OPEN SOCIETY FOUNDATIONS

TRANSCRIPT

"DRUGS COURTS: A FRESH APPROACH OR A CONTINUATION OF THE OLD PARADIGM?"

A Conversation With Jason Cherkis, Rick Jones, Jim Parsons, and Elaine Pawlowski

Moderator: Denise Tomasini-Joshi

ANNOUNCER:

You are listening to a recording of the Open Society Foundations, working to build vibrant and tolerant democracies worldwide. Visit us at OpenSocietyFoundations.org.

DENISE TOMASINI-JOSHI:

Some years ago, I was working-- at the intersection of mental health and criminal justice on trying to-- develop diversion programs for people with mental illness from the criminal justice-- system. Mental health court started popping up.

And they were based very much on the drug courts model. And I will admit that I was one of those people that (NOISE) initially thought this was a good idea. So, you know, we have this over-- punitive approach. We have over-incarceration and the idea that you get to divert people into treatment just sounded, well, much better than what we had-- essentially.

So I started doing evaluations of mental health courts, just seeing how they operate, going to different towns from very big cities like here in the New York, to very small places like Idaho Falls, Idaho and Albany, Georgia. And I found myself in all these places looking at all these different ways in which this mental health courts operate.

And there isn't really one model. There's many different models. But all of them have certain basic problems. And the more I saw them, the less comfortable I was with the idea-- of mental health courts. I know specialty courts (UNINTEL) a little bit more generally. So part of what I saw was that there were a lot of people there --

in drug court specifically who didn't seem to need treatment. They were just caught with drugs, but they didn't really need treatment. And-- and they knew some (UNINTEL) were in a mental health court-- in a drug court-- getting treatment.

The other problem that I saw is that there were a lot of diverting of local resources. So in a place where you used to be able to find a spot, perhaps with a small waiting list on a drug treatment prob-- program suddenly-- all of the spots in the drug treatment pro-- program were taken up by the drug court.

And unless you got arrested, there was no way of accessing that treatment. The other problem was the whole widening the net-- things that used to be dealt with-- as an-- infraction or that maybe would have-- probation, suddenly required you to attend-- treatment for a year. And you were just caught-- in this cycle of violating the terms and then having to go back to prison. And finally, it just became-- clear that it wasn't really an alternative-- to prison.

Because a lot of the sanctions for not doing well in the program-- was that you went to prison. So I became uncomfortable with that. And I moved away-- from doing that kind of work and came here to-- OSF. And I started seeing, internationally, these drug courts popping up-- in many different countries. In Chile, you have a system where they can't really-- drugs are not-- criminalized. So technically you're not supposed to be in the court system if you're caught with drugs.

But because they have a drug court, they kind of-- there's this moral coercion to get you to agree to be in court. Even though technically, under the law, you don't have to be in court. In Mexico, a lot of these just deal with alcoholism rather than with actual drugs. But they call them drug courts. So there's a lot of issues around that. And-- and what I-- and what started bothering me about the internationalization of this movement is that there was no context.

There was no context of how these courts came to be in the U.S. And there was no local context in how they were being applied. So again, the drug courts might look better than what we have if you're dealing-- in an over punitive approach with a lot of extra incarceration. But not so much in another country. In Mexico, there is a national healthcare system. And in theory you should be able to access treatment-- without having to go through the courts.

So why is treatment being tracked through the courts? But there is-- there's no question around it. Because again, there's no context. Finally, last year I was at the Commission of Narcotic Drugs and I hear-- somebody-- say very vigorously promoting with the government of Canada, drug courts-- every country should have a drug court. And they say, "Well, you know, in the U.S. we no longer arrest people just for using."

That doesn't happen in the U.S. And it just took my breath away. (CHUCKLE) Because you can give the charitable assumption for people who believe that this is okay. But then when you hear that and it is just so patently untrue, then you realize that we have a problem and we have a PR issue and we really need to get out there with some evidence of what the other side of the coin is.

So at least people can ha-- can make an informed choice when they are-- deciding to choose these things. So this panel is an attempt to do just that-- trying to highlight the other side of the coin. Why is the evidence around drug courts not as steady as people think it is-- why they're kind of-- so we call the drug courts equivocal evidence on a popular inter-- intervention. The-- brief that we put together-- the author, Joanne, is right here if you wanna talk to her about it.

And I'm hoping that you also-- get to speak to some of these panelists about their experience. I'm gonna present them-- very briefly. And then-- we're gonna start with a short intervention. They are then gonna perhaps react to what each other is saying. And then we're gonna-- open it up for you guys to ask some questions. Jason Cherkis is a national investigative reporter for the *Huffington Post*.

He previously worked as a crime reporter for 14 years at *Washington City Paper*, where he was a two-time Livingston Awards, a young journalist finalist. And received multiple awards from the association of *Alternative News*-- weeklies. Jason has written a number of stories about drug treatment and in particular about court mandated drug treatment. Notable among these-- was the heartbreaking piece-- dying to be free that recounts the overdose death of Patrick Kahey (PH) in the context of Kentucky's drug court policies. So I'm gonna start with Jason.

JASON CHERKIS:

I just wanted to talk a little bit about the recent story that I did about-- drug treatment in the U.S. and more specifically in Kentucky and sort of what I found. Specifically when it relates to drug treatment and drug courts, what was shocking to me when I interviewed-- people in Kentucky, especially I focus on (NOISE) treatment (UNINTEL) that were the hardest hit.

These were the counties that-- had higher rates of overdose deaths than any other place in this-- in the-- in-- in the state and-- and for most of the country. Kentucky is one of the hardest hit-- in terms of opiate addiction-- pills and l-- so many of the addicts had made the transition from pills to heroin. And in Northern Kentucky, they were really, really, really hit hard. And I interviewed-- several-- I think three of the-- of the judges from drug court there. And I never got a sense from them that they understood the differences between an opiate addiction and, say, an addiction to alcohol or to-- to-- to cocaine.

They all had-- a one-stop solution-- for all of their defendant's, no matter what-- addiction they came in, they were gonna get a 12-step. They were gonna get an abstinence-based drug program. They-- forced people off of methadone. And would force people off of Suboxone. And so if somebody was doing well on these medications, and they-- and they got a charge-- it could be anything.

They got a charge, they ended up in their courtroom, they'd be forced to taper off or to just get off the medication. And that-- I thought that was just these three ornery judges. But that's actually the entire policy for the state. They-- it's just their policy

that they don't allow-- medically assisted treatments. As I-- as I interviewed other-- judges and other officials-- around the state, they were adamant that you are really either masking the addiction or you were treating one drug with another drug, the usual stereotypes.

None of the judges that I interviewed seemed like they had consulted a doctor. A lot of if was just who the treatment official-- who are the most well-known treatment official was in their county. And in-- for the most part, that's gonna be somebody in the AA or 12-step community 'cause it's the dominant form of treatment.

So that's sort of one of the shocking things that I found was just sort of the-- the judges were forcing-- addicts to not take s-- Methadone or Suboxone, even if they were doing well on the medications, and their limited knowledge base. And I felt that that had-- had an effect on the defense attorneys-- who were representing these clients. That they were so fatigued by-- by what the judges were doing, that they never really challenged it.

They never thought it was worth challenging the judges. And so routinely, they would-- you know, they would plead their defendants to-- to-- maybe methods that they didn't agree with-- forced into-- to attend NA or AA meetings f-- and forced off Methadone. There was one case of a defense attorney that told me that-- her client was forced off Methadone. And shortly after he was forced off it, he committed suicide because he did not-- he knew that he wouldn't be able to handle his addiction without the Methadone.

And so he killed himself. And afterwards, the prosecutor emailed the defense attorney and-- and-- and the prosecutor said, "It's all your fault. You know, you did this to him." And I don't understand why he-- why-- why he blamed the defense attorney. But that's what he did. There's a sort of-- you kind of get a sense of the sort of mean-spiritedness of some of these places.

The other thing-- two other-- points I'll make is just that I have found-- for-- I studied-- all-- 93 overdose cases in Northern Kentucky. What was shocking to me was so many of them had spent the last moments or last months of their life adjudicating a previous overdose where they had survived. They would-- after they overdosed, the police would then come back and then charge them with a drug paraphernalia charge or, you know, something to that effect.

And then they would spend the rest of their year in the courtroom-- either on probation or going in and out of jail or, you know, it's just this litany of-- of little court appearances. And it happened so many times. And not once did-- did a doctor-- either at the ER where they were treated or the emergency-- you know, the paramedics or a judge ever said-- said to them, you know, "Let's figure out what the best treatment is for you. And let's look at your treatment history, your addiction history, your history, your life and see where the treatment would work best for you."

Instead they were just to funneled all into the same program. And-- the other-- the other thing I'll just mention briefly is just that-- for so many parents in Kentucky and probably a lot of other places where opiate addiction is sort of booming-- they don't

know where to turn. And many parents-- in Kentucky, they have a law where you can turn your child in.

They call is Casey's Law. It's named after a child that overdosed, that died. And so that parents can just turn their kid into the courts. And when the j-- (THROAT CLEARING) it'd guarantee their son or daughter, loved one-- get access to treatment. And they just thought that was the surest way to get treatment, was through the court. They-- everywhere they turned there was a waiting list. It was, "Sorry-- it was too much money."

They knew that the courts would guarantee that their son or daughter some kind of treatment. And some cases, you know, you had brought up this constant sort of adjudication or this, "Hey, we don't prosecute-- users." We may not-- we may be leaning against the sort of mandatory minimum of, like, 20 years or these exorbitant sentence that we have all-- are outraged by.

But in a sense we've-- just replaced it with, like, instead of 20 years, it's sort of-- it's ten years of in and out of the court system. It's tied to-- your drug testing. You gotta pee in a cup every two days or every week. And then you gotta-- if you violate your probation in any kinda way, you're back in jail. And I've seen that happen over and over again in cases. So that's (UNINTEL PHRASE).

DENISE TOMASINI-JOSHI:

So next we're gonna have Rick Jones, who's the executive director and a founding member of the Neighborhood Defender Service of Harlem. And he's also a lecturer at Columbia Law School-- where he teaches criminal defense externships on a trial practice course. He's frequently invited to lecture on criminal justice issues throughout the country and has co-chaired a number of task forces, including the special task force on problem solving courts. So Rick, how does this track with your experiences?

RICK JONES:

Well, l-- let me-- let me say-- let me say a couple things. And I-- and I really do apologize that I have to-- that I have to leave in an hour.

MALE VOICE:

Would you mind turning your microphone on?

RICK JONES:

Oh, sure. Certainly. Sorry. Is that-- is that better?

MALE VOICE:

Yes.

RICK JONES:

Is that better? All right. So I'll apologize again. I have to leave in an hour. I apologize. I apologize for that. And I will-- and I will tell you that-- that-- prior to-- my sort of exploration of-- of problem-solving courts and drug courts around the country-- I never practiced in-- in a drug court-- or any sort of problem-solving court.

I had been a-- trial lawyer for-- 15 years or so. And-- and at the time when I was in-- invited and asked, really-- to go on this sort of listening tour-- around the country, I was-- I was trying murder cases. And-- and really hadn't given much thought to issues of substance abuse or-- or-- drug courts at all.

I was much more worried about people not spending the rest of their life in-- in prison, than I was about-- about drug courts. But it 2007-- the National Association of Criminal Defense Lawyers-- put together a task force, convened a task force to look at this question of-- of specialty courts and problem-solving courts and drug courts.

And because they were sort of-- this-- this burgeoning, you know, cottage industry in the criminal justice system, what were they, why-- why do they exist-- and-- and were they a net good and the bad-- what-- what was the sort of verdict on these courts. And-- we-- the task force was convened. We did hearings around the country in seven different cities.

We started in Miami, which is where-- the first drug courts were-- were really sort of founded in this country. And we went to San Francisco and Tucson. Hearing-- held hearings here in New York, Milwaukee-- Austin, Texas and D.C. We heard from-- more than 130 witnesses. And there is about 3,000 pages of testimony-- that was amassed in the course of our-- in our travels. And in all of that-- and-- and we produced a report-- which-- which came out in-- in 2009.

And it's amazing to me that it's been that long. And-- and I was hoping to bring copies of that report 'cause we had thousands of them at one time. And then we went to look for them-- today where there-- there are none. But you can find them-- if you want at www.NACDL.org/drugcourts. You can find the report there and-- and the transcripts and the testimony and the hearings and all that stuff-- wealth of material-- that you can-- that you can access.

And-- and so-- and so there's two interesting questions here, right? The-- the first is-- the efficacy of drug courts and whether or not they should exist. And then the-- and then there's this secondary question of-- of exporting them-- around the world, right? And-- and I will say two things sort of quickly about-- about both of those questions. And the first is that-- I think the overarching takeaway-- from our, you know, study of drug courts and from our work-- at these hearings was that-- was that-- you know-- so much-- and I'm-- I'm sure that I'm, you know, to some degree-- greater or lesser

degree.

I don't know exactly who this audience is. But a bunch of smart folks who think about this stuff and to the extent that you're smart folks and you think about this stuff-- and I see-- I see-- I see a good friend in the back-- Lenny Noisette (PH). You know, you understand that at-- that at almost every step in-- in-- in-- along the way, our criminal justice system is broken.

And not (NOISE) only is it-- is it-- is it-- is it broken, but it's-- but it's-- racially disparate. It-- it-- it-- it-- fairly-- impacts-- the poor. And-- and so-- and so drug courts are merely sort of a manifestation of-- of that, right? You know, the-- the-- the overarching sort of principle that we walked away with from our-- from our-- inquiry into these courts is that-- is that this is really a public health issue.

That this is not an issue that should be in the legal system at all. You know, were there resources in the communities? Were there public health resources that people could access? Then we could more effectively use our criminal justice system for other things-- and not be spending huge amounts of resources on-- on-- on-- on drug courts and other problem-solving courts and dumping all of society's sort of problems at the doorstep of the criminal justice system where they-- where they don't belong and where they're not most effectively-- effectively-- treated.

The-- so that was-- so that was sort of the major-- the major takeaway. To the extent that-- that we realize that drug courts are prevalent in-- in-- the American criminal justice system, we made a handful of recommendations. And I will run through them very-- very quickly. 'Cause I'd much rather-- answer your questions and have time to have the other folks on the panel talk.

The first is that you shouldn't have to plead guilty-- to get treatment. Most of the courts that we found around the country were pre-plea courts, which means that you-- that-- that you had to have been arrested and you had to plead guilty to get access to the treatment and-- and we felt like that was-- obviously-- not the way it should be.

Also that-- that in-- in many-- you-- that your case-- once you successfully gone through the drug court program, however long that might be, six, 12, 18, 24, 36 months-- the case ought be dismissed. And in many cases we found that that was not the case either because lots of times people don't-- don't succeed all the way to the end of the drug court. And when you fail, the penalty is often much harsher and more severe for having tried and failed, than had you never gone into drug courts in the first place.

The other recommendation that-- (MIC-NOISE) that we-- that we-- that we're making based on what we found is that in many places across the country, prosecutors are the gate keepers. Prosecutors are the ones who decide who gets in and who doesn't into drug court. And that has all kinds of problems-- in terms of-- in terms of fairness, in terms of transparency, in terms of-- whether or not-- you know, what the objectives of drug court are.

Many times prosecutors are much more-- concerned about success rates, than they

are about individuals. Because-- and success rates often times are-- are dovetailed or tied directly to funding. And so to the extent you can say that my drug court has a 95% success rate-- you're much more like-- that's more-- much more likely to be thought out as a success and the funding follows. As opposed to-- we were in Miami. And one of the founders-- of drug courts-- of the drug court phenomenon said that he had distanced himself and walked away from drug courts because of that very fact.

That-- that really the folks who ought to be in drug courts are not non-violent first-time offenders who-- who are likely never gonna be back in the criminal justice system again, likely have all kind of supports in terms of parents and teachers and counselors and s-- and coaches. And so-- and-- and aren't really addicted to anything anyway.

So don't really need to be in drug courts. But the folks who really need them-- you know, s-- people who have an addiction-- people who have-- a record or prior felony conviction, people who have violence in their background, the people who really need drug courts are precluded from getting them. And-- and so we're misusing those resources. And the guy who-- the-- one of the guys who was in on the ground floor just said that-- that really what we oughta be saying is that if you're taking those folks and you have a five, ten, 15 percent success rate, all hail.

Because those are the folks you really need to be taking. If you have a 95% success rate in your drug court, it-- it merely means-- it only means that you're takin' the wrong people and you're not really doin' anything. And then-- and then the last thing-- I'll say and then I'll be quiet, was-- that we found that there was a need.

In-- in lots of places, what we found was that to the extent that you really-- if you go into local courthouses around the country, you really don't see very many white folks who are defendants. But to the extent that you do, you find them in these specialty courts. You find them in-- in-- in drug court or mental health court or gun court or whatever it is. And they're-- and they're sort of siphoned off of the regular system and they're put into these specialty courts.

And-- and black and brown and poor and immigrant folks are not. And one of the things that we found that was really troubling-- particularly with respect to the-- to the-- to the-- the fl-- the-- the immigrant community was that-- was that-- they were-- they were effectively barred from drug court because merely the fact that you were arrested and pled guilty.

Even if that plea were ultimately gonna be set aside and even if that conviction were ultimately gonna be dismissed, the fact that on the front end you pled guilty was a bar to you-- from-- from participating in drug court because it meant that you were likely to be deported anyway during the process. So there was a real bar to the non-citizen-- the non-citizen community in these courts. And we found that-- that-- that there needs to be much more objective, fair, transparent standards-- on the front end-- with respect to-- with respect to all folks. So I'll stop there and-- and invite any questions that you might have later.

DENISE TOMASINI-JOSHI:

Thank you, Rick. Thank you, Rick. So now we're gonna hear from Jim Parsons who's the vice-president and research director of the Vera Institute of Justice where he shapes the research (UNINTEL PHRASE), works with practitioners, government officials and primary seclusions to implement research findings. He is warehousing (UNINTEL) evaluation of the implementation of impacts on drug-- reforms in New York City. And he's gonna tell us a little bit about those-- drug law reforms and-- around drug courts specifically.

JIM PARSONS:

Thanks, Denise. Hi, everyone. So-- as Denise mentioned I work a non-profit in New York City called the Vera Institute of Justice. I'd like to talk a little bit about some work that we did looking at the-- changes to the New York State drug laws, changes that came into effect in 2009, which were hard-fought and hard-won in terms of the addressing and extremely punitive system of sentencing, which-- came into effect in the early '70s.

I should mention that I am-- there's some researchers, drug law research is what they do. That's not me. I'm a researcher who's interested in the overlap between the public health-- between health and-- and the criminal justice system. We are interested in the changes in New York State.

Because we wanted to know what happens when you try and change drug laws in-- in a large city and-- drug laws which have become emblematic of the extremely punitive approach-- to drug use, which is-- of course, since the r-- since the Rockefeller drug laws were implemented in the early '70s, has swept across the country.

It's important to-- to-- to-- to note when I go through these-- some of these findings, that this isn't-- this isn't meant to be representative of drug courts around the country. This is the experiences of New York. (MAKES NOISE) I'll talk a little bit about I think most of you are-- are probably very familiar with the Rockefeller drug laws. I just wanted-- a couple of facts which just-- just really exemplify-- how punitive they were.

As you know, when they were signed-- in-- in-- into-- into being in the early '70s, if you were arrested-- four ounces of a range of different drugs, you were facing a minimum sentence of 15 years and a maximum of life imprisonment. And-- following the implementation of the Rockefeller drug laws, the number of people in New York State prison where who held with drug offenses increased by a factor of 15. So in 1973, there were just-- just about one and a half thousand people. But 1999, there were more than 22,000 in New York State prisons for drug offenses.

So-- and-- and I'll return to this. Because thinking about the-- the way the Rockefeller drug law reforms were implemented, it's important to-- to note the cons-- the context in which they're implemented-- political context, the social context. Also

the Rockefeller drug laws are widely criticized for their racial-- racially disparate-- impact.

My co-investigator on this study, Ernie Drucker (PH), in a paper published-- ten or so years ago-- calculated that for every white person-- every white male between the ages of 19-- and-- sorry, 21 and 44 held in New York State prison for a drug offense, they were 40-- African Americans-- in the same age range. So this is-- you know, provides some context of the-- of the extremely punitive and dysfunctional state of-- of-- of New York's-- drug laws prior to 2009. So we got funding to s-- to-- to answer three basic questions.

When the laws changed, what happened-- what did it mean in terms of recidivism for people who got treatment? And what did it mean in terms of cost? And I'll go over these-- very quickly. I won't talk about methods too much. But basically what we did was we-- we took people from before, who were arrested on drug felony offenses, before the law changed.

Matched them with people post-- after the law changed. And then tried-- and then tracked outcomes of both of those groups. So we were trying to compare apples to apples. There is some methodological issues which I can talk about, about the way we did that. And some of these challenges are common to many studies of-- of drug cost. So just quickly to go through some of the findings. We found that of people who were diverted to drug court-- I'm sorry, the-- the laws led to a 35% increase in the-- in the rate of diversion to treatment for people passing through the courts.

However, (MIC-NOISE) only one in five people who were eligible on paper for treatment actually received-- actually were diverted-- to treatment of other drug courts. And of those people who are eligible, about roughly equal percentages went to treatment, received a jail sentence or received a prison sentence.

So this movement, which is supposed to be this panacea for reforming the New York State-- the New York City-- court system, didn't have that kind of sea change, kind of impact that-- that-- that people who pushed for these changes hoped for. Also-- we found there was-- as-- as I mentioned before, a huge racial disparity. We found that four of the laws changed. If you were African American or Latino facing a drug felony charge, you were three times as likely to go to prison in New York City than if you were white.

After the laws changed, the racial disparity reduced. But still, you were twice as likely to go to prison if you were a person of color compared to if you were a white defendant. And we found of the people who went to treatment, there was a reduction in recidivism. So-- we went from-- 54% of people who went to-- to jail or prison-- before the reforms, recidivating within two years.

People who were equivalent but went to treatment after the reforms, 36%. So a reduction of recidivism. However, the reforms didn't reduce the use of prison or jail overall. Many of those who were diverted were sent to residential treatment, which in New York State, basically is therapeutic communities. Some of the places that Jason wr-- wr-- wrote about in his article. And people went there for long periods. So

their average length of stay was 16 months-- in a residential community.

And many of those people who went to therapeutic communities self-reported their main drug abuse as marijuana. Self re-- self reports-- (UNINTEL) speak to the prosecutors. The prosecutors will say, "Well, that's just because they want a easy ride. So they're just saying that marijuana is their main drug-- drug of-- drug of choice. We weren't able to assess that. But certainly it's our-- we-- we think that there are people who really don't need therapeutic (UNINTEL) who are being diverted to this kind of treatment.

And as a result, the drug lor-- drug law reform is expensive. For-- when we compared people who were sent to jail and prison before the laws changed with people who when to treatment after the laws, it cost $13,000 more to send someone to treatment after the laws changed, than when you compared them to the criminal justice kind of equivalent. And also-- we-- we-- we reported that the courts don't allow people to graduate from treatment if they're using Methadone, Buprenophine or other kind of medi-- me-- medica-- medically assisted treatment.

So again, a big barrier to people who use opiates and needs these kind of-- medications in order to remain stable. So I-- some of the-- some of the limitations and observations of this work for the use of drug courts elsewhere-- so-- we compared treatment to a punitive sentence when we did this work.

So when I talk about reductions and recidivism-- we are comparing going to prison or jail with receiving treatment. We're not comparing receiving treatment in the criminal justice-- system with receiving in the community. We're not comparing receiving treatment with and-- just being left alone and not going to treatment at all. So and I think that's an im-- important-- important feature. So-- and we didn't test whether the court mandate actually meant that people were more likely to succeed in treatment.

Also, in the study we did, we didn't randomly assign people to receive treatment or not to receive treatment. So there's-- you know, we could have a conversation about the methodological limitations of doing that. I'm confident that our study was fairly robust in methods. But still, you know, it-- it was not a perfect randomized controlled trial-- which, you know, is the gold standard for this kind of work.

And so thinking about our findings, I mean, in terms of New York City there were some-- some-- some promising findings but a long way to go. But if other countries or other settings are thinking about learning from New York City's experience-- Denise mentioned this. New York City was starting from a very low point from people serving long sentences for drug felony charges-- people not having access to-- to treatment in the community when they were-- and-- and only being able to get services in the criminal justice system.

So for New York City it might have been a step forward. For many places that don't have such a racially biased and punitive criminal justice system, adopting these changes might well be-- a step backwards. And I think that's just-- an important point to note when you think about what other countries can learn about the drug

court experience in the U.S.

There's no other country which is as a punitive as the U.S., as we know in terms of use and incarceration. So we-- so the U.S. is-- we are-- far to the-- to the end of the scale. And also we found that it's expensive. So for people who went to these therapeutic communities, to residential treatment, it cost $34,000 to send someone to that treatment for the 16-plus months. So we didn't-- we didn't raise the question about what people are gonna do with $34,000 if you were to use it differently in terms of helping people succeed.

So-- we have some-- I have some recommendations for what our findings say about how you would think about implementing drug courts or improving drug courts, which I can go over. But-- I'll leave those to see if they can't be questions, I think. And-- pass it to the next person.

DENISE TOMASINI-JOSHI:

Sounds good. Next, we're gonna hear from Elaine Pawloski. She lists her bio as mother and educator. And while that sums it up nicely-- I'd be remiss not to point out that she has been a vigorous and necessary voice-- to push for more-- careful interrogation of the role of-- drug courts in medical matters. The need and indeed propriety of having judges overrule doctors-- and the evidence that gets trotted out in support of drug courts and the measures that we use to declare drug courts as a successful intervention.

She has been a strong supporter of measures like California's Prop 47, which eliminated the use of drug courts for non-violent drug offenders. And I would like her to tell us a little bit more about how she got there and her experiences with drug courts.

ELAINE PAWLOSKI:

Hi, my name's Elaine Pawloski. I'm a retired educator, actually, here form New York. I'm a mother. And-- in January, I'm a first-time grandmother. But on July 4th, 2012, my middle f-- son was found dead in his New York City East Side apartment.

He was 29 years old. He was a vibrant well-educated working professional here in New York City. And he was being treated by his own physicians for substance issues. He recognized that he needed-- care. And he was getting the professional help from his own doctors here. And he was doing very well. But he made a mistake. We know much of the dilemma that he had-- on that last day. And we know he was in a crisis situation.

We know that he could not present himself to the emergency room without breaking his probation. We know that the 911 New York Good Samaritan Law wouldn't have protected him either because he wasn't draw-- involved with the drug treatment court-- with the city here. On the day he died, he didn't go to the hospital, as he

always did. He didn't call 911.

And neither did anyone that he may have been with. We don't know. He passed away in his home in Manhattan even though he lived one block from Lennox Hill Hospital. And that's where his doctors were. Why didn't he call 911? In 2010, my sons lawyers recommended that he placed in New York-- drug treatment court for a driving alcohol violation. This would change our lives forever. I've experienced a New York drug court as a supportive mom.

And have learned more since 2010 than I care to know about the stigma that substance use has on the courts, on drug policy, on journalism, as well as advocacy. We didn't feel shame my son was addressing his misuse of stubstances (SIC). We supported his efforts. And we openly talked about his life. Drug treatment courts and probation (MIC-NOISE) set a new (UNINTEL PHRASE) that we happened never witnessed before.

It's the dark dirty secret that many families keep to themselves. Not only participants berated and shamed in public forum. But family members are publicly humiliated and demeaned for their support of their own child, their partner or spouse. At times it is not only the particiment (SIC) that is under the drug treatment court supervision, but the families as well. Private medical information is aired in public. Family shortcomings, as well as romantic relationships and breakups are discussed. Hearsay or gossip is treated as truth.

Sitting in court, I learned more about each of those participant's personal lives than I knew about any of my friends. Judges and district attorneys take on a reality show demeanor that the public views as acceptable. In fact, the National Association of Drug Court Profession who's opening web page has a link to NBC's Dateline, which follows Scary Mary, the tough-talking judge of the Michigan drug court.

When these so-called news investigations highlight this type of scare tactics as normal and acceptable, we need to ask ourselves what has happened to our society to allow this behavior from our court officials. The court antics and atmostere (SIC) destroy all trust in the process. This cannot be a standard of what they call as a innovative court. But we allow this tough love behavior because society also views those with substance issues with contempt and stigmatize them (NOISE) as unworthy criminals and deserve what they get.

We believe that they should be more than thankful to participate in drug treatment court and remain abstinence (?). They should not question. They should just obey. In order to graduate and absidence (SIC) only philosophy is impor-- imposed on each individual in drug treatment court, even those who are not substance use issues.

Participants may have been arrested for marijuana, like many of them said here, or other substances under the New York punitive drug laws. And in lieu of prison, they are also receiving forced medical care that is not needed in order to stay out of the prison system. According to the National Institute of Health Outcome Trajectory Study, one-third is estimated that our placed in-- drug courts do not have issues with drug or alcohol abuse, yet they're receiving mandatory treatment.

These individuals are accepted into programs. And maybe used to boost the success rates while others are denied. It's state approved programs that do not rely on the court system feeder program to stay aloat-- afloat. These unused beds would be available for those that really need care, which is basically mirroring what many of them have said.

Once my son entered the drug treatment court program, he had no control over his medical care. His doctors at that time wrote letters to the court about what they recommended for his treatment. It was all ignored. Not only was his physician's treatment plan ignored, but so too was the drug treatment team's recommendations ignored. The lawyer at the time laughed at what her own team recommended. Since the judge agreed, my son was remanded to prison until they could find a place that they could both guaran-- agree upon.

Granted, the lawyers and the judges have no medical degrees. Yet they chose to ignore a respected physician's treatment plan, their own team's recomma-- recommendations and instead sent my son to prison until they could find a program that would work for the two of them. Why did this happen? I have yet to find out. After my son's death, I've petitioned for all the treatment notes, discussions, transcripts, procedures and court documents.

I have yet to receive any of the treatment notes. Drug treatment courts operate behind closed doors. Judges, lawyers and poorly educated counselors make medical decisions without any medical degrees. It is becoming modern common practice for medical-- drug companies to solicit drug courts judges with new medications as some of the-- treatments have-- have changed and some of them are allowing-- certain medications. But yet the judges have no medical training to understand the rhetoric.

Furthermore, doctors are liable for the medical decisions they make. Judges and drug treatment court members are not. They're left to practice medicine without any liability. The drug treatment court contracts that are signed by participants are legally questionable and are not updated with medical standards of care of reviewed by experts for the participants protection.

When bringing my son's signed contracts to two respected New York attorneys, the response was similar. And I quote, "Now, the defendant must accept the most severe authorized sentence, a state prison sentence and then put himself at the utter mercy of these people for many years. He must waive the right to counsel, the right to an attorney, client confidentiality, all rights to privacy, the right to seek bail on a new arrest and to-- oppose extradition.

And the right to oppose a probation violation on the basis of mere hearsay. And you must even accept indefinite and ill-defined obligations such as to promote this program indefinitely. Participants-- participants have to make an agonizing decision to accept this program as an alternative to having their case adjudicated in the usual way and the risk that he would have received a conviction or jail or prison time.

Many of these agonizing decisions are simply money related. And I would say that my son's probably was too. It cost money to go to court to defend yourself and a plea

is expected. Getting your day in court is no more. It's just not common practice anymore. The show in the public drug treatment court (UNINTEL) is just that. It's a show. The teams are held accountable for the ge-- are not held accountable for the legality of their contracts or their treatment recommendations.

They are not held accountable for their mistakes. They're not held accountable for the injuries or deaths under their watch. Neither are the injuries or death counts regularly recorded. You can't find them. Each drug court operates so differently than in the over 20 years of the expanding drug (UNINTEL) we really have no idea how many iventividual (SIC) and families have been hurt or what due process rights have been broken.

The data just doesn't count. Furthermore, participants of drug treatment court are placed on ro-- probation and do not have the same rights as others when it comes to getting emergency care for drugs or a-- alcohol. New York's 911 Good Samaritan Law designed to save lives by encouraging people to call 911 during an overdoes, doesn't offer those on probation and in drug courts the same protection as others. Even though drug court say that drug abuse can be a chronic and relapsing condition, they and their families are left to fear arrest, fend for themselves and risk death from overdorse (PH).

For me, this is completely discriminatory and a state crime. But that's a personal opinion. The U.S. Government has marked substance abuse as an illness in need of medical support and promotes drug treatment court as the compassionate answer to illegal substance use. In actuality, it continues to treat these individuals as morally defective and in need of behavior modification.

Judging and lawyers are left to device forced a-- abstinent treatment that does not meet standards of care and are allowed to order participants into their own biased programs. Although there maybe a recommended practice booklet for drug treatment courts, drug courts are not evaluated regularly to demand that procedures are followed or that education of team members are up to date. There's no oversight of any of these medical recommendations.

The National Association of Drug Court Professionals continues to pr-- pr-- parade celebrities in support of their programs. And I have since wondered if these celebrities do not have the choice to refuse, as they too may be still under obligations from their own drug treatment (CHUCKLE) court contracts. Judges are left to do as they please, as the public relation teams mislead the public, sensationalize the process and sugarcoat the details with catchy phrases and public service announcements.

Nowhere do they rep-- do they present an expert example of what should happen end of the day-- to day proceedings of the drug court. My son may be alive today if he did what he always did. He was taught to call 911 just like every kid. But because of the punitive drug laws and the stipulation of drug treatment court, he hesitated and questioned whether it was worth it.

A call was not made and neither did he walk the one block to the hospital. He died

like others here in New York, alone. Furthermore, the police assumed he was yet another investment banker that partied way too much. Although the police had many questions, they just waited for the toxicology reports and no real investigation has been done. My son is home now. He's on the (CRYING) 29th step of the Morris Island Lighthouse in South Carolina.

And I continue to support the restoration of the lighthouse in the memory of my son. But there's no mother should have-- that should have to go through this. There's 2,500 drug court programs operating in the United States. And they're trying to get them-- more of them and spread it across the world, the-- the-- the globe. We need to hold the judges responsible for the medical decisions made under their watch. And we need to hold drug treatment courts accountable for what they profess to do.

We also need to expand the 911 Good Samaritan Laws to protect all of those that may be dying, not just select groups. And no one should fear punimish-- punishment for calling 911 if they are in a desperate situation. I have also been actually allowed to-- I don't know why they-- they print them. But (CHUCKLE) I do write a few blogs for the *Huffington Post*. And I've been researching this since my son was-- has passed away. Thank you. (APPLAUSE)

DENISE TOMASINI-JOSHI:

Thank you so much, Elaine. It's a really important perspective and experience and one that I unfortunately have not heard as often when these drug courts are-- discussed. Usually what you get are these-- before and after evaluations where-- people come out and they don't have an addiction prob-- problem. And they say, "Well, look, they don't have addiction problem." And I'm thinking, "Well, yeah. If you give me-- treatment for prostate cancer-- I am in the end, not gonna have prostate cancer."

But it-- it's this before and after evaluations that get-- pushed and-- supported as evidence that they work and what you hear constantly. So I thank you for coming and sharing your experience because we need to hear more-- about what other side is. And I-- I'm gonna give-- each speaker-- a chance to-- react to each other's presentations. And then we're gonna take some questions from the audience. Thank you.

JASON CHERKIS:

I just had a question for Elaine. When your son was before the drug court, what did-- what did his doctor recommend that they laughed at? I'm just curious at to what? 'Cause that seemed interesting.

ELAINE PAWLOSKI:

He-- he had-- doctor here--

(OFF-MIC CONVERSATION)

ELAINE PAWLOSKI:

Oh, I'm sorry. He had doctors here that-- wrecked-- recommended a-- certain facility. And they felt-- or he felt was, you know, the best place for him. It was quite a high-priced facility. The public def-- not the public defender, but the-- the attorney, you know, looked at it and thought, "Here's another-- here's a rich kid. He's going to a rich program. That's not acceptable."

It's the same thing as the treatment court-- professionals. They had recommended a place. And I don't know why they didn't take at least the drug court te-- treatment team's advice. That, like, floored me. (CHUCKLE) And I-- I've yet to find that out.

I've petitioned to have all my son's-- records from the court. And our attorneys and myself have been jumping from one hoop to another. And they haven't released-- much of that information. Some of the information that I do have is not complete.

They've pulled a lot of records that I know happened because I was there. So we're just still in a process. So a lot of those questions I can't even answer because I don't know what they were thinking. And nobody does because that type of-- discussions are left in closed doors. And it's behind the scenes. And there's no openness about how they make those decisions.

DENISE TOMASINI-JOSHI:

So when I visited some of these specialty courts, one of the things that they said about not having-- strict requirements about what records they keep or where they send people is that the flexibility is part of what makes it great.

That their regular justice system runs people through, like, a mill. But the specialty courts can really take care of people. So it's important-- to hear your story and to hear examples of-- as Jason was saying, of people not really being individualized in treatment because the reality is that it isn't a very personalized approach. It's flexible in the sense that every court can do something different. But not necessarily individualized, which is what I think some people need. Can you reflect on that, Jason?

JASON CHERKIS:

Yeah, I-- I can. Actually, as the heroin epidemic hit Kentucky-- they actually lost bed space. So they were losing capacity to even treat kids in-- in any of their treatment

facilities. But one thing was interesting was as the epidemic was hitting-- the department of corrections and through the courts-- they would have-- they signed up these contracts with different facilities. So in one of the main facilities in Northern Kentucky, they had more than 50% of the beds. And they decided-- about, like, a year ago, just randomly almost, that they were not-- they were only gonna pay for a certain amount of days.

And so they cut the amount of time that a person can be their treatment under the court supervision by, I think it was, 90 days. So instead of having, like, the extended period of time to-- to get treatment or to whatever-- they just sort of mand-- mandated that it was a c-- you're gonna get one-third of your time is gonna be reduced. And that was across the board. I don't think that was made because a doctor said it was the be-- better way. I think was a cost-cutting measure.

And so a lot times, I think, a lot of the motivation really comes from actually how much is this gonna cost. I think in your case it was. And when I've seen Medicaid or-- or others who are medical professionals talk about it, they only talk about, say, the medical-- medication, this is-- the MAT-- treatment-- in terms of how much it costs. Suboxone does cost a lot of money.

In the facilities that-- the drug court favors, their big selling point is that they're super cheap. That that's like-- you know, on their website they will say, you know, "We only cost, like, $.35 a day and, you know, we are super cheap and affordable." And-- and that's sort of the main selling point. Nevermind their-- the actual care.

ELAINE PAWLOSKI:

If I can add to that. If you have insurance, they make you use your insurance. And if they recommend a place and you don't have the insurance or it costs more, the family members have to pay for it. So where they ended up sending my son, his insurance had worked to a certain point. And they also agreed that it was not necessary for what the court was going to recommend. But since I didn't want him to sit in jail, I ended up paying for the treatment that they recommended just so he could get out of jail.

So it works both ways. They wanna get money for the pos-- specific facilities that they have on their list. And they will use the person's insurance first to cover it. And then if the judge deems that you haven't jumped through enough hoops, somebody else has to come along and pay for it. And it's usually a family member or they sit in jail until there's an opening for them to return because the judge has mandated that.

DENISE TOMASINI-JOSHI:

Rick, I'm wondering if you can-- reflect on Jason's-- comment about the-- public defenders feeling-- beaten down in Kentucky. What-- what has been your experience seeing-- public defenders having to deal to deal with this system? How much do they

feel like they can do in this context. And-- how do they feel about this courts and working in them?

RICK JONES:

Sure. I-- just-- just-- just a couple of-- a couple of thoughts. I forgot to talk-- you know, it-- it-- it baffles me-- that-- that places-- other places around the world have been many interests in exporting-- parts of our criminal justice system.

It-- it-- it really baffles me. I-- I-- I-- I-- I was part of a United Nations delegation last year to-- I went to Ghana and to Liberia. And I got to spend-- ten days with-- there are 24 public defenders operating in the entire country of Liberia. And they-- and I think this was the first time that they all came together in one place.

And we-- and we-- and we-- got to take a real sort of hard, close look at-- at how the criminal justice system works in Liberia. And one of the things that I-- that I walked away from-- that experience understanding is that-- you know, there-- you have to-- you have to have respect for the places that you go.

Because there are lots of things that they do better than we do. And there are lots of things that they do in Monrovia and in other parts of-- of Liberia that are-- that are more enlightened in terms of dealing with-- with people-- and-- and issues, in criminal justice issues and what should be and should not be in the criminal justice system and how you handle that stuff.

So-- so the-- the thought that-- that-- that places are-- and I agreed-- just last week, to go to Katmandu later this year-- to do a similar kinda thing. But I'm going their wiser-- understanding that-- that-- that there are lots of-- of things that-- that people do-- in their-- in their-- in their homelands and in the native countries that are much more-- enlightened than the things that we do here. And certainly I would-- not want to be-- an exporter of-- of problem-solving cooked (?) in drug courts to other-- to other countries.

Because I think that they're much more effective and meaningful-- impactful ways to-- to deal with these kinds of social and human-- and human issues. The other thing that you said that really-- that I had not thought about. But it's-- but it's true is-- and I'll-- and it sorta ties in with-- with what-- the question you asked me about public defenders. Is that the concept in these problem-solving courts, the concept in-- in these-- these drug courts is one of a team sort of concept.

That the prosecutor and the defense attorney and the judge and the-- and the social workers and-- and all the treatment folks are all part of the same team. And-- and sort of the-- the-- the-- the fourth, fifth and sixth amendment sort of fly out the window. This idea of zealous advocacy is sort of gone. And everyone supposed to be sort of on the-- on the same team. The-- the client, the defendant will stand up frequently in open court and talk directly to the judge.

And the defense-- lawyer-- has either bought into this in many parts of the country

or-- or feels constrained-- to-- to-- to stop it. And-- and so I think that-- and to the extent that-- that in these team meetings-- they-- they are dealing with people who have public health issues. And they are dealing with people who have substance abuse issues-- and who need good medical guidance.

You know, it's an interesting idea that I suspect it would put a diff-- it would cast a different pall on these courts if there really was some accountability. If there really was some idea that a judge could be f-- could find himself smack dab in the middle of a medical malpractice suit because he had not done, you know, what was provident from a medical perspective, having no medical sense whatsoever. I bet you if there were that kind of liability-- and there is not.

But if there were that kind of liability, I bet you it would change-- a little bit the way that-- the way that people think about-- about these courts. And your right-- from the-- from the defense perspective-- it is a-- it is a-- a-- a sort of neutering experience. It-- it really is a-- a-- an experience where-- the-- the-- the ability to be a zealous advocate, the ability to-- to-- and the private bar is almost non-existent in these courts.

So the-- the ability to-- to really-- stand up and represent your client in a meaningful way-- in an adversarial way, which is what our justice system is really all about and oughta be about. And we oughta be limiting it to those kinds of-- I mean, when you start to bring all societies problems to the criminal justice system, this is what you get. And so that's why defense attorneys find themselves often times-- standing mute while clients are-- are saying all kinds of incriminating things to a court. And decisions are being made in back rooms-- by a team-- where-- where-- they're not, many times, in the best interest of-- of that individual.

JIM PARSONS:

I'd just like to-- just to-- to pick up on the issue of d-- of-- of public defense as well. We're-- also we're-- at Vera we're doing some work on how public defenders negotiate conversations with-- with clients who have serious mental illness.

So a different population, but still a population that has a h-- a public-- basically a health need. And what we're finding is that whereas some defense services such as the Harlem Neighborhood Defenders of the Bronx Defenders or other agencies may have access to social workers or clinicians, most public defenders don't have the qualifications or the ability to make decisions about what treatment-- treatment needs their clients have either.

So saying you need zealous public defense when you're dealing with what is primarily a treatment issue, yes, you do need zealous public defense but neither the prosecutors the defenders or the judges are qualified to make decisions about whether their client has a treatment need, if their client does have a treatment need, what service they need-- require.

And then also whether it's a good idea. I mean, we of-- we talk to-- to def-- to-- to a

number of public defenders who are conflicted about when they should raise these kind of issues of people's public health needs in court. Because of the concern about what will happen-- to their clients if they get caught up in something like a drug court or a mental health court, when they may be facing a fairly minor charge. So I think that defenders are often conflicted. They don't want to raise the issues. They don't know what will happen.

Because it w-- may mean that their clients get further sucked into the criminal justice system where often I think their approach is just, "Kinda keep your head down. We'll get you out of the court. You will get treatment. So, you know, it may mean that you're back here on another drug offence in a year's time. But let's just, like, not get you caught up in what can be a very deep and tangled moment in the court system if you end up going to a drug court and you get revoked and you end up in prison."

So I think-- I think public defense is, of course, essential for people in the justice system. Good public defense is essential. But it's not a-- it's not a substitute for somebody who has clinical experience who can determine what-- what someone's treatment needs are.

ELAINE PAWLOSKI:

Uh-huh (AFFIRM). And-- and I would say that there's not a doctor on any of these courts that are advising them. There maybe a counselor. They may have six weeks of counseling-- in drug addiction. And when they're talking about how much it cost to run those courts, if you're going to AA, which doesn't cost anything and the judges are recommending AA, they don't have to worry about the cost.

If there's not a doctor on call (CHUCKLE) charging his fees, there's going to be no cost if they don't have 'em there. If that was part of the process, those fees would go up. And like Jason said, they're going to cut-- because it costs too much money.

If they had to put a doctor on all of these courts, they would not be able to run these courts. They would be just too much money. And I did wanna add to your-- your comment about lawsuits. In 2014, Clark, Indiana has a class action suit pending-- for a judge in Clark County.

And it's a class action for too much jail time. Because, like Jason said and other said-- and my son was sitting in jail for a certain amount of time. The lawyer also for my son, he recommended not to prosecute that. You know, 'cause I could have gone and said, "You have my son in jail for too long. And because he didn't want to-- interfere with the judge." Because so much is done by the judge, if you're not on the good side of the judge, he can just, for any reason, put you in jail. So that's part of the problem as well. There's just no accountability anywhere in these courts.

DENISE TOMASINI-JOSHI:

So I'm gonna turn it off to-- turn it over to the public now. If anybody has any

questions, please walk over to the microphone so that we can-- record-- we're recording the session. Thank you so much.

JOANNE CHELLA:

My name is Joanne Chella (PH). Thank you very much for-- to everyone on the panel for those excellent presentations. I just wanted to say more in the guise of comment than question, in response to this question of why is it that any country would be interested in exporting or importing this model.

Well, if you could hear the way that the United States represents it in UN meetings and in other international forum, you wouldn't ask-- ask that question. Because this is now-- very consciously on the part of the administration, the magic third way between lock 'em up prohibitionism and crazy legalization on the other side.

And drug courts are spoken of as the true solution. And there are-- dr-- drug court judges who are trotted out to these international meetings and drug court judges from outside the U.S. who-- from countries that are alive to the U.S. who are s-- telling stories about drug courts that, again as Denise suggested, give before and after beautiful stories of lives transformed.

So-- part of the context I think that we should be aware of-- of-- for this discussion is that next year, here in New York, at a special session of the UN General Assembly, there will be a major-- moment for reflecting on the global drug regime.

And the United States will come to that meeting and U.S. allies will come to that meeting with drug courts as a major new avenue for the global-- for global drug control. And so as you have a chance in all of your lines of work, there'll be a lot of journalists. They'll be a lot attention to this meeting to speak on this. Please, please, please, bring the evidence. Because the evidence is being completely distorted. Thank you.

JASON CHERKIS:

Can I just say about that, that was-- you know, it reminds me-- this is a few years ago now. I was on a panel-- some-- somewhat similar to this talking about this issue. And there was dr-- a judge from a drug court-- who was on the panel-- with me.

And one of the success stories-- from the drug court. And it was-- it was a woman. She was probably in her-- in her late '30s, early '40s. She was a mother. And she-- and she-- and she give-- she told a very compelling story about how at a very young age, 12, 13 or so, she got involved with drugs and it got increasingly worse and all of the horrible things that it led to and all the-- the-- the r-- all the different ways and reasons why she'd been arrested and the horrors of her life. And how-- at-- at-- at-- and she had this long rap sheet of, you know, all kinds of different-- different-- with all kinds of different convictions. And finally she landed in drug court and it's-- and it changed her life.

And-- and-- and-- (NOISE) and because of drug court, she was now-- back with her kids and-- and-- and-- and had a job and was, you know, back on the road to-- to-- you know, wherever. And-- and at the end of that, and at the end of her presentation-- I asked the question-- "Well, what would've happened if in society there had been a place for you when you were 12?"

"You would probably have avoided all of the next 30 years of pain," right? And-- and l-- this is literally a true story. The-- I was here and the judge was there. And-- and-- and the woman he brought was sitting there. By the time we finished the panel, the woman he brought was sitting next to me. (CHUCKLE) And-- and-- and-- and she had-- she had-- she had realized-- that-- that although-- she was in a good place now, had there been resources for her-- when she was 12 or 13 or 14 or 15, someone to listen to her and-- and-- and guide her in a different way to the public health resources-- she would've avoided those 30 years of pain. And so I think that that's really sort of the classic example of-- of how we-- how we deal with sort of this-- this, you know-- presentation that is made by-- by-- by drug courts and drug court judges.

ELAINE PAWLOSKI:

And-- and also if I could say that I've written to the American Medical Association as well. And they've called me back. And it's the same thing there. The medical profession (UNINTEL) are not educated in this. So it's easier for them. And they promote the drug courts as well.

Because therefore, they don't have to deal with the treatment issue at either. They don't even have licenses to be able to understand how to-- do a maintenance-- treatment. Or with-- with the drugs either. And they rather pass that off. And so they can't access treatment. And there is especially, not just for adults. If you look at it in the juvenile system, it's even worse. It's just even worse.

JASON CHERKIS:

I mean, I would say also-- when you talk about PR efforts and-- and-- and that kinda thing, judges and-- and the police, they know how to come across as empathetic-- as empathetic. They know that, you know, the country is moving more towards-- legalization or at least dr-- severe drug reforms, good drug reforms.

MALE VOICE:

De-criminalization?

JASON CHERKIS:

De-criminalization. That's a good court word, sorry. And so they'll-- the judges-- no matter what, they'll say the same thing that-- more progressive side would say. "Oh-- addiction is a disease. It's just like Diabetes." But it hasn't-- the-- the rhetoric has not translated into a new system or-- an empathy towards defendants. They still viewed-- defendants and say, "Wait-- I felt that they still had the same animosity towards them, even if they were in their courtroom.

The presumption of guilt-- looking at them-- everything they do is a lie or s-- with very harsh skepticism. They'll only say it's a disease-- I mean, they'll say it to me but they won't really put that into practice. And I'll say there was one-- this is-- don't wanna dwell on this on point.

But there was-- a facility in Baltimore that realized that-- it was a Methadone clinic. And they were operating-- very punitively. You missed a day, you were gone. You-- ended up in jail, you were out of there-- off their-- their roll, the roster. All these other rules, you talk back once, you're outta there. You know, all these different things. And they realized that they were not-- they were saying it's a disease, but they were not acting as if it was. They were not treating the clients with respect as-- as if they have a disease like any other disease.

And they changed their policies. And their dropout rate actually, not surprisingly-- decreased. They now have-- their attitude now is if the-- if somebody quits their program or leaves without completing it, that's their failure, not their-- not the-- addicts failure. And that was a change that they had made. They realized that they were ch-- talking a new game. But they weren't really practicing it.

JIM PARSONS:

Just-- just so I-- so a very quick point. I know we're all-- treating drug court research with a healthy dose of skepticism. The-- the research which looks at the things which predict success, the most important predictor is the judge. So-- I think that while there may be some-- some-- some challenges and flaws that we've-- we've identified in the drug court model, I think that there is also a huge range in the application of drug courts.

And I think often-- I mean, prosecutors are the gate keeper to drug courts, where the judges are the people who operate them and make decisions often about what happens to people in drug-- drug court and how-- how it's operated. So-- I think that just bears out what you're saying. Yeah.

DANIEL WOLF:

Hi, thanks. My name is Daniel Wolf (PH). I'm the director of the (UNINTEL) program in public health (UNINTEL). I have a comment and a question. The

comment is though I work internationally, I guess I would add a note of caution about the idea that a doctor's presence will necessarily result in-- appropriate treatment. Because there are so many instances when doctors share as Elaine's last comment highlighted, there's some of the same biases and discomfort around what we mean by success in drug treatment. And as long as abstinence is taken as the only gauge, in fact, it's not an honest medical conversation.

And there are, of course, are doctors participating in many of the treatment facilities to which people are being referred. And I'm-- and this leads me to my question, which is I know we focused on the criminal justice side. Obviously there are also powerful vested interests in filling a bed for 18 months.

In fact, in many places, corrections and drug courts are the only people who would pay at this point for such long-term treatment. And that's regardless of whether it's necessary or-- or not. Because in fact, it's doing double duty as a place to sort of-- contain people. And I'm curious if any of you have looked at the role or scrutinized the role of the drug treatment providers. I would-- and-- and Jason, in your piece in the *Huffington Post*, you made an important distinction, which you didn't make here today between AA and-- and which is actually free and not a for-profit entity.

And 12-step programs in the context of treatment providers, which obviously have a vested interest and-- a sort of revenue stream. So I'm curious about the-- the-- the role of the healthcare providers actually perpetuating the system and if anyone has looked at it. Thanks.

JIM PARSONS:

I-- just (THROAT CLEARING)-- perhaps not directly addressing your question. But it's interesting that with changes in healthcare policy and the-- and the Affordable Care Act, now certainly there will need to be a justification made for ne-- medical necessity in order to get drug treatment services (THROAT CLEARING) covered by the federal government. And I expect that this will have a massive impact on drug courts. Because demonstrating that long periods of residential treatment are medically necessary, is gonna be difficult.

And the insurance and the insurers, private insurers and the federal government are gonna push back hard against that. So-- it will be interesting to see how that kind of filters through the drug court system-- and if you're theory is correct, which I-- which I strongly suspect that it is in many cases, that there is a-- a need to fill beds-- I think that-- that we'll see a big change in that hopefully over-- over the next couple of years.

DENISE TOMASINI-JOSHI:

One reflection is that-- during my years visiting-- specialty courts, I noticed that I never heard a judge ask a participant if they liked their treatment, if their treatment

provider was treating them well-- how that was going. So I realized that there was kind of no quality control for what the treatment providers were doing. And I noticed that the worse the treatment providers were, as far as I could asses-- the more they loved the courts. (CHUCKLE)

Because you don't need to provide good services if the court is requiring people to be there. So there was never any incentive to have any kind of-- customer-oriented approach or, you know, person-oriented approach. People were required to be there. And I mean, and it was great. The bad treatment providers loved the court. They loved the fact that they didn't have to do a thing, just tell people, "I'll call your judge-- if you don't come."

So there was a perverting effect that the courts were having on treatment providers. Whereas some of them would perhaps have engaged in that process of reflection-- that you're talking about and asking, "How can we keep people in by providing better services, by-- you know, getting people to want to be in treatment." They just never had to look at that. And it created this weird-- it created this weird-- disincentives to-- not be very good. So that's a reflection on how the court is actually having a very negative effect on what-- of the treatment that is available.

SHARON STANCLIFF:

Sharon Stancliff (PH), medical director of the Harm Reduction Coalition. Daniel said a lot of what I wanted to say. But I thought it would be good to get a doc to get up and add onto it a little bit. Yes, there are doctors behind every one of these treatment or these programs.

At least in New York State, they're asked to do things. They're asked to have Medicaid pay for it. And Medicaid has come around and said, "No, you can't do that." I worked for an agency that had, not residential, but mandated people. And that was a huge struggle with the courts to say, "No, this person doesn't need it. We're not gonna give it." And then, you know, personally I felt like I had to leave for a number of reasons.

But one of which is, okay, so they're calling it a disease. And we're gonna treat this person. And if I don't do a good job, they're going to prison. That's really interesting. And I think-- I think, you know, there may-- there's not really a great road in through-- like, the American society of addiction medication. But physicians need to understand a little better what they're doing. And as an add on, I was in Northern Kentucky yesterday. Wow. (CHUCKLE)

JASON CHERKIS:

I-- I just wanna get to a couple points that were-- were raised. (NOISE) One, I think the treatment system, no one really talks about the quality of care. The debate and the discussion is always about bed space and money and funding. A lot of the

funding, a lot of the way the places are, the way the system is set up is by, "Oh-- funding streams." So for example, in Kentucky and sort of-- I always bring it up (UNINTEL) because I went there. But like-- the-- the major drug treatment system is these 14 facilities.

They're not run out of the department of health, they're run out of the department of housing. Because they get money from HUD. So like, the guy in charge is like a housing guy. He's pretty knowledgeable and I don't wanna slam him for that. He also is really tight with the-- you know, the-- the governor's-- the first lady. She serves on the board.

And so I forward, you know, their emails together. And they had quite a cozy relationship where she often asked him-- for-- medical opinions, which he was completely unqualified for, such as, "What do you think of residential treatment for-- you know-- kids with-- bipolar-- mess-- or depression?" And, you know, he's an adult who-- who mainly works with adult addicts. He doesn't know anything about kids. But she asked him. And-- or she'll ask-- you know-- the list can go on and on.

But so there's those kinds of relationships. There's not really-- a debate about what is good treatment versus bad. And the-- the oversight over these facilities is-- is negligible or-- or straight up lies-- or just bad science. And I feel like-- with the kids with the judges (UNINTEL) say in Northern Kentucky, they rely on what's in their community. And so what-- what's in their community is like this outspoken abstinence guy, they're gonna go to him.

'Cause they-- 'cause he goes to the meetings. They're not gonna go to the doctor. And think about all the ways that they make doc-- make it really hard for doctors to practice and to treat and annex. Doctors already don't wanna do it. It's not taught in schools. And to even get-- a certificate to-- to do Suboxone, you gotta be certified. And you have a patient limit. You're also under incredible scrutiny for doing it. So many doctors I talk to, talk about (UNINTEL PHRASE).

The police show up at their door. The DA, if you're over a certain limit or in one case, the police just park in front of the office all day, just sit there. Just-- and wr-- and-- and wr-- take down a license plate numbers of the-- of the-- their clients. So I mean, that-- we have this sort of weird system where it's-- we-- we can go after doctors.

But we're-- we don't focus at all on the treatment facilities. When-- I'll just leave you with this one thing and I'll stop-- I'll stop blabbing. But a lot (MIC-NOISE) of these facilities have-- what's on their wall, like a death wall, they call it. All the people that died having graduated from their facility. And this is not seen as, "Oh, my God, we have to reevaluate how we operate." (CHUCKLE) This is-- they always see this as a lesson to the-- the ones that are coming in. "You better fly right or you could die."

And it's not-- they don't use-- these kids as an example of how they failed. But they see it as-- as-- they failed this system and it's a warning to all the other kids. They don't view-- it's not seen as, "Oh, my God, we need a crisis of consciousness." It's a (UNINTEL).

ELAINE PAWLOSKI:

The other thing-- with that-- Jason, is the institution, they have that wall. But if they're in the drug court, the drug court doesn't have that wall. They don't even count them.

JASON CHERKIS:

Good point. (CHUCKLE)

ELAINE PAWLOSKI:

So they are like nonexistent. Because they expect the facility fail them or the person failed. But yet, the court doesn't have to keep track of any of this. And neither do they have to keep track of anyone who may be injured in the treatment facilities, which I had written an article about some of these facilities, even in the drug court that my son was at, a girl s-- stood up and said how she was sexually assaulted and so on and so forth. And the judge looked away. And-- you know, I don't know if it went anywhere. But those things aren't recorded either.

KENNETH ANDERSON:

Hello, I'm Kenneth Anderson from Hams (PH) Harm Reduction for Alcohol. And I wanted to-- make a couple comments. Rather than the AMA, you might wanna contact the American Association of Addiction Psychiatrists, the AAAP, which seems to me, pretty good.

I just started checking 'em out recently. Some of our most popular treatments, the 12-step treatment programs, the last time they were analyzed with a controlled trial was 1980. And they did worse than the control group. So I mean, the normal outcome of addiction is people get over it on their own. So saying, "Oh, look, people got better," that proves nothing. You gotta get better than the control group.

And also (NOISE) in the majority of-- states in the United States-- mandated 12-step programs has been ruled unconstitutional. It's a violation of the First Amendment, Freedom of Religion Clause, especially with the-- Ninth Circuit judgment that-- that all these states. So it's really not constitutional to send anyone to a 12-step program. And well, those were the comments that I wanted to make. Thank you.

DENISE TOMASINI-JOSHI:

Thank you.

DOCTOR NEWMAN:

Thank you. I'm-- Doctor Newman. I wanna-- absolutely agree with what-- what has been said about the very, very negative role of a lot physicians in-- in connection with the drug courts. In observation, I think there is nothing that professionals, be they journalists or be they-- lawyers or doctors can say with regard to drug courts and the adverse impact of drug courts, that comes anywhere near being as compelling as the voice of somebody who has had family members go through it and personally suffered.

Elaine is one-- case in point. A few months ago, there was a-- brief TV coverage-- of a drug court-- judge in Nassau County-- it was either Nassau or Suffolk County. And it was a father who said his son had been doing very, very well. He had been on Methadone.

Got his life together. He was-- caught up in some, I think, pre-- court case, a warrant. Forced to go off of Methadone and the father found him dead in his bed-- just a few-- weeks later. Just-- one other-- really word of caution in terms of terminology. There have been several references to addiction, substance-- misuse being a public health problem. There are certainly public aspects to almost any kind of illness, where it's Diabetes or epilepsy or anything else.

But the individual person who is being presented for treatment to healthcare providers, I feel, has to be viewed as an individual patient with an individual problem. As soon as you say we're treating this person as a public-- as an-- example, as an illustration of a public health problem, then you open the door to justifying anything and everything that's done by the prosecutors, by the judges, by the social workers who work with the courts, by the treatment providers who participate.

Because they can say, "Hey, you know, sure we're treating an individual. But our goal is protect and help the public." And you can get away with almost anything if you say that, especially 'cause ultimately we're looking to the public to support the views that have been expressed today about-- about-- drug court. So sure, there are public health components. But we're talking about individuals with individual problems. And that's the way they should be treated. Thanks. (APPLAUSE)

HELEN REDMAN:

I had-- a comment and a question. My name is Helen Redman (PH). I'm a licensed clinical social worker and I've worked with drug users for a long time. And I'm also a journalist and I write about different aspects on the war on drugs. And when I listen to all your remarks, I-- I kept wondering where is the drug user in all of this?

It's what the judge wants. It's what the prosecutor wants. Everybody else except the person with the drug problem, that they're voice is somehow not at all a part of this process. And that's-- that's a problem. Because people who use drugs, they actually know what they need. And to discount that voice is really problematic.

The second thing is it's evident that our drug treatment system is a disaster. It's an absolute disaster. It's full of people who wanna punish drug users, who don't have much education or licensure. And we need a revolution in our drug treatment system and to move away from abstinence to a more harm reduction approach, which understands that relapse is normal and natural. And so my question to-- to those of you still here on the panel is do we need to get rid of drug courts? Do we need to abolish them? And if you think we need to abolish them, what do we put in it's place?

JASON CHERKIS:

Go there. (CHUCKLE)

DENISE TOMASINI-JOSHI:

Not me. (CHUCKLE)

ELAINE PAWLOSKI:

I'll go there. (CHUCKLE) That is the issue. It's the stigma. And it's also the laws. You know-- if you are caught with alcohol, it doesn't matter, it's against the law. If you're caught with marijuana, it doesn't matter, it's against the law.

So what do you do with them? You have to put them somewhere. Because the law says it's illegal. So everybody who is a drug user is basically a criminal. Whether they're caught or not is where they're labeled a criminal. So really it is going through and changing the laws, the drug laws.

Because what do you need the drug court for if it's all right to have marijuana. (VOICE) So that may change because the laws with marijuana are changing. So you don't have to go there. If you're a youngster and you're doing alcohol in high school, you're-- you're gonna be in a big problem, where most of the kids do alcohol in high school. They're just not caught. So it's really changing the whole philosophy of the society. And I just don't know how (UNINTEL) will take.

JASON CHERKIS:

Well, I-- I mean, I think it's all been sort of touched on how the drug court is sort of an inadequate-- and potentially and-- and in some cases-- harmful-- substitute for a real drug treatment system, or a real system where-- as Dr. Noonan pointed out in-- people can be cared for as individuals.

When I was doing my story, towards the end of it a doctor-- and we were going through this story and hashing it out. And she had this ideas-- and-- and she wanted

me to-- to-- to talk about the differences in-- in how Methadone-- versus Suboxone, versus whatever could be used-- for an individual who was suffering.

She had said that Methadone for-- is really-- an effective treatment for-- you know, your most hardcore user, the one that's been using for-- for the longest or that's (MIC-NOISE) had s-- the most struggles. And, you know, it just dawned on. It's like, "Well, we don't really have that choice."

It would be great if an addict could go to a doctor or a professional who understands medicine. 'Cause we-- it's been raised that sometimes doctors don't really understand what they're talking about. And-- and make a decision based on the science and based on their history. I don't think we're getting that at all.

We're getting this other thing. And you brought up a great point, we don't hear from addicts that much. And the addicts that I interviewed-- in the different facilities-- or I would-- in some cases-- collect the writings of people that had passed away or interviewed friends. And the thing that I had sort of-- you know, statement the parents would say, you know, they were lying all the time or-- you know, always looked at them. In a way, parents sort of adopt what we all do, which is like the 12-steps sort of cultural thing.

It's all sort of part of our language now. You know, they didn't read (UNINTEL). I was enabling them," and all this other stuff. And, you know, some of the parents, like, took their car away, drove their kids everywhere. The-- the kid still died.

And so-- what I got a sense from reading the write-- their writings and from interviewing addicts is that they were all really scared. I was surprised by how many-- addicts that I interviewed who had tried to kill themselves, who were-- who the addiction was so great, it was so painful on all different levels that they had tried to overdose-- had thought about overdosing or just thought they eventually were gonna kill themselves. That surprised me. No one that I interviewed-- very few that I interviewed had great stories about what it was like to be a heroin addict.

Like, "This awesome time me and my buddy shot up and it was great. We sat around in my parent's basement." That was a story that someone told. That was the best of it. Most of it was like, "I robbed someone's house," or "I was desperate and I used somebody else to get drugs." Heroin is so cheap it generally-- doesn't really require much.

I got a sense from most people that they were really frustrated. And a lot of the addicts that had died had already knew that they were hitting a wall, that abstinence wasn't working. And they didn't know what to do because that's all they had. So they were hitting a wall and-- and didn't know where to turn.

JIM PARSONS:

Just-- just-- just time to go that-- that-- that question a little bit with the comments from the doctor earlier about the issue of public health. And I-- I think that actually

there's a li-- a slight misinterpretation of public health when you say that it doesn't focus on the individual.

Because I think public health is a call to use the-- the-- the-- the tools of epidemiology, the tools which public health as a field, applies to epidemics, applies to disease. And to say we need to-- we need to treat addiction as a public health issue, we need to understand that it's-- there are social determinants of health, is to do an incarceration, is to do with the kind of challenges that people face.

We need to use those tools of medicine and public health to address this issue. It doesn't-- that side-steps the question about what do we need instead of drug courts, or do we need drug courts. Certainly in New York State there was-- a concerted effort by many progressive organizations to overturn the Rockefeller drug laws. There wasn't the call to-- to decriminalize drugs. Perhaps the call was a step towards that. It was reducing the harm of incarceration by-- by overturning the drug laws, was the first step.

So-- that's perhaps a pragmatic response and then perhaps a wrong-- wrong-minded response. But going from a system where-- which is extremely punitive, to thinking about how you reduce the harms of the excessive incarceration. I think many people see drug courts as being a step in the right direction w-- obvi-- maybe not enough of a step in the right direction, clearly you (UNINTEL). I think that's often why people end up at-- advocating their (?) court rather than a run in prison.

ELAINE PAWLOSKI:

And the other thing that no one's really investigated is if your going to a drug court, you're signing contracts. So you're really-- if there was a really big investigation on what these kids are signing or what the adults are signing, the contracts in and of themselves really need to be investigated. Because that's where you get more of the going back to jail because you didn't follow the contract.

Some of the contracts that I've seen even out in Florida, part of it is dependent on where you live in the country. The stipulations are different. In Florida, one of the ones that I read, you have to go to church every week. It doesn't matter if you're Jewish. It doesn't matter what nationality you are. But you do have to go to church week--

JASON CHERKIS:

And so (UNINTEL PHRASE)--

ELAINE PAWLOSKI:

And if that's not in there--

JASON CHERKIS:

--did it say what kinda church?

ELAINE PAWLOSKI:

--you don't go.

JASON CHERKIS:

I mean, was it-- (CHUCKLE)

ELAINE PAWLOSKI:

I-- I don't think remember.

JASON CHERKIS:

A Holy roller one? (CHUCKLE)

ELAINE PAWLOSKI:

And part of my son's contract, you can't use aftershave. You can't go to a restaurant. You can't-- I mean, there's so many stipulations on that. And the other component of that is that if someone sees you there, they will call the judge or they will tell somebody.

And, you know, it's brought up in court. My son's first day there, the judge said to him, "I saw you in such and such a bar." And my son looked at him and like, "No, I was at work." And he goes, "Well, you were at work at 10:00 at night?"

And he goes, "Well, I work in investment banking. I (CHUCKLE) work 50 hours a week. I wasn't there." And he goes, "Well, I guess it wasn't you." But that's (CHUCKLE) what goes on in those courts, is that anything that's being said or whatever's written in these contracts can come back.

FEMALE VOICE:

Yeah, so-- I'm an attorney, but I've never practiced criminal law. And in fact, what I do it health policy. So this whole discussion is completely-- you mentioned the Affordable Care Act. I mean, where health policy is going is completely in the opposite direction from this.

So we're all working on-- the triple aim is to-- to not just reduce cost but really to focus on quality of care and-- and everything is becoming a combo care organizations and managed care. And the idea of social determinants of health that you have to long-- look be-- beyond.

Like, clinical practice of care to what are the social determinants of how-- like, housing and education and poverty and all these other things. So, like, I'm-- I'm thinking, like, maybe the answer is somewhere in this reform that we're doing now of the-- the healthcare system and, yes, to decriminalize and to try to really address this with-- with a really-- with-- with this new health system that they're trying to create.

I'm not that optimistic (CHUCKLE) about it. But-- and that's why I have been focusing most recently on quality of care measures and the idea that this other system is out there with absolutely no quality of care measures being imposed on.

Because that's where the healths-- care system is going. You are being required to prove quality and to, you know, outcomes. (CHUCKLE) And you know, it's just-- I-- it's just amazing to me that they're getting away with this. So, you know, whenever I have a chance, I'll-- I'll try to bring out this other system out there.

DENISE TOMASINI-JOSHI:

Yes, do. Thank you. I-- I think if even a grain of that comes through, it'll be much better than what we have right now.

FEMALE VOICE:

Hi-- I'm a social worker in a public defender's office. And the topic of the judge who oversees the problem-solving courts was brought up. And since problem-solving courts had expanded to mental health and also to other things-- especially New York, how do you recruit the right judge and the right ADA into these problem-solving courts-- so that maybe they're a little bit more empathetic or maybe they protect clients privacies or a lot of things that were brought up?

DENISE TOMASINI-JOSHI:

Well, that's a tough one.

JIM PARSONS:

I mean, so-- so-- so I know-- in New York City, judges-- who work in the mental health courts who I would say were exemplary in terms of their approach. I don't know-- I don't-- I think often people self-select. Peo-- people may self-select for the right reasons or they may self-select for the wrong reasons.

Because they have a particular philosophy about treatment which they want to expand, whether that's the right philosophy or whether it's-- whether it's not. Yeah, I think we've all read about the zealously religious-- judges who will-- who will have requirements which-- which may not be to everyone's beliefs. So-- but-- yeah. I don't have much more to offer than that, I'm afraid. (CHUCKLE)

DENISE TOMASINI-JOSHI:

I-- I would say you want a judge who's pretty political bulletproof. Because you want a judge that can set their own measures of what success is, rather than-- have to play to the lowest common denominator-- of success-- which is (NOISE) just like absolute abstinence for people. You know, who used to smoke pot on the weekends and then don't smoke anymore. So I don't know, I-- I mean that's really-- I-- I feel like in a sense it's a little bit rearranging deck chairs on the Titanic to talk about (MIC-NOISE) how (UNINTEL PHRASE) put the right judge for a drug court.

So it's a very difficult-- question to answer. Because in the end what you want is an acknowledgement that people using drugs is not the worst thing that can happen. And-- and-- elephant in the room is just really the stigma that you referred to and where are the drug user voices.

And as long as we have-- a system and we live in a country where using drugs is considered just the absolute worst thing, worse than losing your civil rights, worse than losing your freedom, worse than losing your autonomy-- worse than, you know, signing a contract where you can't go to a restaurant or use aftershave.I mean, it's just-- it's really worse than shaming your family. That we can't really have a good positive drug court.

I mean, it's just-- the drug court would not exist in a world where-- where we would acknowledge that there are worst things that can happen to a person than using drugs. And that in fact drug courts do a lot of those worse things. So-- (APPLAUSE) so this is-- this is part of the conversation that we're having.

And perhaps opening people's eyes a little bit to what-- what are the negative effects of these-- drug courts. And-- and I do wanna say because I will be criticized for not saying it-- if I don't say it. That I understand that a lot of the individuals that work in drug courts have very good intentions. And they think that they're doing the right thing. And they're working in a very difficult system that-- puts the wrong incentives on the wrong measures on them and they're trying to do their best. So I don't wanna demonize the people who work in these drug courts.

But it is a system that is fundamentally wrong for the ends that we wanna achieve. And we do need to highlight the due process costs of these interventions which have to do with Civil Rights and-- with-- diminishing our adversarial system of justice. And we do have to talk about the medical cost of these interventions which also have to do with-- you know, diminishing people's human rights and right to-- make their own-- medical decisions and right to the autonomy of their bodies.

So on that note, I'm gonna close it unless somebody else has something to-- that they wanna ask publicly. Otherwise you can just come approach us and we can chat a little more, drink some wine, have some food. Thank you all so much for coming here and helping us be part of this conversation. (APPLAUSE)

(OFF-MIC CONVERSATION)

* * *END OF TRANSCRIPT* *