made a protocol. It's
4 the key component of the LEAD program.
5 It's meant to address the revolving door
6 of people within the system that where
7 they are -- revolving door addiction and
8 arrest that ratchets up the costs of the
9 criminal justice system and it's the only
10 way for officers to determine who
11 qualifies for the program. So a person
12 who has already been arrested may be
13 diverted in another court or put in jail,
14 but they may just return years later
15 because of the system not serving them.
16 It's failure to address specific issues
17 within each place. So in Seattle, their
18 problem was mostly with open-air markets.
19 So most of their participants were, I
20 guess, mostly black and also homeless at
21 the time.

22 In Santa Fe, their main problem
23 had to do with opiates. They targeted
24 the protocol towards opiate users and
25 also the associated property offenses

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2 that went with that.

3 And so from here, we see that
4 Philadelphia has the opportunity to
5 examine these needs and make
6 data-informed decisions about which
7 protocol is best for the City based on
8 information we have about our specific
9 targeted districts and the City.
10 Philadelphia specifically will be able to
11 target racial disparities in the arrests
12 for possession of drugs like crack
13 cocaine, PCP or heroin or wet, as was
14 mentioned earlier, delivery of recovery
15 services, as well as provide education
16 and job training specifically for young
17 people in these districts.

18 Typical determiners of who
19 would be in the LEAD program would be
20 whether they are disqualified for a
21 certain criminal history; is the offense
22 one of the ones that makes them eligible
23 for LEAD participants; do they have any
24 medical conditions or emergency medical
25 needs; have they given informed consent;

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2 does the person have an existing no
3 contact order or restraining order; and
4 also do they display interest in becoming
5 part of this program and also recognizing
6 that they have an issue that they would
7 like help with.

8 Evaluation indicates that LEAD
9 works. Using a control group of
10 individuals in Seattle who were arrested
11 and prosecuted as usual, the evaluation
12 showed LEAD significantly reduced
13 recidivism. People in LEAD were 58
14 percent less likely than people in the
15 control group to be arrested. We've
16 included portions of these reports in our
17 supplemental materials.

18 There are significant cost
19 benefits to LEAD as well. One of the
20 benefits to LEAD in the point of view
21 from the City is that currently placing
22 somebody in jail is \$40,000 a year for a
23 person to be incarcerated. In Seattle,
24 criminal justice and legal system
25 utilization and associated cost

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2 evaluation, they found that the cost of
3 LEAD averaged \$899 per month, or after
4 their year period, at the end it was \$532
5 per month. Even at that 899 per month,
6 that would lead us to about 11,000 per
7 participant.

8 Post-evaluation analysis as
9 well showed the LEAD group cost the
10 criminal justice system \$4,763 per person
11 compared to a control group, with many
12 variables related to that, cost the
13 criminal justice system \$11,000, and that
14 that was in Seattle.

15 There are more post-evaluations
16 to come in Seattle and Santa Fe and also
17 information that we can learn from Albany
18 and all the other cities currently
19 implementing LEAD.

20 The outcomes to this point
21 indicate Philadelphia should at least
22 consider implementing a pilot to learn
23 from the effects of criminal justice
24 costs, recidivism rates, recovery rates
25 on the community and also, I would say,

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2 just evaluation of community and police,
3 just dealings between each other, which
4 would be a part of any evaluation of this
5 program.

6 Thank you.

7 DEPUTY COMMISSIONER BETHEL:

8 Thank you.

9 MS. WEST: My name is Noni
10 West. And can you hear me fine? Yes.

11 DEPUTY COMMISSIONER BETHEL:

12 Pull that mic a little closer.

13 MS. WEST: I work for the
14 Council of Southeast Pennsylvania and,
15 more specifically, PRO-ACT, Pennsylvania
16 Recovery Organization Achieving Community
17 Together. I am also the coordinator on
18 the Open Society grant, and I am in
19 recovery.

20 The Council, who is the holder
21 of the grant, is a 40-year-old private
22 non-profit organization affiliated with
23 the National Council of Drug Dependence.
24 We serve the five counties in
25 Southeastern Pennsylvania. Our mission

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2 is to provide services and opportunities
3 to reduce the impact of addiction,
4 trauma, and related health issues for the
5 entire community. This is accomplished
6 through prevention, consultation,
7 education, advocacy, assessment, and
8 recovery support services. PRO-ACT is a
9 16-year-old grassroots advocacy and
10 recovery support initiative of the
11 Council.

12 PRO-ACT has six community
13 centers throughout the region where
14 individuals and families receive peer
15 support services to assess and sustain
16 long-term recovery. Two of our centers
17 are in Philadelphia. The Philadelphia
18 Recovery Community Center is North
19 Philadelphia West and serves as a base
20 for connecting people with peer-based
21 recovery support services and is a hub
22 for mobilizing and establishing healthy
23 recovery. Our second location is in
24 Northern Liberties. It's a recovery
25 training center, and the Office of

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2 Addiction Services supports our recovery
3 centers.

4 Last year we performed the
5 beginnings of an environmental scan of
6 the community surrounding the
7 Philadelphia Recovery Center, which is at
8 17th and Lehigh, for the purposes of
9 determining how we could better serve the
10 community. What we determined and found
11 out is that the area was suffering from
12 generational toxic stress that goes back
13 to the '50s when manufacturing left for
14 the suburbs to have one-level
15 manufacturing or two-level manufacturing
16 and have access to trucking for their
17 goods, and the area has never really
18 recovered.

19 The Police District 22 is
20 considered to be the most violent in
21 Philadelphia, and the demographics and
22 hard data for the area is
23 approximately -- for zip code 19132, the
24 population is approximately 36,000
25 people. It is 94 percent African

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2 American. The median household income is
3 \$24,233 for a family of four. Forty-one
4 percent live in poverty. Eighty-three
5 percent of the families dwell in
6 single-family households. And compared
7 to the rest of Philadelphia, there are
8 2.6 times the number of arrests for
9 narcotics possession. There's 2.9 times
10 the shootings and homicides, and the 20
11 percent higher use of the services of the
12 Department of Behavioral Health and
13 Intellectual disAbilities in un and
14 underinsured services, and there is a
15 lower number of supports for community
16 supports, specifically programs like NA
17 and AA.

18 When we became aware Open
19 Society Foundation was issuing an RFP for
20 the LEAD planning grant, we realized it
21 was an opportunity to facilitate a system
22 change that would not only help stem
23 growing criminal justice budgets and
24 overcrowding of jails, but also help the
25 community and its individuals. We worked

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2 with the Philadelphia Police Department,
3 at that time it was DC Bethel; the
4 District Attorney's Office was DA Riker;
5 and the Department of Behavioral Health,
6 who we work with through our community
7 centers and obtain their approval.

8 It took them a long time
9 actually to award the grant. We knew
10 sort of in June that we were one of the
11 seven finalists, but with Open Society,
12 apparently it takes a while. So we were
13 awarded the grant in December. From that
14 point on, basically what we have done is
15 to realign some of our connections
16 because of the change in Administration,
17 and also what we found out through DA
18 Riker is that the City was waiting for
19 the award of the MacArthur Foundation
20 grant. And what we've been wanting to do
21 there is a pre-booking diversion
22 component in the MacArthur Foundation
23 grant and we wanted to wait until that
24 was awarded so that we could start to
25 merge the efforts between our two grants.

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2 So we have been working with the
3 MacArthur Foundation team and with Julie
4 Wertheimer and the other people that
5 we've mentioned.

6 There are a tremendous amount
7 of advantages to trying to implement a
8 program like LEAD in Philadelphia in
9 Districts 22 and 39. One, the City is
10 aware that there is a need for system
11 reform. Also Philadelphia is one
12 jurisdiction. Trying to implement the
13 program in some of the other counties
14 would be fine, but because each
15 municipality has their own chief, we
16 would have to sell and resell and resell
17 the concept, whereas Philadelphia has one
18 Commissioner, they have one District
19 Attorney, and once we do a pilot program
20 with LEAD and it proves successful, it
21 can be expanded throughout the rest of
22 the districts, and that was an issue that
23 was very attractive to Open Society and
24 actually came up in our Skype interview
25 with Open Society Foundations.

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2 And then last, but not least,
3 is the behavioral health system of
4 Philadelphia and its recovery-oriented
5 system of care. The healthcare intensive
6 case management system is integral to the
7 whole process and success of LEAD,
8 because it essentially replaces the
9 criminal justice system. Under the aegis
10 of Commissioner Evans and Deputy
11 Commissioner Roland Lamb, Philadelphia
12 has built a system open to multiple
13 pathways of recovery, recognizing that
14 individuals need to address and develop
15 the recovery in a way that builds upon
16 their strengths and addresses weaknesses,
17 their own weaknesses. The
18 one-size-fits-all remedy does not work
19 for addiction. Our certified recovery
20 specialists help individuals roadmap
21 their recovery and develop a recovery
22 plan as they meet people where they are.
23 We have programs -- Gateway to Work helps
24 people to learn how to find jobs. We
25 give them -- if they don't have computer

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2 skills, we work on that. Is housing an
3 issue, are there family problems. So we
4 help somebody to rebuild their lives sort
5 of working from the point that they are
6 in their life and move it forward.

7 LEAD itself is considered a
8 harm-reduction model, and actually when
9 we were applying for the grant, I didn't
10 realize that it was a harm-reduction
11 model because it's so closely aligned
12 with the recovery-oriented system of care
13 that I sort of felt it fell into that
14 model, but now with working more with
15 Open Society and our trainings, it is
16 officially considered a harm-reduction
17 model. The principles for harm reduction
18 are pragmatism. It recognizes that drug
19 use is a complex and multi-faceted
20 phenomenon, and it encompasses a
21 continuum from abstinence to chronic
22 dependence and produces varying degrees
23 of personal and social harm and behavior.
24 It focuses on harm to decrease the
25 negative consequence of drug use to the

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2 users and others rather than eliminate
3 drug use itself.

4 And I'm going to stop at this
5 point to say that that is something that
6 the LEAD group, when they work with us
7 and work with other people, emphasize
8 over and over and over again. But
9 working -- having worked with the
10 Department of Behavioral Health and in
11 our centers, it really isn't something
12 that for us we really have to focus on
13 and to understand, because the
14 recovery-oriented system of care
15 recognizes that you meet people where
16 they are. So there isn't going to be a
17 huge transition in thinking to go for
18 Philadelphia to move into the model that
19 is called LEAD.

20 Harm reduction also focuses on
21 human rights and their dignity and
22 focuses on the active participation of
23 people who use drugs, is at the heart of
24 harm reduction.

25 So very quickly, the core

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2 values of the Philadelphia
3 recovery-oriented system of care are
4 strength-based approaches that promise
5 hope, community inclusion, person and
6 family directed, family inclusion and
7 leadership, peer culture and support and
8 leadership, people-first approaches,
9 trauma-informed, holistic approaches,
10 care for needs and safety of children and
11 adolescents, and partnership and
12 transparency.

13 So in short, after all this,
14 basically what I'm saying is that the
15 City's healthcare system is equipped to
16 deal with the LEAD model. As Marvin
17 Levine said in our meeting with Open
18 Society, all we have to do is get them to
19 the door and the system is ready, and
20 that is very different from some of the
21 other grant holders and probably was
22 different, very much so different, for
23 Seattle. They had to go to Medicaid and
24 do special waivers in order for the
25 program to work.

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2 We're also fortunate to be
3 working in Pennsylvania where at the
4 state level combatting substance use
5 disorders has been made a key priority.
6 The 5/17 budget includes funding for 50
7 health homes to treat individuals with
8 substance use and co-occurring disorders.
9 The budget also includes funding to
10 expand treatment options and
11 community-based services for those with
12 SUDs, it's called, substance use
13 disorders, mental health conditions,
14 homelessness, and veterans-related issues
15 instead of incarceration, by creating new
16 problem-solving courts and expanding
17 intermediate punishment options, and
18 actually Philadelphia is ahead of the
19 curve compared to the rest of the state.

20 The state is also advancing
21 dialogue around opportunities using
22 Medicaid dollars for supportive housing
23 services, which may create additional
24 opportunities for peer supports and
25 strengthening recovery models. And

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2 Pennsylvania has fully expanded Medicaid
3 in 2015, which is going to help support a
4 program and model such as LEAD.

5 I would also say that with the
6 ACA and Medicaid expansion, there is
7 funding to also support health homes that
8 just give services to people who are
9 addicted to opioids.

10 Some of our grant partners face
11 difficult environments in which to forge
12 the trail for LEAD. North Carolina and
13 Maine are not really comfortable
14 environments and are much more
15 conservative, and their Governors have
16 been high profile in the press in the
17 last two years. Those are not issues
18 that we have to deal with, and we're
19 actually going to be finding out what our
20 other grant partners are dealing with in
21 Santa Fe next week because there will be
22 a convening of all of us. And the City,
23 the Department of Police, is sending a
24 representative, Stacy Harris from
25 District 22, and the District Attorney's

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2 Office is sending ADA Jeffrey Fair to
3 come join us, which is going to be
4 fabulous, because we will be learning
5 together and be able to come back and
6 share a lot of that information.

7 Also what I would like to say
8 is with the grant, we are going to be
9 pulling -- now that the MacArthur grant
10 is here, we will be moving forward a lot
11 more quickly than we have in the past
12 couple months, and we will actually be
13 having a team from Seattle come and
14 present to us, to our key stakeholders
15 and extended stakeholders, as we're
16 calling them, so that we can ask
17 questions and probe the whole model. And
18 I would say we will probably be doing
19 that in the next month or so, and I
20 extend that invitation to anybody from
21 the Committee who would like to come and
22 join us, and we'll let you know when they
23 are coming.

24 The Open Society grant
25 management team has met with our key

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2 stakeholders, which included Captain
3 Francis Healy and Derek Riker and Marvin
4 Levine, who is the Deputy Director of the
5 Office of Addiction Services. And I have
6 to say that they were very, very
7 impressed, especially with our diversion
8 court and especially with the police in
9 their approach to -- the trauma-informed
10 approach to the Police Department. And
11 actually we never got to ask them any
12 questions. They were really more
13 interested in interviewing Captain Healy
14 and ADA Riker than they were -- we
15 couldn't really ask them any questions
16 that I was hoping we would get out of it.

17 Our plan for the provision of
18 services for the LEAD program is for the
19 Philadelphia Recovery Community Center to
20 be the first point of contact. That
21 makes a lot of sense as we're looking at
22 a pilot program. We'll probably try to
23 monitor the number of people who come
24 through the system to test it, the
25 effectiveness of it and its capabilities.

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2 And the Recovery Community Center is
3 there at 17th and Lehigh, which just
4 borders 39th and the 22nd District.

5 Trauma-informed case managers
6 will be housed there. PRO-ACT is already
7 staffed with certified recovery
8 specialists who are trauma-informed and
9 is currently staffing for mobile
10 certified recovery specialists, which
11 would be an important component of the
12 LEAD model. Every individual will go
13 through an assessment and then be
14 diverted to resources and the appropriate
15 level of care.

16 The prosecutors and Police
17 Department will work closely together
18 with the case managers to ensure that the
19 LEAD contact is moving forward, and the
20 teams will meet on a regular basis.

21 We have developed a group of
22 extended stakeholders for their input and
23 also to assist with community education.
24 In particular, Seattle had difficulty
25 with the business community at first, and

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2 it's probably because they wanted the
3 people gone and off the street. Eighty
4 percent of the people in their program
5 are homeless. We have the opportunity to
6 change the protocols that were in Seattle
7 and Santa Fe, and I think also
8 particularly with our recovery-oriented
9 system of care, we'll be looking for a
10 broader group of people than just the
11 homeless and open-air markets.

12 Our extended stakeholders
13 include mental health advocacy,
14 healthcare advocacy, harm-reduction
15 expertise, 22nd and 39th District
16 outreach, multi-faith advocacy, judicial
17 system expertise, local legislators, and
18 the business community. The Pennsylvania
19 Health Access Network is part of our
20 extended stakeholders. Town Watch is
21 part of our stakeholders, the 22nd Street
22 Business Association, and of course what
23 we will be doing is including the
24 stakeholders who are part of the
25 MacArthur Foundation grant. So as

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2 mentioned, we are working with the
3 MacArthur group.

4 There's one thing that I would
5 like to do. I got this last night. Kris
6 Nyrop is our contact with Seattle and is
7 very -- actually, he is one of the people
8 who conceived of the idea, sold it into
9 the police, and sold it into funders
10 separately and then got them in a room
11 and told each group who agreed that they
12 would do it and never believed it would
13 happen and got them in a room, and that's
14 how things moved forward. He is
15 extremely knowledgeable in the program.
16 And so I asked him about success, how
17 many people did go through the program,
18 how many people didn't go through the
19 program. So we could present a sense of
20 how the program performed. So I'm just
21 going to read from his e-mail.

22 So at this point, less than one
23 percent of individuals offered LEAD by
24 officers have said no. Of those, 89
25 percent completed their intake within the

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2 specified time of 30 days. That means
3 they are officially in LEAD and have
4 fulfilled all requirements for not having
5 the referring charge filed by the
6 prosecutor. Anything they choose to do
7 after that is entirely up to them. They
8 can choose to receive the wide array of
9 services available or can simply walk
10 away. There were very, very few
11 one-and-done's, but they should not be
12 regarded as failures. From an evaluation
13 point of view if they walk away and are
14 not arrested, that helps our recidivism
15 rates and helps in terms of cost
16 evaluation.

17 I think the primary question we
18 get is around the harm reduction, no
19 failure, graduation aspect of LEAD.
20 Again, the Seattle program was
21 specifically designed to address folks
22 who are chronically dependent and who are
23 cycling in and out of the criminal
24 justice system. These are the folks that
25 are costing the system the most money and

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2 for whom jail and other sanctions clearly
3 don't work. If someone has 56 prior drug
4 arrests, which was actually their very
5 first participant, the odds of the 57th
6 arrest is going to make them stop usually
7 are vanishing small, and these are folks
8 who either will not accept drug court or
9 who will fail at it. The whole point of
10 LEAD is to break the revolving door, and
11 the way to that in our experience and our
12 evaluations show is through long-term,
13 intensive, non-sanctioned-based case
14 management that relies on evidence-based
15 theories on how people actually change
16 their behavior, the stages of change, and
17 practices such as motivational
18 interviewing.

19 So with that, I would like to
20 say thank you to everybody actually in
21 Philadelphia who has laid the groundwork
22 that would make it possible for us to
23 even consider a model like LEAD, and I
24 would like to thank the Committee for
25 letting us testify. And I hope that the

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2 implementation of a LEAD pilot program
3 will lead to the system, the individuals,
4 and the community all rising.

5 DEPUTY COMMISSIONER BETHEL:

6 Any questions?

7 MR. COSLEY: Yes.

8 Jason Cosley.

9 Couple of questions. Number
10 one, just congratulations on your support
11 form from the Open Society.

12 MS. WEST: Thank you.

13 MR. COSLEY: I do understand
14 that this is a planning grant. Is there
15 any flexibility to extend the boundaries
16 of -- right now your primary boundaries
17 are 19132 and 39. Why were those
18 boundaries specifically chosen?

19 MS. WEST: Well, because
20 District 22 is a very difficult district
21 and basically the Recovery Center is
22 there. So we saw that as being the hub
23 of the diversion into the social services
24 system and District 39. And actually in
25 talking with the North Carolina group and

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2 the group in Maine, the areas that they
3 are covering, the demographics are pretty
4 much the same as the demographics that
5 we're talking about covering.

6 We can -- I am sure they're
7 open to expanding that. The District 25
8 is in the MacArthur grant. So we are
9 actually sort of going to morph into that
10 area with our plans as well as we start
11 working and planning with the MacArthur
12 group.

13 MR. COSLEY: I would suggest
14 also including the 24th District. When
15 you look at the high-crime, high-poverty
16 areas in the City, that 24th and 25th
17 District rank among the highest, and
18 that's also including American Community
19 Survey data. And my other question --

20 MS. WERTHEIMER: Can I jump in?
21 Can I respond to that? So I think the
22 one thing that's important and we want to
23 set ourselves up for success both as the
24 City and with working with PRO-ACT is, we
25 don't want to bite off more than we can

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2 chew. This is specifically outlined to
3 be a pilot program, so starting with two
4 districts and then rolling out.

5 I think if we had to make a
6 priority list, the 24th and 25th would
7 absolutely be high up there, but we don't
8 want to take on more geography than we
9 can at once. So I think it's important
10 to understand the rollout and the plan of
11 ramping up in this process.

12 MR. COSLEY: Understood.

13 Is there any planned outcomes
14 or is there a number that you had in mind
15 as to what LEAD could -- the services
16 that they could reach within that target
17 area in terms of clients/participants?

18 MS. WEST: I think that we said
19 we would serve 100 to 150 people in the
20 first year.

21 MR. COSLEY: Okay.

22 MS. WEST: But we have to work
23 our plans out. I think the potential
24 numbers are much larger, but the goal, as
25 Julie said, is for us to make the program

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2 successful and to ease everything in and
3 go step by step so that it will work in
4 the long run.

5 MR. COSLEY: Thank you.

6 MS. SCHWARTZMAN: So it sounds
7 to me like this is really a one-stop shop
8 where people could come in, but the focus
9 is on the drug addiction piece of it.

10 MS. WEST: And mental health.

11 MS. SCHWARTZMAN: And mental
12 health.

13 MS. WEST: I mean, it starts in
14 the protocol, is basically around drug
15 possession and quantity, but I realized,
16 especially with the presentation, that
17 mental health is a core part of this as
18 well.

19 MS. SCHWARTZMAN: So in a way,
20 this is really the paradigm shift that
21 our previous testifier was talking about
22 as far as really focusing on the needs
23 that people have as opposed to just
24 looking at a criminal justice solution.

25 MS. WEST: Yes. I was

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2 delighted. We didn't know that that was
3 going to preface our testimony.

4 MS. SCHWARTZMAN: I think this
5 looks promising and particularly with the
6 involvement of family as well as the
7 community and all the holistic aspects.
8 So it will be interesting to see how this
9 goes.

10 DEPUTY COMMISSIONER BETHEL:
11 So, Noni, you know I was involved with
12 your grant but, more importantly, I went
13 to Seattle. I looked at the LEAD
14 program. You know my early concerns was
15 the sheer cost. They were doing a lot,
16 housing and food vouchers, and whether
17 the system could sustain something like
18 that.

19 When you hear Dr. DeMatteo's
20 statement about the length of time that
21 it requires that kind of care, are you
22 positioned to be able to work with
23 somebody for a full year in their
24 recovery based on the model that's going
25 to be presented under the LEAD?

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2 MS. WEST: Absolutely.

3 DEPUTY COMMISSIONER BETHEL:

4 Okay.

5 MS. WEST: The cost that
6 Sterling just quoted, they said that
7 their costs went down over time. And so
8 for -- in Seattle, it was \$11,000 per
9 year. Now, I think that's for the first
10 year.

11 MR. JOHNSON: Yes.

12 MS. WEST: So when we're
13 looking at that as opposed to putting the
14 individual into the criminal justice
15 system or into jail, there are savings
16 there, but that's something that we have
17 to look at in the planning stage very
18 carefully.

19 DEPUTY COMMISSIONER BETHEL:

20 And this is not a statement to you, but I
21 challenge anyone when -- I always hear
22 this cost issue, and I say to them,
23 unless you're going to shut the prison
24 down, some people take -- we have 10,000
25 prisoners and we divide it into how much

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2 the building costs and how much the care
3 is and that's how much it costs. Well,
4 that's not reality. I think oftentimes
5 we have to get economists involved to
6 really do a thorough assessment. I know
7 Vera does a lot of work around that, but
8 really caution myself and others now,
9 they just take this number and divide it
10 into an arbitrary number -- and I'm not
11 saying you're doing that -- where we
12 say -- and people are looking at you, Oh,
13 you got this \$30,000 savings. Oftentimes
14 that's not reality. If the building is
15 still opened, the lights have to be
16 turned on, it still has to be housed.
17 There's a cost with the building. Now,
18 shut down and, yes, we can recognize
19 that's an immediate savings, but as Julie
20 talked about earlier, when we're trying
21 to make these indications of where the
22 savings are, we really have to be very
23 thoughtful about where we are going to
24 save money, and I'm curious to see how
25 that works out as we move through this

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2 process, particularly when you hear
3 Roland talk about how many people need
4 servicing. You know, 150 people is a
5 drop in the bucket when we look at the
6 24th and 25th and even the 22nd District.
7 So we have a lot of work to do, but I
8 appreciate your work.

9 MR. JOHNSON: I do just want to
10 just piggyback on this. The idea -- I
11 know -- I was worried kind of about the
12 cost issue, and I think an essential part
13 of LEAD would be the idea of peer
14 support. So whoever goes through it
15 becomes part of the program and then
16 communicates that. We're creating a
17 culture of recovery, whether it's in
18 mental health or drug use. So the costs
19 are always up front, and I don't know
20 what they are, but it's about this
21 culture change that can happen. I'm just
22 always so impressed at what's already
23 happened, and this is the way to push it
24 even further.

25 DEPUTY COMMISSIONER BETHEL: I

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2 agree. The culture is the issue, and
3 it's ironic because when I was in
4 Seattle, I was frustrated with all of the
5 care that was going, but when I hear Dr.
6 DeMatteo's conversation, now I realize
7 why it's such a long-term process. I
8 couldn't imagine they still had people
9 two years later, and I said this is
10 crazy. But now I understand it now with
11 his presentation that it takes that long
12 to get people through.

13 Any more questions from the
14 panel?

15 MR. MOSEE: Yes.

16 So there's a big difference
17 between somebody who voluntarily enters
18 treatment and somebody who is compelled
19 to go into treatment. And so if this
20 intervention is initiated by the police
21 as a result of criminal conduct, how do
22 you keep people in treatment when they
23 really didn't want to be in treatment in
24 the first place? What special provisions
25 do you have, whether it's special case

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2 management? How do you deal with that
3 part of the equation?

4 MS. WEST: Well, the approach
5 of LEAD is that people choose the
6 process. Now, as I read in Kris's
7 e-mail, less than one percent decline and
8 then 89 percent follow through. My
9 suspicion is that the 11 percent who
10 didn't follow through are some of the
11 hard-core cases. We're also talking
12 about low-level drug arrests. So I think
13 that it is a matter of how the case
14 managers approach them, and the whole
15 issue of approaching people and treating
16 them where they are at is more successful
17 than forcing people into recovery. So
18 there is not or, as the harm system would
19 say, they don't have to -- they don't
20 need to abstain. They just need to
21 maintain or to behave properly.

22 So it's a matter of approach.
23 And also we use certified peer
24 specialists. So there are people who
25 have lived experienced with addiction,

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2 and a lot of people who are in addiction
3 or have mental health problems respond
4 much more positively to somebody who has
5 experienced what they have experienced.
6 It's a higher success rate.

7 DEPUTY COMMISSIONER BETHEL: So
8 before we break, I think we need to
9 recognize the Philadelphia Police
10 Department and Commissioner Ross and his
11 executive team for going down this path.
12 As you indicated, the culture change. So
13 though I'm not in the Police Department
14 anymore, I definitely have to give
15 acknowledgment to them for really
16 considering this as an opportunity to
17 change the culture and look at this in a
18 different way. So I'm sure they're
19 looking forward to working with you.
20 We're excited about how that direction is
21 going and see what was started out as a
22 lot of work last year to come to
23 fruition. So thank you for your work.

24 MS. WEST: Thank you.

25 MR. JOHNSON: Thank you.

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2 DEPUTY COMMISSIONER BETHEL:

3 The Clerk will now call the third panel.

4 THE CLERK: Panel 3, Derek
5 Riker, Byron Cotter, and Chris McFillin.

6 (Witnesses approached witness
7 table.)

8 DEPUTY COMMISSIONER BETHEL:

9 This team here. I'm getting scared over
10 here. I'm just a little nervous.

11 So I guess we'll start with
12 you. Doesn't matter. Can you start.

13 MR. COTTER: Good morning and
14 good afternoon. It's a pleasure to be
15 here and it's certainly a pleasure to be
16 on a panel with my two colleagues, my two
17 other colleagues that I work on an
18 everyday basis with.

19 The Defender Association is in
20 a unique position to take a holistic
21 approach with our clients. We are
22 reconfiguring our social services
23 department to better identify needs and
24 address the reasons individuals come into
25 contact with the criminal justice system.

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2 We plan to engage the community in each
3 of our zones to improve the chances of
4 its success and reduce barriers to
5 reentry. Our goal is not only to provide
6 our clients with the best legal
7 representation, but also to address their
8 needs and prevent them from recidivating.
9 We work on an individual basis with our
10 clients to discuss the problems and needs
11 from our first interview and up until the
12 final disposition, and then my department
13 continually works with the client once
14 they're paroled if they have any
15 problems. The information we gain from
16 our clients is then used to help the
17 courts understand our clients' needs and
18 to help fashion a sentence that will
19 address our clients' needs.

20 After establishing our clients'
21 need, we work to effectively place them
22 in many existing alternative pretrial
23 programs. Our goal is to place the
24 client in the program that will provide
25 the services that they need while helping

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2 to prevent recidivism. And really
3 there's many programs, post-trial and
4 pretrial. We have the unique position
5 where we discuss the client's problems.
6 They trust us. And then we try to place
7 the clients in the programs that will
8 best benefit them.

9 For example, as of April 30th
10 of this year, in a pretrial sentencing
11 alternative for programs, we had placed
12 1,287 clients under the FIR umbrella of
13 services, and this includes the AMP
14 program, which I know Derek is going to
15 speak about, Treatment Court and other
16 pretrial programs.

17 In the future, we hope to have
18 the ability to create individualized
19 pretrial program tailored to our clients'
20 needs, and these programs are not
21 existing now for certain portions of our
22 clients.

23 We're continuing to assist
24 working with other criminal justice
25 partners to explore and come up with new

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2 and innovative diversion programs. If a
3 client is sentenced to a period of
4 incarceration, we then review every
5 sentence. For example, yesterday I was
6 up at the Philadelphia County Prison in
7 the women's prison. I worked with 60
8 women in the Options Program, which is a
9 drug treatment program in the prison.
10 It's my goal to do a continuation of
11 services. Once they're paroled out of
12 the Options Program, I'll come up with a
13 parole program that will continue the
14 services they're receiving in prison.

15 We worked with the FIR program
16 in order to make this happen. We parole
17 them to almost 80 different FIR programs
18 that are available to us to individualize
19 the programs that we're patrolling them,
20 and they meet almost all of our clients'
21 needs. However, there's some needs and
22 clients that do not fit into the FIR
23 umbrella, certain charges, certain
24 disabilities. So in that instance, then
25 I have to go back to our social services

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2 department and say we need to come up
3 with a specific individualized program
4 for this client. We do that, and we're
5 often very successful. We hope to place
6 our client, from the beginning, in a
7 program that fits their needs. In this
8 way, we hope that they do not recidivate
9 because their needs were not met. It's a
10 very difficult balance to work with a
11 client to come up with a plan that meets
12 their individualized needs.

13 Each of those women that I
14 talked to yesterday had different needs,
15 housing, mental health, drug treatment,
16 trauma in their past. We have to look
17 and work with all those needs and then
18 try to fit them into the right program.
19 If we do that from the beginning,
20 hopefully there won't be this recidivism
21 problem that increases the population of
22 our prisons. And I think we've been
23 successful, and I think that's why our
24 prison population in the last few years
25 has been going down.

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2 To end, we are in a unique
3 position to provide a holistic service to
4 our clients, and I don't think any other
5 of the criminal justice partners has the
6 individual and personalized working
7 relationship with the client to help
8 place them into the correct program.

9 We've created many post-trial
10 programs, which I've given to City
11 Council in the past. I'm going to just
12 talk about one of them, if you'd like to
13 hear about one. For the University of
14 Pennsylvania, we call it the Goldring
15 program. A donator that went to the
16 University of Pennsylvania has provided
17 funding where their graduate social
18 workers work with our clients behind the
19 walls for three months, and then once
20 they're paroled, they provide them with
21 services to keep them from recidivating.
22 When they're behind the walls, they work
23 with them to go over all the needs that
24 our clients need. We meet monthly with
25 the Probation Department, the DA's Office

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2 in order to go over each client and to
3 make sure the client is on the right
4 track. We just graduated 100 clients.
5 We had a beautiful graduation ceremony,
6 which all the clients, all the parties
7 were present at. And you can see how the
8 coordination of the criminal justice
9 partners with these unique programs that
10 we have developed is really helping the
11 client and keeping them from coming back
12 into the system.

13 Questions, or next.

14 DEPUTY COMMISSIONER BETHEL:

15 We'll hear from the other two.

16 MR. McFILLIN: On behalf of the
17 Philadelphia Adult Probation and Parole
18 Department, my chief, Charles Hoyt, and
19 my Deputy, Darlene Miller, I'd like to
20 thank you for having me here today. My
21 name is Chris McFillin. I'm the Director
22 of Specialized Supervision in
23 Philadelphia Adult Probation and Parole
24 Department. We supervise 45,000
25 individuals. That's 45,000 individuals

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2 with 63,000 cases. We have the task of
3 supervising one of the largest probation
4 and parole populations in the county and
5 assigned to a dedicated staff of
6 approximately 246 case-carrying probation
7 officers. We have over 80 administrative
8 staff assigned to the Department.

9 The mission of the Probation
10 Department is to protect the community by
11 intervening in the lives of the
12 individuals. We hold them accountable by
13 enforcing the orders of the court through
14 a balance of enforcement and treatment
15 strategies. We afford the individuals
16 the opportunity to become productive,
17 law-abiding citizens. We provide all
18 possible assistance to the victims of the
19 individuals we supervise.

20 The supervision population is
21 representative of a wide spectrum of risk
22 and needs, requiring our officers to
23 identify and develop a unique supervision
24 approach that is fair, firm, and
25 consistent. The theme of 2016 for the

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2 Department is a full implementation of
3 the Risk-Needs-Responsivity Principle,
4 the R-N-R. This is an evidence-based
5 strategy that takes a holistic approach
6 to each individual of the supervision
7 population by assessing the risk level
8 through the use of our world-renowned
9 risk tool. It was created by the
10 University of Pennsylvania and it's
11 offered through the use of a SMART Grant
12 Needs Tool and matching the appropriate
13 services to the individual in an effort
14 to provide them the best opportunity for
15 success.

16 While I serve as Director of
17 the Specialized Supervision Division,
18 there are other divisions in the
19 Department that I would be remiss not to
20 acknowledge at this time. We have an
21 Anti-Violence Division that specifically
22 supervises those individuals of our
23 supervision population that represent the
24 greatest level of risk to reoffend. This
25 division's approach to supervision is

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2 intense through a combination of weekly
3 contacts and community interaction.

4 Individuals of this division also have an
5 opportunity to participate in our
6 cognitive behavioral therapy, CBT. This
7 program was developed several years ago
8 and continues to evolve today, having
9 positive life-changing impact on its
10 participants. We are also in the process
11 of expanding the reach of this program so
12 more individuals can take advantage of
13 its rewarding experience.

14 The remaining divisions of the
15 Department are General Supervision and
16 Administrative Supervision.

17 The General Supervision
18 Division supervises the largest portion
19 of the population, approximately 12,000
20 supervision individuals. The supervisors
21 and officers of this division supervise
22 the most diverse of all populations in
23 the Department. Through the application
24 of such techniques as motivational
25 interviewing and R-N-R, each officer is

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2 working diligently to reduce recidivism
3 and provide the best possible service
4 outlets. The Department is constantly
5 seeking to evaluate and adopt new
6 approaches to addressing this population.

7 The Administrative Supervision
8 Division is the most technology advanced
9 of all our departments, adopting new
10 means of supervision through the
11 advancement of interactive reporting
12 services involving computers, tablets,
13 GPS, and mobile devices. The use of such
14 technologies has improved resource
15 allocation and overall efficiency for the
16 Department. This allows the Department
17 to address other areas of need through a
18 strategic shift in staff while
19 maintaining the highest degree of
20 required supervision and offender
21 interaction.

22 Now I'd like to talk to you
23 about the division that I oversee,
24 Specialized Supervision. It's 8,500
25 individuals in the division, and inside

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2 this division we have units such as the
3 House Arrest; Forensic Intensive
4 Recovery, FIR; Intermediate Punishment,
5 which is IP; Domestic Violence; Mental
6 Health; Sex Offender; Specialty Courts,
7 and a collection of various new court
8 initiatives that the doctor had touched
9 on that the Probation Department, the
10 First Judicial District are already
11 doing. Veterans Court, Mental Health
12 Court, DUI Treatment Court, and Dawn
13 Court, which is for prostitution charges.

14 So I'll talk specifically about
15 two units that deal with intervention
16 with the drugs, FIR Unit and our IP Unit.

17 As Roland Lamb said, that we're
18 involved with his agency and we supervise
19 700 people for the FIR Unit, with 1,300
20 dockets. In this unit, all individuals
21 undergo an assessment conducted by FIR,
22 PHMC, which is the Public Health
23 Management Corporation. Using the
24 individual's self-reported information, a
25 report recommendation is developed with a

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2 referral to inpatient treatment or
3 outpatient treatment. Once sentenced,
4 the individual must comply with the
5 treatment recommendation as a condition
6 of probation supervision.

7 In a lot of cases, the
8 individual is in custody and will be
9 streamlined to the recovery house with
10 Sheriff to transport so there's no gap in
11 the supervision process. He goes from
12 prison to the treatment center. If it's
13 an outpatient situation, the Sheriff will
14 actually take him to the outpatient
15 place.

16 In April of this year, we
17 administered 390 urinalyses. Unlike the
18 other units in the Department, the FIR
19 program accelerates the process of
20 assessing the level of care and
21 identifying the funding source, which
22 significantly reduces delays and
23 responding to the needs of the supervised
24 individual.

25 Similarly, the IP program

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2 addresses the addiction needs of its
3 supervised individuals but with respect
4 to a particular population. These
5 individuals were arrested for charges
6 that had a mandatory minimum added to
7 them, and for them to go into the IP
8 program, we would release them from
9 prison in the same way with FIR where
10 they're having evaluations and case
11 management services, and they're
12 streamlined to the recovery house also,
13 but there, at that point, will be home
14 detention at the recovery places. Roland
15 was saying we could have three or four
16 offenders in one program where they are
17 monitored by house arrest.

18 Some of the new innovations
19 that we have going on with the Probation
20 Department in regards to treatment is a
21 program called PREATS. It was generated
22 by Judge Ramij Djerassi, and what it
23 stands for is Prisoner Reentry Enhanced
24 Accountability. It's a pilot program
25 that we're doing now where the individual

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2 will give us their thumbprint at
3 Probation, and then when they get to the
4 treatment program, they'll thumbprint
5 too, and that live time we'll know that
6 that offender is at treatment when he's
7 supposed to be. So along with the Drug
8 Court treatment model, there's graduated
9 sanctions, but we're looking for early
10 intervention immediately. So if the
11 person does not show, we're immediately
12 calling them and getting them either back
13 into the office or back with treatment.
14 And it's a whole process that we've
15 worked out, about five or six graduated
16 sanctions if the person is not complying.

17 Just recently, we had a guy
18 that missed and we were able to call him,
19 get him back in the office. We put him
20 on weekly reporting, took urines. The
21 urines were clean. He's going to
22 treatment. Now we'll go back to every
23 other week with his reporting. So we're
24 really excited about this program.

25 I was going to talk about AMP a

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2 little bit, but I think Derek is going to
3 touch on that, so I'm just going to pass
4 on that.

5 It's just a tough situation we
6 have with the Probation Department, the
7 amount of people that we're supervising
8 with the addicted offender. The addicted
9 offender is the hardest person to
10 supervise. Their compliance rate in the
11 beginning might be good and then it tails
12 off, and it puts us in a position where
13 we have to act. But, generally speaking,
14 as Byron said and Derek, I see these guys
15 all the time with all the programs that
16 we have out there. We have at least 20
17 reentry programs that we're involved
18 with, and everyone has the same concerns
19 of early intervention and trying to make
20 a difference.

21 Thank you.

22 MR. RIKER: Thank you for
23 having me, Mr. Chairman. On behalf of
24 the District Attorney's Office, I'd like
25 to thank you for holding these hearings

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2 today. I'm going to speak about the
3 largest diversion program that we have in
4 the City. It's the Accelerated
5 Misdemeanor Program. Rather than going
6 over my written testimony, which has been
7 submitted for the record, I'm going to
8 begin, try to give you a little bit of a
9 breakdown and understanding about how the
10 Accelerated Misdemeanor Program, or AMP
11 as it's more commonly known, is operated.

12 But to begin any discussion
13 about alternatives to incarceration for
14 substance abuse, especially in
15 Philadelphia, it begins with
16 Philadelphia's Treatment Court, which
17 began almost 20 years ago under the
18 leadership of then-Municipal Court Judge
19 President Louis Presenza, with some help
20 from esteemed colleague Mr. Mosee on the
21 panel. That program has been replicated
22 many times, not only in the state but
23 around the country. It's led to some
24 tremendous success for thousands of
25 individuals.

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2 The court does an amazing job
3 of helping people address their substance
4 abuse issues while allowing them to avoid
5 both jail and a conviction.

6 Unfortunately, it's an intensive,
7 resource-heavy process that limits
8 participants to only about 450 at any
9 given time. In a city with nearly 40,000
10 arrests each year, there needs to be
11 alternatives, and the AMP program is one
12 of those alternatives. It's a quasi
13 community court structure program.

14 Originally it was envisioned as a way to
15 dispose of low-level misdemeanor cases
16 through community service. However, in
17 2011, it expanded into a two-tier system,
18 which is ever so creatively named AMP 1
19 and AMP 2. AMP 1 follows the concept of
20 restorative justice. It remains a way
21 that first-time arrestees can avoid a
22 conviction by completing community
23 service in the neighborhoods where they
24 committed their crime. AMP 2, however,
25 is the real innovation. It's a unique

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2 program that focuses on repeat offenders.
3 Most often they are addicts who are
4 brought into the system every year, year
5 and a half or so, typically because of a
6 drug-related arrest like possession,
7 prostitution, retail theft. It would not
8 be unusual to have an individual in the
9 program who has dozens of prior arrests
10 and convictions.

11 What we're looking for is not
12 the quantity of arrest. It's the types
13 of arrest. We are looking to avoid
14 violent offenders coming into the
15 program.

16 Each case is reviewed at the
17 time of preliminary arraignment by our
18 Charging Unit. When a potential
19 participant is identified, we agree at
20 the time of the bail hearing to release
21 them ROR, released on their own
22 recognizance, so they don't spend any
23 time in custody before they appear in
24 court.

25 Another great innovation of the

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2 program is that in the most traditional
3 trial sense, after you're arrested and
4 bail is set, it will be about three weeks
5 before you go to formal arraignment and
6 then maybe another three or four weeks
7 after that before your trial is listed.

8 In AMP, these cases are heard within days
9 of the arrest. So there's a really quick
10 interaction with the defendant to try to
11 get them service as soon as possible in
12 case they're in an active crisis.

13 The process is fairly
14 straightforward. When a defendant comes
15 into court for their first listing,
16 they're given the opportunity to
17 participate in the program. They're told
18 about the program, or they can ask for a
19 trial. If they're interested in
20 participating in the program, that day in
21 the courtroom there are case evaluators
22 from the Public Health Management
23 Corporation, PHMC, who do a mini
24 evaluation with them in the courtroom.
25 They determine a plan of action. It

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2 might be anything from going to a more
3 formal evaluation to simply reengaging
4 with the treatment provider that they've
5 already been working with. For somebody
6 who is in crisis, setting them up with a
7 detox right that day. They work with
8 them to make appointments. They give
9 them paperwork instructions of how to go
10 about doing these steps. If there's any
11 sort of funding or insurance issues, they
12 walk them through the process. They'll
13 help them with the nuances of public
14 assistance.

15 When the defendant leaves court
16 after that first listing, they will have
17 all of this information at their hands.
18 They will have these appointments made
19 for them, and they will be instructed by
20 the judge to come back in about a month.
21 If they come back in about a month's time
22 and they've done what we've asked them to
23 do, if they're engaging in treatment, if
24 they're starting to get that test clean,
25 at least test them at lower levels in

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2 their urines, we will enter a plea at
3 that point. It could be a no contest
4 plea, which will help them potentially
5 preserve their record, or it might be
6 proceeding by way of a stipulated trial.
7 They will be found guilty, but it's based
8 upon their prior contacts with the
9 system, and there's benefits for them in
10 the program that they are willing to do
11 that.

12 They then, once again, meet
13 with the PHMC professionals in the
14 courtroom, review the plan. We tell them
15 to come back another month later. If
16 they come back a month later still going
17 through their appointments, still testing
18 clean, their case is closed. There's no
19 probation. There's no jail. That's a
20 tremendous benefit to this program
21 especially for the participants.

22 Since the fall of 2011, over
23 20,000 cases have been referred into the
24 AMP program, 12,000 alone into AMP 2.
25 Just to give you a sense of the volume

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2 that we're dealing with, in 19 years that
3 Philadelphia Treatment Court has been
4 around, there has been a little over
5 3,000 graduates. Just last year in AMP 2
6 we disposed of 1,500 cases. So the
7 volume that we're working with is high,
8 and all this work is amazingly done with
9 the scarcest of resources. It's not
10 unusual for an AMP list to consist of
11 120, 130 cases a day. We typically are
12 able to do it with two public defenders,
13 a DA, and a paralegal and regular court
14 staff. The only special funding that
15 really is allocated to the program comes
16 from the Office of Addiction Services,
17 who provide the funding to pay for the
18 three PHMC case managers who come to
19 court with us.

20 Some naysayers will argue that
21 AMP doesn't really address the prison
22 population and reducing the prison
23 population, because these are the types
24 of cases that more often than not would
25 result in a probation sentence if there

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2 was a finding of guilt. But three points
3 to that is, the first being all these
4 people who participate in AMP have no
5 bail set on their case. They're ROR.
6 They're not held in custody from the
7 start.

8 The second is that our hope
9 through AMP is that we're giving these
10 people the services that they need to
11 fight their addiction, to kind of address
12 the underlying cause that brought them
13 into the justice system in the first
14 place. So that when they're done with
15 the program, they don't reoffend, that
16 they don't come back in the system and
17 they don't come back in the system for a
18 more serious crime that might lead to
19 jail time.

20 And then the third part of it
21 is since these people aren't ending up on
22 probation, as the first presenter talked
23 about, sometimes probation becomes more
24 of a challenge and more of a deterrence
25 to successfully beating an addiction than

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2 a help. So this is a way to help people
3 who are fighting an ongoing battle and
4 ongoing illness to avoid the cycle of
5 potential technical violations on
6 probation, detainers being lodged,
7 potentially being taken into custody. So
8 there are aspects of this program that
9 really go to the heart of dealing with
10 addiction while doing it outside of
11 custody.

12 The program provides defendants
13 with the tools to help themselves with
14 experts in substance abuse to guide them
15 through the process and with a promise
16 that if they hold themselves accountable
17 for their actions of sobriety, that they
18 will avoid the consequences and pitfalls
19 of incarceration. Again, we do this with
20 very little resources, at a high volume,
21 and an accelerated rate.

22 By no means are we suggesting
23 that AMP is a better program than
24 year-long programs like Treatment Court.
25 It's merely another tool in our arsenal

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2 to combat addiction in the City and help
3 address the prison population.

4 And I'm happy to address any
5 questions that the Committee has on this
6 program or any other diversion programs
7 along these lines.

8 DEPUTY COMMISSIONER BETHEL: So
9 one of the things which I like to have
10 this panel hear, when I talk to my
11 co-chairs, I say, you know, oftentimes I
12 say, we have to slow it down a little
13 bit. Oftentimes those folks in the field
14 don't get to talk about the stuff that
15 they're doing, and though the room is not
16 full, hopefully the viewing public and
17 the folks who will look at it later on
18 can see that there is a lot of work done
19 behind the scenes by many people in the
20 system trying to work to help people get
21 through this process.

22 So first and foremost, I
23 applaud all your agencies for the work
24 you're doing. I guess my question,
25 Derek, is, is an evaluation -- do we

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2 have, I guess, an evaluation at this
3 point to say that AMP is working? I
4 think you said you have about 3,000 --
5 there's about 3,000, you said, have come
6 through the process or completed the
7 process?

8 MR. RIKER: We've actually
9 had -- we referred 20,000 people through
10 the program. Last year between AMP 1 and
11 AMP 2, we probably disposed of close to
12 3,000 cases, a little over 3,000 cases.
13 So it is a big number.

14 We've never had a formal
15 evaluation. We've done some own internal
16 studies, our own office has and I know
17 the Defenders had, and we've come up with
18 very similar numbers. In terms of
19 recidivism, for offenders after the first
20 year of the program, it's roughly about
21 20 percent. Three years looking forward,
22 we took a pool of about 500 people to
23 look at, and after three years, it had
24 only gone up to 30 percent. So we feel
25 pretty good about those numbers.

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2 DEPUTY COMMISSIONER BETHEL: So
3 how do you deal with the first part of
4 it, with the AMP 1 where Kevin Bethel
5 comes in, we know he's addicted. He's
6 not offered services at that point?

7 MR. RIKER: Officially part of
8 the process is they're not required to
9 take services. However, when the
10 defendant comes into the courtroom and
11 more often than not it's the Defender's
12 Office meets with their clients, they
13 will sit down and talk to them and
14 explain, Here's your opportunity to do
15 community service. If there's some other
16 reason that led you into the system, we
17 have these resources available for you to
18 take advantage of. So they can meet with
19 the PHMC case managers as well. There's
20 nothing preventing them from doing so.
21 And we also let them know that if they
22 wish to participate in a treatment
23 program, we'll waive the community
24 service and we would prefer them to take
25 the treatment program.

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2 MR. COTTER: We're going to
3 work with the client. The second he
4 steps into our office and we interview
5 him, discussing his individual problems.
6 If he chooses to take AMP 1 and he tells
7 our attorney, which he more than likely
8 will do, because we try to emphasize to
9 the client we're there to help them.
10 We're there to help them stop
11 recidivating, stop coming back into the
12 system. We believe that a felony
13 conviction is a lifetime sentence,
14 because you cannot get employment once
15 you get that felony conviction. We want
16 to stop them from day one from
17 recidivating, from becoming involved in
18 crime.

19 So if he tells us -- and
20 normally they will. They'll open up to
21 us. They feel comfortable with us.
22 They're going to say, I have a program,
23 can you help me with that program. Our
24 attorney or to me, Mr. Cotter, can you
25 help me, and we will find them a program,

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2 and as Derek said, if they take the
3 program, they don't have to do the
4 community service, and often that
5 convinces them that they should in fact
6 take the program.

7 Now, I think clients who really
8 want the treatment -- there was a
9 question about one of the other panels.
10 Well, what happens if the clients aren't
11 forced into treatment. I think the
12 District Attorney asked that question,
13 Mr. Mosee. But the answer is that most
14 of the clients, when you meet with them,
15 really desire the treatment and the
16 services they need. They don't want to
17 be in this cycle of crime. They want to
18 get out of that. They want to be
19 successful citizens. They want to make
20 their parents, their mothers and fathers
21 and grandparents see that they're happy
22 and they're successful. So they really
23 do want to get out of that, and I think
24 it doesn't have to be forced on them.
25 The voluntary system works very well.

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2 DEPUTY COMMISSIONER BETHEL: So
3 you heard Dr. DeMatteo talk about the
4 system mapping. Do we have a system
5 mapping in this process where all of you
6 know exactly that whole process? Have we
7 ever done that kind of model to see
8 exactly how we're treating Kevin Bethel
9 when he comes in the system? And if not,
10 would that be fruitful for you as part of
11 a recommendation coming from this
12 Committee and whether that's even a
13 single tool order that he talked about?
14 Is that something that would benefit -- I
15 know we kind of do it with the MacArthur
16 project but in a more, I guess, strategic
17 way.

18 MR. RIKER: I think it would be
19 helpful to look at the different
20 treatment providers in the City, about
21 the different processes that people go to
22 engaging those providers, because there
23 are so many different paths people can
24 take towards treatment. It would provide
25 us with some more guidance to see what is

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2 most effective for people.

3 DEPUTY COMMISSIONER BETHEL:

4 You had a question?

5 MR. COSLEY: Jason Cosley.

6 It's great to hear all the new
7 programs that are underway from your
8 various departments. My question is
9 specifically for the Prisoner Reentry
10 Enhanced Accountability program that's
11 currently underway. How long has that
12 been underway and is there any successes
13 or barriers that you can speak to at this
14 particular time?

15 MR. McFILLIN: It's fairly new.
16 We only have five participants right now,
17 and it's a pilot project between two
18 treatment centers that we're using, and
19 it's strictly in the IP program. As the
20 doctor was saying earlier, a lot of
21 success comes from one judge and one
22 program, and we've geared it to that
23 situation. So right now it's just a
24 pilot and we're hoping it takes off.

25 MR. COTTER: I think it's the

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2 wave of the future, though, because it's
3 immediate response. The client that
4 goes, as Chris said earlier, where he's
5 25 minutes late and the next day he's 25
6 minutes late, the probation officer calls
7 him up and says, Come on, you're 25
8 minutes late, he realizes that somebody
9 is watching, that somebody cares, and
10 this will push him to be successful in
11 the program. And I think eventually that
12 all the programs will have this immediate
13 response time, and our office is for it.
14 We think it will help the client and we
15 think it will help the community as a
16 whole to overcome addiction.

17 MR. COSLEY: I know the program
18 is very new, but given the tight
19 timeframe that we're under as this
20 Committee to make recommendations, is
21 there any recommendation that you would
22 like for us to make that would help sort
23 of facilitate this program along?

24 MR. McFILLIN: Ann is actually
25 a member of the PREATS committee. I

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2 don't -- we want to speed it up, but at
3 the same time, there could be a lot of
4 glitches. So when we're dealing with a
5 lot of people and a lot of different
6 agencies, we kind of have issues. So
7 when we first got it up, one of the
8 programs maybe forgot to have the guy
9 thumbprint or he didn't thumbprint when
10 he left and now we're calling saying, The
11 guy didn't come.

12 Oh, he was here.

13 So we just can't throw 60, 70
14 people into this. We have to take baby
15 steps in the beginning.

16 DEPUTY COMMISSIONER BETHEL:

17 Thank you.

18 MS. SCHWARTZMAN: If I can just
19 jump in. It's another collaborative
20 program, but the first step is to see if
21 it even makes sense to take it to the
22 next level. So there really is no
23 request at this point, but there might be
24 something in the future, and hopefully it
25 shows some good information.

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2 But I did want to ask a
3 question, especially with AMP. Is that
4 something that's based in the community
5 and either by police district or the
6 zones that you have? And is there a way
7 then to build on that to include family
8 members as well who might have identified
9 needs that are connected to the
10 individuals who actually come into the
11 program?

12 MR. RIKER: Yeah. That's a
13 great question. It is -- we consider it
14 a quasi community court already. We meet
15 each day at a different -- one of the
16 different detective divisions in the
17 City. Today is Friday, so they'd be up
18 in the Northwest at the 35th Police
19 District. And so the great part about
20 that is, people are able to not --
21 they're able to go to this central place
22 to have their cases heard. Typically
23 it's in their community that they live.
24 The services that we try to provide to
25 them, we try to give them services in the

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2 communities that they live. So we try to
3 keep it as community-based as possible,
4 which has proved very beneficial.

5 In terms of expanding the
6 services, we have actually had situations
7 where people have come in and said, This
8 is fantastic, can you help my sister, can
9 you help my brother, something like that.
10 And we've rolled those services out to
11 those people. The PHMC workers will go
12 and meet with individuals who are not in
13 court or not court ordered to be there.

14 Whether or not we could do full
15 family engagement, that might prove a
16 little bit logistically difficult at this
17 point. Like I said, we have a case list
18 of 120 on a given day, and putting all
19 those people into the courtroom that we
20 have is already a little bit of a
21 logistical nightmare. So sometimes it's
22 organized chaos, but we make it work, and
23 to expand it would probably require some
24 sort of more intensive resources,
25 commitment from somebody to fund it.

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2 MR. COTTER: As Derek said, our
3 office, the Defender Association, and the
4 District Attorney's Office receive no
5 money for this program. We provide our
6 attorneys because we think it helps our
7 clients, and I'm sure the District
8 Attorney's Office thinks it's a very good
9 program.

10 Our office is in the process of
11 reaching out to community members in each
12 zone and into the churches in each zone
13 to create better community reentry
14 programs, and this will coordinate with
15 AMP so that we can tell our clients right
16 there, Well, you can receive these
17 services down the street, go to this
18 place and you'll get the services that
19 you need. We know that this has to be
20 done. Obviously if we had more money, we
21 could do it quicker and faster. However,
22 we are trying to establish those services
23 in each zone through community partners.

24 MR. COBB: William Cobb.

25 My question is for the

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2 representative from Probation and Parole.
3 It indicates here that you guys currently
4 supervise 45,000 individuals with a mere
5 246 case officers. Is that correct? And
6 if that is correct, does that mean that
7 the officers are actually managing
8 caseloads of an average of
9 180-something-odd people at any given
10 time?

11 MR. McFILLIN: Well, we
12 don't -- it's not averaged out like that.
13 Certain units carry smaller caseload
14 size. So a high-risk offender is not
15 going to be in a big caseload like that.
16 That's why we've developed a low-risk
17 protocol where the caseloads are larger,
18 and as the doctor was saying, with the
19 low-risk offenders we don't want them to
20 come down. They seem to get more
21 recidivate if they maintain connection
22 with the high-risk population.

23 So to answer your question, no,
24 the caseloads aren't 180. Some caseloads
25 in our general supervision might be up to

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2 150. Generally in our Mental Health
3 Unit, we're carrying about 110. Our sex
4 offenders are carrying 90, domestic
5 violence 110. So, I mean, there are
6 large caseloads, yes.

7 MR. COBB: Because you
8 expressed a frustration with the limited
9 amount of resources in order to be able
10 to effectively impact recidivism rates
11 and public safety. So because we're
12 taking an unprecedented -- this is
13 unprecedented what the City is currently
14 doing. It also presents an unprecedented
15 opportunity to make bold asks, because as
16 we think about the reinvestment of
17 dollars, we definitively want to know if
18 you are given more resources, will that
19 have a definitive impact on public safety
20 and recidivism rates. The math to me is
21 kind of off still, because -- I'm not a
22 mathematician, but with 44,000 people,
23 246, somebody is carrying a load greater
24 than 110 in order for all of those
25 individuals to actually be represented.

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2 And if that's the case, I think it
3 behooves this Committee to literally take
4 a better look at that and make a strong
5 demand for reallocation of resources.

6 The money is there. It's just how are we
7 going to spend money if we want to
8 produce a far better outcome than the
9 ones that we are currently living with.

10 None of us are happy with the
11 quality of life in our neighborhoods due
12 to high crime rates. None of us are
13 happy with the lack of money that are
14 available to invest in other things such
15 as our infrastructure and education.

16 So I would just push back
17 gently and ask you to literally make a
18 bold ask, because I feel like this is the
19 best opportunity that the City has had to
20 actually take a look at this and to do
21 something very differently than what
22 we've currently done.

23 MR. McFILLIN: Without
24 question. I mean, we can do so much more
25 with so much more resources, but we're a

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2 product of what our budget calls for and
3 what we can allocate to, and that's why
4 we had to stratify it to high, moderate,
5 and low, so we could push more officers
6 into our higher-risk offenders and deal
7 with more of the violent offenders that
8 we're dealing with.

9 But absolutely. In our
10 specialty courts, some of the caseload
11 sizes might be 35, and we have
12 outstanding results. But we're doing the
13 best we can with what we got, but, yeah,
14 we'll take more money any time.
15 Absolutely.

16 MR. COBB: It's great that
17 we're going to do more. We want to do
18 more, but I'm actually going to reach out
19 to you and ask for what the current
20 budget is so that we can all see how
21 those monies are being spent, because we
22 really do need to reinvest in criminal
23 justice.

24 So thank you for your testimony
25 today. Appreciate it.

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2 MR. COTTER: If I may just
3 respond quickly to that. Also the
4 post-trial diversion programs often have
5 case managers that work with the
6 probation officers and help them devise
7 plans for the clients. So those
8 additional diversion programs provide
9 those additional case managers that aid
10 those probation officers with those large
11 caseloads.

12 DEPUTY COMMISSIONER BETHEL:

13 George.

14 MR. MOSEE: I think that the
15 purpose of this Committee is twofold.
16 Certainly the stated purpose is to
17 develop recommendations to help reform
18 criminal justice, but I think part of
19 what we're accomplishing in the process
20 is even more important. We're exposing
21 the realities of what currently exists in
22 criminal justice. And so I have two
23 questions related to that purpose.

24 The first question is, is it
25 accurate when people say that we

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2 incarcerate people because they abuse
3 substances, because they have addictions?
4 Is that accurate?

5 MR. COTTER: Absolutely.

6 MR. McFILLIN: I would say no.

7 MR. RIKER: I would say no as
8 well.

9 MR. McFILLIN: We go through
10 great pains not to incarcerate people
11 that are testing positive for drugs. We
12 try to move mountains to get the
13 offenders into treatment and respond to
14 treatment, but we're left at a position
15 when we have someone on for a gun case
16 and we have five positive urines for
17 cocaine and they are not complying with
18 treatment, we have to take them into
19 custody. But prior to taking them into
20 custody, we have done everything that is
21 expected us to do to get this person on
22 the right track. So we just don't throw
23 anyone into custody for testing positive.

24 MR. MOSEE: Go ahead, Byron.

25 MR. COTTER: I would agree that

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2 they're making every effort not to
3 incarcerate. However, clients are still
4 being incarcerated for pure drug usage,
5 and we must react much quicker, as the
6 PREATS program will do in the future,
7 where we see that the client is
8 continuing to abuse and step up the level
9 of their treatment or get them into a
10 treatment immediately before they reach
11 using the cocaine the fifth or sixth time
12 and the probation officer sees it. So we
13 must address it quicker. Therefore,
14 prevent the incarceration. Right now
15 when we don't address it quickly, the
16 client is incarcerated, and it sometimes
17 takes months before the client is then
18 released into treatment. We can't put an
19 exact figure on that, but it's costing
20 thousands of dollars to keep that client
21 in jail for three, four months before we
22 can place them into treatment.

23 DEPUTY COMMISSIONER BETHEL:

24 Kevin Bethel is addicted to heroin. I'm
25 in North Philly. I get stopped by the

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2 police officer and I have a packet of
3 heroin. I'm more likely going to be in
4 the AMP program, right?

5 MR. RIKER: Correct.

6 DEPUTY COMMISSIONER BETHEL: I
7 get stopped a second time. I may go to
8 AMP 1 again?

9 MR. RIKER: The second time you
10 would go to AMP 2.

11 DEPUTY COMMISSIONER BETHEL: I
12 mean AMP 2. So I'm kind of stopped a
13 third time. You said they're getting
14 penetrated. Are they penetrating that
15 far? I mean, does it come to a point
16 where the possession user is getting
17 stopped that many times that he
18 ultimately is incarcerated?

19 MR. RIKER: No. I would
20 argue --

21 MR. COTTER: The answer is yes,
22 in my opinion.

23 MR. RIKER: I would argue no.
24 I would argue that we give -- we have
25 individuals who have multiple possession

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2 arrests in a given year who don't end up
3 incarcerated. The times where people
4 typically end up incarcerated are when
5 they're not compliant with treatment,
6 correct, but it's often in an effort to
7 help save that person. The fact that
8 they are offending so much and they're in
9 such a terrible state health-wise, that
10 some judges see it as an opportunity to
11 protect that person by putting them in
12 custody. There's also a concern that if
13 this person keeps offending is that the
14 types of crimes might increase, might go
15 from just possession to now it's car
16 theft break-ins to now burglary. So
17 there's a concern along those lines as
18 well. But every effort is made at the
19 front end to avoid any sort of
20 incarceration for users.

21 DEPUTY COMMISSIONER BETHEL:

22 Because I think one of the things we
23 can't forget in this process for a system
24 here, we have victims out there too. I
25 think the conversation is geared to a lot

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2 about -- and I understand that, but we
3 also have to be mindful of the victims.
4 Things are happening as individuals
5 engage in that type of behavior. So we
6 just can't automatically separate the
7 two. And you come in, burglarize my
8 house, I'm expecting something to happen.
9 You know, most people are expecting that
10 person is taken into custody, that
11 something more stringent is happening.
12 But, again, it's just part of another
13 conversation, not for this group.

14 MR. MOSEE: So I think it's
15 fair to say that when somebody is
16 determined to be a drug abuser, the first
17 thought of the Philadelphia system is not
18 we need to lock this person up. The
19 first approach is always we need to find
20 a way to help this person get the
21 treatment that they need.

22 MR. COTTER: That's correct.

23 DEPUTY COMMISSIONER BETHEL:

24 Ideally, we'd like a system that every
25 time we had that, we had some place to

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2 put them.

3 MR. COTTER: But addiction also
4 means relapse, and it often takes a
5 client three, four times to stop that
6 addiction process. And if we can react
7 to that relapse much quicker, we can
8 prevent incarceration. Incarceration is
9 not in any way addressing his health
10 issue. It just doesn't. He needs to be
11 in treatment, and that will address the
12 issue, and that will prevent the client
13 from going out and burglarizing someone's
14 home, and we all, everyone sitting here,
15 wants that to stop.

16 MR. MOSEE: So the second
17 reality that I wanted to expose by taking
18 advantage of your presence here is that
19 you three aren't strangers to one
20 another; is that correct?

21 MR. COTTER: That's absolutely
22 correct.

23 MR. MOSEE: In fact, you work
24 closely together.

25 MR. RIKER: Every day.

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2 MR. COTTER: Yes.

3 MR. MOSEE: Mr. Cotter, you're
4 from the Defender Association.

5 Mr. Riker, you're from the District
6 Attorney's Office, and we have Probation
7 in the middle. But when you guys are
8 doing what it is that you do, you work as
9 a team; is that correct?

10 MR. COTTER: Absolutely.

11 MR. MOSEE: So would somebody
12 talk a little bit more about not just the
13 spirit of collaboration in criminal
14 justice in Philadelphia but what that is
15 in reality.

16 MR. RIKER: The reality is,
17 especially for diversion programs, is
18 that it has to be a team mindset, that
19 you have to come in with a united
20 approach as to how you're going to work
21 with this individual, because it's not a
22 traditional courtroom process. It's not
23 a traditional defense versus prosecutor
24 process. It's we come together as one
25 because we have a common goal of helping

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2 the defendant, the participant, get
3 better, get helped. And if we're not
4 working together, if we have conflict,
5 then we can't help that person.

6 So at its onset, when we agree
7 to work on a diversion program, we agree
8 to work together, and I think we've seen
9 the benefits that programs like Drug
10 Treatment Court have had and how much
11 success we've had working together as
12 opposed to on opposing sides.

13 The benefit for the prosecutor
14 is to try to get this person clean so
15 they don't recidivate. The benefit for
16 the Defender is help this person get
17 clean so they don't recidivate. We have
18 the same common goal. So it makes it
19 easy for us to work together.

20 MR. COTTER: And to have a
21 safer city. That's the goal of all three
22 of us.

23 MR. COSLEY: My question is for
24 Byron. You mention that the PREAT
25 program, you would like to see a step-up

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2 as opposed to them being incarcerated.
3 So the only logical step-up is them going
4 into inpatient treatment.

5 MR. COTTER: Right.

6 MR. COSLEY: I'm not familiar
7 with those costs per day, but would you
8 think it is a much cheaper cost for the
9 City to go that direction as opposed to
10 the latter, which is them getting
11 incarcerated?

12 MR. COTTER: Absolutely.
13 Mr. Lamb could speak better on the exact
14 costs, but treatment is cheaper and has a
15 much higher success rate than
16 incarceration. Incarceration, the
17 recidivism rate is 50 to 60 percent. The
18 success rate for most of these programs
19 is a recidivism of 20 percent, in that
20 range. So you're reducing recidivism by
21 at least 30 percent.

22 Often clients are evaluated and
23 because of funding concerns are placed in
24 outpatient treatment. Often they need
25 inpatient. So with the PREATS program,

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2 you're going to see that this client is
3 not being helped by an outpatient program
4 and that we'll see this rapidly and we'll
5 step him up so that the usage won't
6 continue, that he won't be going out,
7 buying drugs or burglarizing homes.
8 He'll be stepped up to the treatment he
9 needs. And that helps us keep an eye on
10 the client to see -- to move him to the
11 correct level of treatment.

12 MR. COSLEY: Thank you.

13 MR. McFILLIN: I just want to
14 go back to incarcerating offenders for
15 drug use and what you said earlier about
16 having people on the ground. What I want
17 to bring to everyone's attention too is
18 that a lot of times we take people into
19 custody because now we have the body and
20 now we can do something for this person.
21 When we have someone coming in and
22 leaving, coming in and leaving, testing
23 positive for cocaine, this guy is on the
24 street, he's homeless or he's bouncing
25 from house to house. If we grab him, we

1 5/13/16 - SPECIAL COMMITTEE - RES. 160101
2 have the body. Now we can do something
3 with him. We can move him to this
4 program. We can put him in inpatient
5 here. We can put him on house arrest.
6 That's the main reason why we grab him.
7 We don't grab him to bury him. We grab
8 him to help him.

9 MR. COTTER: I completely agree
10 with what he said, but he needs the
11 immediate services to place him in that
12 housing, into that treatment and not have
13 to put him up on State Road and to
14 incarcerate him for a month before we can
15 get that or sometimes up to three, four
16 months before we can get that treatment
17 in place. He needs those services. And
18 I agree that if he had those services,
19 that's what they would do.

20 MR. COSLEY: What's the
21 timeframe when you grab that body? Does
22 that person have to get placed that day
23 or are they going back to State Road
24 immediately?

25 MR. McFILLIN: It's generally

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2 because it comes down to funding. So if
3 I have this body, I just can't transport
4 him to Kirkbride, because who is going to
5 pay for him to be in Kirkbride? So if I
6 incarcerate him, the process starts where
7 the funding kicks in.

8 If the Committee is looking for
9 a recommendation, if we had a DPA worker
10 in our building where I could refer them
11 to the basement and have Department of
12 Public Welfare interview this person for
13 insurance, that would streamline it a
14 lot, because our process has to be, All
15 right, go to your Welfare Office and get
16 insurance and come back with the proof
17 that you got it. A week goes by and the
18 guy comes back in and he never went. So
19 now I tell him to do it again. So it's a
20 process we don't have funding. And I
21 don't think when people talk about
22 helping people in addiction services
23 realize, well, someone has to pay for
24 that. Like who is paying for him to go
25 to Kirkbride? Who is paying for him to

1 5/13/16 - SPECIAL COMMITTEE - RES. 160101
2 get to Kirkbride?

3 DEPUTY COMMISSIONER BETHEL:

4 That's why I think system mapping is so
5 important, because Kevin Bethel is
6 identified at the front end to start that
7 process, so by the time he gets there,
8 he's already enrolled instead of waiting
9 until you get to that place.

10 But we are -- oh, you have a
11 question. I'm sorry.

12 MR. COBB: I do, and I think
13 this is pretty much a comment, for the
14 sake of the Committee and for the sake of
15 individuals who are professionally
16 engaged in dealing with people who have
17 been in conflict with the criminal
18 justice system. It befuddles me that we
19 sit here and we talk about where the
20 money is going to come from in order to
21 treat people like people so that they can
22 be productive in our society. It's
23 amazing that a representative from
24 Probation and Parole expresses
25 frustration about not having resources,

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2 but when he wants to arrest someone,
3 there's not a question as to whether or
4 not he can do so. And we all know that
5 what we are currently doing is not
6 working.

7 So I guess my point is that for
8 all of us who are advocating to reform
9 our criminal justice system because we
10 are unhappy with what it has produced at
11 date, I think we're all responsible for
12 stating evenly that the money must be
13 diverted. It's not a question as to
14 where the money is going to come from.
15 It's going to come from the budget for
16 the prisons. It's going to come from the
17 budget for other criminal justice reform
18 things. It's going to be diverted. We
19 spend nearly \$300 million a year on
20 incarcerating poor and drug-addicted
21 people on State Road. That's deplorable.

22 So to all of you, I really
23 thank you for your time today. I thank
24 you for your honest and frank
25 testimonies, and I hope that my injection

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2 into your spirit about how we treat
3 people and how we're spending our money
4 emboldens each of us to demand that
5 monies are put where they're better
6 suited to produce the outcomes that all
7 of us as citizens of the United States
8 want to actually live with. We don't
9 have to ask for it. We must demand it.
10 And as you guys being experts in your
11 field and your expertise, the dollars
12 have to be diverted to diversionary
13 programs, because they're far more cost
14 effective, they increase public safety,
15 and they do a better -- they benefit
16 society rather than shackling us down
17 with debt and conditions that none of us
18 are happy with living with.

19 DEPUTY COMMISSIONER BETHEL:

20 That's a better closing than I was going
21 to provide.

22 So thank you, gentlemen.

23 (Thank you.)

24 DEPUTY COMMISSIONER BETHEL: I

25 think we have one final panel and then if

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2 there's anyone from the community. I
3 don't see anyone, but we may have
4 someone. But Panel 4.

5 THE CLERK: The last scheduled
6 witness is Joan Vieldhouse.

7 (Witness approached witness
8 table.)

9 MS. VIELDHOUSE: Good morning.

10 DEPUTY COMMISSIONER BETHEL:
11 Good morning -- or good afternoon. You
12 started in the morning, but it's
13 afternoon now.

14 MS. VIELDHOUSE: Sorry. My
15 name is Joan Vieldhouse. I'm a person
16 with eight years and three months in
17 recovery from substance use and mental
18 health challenges. As a single mother, I
19 had many challenges. I ended up using
20 cocaine at the age of 22. I became
21 addicted very quickly, as most do. I
22 became involved with the criminal justice
23 system a few times for misdemeanor
24 offenses. I bounced checks to pay bills,
25 whatever. My life became chaotic and out

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2 of control.

3 I went to Chester County Prison
4 for two weeks and I lost custody of my
5 daughters. They were 11 and 8 at the
6 time. Even though I had visitation
7 scheduled and weekend visits, they would
8 just not be home. They refused to allow
9 me to have my visitation, so this sent me
10 on a downward spiral. My drug use
11 increased. Somewhere along the way I
12 started using crystal meth. As long as I
13 thought that no one knew what I was
14 doing, I figured I didn't have a problem.

15 In 2005, I made a sale of a
16 quarter ounce of cocaine to a relative
17 who happened to be wearing a wire. I was
18 not a big-time drug dealer. I was only a
19 delivery person out there in order to get
20 drugs to get high. I was not charged for
21 three years until after the actual sale.
22 In Pennsylvania -- I don't know how it's
23 changed, but at that time, they had five
24 years to prosecute you for drug charges.

25 Because of my association with

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2 an outlaw motorcycle club, they have a
3 task force called the Ice Squad run by
4 the Pennsylvania State Police. They
5 thought that I had information that I
6 didn't have. As a woman, we don't get
7 that kind of information. This was my
8 first and only drug-related offense. The
9 county refused to waive the mandatory
10 minimum sentencing.

11 I could have greatly benefited
12 from a diversion program like LEAD. I
13 spent almost a year in the county system.
14 I was eligible for and recommended for a
15 treatment court, but was denied. I
16 completed both intense outpatient and
17 outpatient treatment while in the county.
18 Then I received a state sentence of 33 to
19 66 months for my first offense.

20 Once you become property of the
21 Commonwealth, any programming that you
22 have already completed is not recognized
23 by the Department of Corrections. Once
24 you are taken to state prison, you don't
25 receive programming until six months

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2 prior to your minimum release date, which
3 in some places that can be a couple years
4 down the road.

5 A person needs treatment
6 immediately, not in a couple of years.
7 When I was in an inpatient program, my
8 parents died 15 days apart in May of
9 2010. You do not receive help for grief
10 in a prison setting. I ended up having a
11 breakdown and was discharged from the
12 program. Parole slapped me with an
13 18-month violation, which means I had to
14 wait to be paroled until after that date
15 and completion of another program. I
16 wish the diversion program had been
17 available to me instead of receiving the
18 felony on my record. I feel that if you
19 need treatment, it should be an option
20 for you in the beginning. Most addicts
21 don't set out to become addicted or
22 become a criminal, let alone get caught
23 and go to prison.

24 I was released from Muncy in
25 April of 2012 to Gaudenzia DRC on Henry

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2 Avenue. I met a woman there named June
3 who heads up the Educational Department
4 and Mr. William Boone, the Director of
5 Aftercare. They saw something in me that
6 I didn't. They helped me to research on
7 how I could help other people on their
8 journey. I found an organization called
9 PRO-ACT, the Pennsylvania Recovery
10 Organization Achieving Communities
11 Together. I'm a girl from Lancaster
12 County, and Parole dumped me off in North
13 Philly. So I never heard of SEPTA. They
14 handed me a token. I said, Well, what is
15 this?

16 DEPUTY COMMISSIONER BETHEL:

17 When did they do that?

18 MS. VIELDHOUSE: They dropped
19 me off in North Philly. I'm from
20 Lancaster County. My neighbors were
21 cows. I never heard of SEPTA or a token,
22 and they just dumped me off.

23 DEPUTY COMMISSIONER BETHEL:

24 When you finish your testimony, I want to
25 hear more about that. That might be

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2 something we need to recommend the
3 Committee as well.

4 MS. VIELDHOUSE: So I knew
5 that -- I never knew that places like
6 PRO-ACT existed, let alone had such
7 wonderful recovery support services. I
8 had been looking to find some training
9 for a career that would enable me to help
10 others in recovery. I went to PRO-ACT in
11 June of 2012. I went there for a
12 training session. I walked in the door
13 and I met this big man named Lester
14 DeLoatch, a certified recovery
15 specialist. He took me in and welcomed
16 me with literally open arms. I began
17 coming to the center at every opportunity
18 that I was allowed out of Gaudenzia. I
19 became a volunteer in July of 2012. From
20 that point, I became on a mission. I saw
21 something wonderful. I saw other people
22 who were in recovery and thriving and
23 enjoying life. I came to realize that
24 there was something to this movement of
25 recovery, and PRO-ACT is the heart and

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2 soul of this movement.

3 I volunteered every moment that
4 the center was open. I am now a
5 state-licensed certified recovery
6 specialist, a certified peer specialist,
7 and a Mental Health First Aid instructor
8 for the Department of Behavioral Health,
9 along with a whole bunch of other stuff.
10 I am now gainfully employed full time at
11 John F. Kennedy Behavioral Health right
12 across the street as a mental health
13 worker. I am also a member of the Vision
14 Team for Philadelphia Recovery Community
15 Center. This is a very big deal for me.
16 I walked through the doors at 1701 West
17 Lehigh Avenue a felon and became part of
18 something much bigger than I could have
19 ever imagined.

20 The support from PRO-ACT and
21 their ongoing programs provided were a
22 major influence in my successful
23 completion of parole in May of 2014.
24 Their mantra is, How can I help you with
25 your recovery. They offer recovery

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2 support services to anyone who walks in
3 those doors.

4 If we were able to serve
5 offenders before they enter the system
6 and before they receive a record, it
7 could change their lives and their
8 behaviors. They could learn to have a
9 meaningful life without the use of drugs
10 or the need to market them. Most dealers
11 rely on the selling of drugs as a job.
12 Imagine if they could learn how to use
13 those marketing skills for something more
14 positive, with the right support and
15 guidance. The life of an inmate in jail
16 can be just as bad as the life lived on
17 the streets, sometimes worse.

18 Today, I am gainfully employed.
19 I successfully completed state parole in
20 May of 2014. I have one of my daughters
21 back living with me. I have a house that
22 is mine that I pay for with legally
23 acquired funds. Some days I am still
24 amazed at how far I have come. I don't
25 know that old me anymore. She's a

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2 stranger. I feel that the value of
3 diversion programs such as LEAD could
4 have a tremendous effect on our society
5 and the system but, most of all, on those
6 who would successfully complete the
7 program. If we can teach someone a
8 better way to live and show them how it's
9 possible, then we're making an impact on
10 those we serve.

11 PRO-ACT never called me
12 stigmatized names like a druggie, an
13 addict or pathetic. I once wrote a poem
14 about my life and in it I used the words
15 "from bikers and gangs to handcuffs and
16 chains." That was my reality. This is
17 not the person I am today.

18 Today I am a person in
19 long-term recovery who has been shown a
20 better way. The road hasn't been easy,
21 but good outcomes require hard work.
22 PRO-ACT has opened many doors for me and
23 my continued success. In 2008, I went to
24 jail. Now here we are in 2016 and I get
25 to hang out with people like Dr. Evans,

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2 Dr. Lamb, Fred Martin. And none of this
3 would be possible without the skills, the
4 support, and the guidance that I received
5 at PRO-ACT.

6 DEPUTY COMMISSIONER BETHEL:
7 Thank you.

8 MR. COBB: I don't even know
9 whether it's appropriate, but I want to
10 literally applaud, and I'm going to do
11 that.

12 (Applause.)

13 MR. COBB: Thank you for your
14 amazing, brave, bold, and courageous
15 testimony. As a person who served six
16 and a half years in prison, I completely
17 get the fact that you have done something
18 remarkable. You were provided with an
19 exceptional opportunity, so you have and
20 are producing exceptional outcomes. And
21 you are correct, we definitely need to be
22 provided with opportunities such as what
23 LEAD suggests, and it shouldn't be
24 exceptional, it should be commonplace.

25 So, again, thank you for your

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2 testimony. You are amazing, you are
3 incredible, and we need to create a
4 system that produces more individuals
5 such as yourself.

6 Thank you.

7 MS. VIELDHOUSE: Thank you.

8 DEPUTY COMMISSIONER BETHEL: So
9 I'm sure my panel here all echo the
10 comments just made and just -- I want to
11 thank also Noni and Mary for creating the
12 opportunity to have this panel when I
13 reached out. It was supposed to be a few
14 more people, but I think your testimony
15 by itself stands alone and the impact it
16 has on this process. So it was important
17 that we had a voice for somebody who is
18 going through recovery to sit here and
19 kind of bring it full circle. So though
20 you're at the end of the day, it's still
21 a very, very positive process when we put
22 together this report that we include your
23 testimony into how important it is to
24 understand what's going on.

25 So I think -- I do have a final

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2 question, because I want to come back to
3 that statement about being dropped off
4 down here in North Philly. We have to
5 talk offline about that. I'll take that
6 offline, but I'm curious as to why that
7 occurred and what that all meant, but
8 we'll talk offline. We won't put that on
9 the testimony. I just want to hear in a
10 little bit more detail what that looks
11 like, because I've always heard those
12 things are happening, and when you sit
13 here and say that that happened to you, I
14 just want to hear a little more about
15 that.

16 MS. VIELDHOUSE: Now?

17 DEPUTY COMMISSIONER BETHEL:

18 No; once I walk away from this panel.

19 So I think -- do we have -- I
20 guess at this point the next panel is for
21 anyone. Mr. Calderone? No. All right.

22 The Committee will recess until
23 May 23rd.

24 Thank you, everyone, for your
25 time and commitment.

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2 (Special Committee on Criminal
3 Justice Reform adjourned at 1:20 p.m.)

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CERTIFICATE

I HEREBY CERTIFY that the proceedings, evidence and objections are contained fully and accurately in the stenographic notes taken by me upon the foregoing matter, and that this is a true and correct transcript of same.

MICHELE L. MURPHY
RPR-Notary Public

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