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

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

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

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

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

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

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

allocated towards youth programming.

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

Anyone on the Committee have any dissent on that?

MR. COSLEY: I agree as well.

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

MS. WERTHEIMER: Thank you.

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

Anybody else in the report?

Yes, ma'am.

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

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

DEPUTY COMMISSIONER BETHEL: Any comments on that?

(No response.)

DEPUTY COMMISSIONER BETHEL: All right. I mean, so clearly we're trying to go down a path of being -- so you're not saying going away from evidence-based, you're just saying adding?

MS. SCHWARTZMAN: Right.

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

MS. SCHWARTZMAN: And then

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

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

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

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

Mr. Mosee.

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

DEPUTY COMMISSIONER BETHEL: Duly noted.

Anyone else?

(No response.)

DEPUTY COMMISSIONER BETHEL: Okay. I think we're prepared to move on

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with the session.

THE CLERK: Panel 1 is David DeMatteo, Arthur Evans, and Roland Lamb.

(Witnesses approached witness table.)

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

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

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

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

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

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

MR. COSLEY: Jason Cosley, Impact Services Corporation.

DEPUTY COMMISSIONER BETHEL: Kevin Bethel, Stoneleigh Foundation.

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

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

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

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DEPUTY COMMISSIONER BETHEL: Okay. We're good.

DR. DeMATTEO: Good morning. Thank you very much to former Deputy Commissioner Bethel for inviting me here today. It's a real pleasure. It's a pleasure to speak with distinguished members of this Committee.

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

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

So the first thing we're going

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

percent of prison inmates have a serious mental health disorder. We see higher numbers among jail inmates. Sixty-four percent of jail inmates have mental health disorders and 16 percent have serious mental health disorders. The best estimate is that roughly 15 percent of inmates, jail and prison inmates, have a serious mental health disorder. The rate of serious mental health disorders in the general population is about 2 and a half percent. This is a staggering increase in the number of people who have mental health disorders who are incarcerated.

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

A bit more on mental health.

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

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

We also know that for people who are mentally ill, they are more likely to be arrested than people who are not mentally ill for the same behavior. We know that people who are mentally ill face more serious charges than people who are not mentally ill for the same behavior. We know that they get longer

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sentences.

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

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

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

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

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

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

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

inmates is due to drug charges.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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literature with medications.

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

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

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

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

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

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courts, in particular drug courts.

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

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

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

What we found is that the judge, not surprisingly, is a critical component of drug courts. The judge is one of the things that separates drug courts from the things like probation and parole. The judge has a lot of authority to be able to do things in that context. And what we also found -- and this is an important result -- is that high-risk offenders did better when they saw the judge twice a month. The high-risk offenders did better when they saw the judge on that high dose. The low-risk offenders did worse when they saw the judge twice a month. Interesting effect. The low-risk offenders actually did better when they didn't see the judge at all, and we can talk about that if anyone has any questions.

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These drug courts range from several months to two years. There's misdemeanor and felony drug courts depending on the jurisdiction. Completion results in nolle prosse. And in some jurisdiction, the arrest record can be expunged.

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

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

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countries right now.

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

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

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addressed during intervention.

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

So do drug courts work? There's more research on drug courts than there is on any criminal justice intervention for drug-involved offenders. There's more research supporting the effectiveness of drug courts for drug-involved offenders than there is supporting the effectiveness of anti-depressants for people with depression. This is not hyperbole. This is where we are with an extremely large and well-developed body of research. Put simply, drug courts are the most effective intervention for drug-involved offenders in terms of reducing drug use and reducing recidivism.

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

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

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

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

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

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

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

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50 percent compared to outpatient treatment alone.

What about family drug courts? This is the idea that the family dynamic needs to be assessed. There needs to be an intervention at the family level to help even one individual who has a problem. If any of you know someone who has had a drug problem or if you've experienced it in your family, you know it's not limited to that individual. There's a family dynamic that needs to be addressed.

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

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

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

Also, avoiding secured

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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that's been taking place in Philadelphia.

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

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

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

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

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

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

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

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

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drug use problem.

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

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

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

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

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

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

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

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

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

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

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

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gaps, the resources, the opportunities. You agree on a priority plan, and then you develop an action plan. And this is a one-and-a-half-day process. The first day is, you bring together key stakeholders from various systems. So you have representatives from law enforcement, you have representatives from the judiciary, you have representatives from probation and parole, you have representatives from treatment. You bring together everyone in the same room. It's not uncommon when we do these mappings to have 20 or 30 different representatives in the same room.

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

will be helpful and opportunities for providing additional services.

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

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

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

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

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

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

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

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

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

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

So thank you very much for your time.

DEPUTY COMMISSIONER BETHEL: Well, first, Dr. DeMatteo, let me first thank you for a very extensive and very clear -- when I was looking for you to come, one of the things I wanted folks in the room but, more importantly, the

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

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

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

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

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

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

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reducing relapse in drug use and recidivism.

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

DEPUTY COMMISSIONER BETHEL: Outstanding.

Any questions from the panel?

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

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

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

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

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

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risk factor.

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

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

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

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

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

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

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substance abuse treatment?

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

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

Sir.

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

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

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

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

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

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

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

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

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

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

Thank you.

DEPUTY COMMISSIONER BETHEL:

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Thank you, Councilman.

Let me recognize -- I'm sorry. You got a response. Go ahead.

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

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

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

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

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

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

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

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

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

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

COUNCILMAN JOHNSON: On the Committee.

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

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

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

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

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

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

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

COUNCILMAN JOHNSON: Thank you.

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

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

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

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

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

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

COUNCILMAN JOHNSON: Thank you.

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

COUNCILWOMAN BLACKWELL: Thank you.

DEPUTY COMMISSIONER BETHEL:

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

MR. COBB: William Cobb.

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

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

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

So could you please just speak to that.

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

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

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

"people."

DR. DeMATTEO: That's fair. Okay. Thank you.

DEPUTY COMMISSIONER BETHEL: Well, again, Dr. DeMatteo, we want to thank you, but one of the things I want people to understand, that one of the reasons that the doctor is so effective at his work, he's on the ground with the men and women on the ground from day to day, not sitting at 40,000 feet. He is actually working in the field, understanding what's going on in the field to inform his work.

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

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

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

THE CLERK: The next witness is Roland Lamb.

(Witness approached witness

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table.)

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

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

DEPUTY COMMISSIONER LAMB: Good morning.

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

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

of addiction treatment issues in that respect.

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

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

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

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

DEPUTY COMMISSIONER LAMB:

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

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

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

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

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

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

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

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

DEPUTY COMMISSIONER BETHEL: Anyone else have questions?

(No response.)

DEPUTY COMMISSIONER BETHEL: So, Roland, I would just ask you one question. So when you look at a percentage, where is your gap? Knowing that the individual is in need of treatment and the services you can

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

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

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

DEPUTY COMMISSIONER BETHEL: Very good. Well, thank you, Roland.

DEPUTY COMMISSIONER LAMB: Thank you. And, again, whatever you guys need for me to come up with, I will

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

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

DEPUTY COMMISSIONER LAMB: Thank you all.

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

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

(Witnesses approached witness table.)

MR. JOHNSON: Hello.

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

Ms. Noni, how are you?

MS. WEST: Sterling is going to start.

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

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questions.

DEPUTY COMMISSIONER BETHEL: Can you pull that mic just a little bit forward to you.

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

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

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

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

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

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principles of LEAD are reorient the government's response to safety disorder and health-related problems; improve public safety and public health through research-based, health-oriented, and harm-reduction interventions; reduce the number of people entering the criminal justice system; undo racial disparities at the front end of the criminal justice system; and sustain funding for these alternative interventions by capturing and reinvesting justice system savings; and then, lastly, strengthen the relationship between the community and all systems, including public health and criminal justice in the City.

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

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

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

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

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

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

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

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

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

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

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

So to move on to how the

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

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

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that went with that.

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

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

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

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

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

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

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

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

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

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

Thank you.

DEPUTY COMMISSIONER BETHEL: Thank you.

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

DEPUTY COMMISSIONER BETHEL: Pull that mic a little closer.

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

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

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

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

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Addiction Services supports our recovery centers.

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

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

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

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

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

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

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

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

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

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

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

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users and others rather than eliminate drug use itself.

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

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

So very quickly, the core

values of the Philadelphia recovery-oriented system of care are strength-based approaches that promise hope, community inclusion, person and family directed, family inclusion and leadership, peer culture and support and leadership, people-first approaches, trauma-informed, holistic approaches, care for needs and safety of children and adolescents, and partnership and transparency.

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

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

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

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

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

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

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

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

The Open Society grant management team has met with our key

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

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

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

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

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

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

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

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

mentioned, we are working with the MacArthur group.

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

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

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

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

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

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

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

DEPUTY COMMISSIONER BETHEL: Any questions?

MR. COSLEY: Yes.

Jason Cosley.

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

MS. WEST: Thank you.

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

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

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

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

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

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

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

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

MR. COSLEY: Understood.

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

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

MR. COSLEY: Okay.

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

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

MR. COSLEY: Thank you.

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

MS. WEST: And mental health.

MS. SCHWARTZMAN: And mental health.

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

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

MS. WEST: Yes. I was

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

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

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

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

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MS. WEST: Absolutely.

DEPUTY COMMISSIONER BETHEL: Okay.

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

MR. JOHNSON: Yes.

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

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

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

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

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

DEPUTY COMMISSIONER BETHEL: I

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

Any more questions from the panel?

MR. MOSEE: Yes.

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

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

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

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

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

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

MS. WEST: Thank you.

MR. JOHNSON: Thank you.

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DEPUTY COMMISSIONER BETHEL: The Clerk will now call the third panel.

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

(Witnesses approached witness table.)

DEPUTY COMMISSIONER BETHEL: This team here. I'm getting scared over here. I'm just a little nervous.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Questions, or next.

DEPUTY COMMISSIONER BETHEL: We'll hear from the other two.

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

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

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

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

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

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

intense through a combination of weekly contacts and community interaction. Individuals of this division also have an opportunity to participate in our cognitive behavioral therapy, CBT. This program was developed several years ago and continues to evolve today, having positive life-changing impact on its participants. We are also in the process of expanding the reach of this program so more individuals can take advantage of its rewarding experience.

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

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

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

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

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

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

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

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

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

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

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

Similarly, the IP program

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

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

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

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

I was going to talk about AMP a

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

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

Thank you.

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

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

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

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The court does an amazing job of helping people address their substance abuse issues while allowing them to avoid both jail and a conviction. Unfortunately, it's an intensive, resource-heavy process that limits participants to only about 450 at any given time. In a city with nearly 40,000 arrests each year, there needs to be alternatives, and the AMP program is one of those alternatives. It's a quasi community court structure program. Originally it was envisioned as a way to dispose of low-level misdemeanor cases through community service. However, in 2011, it expanded into a two-tier system, which is ever so creatively named AMP 1 and AMP 2. AMP 1 follows the concept of restorative justice. It remains a way that first-time arrestees can avoid a conviction by completing community service in the neighborhoods where they committed their crime. AMP 2, however, is the real innovation. It's a unique

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

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

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

Another great innovation of the

program is that in the most traditional trial sense, after you're arrested and bail is set, it will be about three weeks before you go to formal arraignment and then maybe another three or four weeks after that before your trial is listed. In AMP, these cases are heard within days of the arrest. So there's a really quick interaction with the defendant to try to get them service as soon as possible in case they're in an active crisis.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

most effective for people.

DEPUTY COMMISSIONER BETHEL: You had a question?

MR. COSLEY: Jason Cosley.

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

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

MR. COTTER: I think it's the

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

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

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

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

Oh, he was here.

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

DEPUTY COMMISSIONER BETHEL: Thank you.

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

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

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

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

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

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

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

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

MR. COBB: William Cobb.

My question is for the

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

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

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

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

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

And if that's the case, I think it behooves this Committee to literally take a better look at that and make a strong demand for reallocation of resources. The money is there. It's just how are we going to spend money if we want to produce a far better outcome than the ones that we are currently living with.

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

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

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

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

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

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

So thank you for your testimony today. Appreciate it.

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

DEPUTY COMMISSIONER BETHEL: George.

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

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

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

MR. COTTER: Absolutely.

MR. McFILLIN: I would say no.

MR. RIKER: I would say no as well.

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

MR. MOSEE: Go ahead, Byron.

MR. COTTER: I would agree that

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

DEPUTY COMMISSIONER BETHEL:

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

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

MR. RIKER: Correct.

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

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

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

MR. RIKER: No. I would argue --

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

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

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

DEPUTY COMMISSIONER BETHEL: Because I think one of the things we can't forget in this process for a system here, we have victims out there too. I think the conversation is geared to a lot

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

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

MR. COTTER: That's correct.

DEPUTY COMMISSIONER BETHEL: Ideally, we'd like a system that every time we had that, we had some place to

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put them.

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

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

MR. COTTER: That's absolutely correct.

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

MR. RIKER: Every day.

MR. COTTER: Yes.

MR. MOSEE: Mr. Cotter, you're from the Defender Association. Mr. Riker, you're from the District Attorney's Office, and we have Probation in the middle. But when you guys are doing what it is that you do, you work as a team; is that correct?

MR. COTTER: Absolutely.

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

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

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

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

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

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

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

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

MR. COTTER: Right.

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

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

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

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

MR. COSLEY: Thank you.

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

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have the body. Now we can do something with him. We can move him to this program. We can put him in inpatient here. We can put him on house arrest. That's the main reason why we grab him. We don't grab him to bury him. We grab him to help him.

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

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

MR. McFILLIN: It's generally

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

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

get to Kirkbride?

DEPUTY COMMISSIONER BETHEL: That's why I think system mapping is so important, because Kevin Bethel is identified at the front end to start that process, so by the time he gets there, he's already enrolled instead of waiting until you get to that place.

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

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

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

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

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

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

DEPUTY COMMISSIONER BETHEL: That's a better closing than I was going to provide.

So thank you, gentlemen.

(Thank you.)

DEPUTY COMMISSIONER BETHEL: I think we have one final panel and then if

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

THE CLERK: The last scheduled witness is Joan Vieldhouse.

(Witness approached witness table.)

MS. VIELDHOUSE: Good morning.

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

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

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of control.

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

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

Because of my association with

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

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

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

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

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

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

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

DEPUTY COMMISSIONER BETHEL: When did they do that?

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

DEPUTY COMMISSIONER BETHEL: When you finish your testimony, I want to hear more about that. That might be

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something we need to recommend the Committee as well.

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

soul of this movement.

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

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

support services to anyone who walks in those doors.

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

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

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

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

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

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

DEPUTY COMMISSIONER BETHEL: Thank you.

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

(Applause.)

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

So, again, thank you for your

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

Thank you.

MS. VIELDHOUSE: Thank you.

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

So I think -- I do have a final

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

MS. VIELDHOUSE: Now?

DEPUTY COMMISSIONER BETHEL: No; once I walk away from this panel.

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

The Committee will recess until May 23rd.

Thank you, everyone, for your time and commitment.

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(Special Committee on Criminal 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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