



**BROOKLYN
DEFENDER
SERVICES**

TESTIMONY OF:

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Presented before

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Hearing on Addressing the Opioid Crisis in Criminal Court

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My name is Yung-Mi Lee and I am a Supervising Attorney in the Criminal Defense Practice at Brooklyn Defender Services (BDS). BDS provides multi-disciplinary and client-centered criminal, family, and immigration defense, as well as civil legal services, social work support and advocacy in nearly 35,000 cases in Brooklyn every year. This includes thousands of people arrested for possession or sale of opioids, and many more fighting deportation, eviction, or a loss of parental rights due to opioid-related allegations or convictions. I thank the New York City Council, Committee Chair Rory Lancman, for inviting us to testify on the opioid crisis in criminal court.

The overdose epidemic is among the most deadly forces in our city today, warranting a strong response from policymakers. According to the New York State Department of Health, 8,444 New Yorkers overdosed on opioids in 2016. 1,769, or 20 percent, of those overdoses occurred in New York City.¹ Importantly, this epidemic is driven not only by opioid use but also by drug mixing, often including a combination of opioids and stimulants. BDS applauds Mayor Bill de Blasio for embracing the Safer Consumption Space model sought by people who use drugs and harm reduction specialists. The four Overdose Prevention Centers, if approved by the New York

¹ New York State Department of Health, New York State – Opioid Annual Report (October 2017), available at https://www.health.ny.gov/statistics/opioid/data/pdf/nys_opioid_annual_report_2017.pdf.

State Health Department, will build on the successes of other such sites around the world and save lives. We hope it becomes an example for the rest of the country, as public health initiatives originating in this city often are. Crucially, these centers must not become dragnets for the NYPD, which could seriously undermine their efficacy.

BDS believes a public health approach is essential to reducing the harms of addiction and recreational drug use alike. The criminal legal system is simply ill-equipped to prevent drug use, meaningfully reduce the supply of drugs, or – most important – help keep people who use drugs as safe as possible and minimize harm to their families and communities. The City’s and State’s discordant efforts to meld the enforcement and public health approaches often result in unnecessary and counterproductive incarceration and criminal records, social stigma, and tragic deaths.

I. DRUG TREATMENT COURTS

Pressed by formerly incarcerated people, grassroots activism and legal experts to reverse skyrocketing incarceration rates for drug offenses, New York City became a pioneer in the creation of drug treatment courts in the early 1990’s and remains one of the jurisdictions with the most developed post-arraignment diversion system. While these courts may in fact reinforce the problematic drug prohibition model, they have helped reduce jail and prison admissions and sentences. A landmark report, *Better by Half: The New York City Story of Winning Large-Scale Decarceration While Increasing Public Safety*, details and attempts to quantify the impact of the these courts, including Drug Treatment Alternative-to-Prison (DTAP) program, originally operated by the Brooklyn District Attorney’s office but later replicated throughout the state. For example, “the proportion of felony drug cases that resulted in a prison sentence fell from 21 percent in 1997 to an all-time low of 11 percent in 2007.”² Largely as a result of decreased drug arrests and an increase in diversion, the City jail population began to fall from its peak in 1991. State prisons followed suit in 1999 (72,899 in 1999 to 49,424 as of June 1, 2018), with the majority of the decline in admissions coming from New York City. It is important to remember that this decline was relative to the surging incarceration rates under the Rockefeller Drug Laws, during which the state prison population increased by a factor of seven. The decline has only been by about one-third since then.³

In Brooklyn, there are four specialized courts for drug offenses and/or criminal conduct linked to substance use disorders: Screening Treatment & Enhancement Part (STEP), Brooklyn Treatment Court (BTC), Misdemeanor Brooklyn Treatment Court (MBTC), and Brooklyn Mental Health Court (MD-1).

a. Screening Treatment & Enhancement Part (STEP)

STEP primarily handles non-drug non-violent felony cases (such as grand larceny, unauthorized use of a credit card, burglary in the 3rd degree) for those who have substance use disorders. The

² Judith A. Greene & Vincent Schiraldi, *Better by Half: the New York City Story of Winning Large-Scale Decarceration while Increasing Public Safety*, 29 Fed. Sentencing Reporter 22, 27 (2016), available at https://sites.hks.harvard.edu/ocpa/cms/files/criminal-justice/research-publications/fsr2901_04_greeneschiraldi.pdf.

³ New York State Corrections and Community Supervision, DOCCS Fact Sheet, June 1, 2018, available at <http://www.doccs.ny.gov/FactSheets/PDF/currentfactsheet.pdf>.

court part also accepts felony drug cases for so-called non-violent predicate felony offenders, or people who have one or more prior non-violent felony conviction in the last ten years. Based upon a clinical evaluation, the participant may receive intensive outpatient or residential treatment. Successful completion of the program results in a dismissal of the case. Unsuccessful completion results in a jail sentence up to one year if the person does not have a prior felony.

STEP also handles Drug Treatment Alternative to Prison (DTAP) cases. DTAP is the first prosecution-led residential drug treatment diversion program in the country. The program diverts nonviolent felony drug offenders with a prior felony conviction to community-based residential treatment.⁴ DTAP requires an upfront plea to a felony charge that will dispose as a misdemeanor or an outright dismissal if they complete the program. DTAP requires a longer residential treatment mandate – usually up to two years, although I once had a client who stayed for three years because he had no place to live. The mandate also requires six months of outpatient treatment with full-time employment and a stable residence. DTAP is thus difficult for our clients to successfully complete. Notably, DTAP mandates are not based on a clinical determination but are based solely on the participant’s criminal record. If our clients cannot complete the program, they are sentenced to prison time that varies based on the case. Once in prison, they will no longer have access to medication-assisted treatment.

b. Brooklyn Treatment Court (BTC)

BTC handles felony drug cases for those who are not predicates. This form of treatment requires the consent of the prosecutor. However, if the prosecutor does not consent, BTC has the capability of offering treatment through judicial diversion which was established under the Drug Law Reform Act of 2009.

c. Misdemeanor Brooklyn Treatment Court (MBTC)

MBTC is designed for people who repeatedly cycle through the criminal legal system on low-level charges due to their addiction. The court has recently evolved to be less punitive toward our clients, with shorter treatment mandates and shorter jail sentences for those unable to adhere to them. Without these shortened mandates and shorter jail alternatives, court administrators, the judiciary, treatment staff, prosecutors and defense attorneys found that defendants were avoiding this option, preferring to take a plea to the underlying misdemeanor with a sentence of time served (or even short jail sentences). Those who complete the treatment program get a full dismissal of their case.

d. Brooklyn Mental Health Court (MD-1)

MD-1 serves those with serious and persistent mental illness and offers community-based treatment as an alternative to incarceration. A special program is offered for those with dual diagnoses for serious mental illness and substance use disorders.

⁴ Prosecutors may also, at their discretion, allow people to participate in DTAP who are charged with or have previous convictions for technically violent felonies, if the underlying conduct of the violent felony was not actually violent and no one was injured. A common example of this is burglary in the 2nd Degree when somebody steals a package from an empty foyer in a residential building.

e. Concerns with the Existing Treatment Court Models

All of the Brooklyn treatment courts refer participants to “outside” or “contract” substance abuse treatment programs. These programs also have patients who have no court mandate and who are not criminal justice involved. However, the overall quality of these programs varies. Some programs cannot take participants who have a diagnosed mental illness while some are better equipped to treat our clients with dual diagnoses.

New York City has limited residential treatment bed capacity, which can mean wait times of a few weeks or more for our clients who are interested in treatment. Sometimes, if the client is incarcerated, the longer waiting periods discourage a person from choosing the treatment program option. More funding for such programs could increase capacity and reduce waiting periods, but it should only be provided with oversight to ensure that recipient programs are actually addressing the need.

All of these courts have contributed to positive case outcomes for individual BDS clients, but in general many BDS attorneys are skeptical of STEP and BTC, and in some cases even MBTC. All of the treatment courts allow for relapses and recurring relapses, but our clients face increasingly harsher sanctions with each additional relapse. Our clients often find such coercive treatment regimens to be less effective than voluntary alternatives that do not involve such sanctions.

II. THE INJUSTICE OF PREDATORY BUY-AND-BUST OPERATIONS

Many of the felony drug cases⁵ we see originate with predatory so-called “buy-and-bust” operations. These buy-and-busts typically involves undercover officers, generally dressed like homeless people and acting desperate, asking or pleading with people who, themselves, are truly drug users, to procure drugs for them. Based on the cases we pick up in court, officers appear to target people who are struggling with either addiction or mental illness or both. Some are what we call “no cash, no stash” cases, in which police do not recover buy money or drugs. Our clients often tell us they procured the drugs out of a sense of obligation to help somebody in need, perhaps in exchange for a single hit. They are almost never actual drug dealers pursuing customers. In some cases, people have walked away with the buy money, and police then arrest them for theft.

Even if law enforcement interventions were an effective tool to reduce the supply of drugs, this predatory NYPD tactic cannot be said to “get drug dealers off the streets.” Police argue that they use this tactic to gain intelligence from people who use drugs to climb the ladder to find higher-level drug suppliers, but we have seen no evidence that buy-and-bust tactics lead to the arrest and prosecution of drug suppliers.

In our experience, prosecutors generally pursue the charges in these cases.

The harm of buy-and-bust operations is that they maliciously target the most vulnerable New Yorkers, those who are homeless, clearly suffering from a substance abuse disorder or mental

⁵ Most of these cases are charged with felony drug possession intent to distribute (PL 220.16) or felony drug sale (220.39).

illness, and prey upon them in order to bump up their arrest numbers. Rather than setting people up for arrest and jail time, NYPD should be working with other city agencies to connect people in crisis with voluntary drug treatment, mental health support, housing and other services.

In one buy-and-bust case that was highlighted in the *New York Times*, a juror actually wrote a letter to prosecutors in the office of Manhattan District Attorney Cy Vance, saying it was “approaching absurd that you would use the awesome power of your office to represent the people of New York County, along with it and the court’s limited resources, on such a marginal case.”⁶ This juror raises a valuable point: Why is the City wasting its resources on targeting the most vulnerable among us, rather than supporting them? If police can identify people struggling with addiction, why not provide them with information on treatment options or other services?

III. ARRESTS AND HARASSMENT OUTSIDE METHADONE CLINICS

For many years, the NYPD has targeted areas surrounding methadone clinics and needle exchanges for enforcement and harassment. This is widely known in public health circles, and police have discussed reforms, yet aggravatingly, the practice persists.⁷ Often, the arrests involve deceptive buy-and-busts or other predatory tactics that sometimes result in serious charges against people who are actively and even successfully turning their lives around. Furthermore, it is impossible to know how many people have shied away from medication-assisted treatment and other widely-accepted and publicly-funded harm reduction resources due to fear of police presence. These harm reduction resources they are infringing upon have been proven to save lives, which suggests that police interventions may in fact be resulting in uncountable deaths.

When discussing the frequency of this practice, one of our attorneys said: “Everybody’s arraigned a guy who’s been arrested outside a methadone clinic. Usually, it’s a Friday and the guy’s got enough for the weekend.”

IV. MARIJUANA PROHIBITION AND THE OPIOID EPIDEMIC

Research funded by the National Institute on Drug Abuse found that legally protected marijuana dispensaries were associated with reductions of 16 to 31 percent in opioid overdose deaths. (HealingNYC seeks to reduce opioid deaths by 35% over 5 years.) Other experts have argued that the criminalization of marijuana led to the over-prescription and over-use of opioids and eventually the epidemic that we are struggling to address today. Simply put, marijuana seems to be a safer alternative to opioids in pain management, but criminalization undercuts that benefit. However, even under the new reduced arrest policy announced earlier this week by Mayor Bill de Blasio, vulnerable New Yorkers will continue to face arrest and possibly prosecution for personal marijuana use. This should end. BDS is proud to support the Drug Policy Alliance’s (DPA) StartSMART campaign to legalize and sensibly regulate adult marijuana use and sale

⁶ Joseph Goldstein, *Undercover Officers Ask Addicts to Buy Drugs, Snaring Them but Not Dealers*, N.Y. TIMES, April 4, 2016, available at <https://www.nytimes.com/2016/04/05/nyregion/undercover-officers-ask-addicts-to-buy-drugs-snaring-them-but-not-dealers.html>.

⁷ John Knefel, *The Common Cure for Heroin Addiction is Also a Magnet for Police Harassment*, BUZZFEED, Feb. 19, 2015, available at https://www.buzzfeed.com/johnknefel/how-police-harassment-at-methadone-clinics-makes-quitting-he?utm_term=.rj94qpORg#.ekNOjm12P; see also VOCAL-NY, *Beyond Methadone: Improving Health and Empowering Patients in Opioid Treatment Programs* (2011), available at <http://www.vocal-ny.org/wp-content/uploads/2011/10/Final-Methadone-Report1.pdf>.

across New York State. The immense harms of prohibition and discriminatory enforcement practices, balanced against the opportunity for advances in racial justice and economic empowerment envisioned by this campaign, warrant urgent action by state legislators and the Governor. The Marijuana Regulation and Taxation Act (MRTA), S.3040/A.3506, sponsored by Senator Liz Krueger and Assembly Member Crystal Peoples-Stokes, would create a well-regulated and inclusive marijuana industry, improve public safety, and meaningfully repair some of the damage caused by existing drug laws, in addition to helping to address opioid epidemic.

V. #HealingNYC, DRUG PROHIBITION AND RESOURCE MISALLOCATION

Although it was marketed as a public health program, approximately half of the city funding for Mayor Bill de Blasio’s initiative to combat the opioid epidemic, HealingNYC, is allocated to the New York Police Department (NYPD). This is an attempt to pair a public health approach to problematic drug use with increasingly aggressive law enforcement tactics – a strategy favored by many policymakers today, but one that does not appear to be rooted in modern science.

We appreciate that Mayor de Blasio is spearheading an effort to expand the use of life-saving naloxone kits and medication-assisted treatment, as well as other important initiatives to reduce the stigma of addiction and mental illness. However, we are concerned this important work could be undermined by regressive law enforcement strategies that further marginalize, stigmatize and ultimately criminalize the very people the Administration seeks to support. Indeed, as Crain’s reported last year, “nearly half of the \$143.7 million budgeted for HealingNYC through fiscal year 2021 will go to the NYPD, mostly to step up arrests of drug dealers.” Much of the funding provided to the police was reportedly to be used to investigate overdoses with the goal of bringing criminal charges against people alleged to have supplied the drugs.⁸

There is a growing recognition among policymakers across the country, many of whom may struggle with addiction themselves or have friends or family members who struggle with addiction, that criminalization and the resulting marginalization are an ineffective and, in fact, often very dangerous approach to drug use. These dangers are only heightened as police and prosecutors pursue homicide-like charges or other very serious charges against alleged suppliers when overdoses do occur. In at least one case, NYPD worked with federal law enforcement agencies, leading to a federal prosecution of a man who had shared drugs, at below cost, with his best friend, who tragically overdosed and died. This strategy aligns with an alarming national trend toward expanded use of drug-induced homicide prosecutions identified by the Drug Policy Alliance in a recent report, *An Overdose Death Is Not Murder: Why Drug-Induced Homicide Laws Are Counterproductive and Inhumane*.⁹ Among many other serious risks, experts have noted that increased enforcement can discourage people who witness overdoses from calling 911 because suppliers are often close acquaintances and may even be the witnesses, themselves.

⁸ Caroline Lewis & Rosa Goldensohn, *Will stepping up drug-dealer arrests help alleviate the opioid crisis?* CRAIN’S N.Y. BUSINESS (2017), http://www.crainsnewyork.com/article/20170522/HEALTH_CARE/170529996/nypd-gets-biggest-share-of-new-city-funding-to-fight-opioid-overdose-deaths (last visited May 30, 2017).

⁹ Lindsay LaSalle, *An Overdose Death Is Not Murder: Why Drug-Induced Homicide Laws Are Counterproductive and Inhumane* (Drug Policy Alliance 2017), available at http://www.drugpolicy.org/sites/default/files/dpa_drug_induced_homicide_report_0.pdf.

Portugal's model for drug policy suggests that we may be able to dramatically reduce overdose deaths and other serious harms related to addiction through a careful and deliberate decriminalization of the use and possession of all drugs coupled with an aggressive public health strategy. In that country, heroin use has been cut by an estimated 75% and, more importantly, overdose deaths have plummeted. Portugal has the lowest rate of drug-induced death in Western Europe – less than 2% of the rate in the United States. In light of the overdose epidemic, lawmakers should seriously study this model and import its successes where possible.

Even if a greater investment in law enforcement efforts against suppliers were an effective approach, the Council should consider whether it makes sense for those funds to come from initiatives like HealingNYC or rather be diverted from other NYPD functions. For example, the most common drug arrest charge in 2016 was for low-level marijuana possession (18,136) and, as referenced above, Mayor de Blasio recently committed to reducing this number. At an April 22, 2017 New York City Council Committee on Public Safety hearing, then-NYPD Chief of Detectives Robert Boyce said of the Department's response to the epidemic: "Our focus is not on the individual addict. Our focus is on the street level as well as interdictions coming into the country." Arrest data provided by the New York State Division of Criminal Justice Services does not support this statement. The most common drug arrest charge in 2016 was low-level marijuana possession, with 18,136 arrests. The next most common NYPD drug arrest charge, or fifth most common arrest overall, in 2016 was low-level non-marijuana drug possession, or Criminal Possession of a Controlled Substance in the 7th Degree, with 16,630 arrests. The most common drug *sale* arrest charge was Criminal Sale of a Controlled Substance in the 3rd Degree, with 5,628 arrests, or approximately one-sixth of the number of low-level drug possession arrests.

When analyzing the merits of drug enforcement and coercive treatment systems like drug treatment courts, it is essential to always consider what the funding required by these approaches could do to address the underlying causes of addiction and problematic drug use, such as lack of access to mental health care in the community.

As a public defense organization, Brooklyn Defender Services is principally concerned with the direct impacts of drug laws and enforcement on our clients and their families and communities. That said, we recognize that the fiscal and economic impacts of drug policy do in fact play a major role in their daily lives. For example, most of our clients or their children attend or attended public schools with inadequate funding. According to the New York State Board of Regents, schools are owed billions of dollars in funding under the Campaign for Fiscal Equity lawsuit, with the majority owed to schools with high populations of Black, Latino and immigrant students.¹⁰ Without the resources for a State Constitutionally-mandated "sound basic education," many of our public schools have infamously become pipelines to prisons and jails. If funds currently spent on drug enforcement were instead reinvested in school-based mental health clinics and restorative justice programs, school environments would improve and administrators and teachers would be better able to address any behavioral problems without calling 911 or issuing suspensions and expulsions. If funds currently spent on overtime for police officers who make buy-and-bust arrests near the end of their shifts were instead reinvested in making

¹⁰ Brennan Center for Justice, *Campaign for Fiscal Equity V. State of New York* (2006), <https://www.brennancenter.org/legal-work/campaign-fiscal-equity-v-state-new-york>.

substance use disorder treatment more widely available, perhaps overdoses would decline rather than increase or plateau at record-high levels.

The fact that drug prohibition is the status quo should not exempt it from close scrutiny. This hearing is a critical example of such scrutiny. These resource allocations expand the disparities in health, economic success, and liberty in our society.

VI. CLIENT STORIES

(All names have been changed.)

Jake was a 40 year-old with a series of prior arrests. He was making progress in overcoming his heroin habit through his participation in a local methadone program in South Slope, Brooklyn. His mental health had deteriorated in tandem with his drug use. An undercover police officer disguised as a homeless man rolled up to him one day, begged him for heroin, and promised to give him a cut of the money. Jake was not interested in selling drugs, but acquiesced, bought him a bag, and was arrested. Ever since, all of his progress against his addiction has stalled. He worries about whether he will be evicted from NYCHA, where he cares for his ailing mother full time. He has now lost trust in himself and his ability to gain sobriety, suffering from severe anxiety and depression. He may go to drug treatment court, but at best it will restore him to his former path toward success, and at worst it will result in a sentence to upstate prisons, where he will have no access to medication-assisted treatment.

David was a 21 year-old with severe cognitive impairment (an IQ of 55) that qualifies as moderate mental retardation. He had struggled with heroin addiction since he was 16. He was living at home with mom in Bay Ridge addiction when he was arrested at 21 for petit larceny after stealing from her to buy drugs. The judge at arraignments set bail set and he then took a plea with a full order of protection to get out of jail. He was forbidden from having any contact with his mother, which resulted in a series of contempt charges, on which a BDS attorney represented him, when he violated the order. His mother never wanted the order and asked for it to be withdrawn, but the District Attorney fought to keep it in place because they deemed his offense elder abuse. He was forced to stay in a shelter. The judge ordered regular treatment, but with his cognitive condition, he did not have the wherewithal to tackle addiction himself. He could not even answer the intake questions. His mom had been his only support. After completing a certain amount of treatment, the judge would agree to lift the order of protection; in other words, his mother could not legally assist her son until he completed his treatment and he could not complete his treatment without her. Seeing no other options, David's BDS attorney and social worker regularly went with him to the methadone clinic. Ultimately, after the case had been open for two years, the judge realized how limited he was, recognized his hard efforts, and accepted his partial compliance with the program, resolving the case with a conditional plea to misdemeanor contempt with a limited order of protection for five years. Unless his mother makes a serious allegation against him, they can remain together.

Francis was found after he overdosed in a public bathroom and, after being revived, was charged with misdemeanor drug possession. With several other misdemeanor cases open, he continued to suffer from substance use disorder. He acquired a gun owned by a family member and intended to sell it for drug money but was caught and arrested for criminal possession of a weapon in the

2nd degree – a C violent felony. He ultimately pled to an E felony with two to four years in upstate prison. He was denied a treatment alternative because his was technically a violent crime.

Anthony, a 46 year-old, was charged with a violent felony for an alleged stabbing. He did not remember the incident. He had used heroin for more than two decades and had been incarcerated for most of his life. Because of the seriousness of the charge, the judge set bail \$300,000 and he was sent to Rikers Island. During his time there, which lasted nearly a year, he was not allowed into any treatment program because he had been charged with a violent crime. Our social workers often find it difficult or impossible to get our clients into such programs for the same reason. Another common reason for such denials is an allegation that the person is a member of a gang, a specious and questionable designation that should have no bearing on access to treatment.

Carlos was an older man with a heavy file, which is indicative of a long history of criminalization. As is often the case with such people, his is a record of mostly misdemeanors. He was ensnared in a buy-and-bust operation and charged with felony possession with intent to distribute. The prosecutor found the arresting officers' documentation deficient and dismissed the felony charge, leaving only the misdemeanor drug possession charge for residue on a crack pipe found in Carlos' pocket. He was released from court with a sentence of time served and, as always, a mandatory surcharge that will likely go unpaid, damaging any credit he might have had. His parting words to his BDS attorney were, "I have a crack problem. When are they going to stop this?"

BDS is grateful to the Council for hosting this critical hearing and shining a spotlight this issue. Thank you for your time and consideration of our comments. We look forward to further discussing these and other issues that impact our clients. If you have any questions, please feel free to reach out to Jared Chausow, our Senior Policy Specialist, at 718-254-0700 ext. 382 or jchausow@bds.org.