The Drug Court Judicial Benchbook

Editors

Douglas B. Marlowe, J.D., Ph.D.

Judge William G. Meyer (Ret.)

February 2011

Updated February 2017

NDCI

NATIONAL DRUG COURT INSTITUTE

The Drug Court Judicial Benchbook

Prepared by the National Drug Court Institute, the education, research, and scholarship affiliate of the National Association of Drug Court Professionals.

Updated February 2017

National Drug Court Institute

C. West Huddleston, III, Chief Executive Officer
Carolyn Hardin, Chief of Training and Research

1029 N. Royal Street, Suite 201
Alexandria, VA 22314
Tel. (703) 575-9400
Fax. (703) 575-9402
www.ndci.org

This project was supported by Grant No. 2009-DD-BX-K149 awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the SMART Office, and the Office for Victims of Crime. Points of view or opinions in this document are those of the author and do not represent the official position or policies of the United States Department of Justice.

Printed in the United States of America.

Drug courts perform their duties without manifestation, by word or conduct, of bias or prejudice, including, but not limited to, bias or prejudice based upon race, gender, national origin, disability, age, sexual orientation, language, or socioeconomic status.

Acknowledgments

The National Drug Court Institute (NDCI) is grateful to the Office of National Drug Control Policy (ONDCP) of the Executive Office of the President and the Office of Justice Programs (OJP), Bureau of Justice Assistance (BJA) at the U.S. Department of Justice (DOJ) for the support that made this publication possible.

NDCI owes its sincere gratitude to drug court practitioners across the nation who submitted or reviewed the individual chapters that form the basis of this benchbook. Without their willingness to share their knowledge, this project would not have been possible. NDCI has made every effort to faithfully present the substance of each chapter just as the author(s) submitted it. The views expressed in each chapter are those of the author(s) and do not necessarily reflect the views of all of the contributing practitioners or reviewers, NDCI, ONDCP, OJP, BJA, or DOJ.

Contributing Authors

Paul L. Cary, M.S.
Director, Toxicology Laboratory
University of Missouri Health Care

Carson L. Fox, Jr., J.D.
Director of Operations, National
Association of Drug Court Professionals

Judge Karen Freeman-Wilson (Ret.)
Former Chief Executive Officer, National
Association of Drug Court Professionals
Former Executive Director
National Drug Court Institute

Steve Hanson, M.S.Ed, LMHC, CASAC
Director, Bureau of Treatment Services
NYS Office of Alcoholism and Substance
Abuse Services

Helen Harberts, M.A., J.D.
Special Assistant District Attorney (Ret.)
Chief Probation Officer (Ret.)
Butte County, California

Carolyn Hardin, M.P.A.
Chief of Training and Research
National Drug Court Institute

Douglas B. Marlowe, J.D., Ph.D.
Chief of Science, Policy & Law, National
Association of Drug Court Professionals

Judge William Meyer (Ret.)
Senior Judicial Fellow
National Drug Court Institute

Judge Jeffrey Tauber (Ret.)
President Emeritus, National Association
of Drug Court Professionals
Director, Reentry Court Solutions

Reviewers and Consultants

NDCI would also like to thank the Drug Court Judicial Guidance Manual Committee for their invaluable contributions as reviewers and consultants. They are as follows:

Honorable Alonso Alfonso
Honorable Michael J. Barrasse
Honorable Joel Bennett
Honorable William F. Dressel
Honorable Leonard Edwards (Ret.)
Honorable Susan Finlay (Ret.)
Honorable Rogelio R. Flores
Carson Fox
Honorable Lawrence P. Fox (Ret.)
Honorable Karen Freeman-Wilson (Ret.)
Carolyn Hardin
Honorable Peggy F. Hora (Ret.)
C. West Huddleston, III
Honorable Kent Lawrence
Honorable William G. Meyer (Ret.)
Honorable Nicolette M. Pach (Ret.)
Honorable Louis J. Presenza (Ret.)
Honorable Bill Schma (Ret.)
Honorable John R. Schwartz
Honorable Jeffrey Tauber (Ret.)
Honorable Avril Ussery Sisk (Ret.)
Meghan Wheeler

This publication could not have come to fruition without the valuable editorial work of the following individuals:

Jill Beres, Consultant

Jane E. Pfeifer, Consultant and Adjunct Professor
Justice Development & Training;
California State University, Chico

Nancy L. Urizar, J.D., Ph.D., Consultant

Jennifer L. Carson, Editcetera

No publication comes to completion without the hard work and dedication of the people who oversee and manage the project. NDCI acknowledges the outstanding work of the following people in helping to produce this publication:

Leonora Fleming, National Drug Court Institute

Kelly Stockstill, National Drug Court Institute

Table of Contents

FOREWORD xi

PREFACE xiii

INTRODUCTION 1

THE HISTORY OF DRUG COURTS 1

THE PRESENT FOR DRUG COURTS 2

THE FUTURE OF DRUG COURTS: THIS JUDICIAL BENCHBOOK 2

CHAPTER 1 DRUG COURTS: BACK TO THE FUTURE 7

I. [§1.1] INTRODUCTION 9

II. [§1.2] THE HISTORICAL CONTEXT 9

III. [§1.3] THE ADVENT OF DRUG COURTS 11

IV. [§1.4] THE CRITICAL PARTNERSHIP OF JUDICIAL LEADERSHIP AND COMMUNITY 13

V. [§1.5] THE IMPORTANCE OF GOING TO SCALE 14

VI. [§1.6] REENTRY DRUG COURT: THE FINAL FRONTIER 15

VII. [§1.7] WHY YOU SHOULD GET INVOLVED 16

CHAPTER 2 GETTING STARTED 19

I. [§2.1] INTRODUCTION 21

II. [§2.2] THE DRUG COURT TEAMS 21

A. [§2.3] Steering Committee 21

B. [§2.4] Drug Court Team 23

C. [§2.5] Extended Drug Court Team 24

III. [§2.6] DEFINING THE PROBLEM 24

IV. [§2.7] ESTABLISHING A MISSION 26

V. [§2.8] MEASURABLE GOALS AND OBJECTIVES 28

A. [§2.9] Program Goals 29

B. [§2.10] Objectives 29

C. [§2.11] Mission Statement 29

VI. [§2.12] GATHERING RESOURCES 30

VII. [§2.13] DETERMINING ELIGIBILITY CRITERIA 31

VIII. [§2.14] SELECTING THE DRUG COURT MODEL 33

A. [§2.15] Pre-Plea Diversion 33

B. [§2.16] Diversion with Stipulation of Facts 33

C. [§2.17] Post-Plea, Preadjudication 34

D. [§2.18] Postadjudication, Probation 34

E. [§2.19] Probation Revocation 34
F. [§2.20] Mixed Model 34
IX. [§2.21] GRADUATION AND TERMINATION CRITERIA 35
X. [§2.22] PHASE STRUCTURE 37
XI. [§2.23] APPLYING PROGRAM CRITERIA 39
XII. [§2.24] EVALUATION 41
XIII. [§2.25] CONCLUSION 42

CHAPTER 3 THE ROLES OF THE DRUG COURT JUDGE 45
I. [§3.1] INTRODUCTION 47
II. [§3.2] JUDGE AS LEADER 48
III. [§3.3] JUDGE AS COMMUNICATOR 50
IV. [§3.4] JUDGE AS EDUCATOR 53
V. [§3.5] JUDGE AS COMMUNITY COLLABORATOR 54
VI. [§3.6] JUDGE AS INSTITUTION BUILDER 58
VII. [§3.7] CONCLUSION 59

CHAPTER 4 ADDICTION AND TREATMENT SERVICES 63
I. [§4.1] INTRODUCTION 65
II. [§4.2] DEVELOPMENT OF ADDICTION 67
III. [§4.3] COGNITIVE EFFECTS OF DRUGS AND ALCOHOL 69
IV. [§4.4] WHAT DOES TREATMENT DO? 71
A. [§4.5] Motivation 72
B. [§4.6] Insight 72
C. [§4.7] Behavioral Skills 72
V. [§4.8] EVIDENCE-BASED PRACTICES AND BEST PRACTICES 73
A. [§4.9] Motivational Enhancement Therapy and Motivational Interviewing 74
B. [§4.10] Cognitive Behavioral Therapy 74
C. [§4.11] Contingency Management 75
D. [§4.12] Relapse Prevention Therapy 75
E. [§4.13] Self-Help Recovery Programs 76
VI. [§4.14] ADDICTION MEDICATIONS 77
VII. [§4.15] LEVELS OF CARE 79
A. [§4.16] Detoxification 80
B. [§4.17] Inpatient Rehabilitation 80
C. [§4.18] Residential Treatment Programs 81
D. [§4.19] Intensive Outpatient Treatment or Day Treatment 81
E. [§4.20] Outpatient Treatment 82
F. [§4.21] Recovery Services 82

VIII. [§4.22] THE ROLE OF THE JUDGE IN DETERMINING THE LEVEL OF CARE 82
IX. [§4.23] TREATMENT PLANNING 83
X. [§4.24] CULTURAL AND GENDER ISSUES 85
XI. [§4.25] SUBSTANCE USE DIAGNOSES 87
XII. [§4.26] CO-OCCURRING MENTAL HEALTH DISORDERS 88
A. [§4.27] Hallucinations 89
B. [§4.28] Delusions 89
C. [§4.29] Negative Symptoms 90
D. [§4.30] Affective Disorders 90
E. [§4.31] Anxiety Disorders 91
F. [§4.32] Attention Deficit Disorder (ADD) 92
G. [§4.33] Personality Disorders and Learning Disabilities 92
XIII. [§4.34] SELECTING AND WORKING WITH TREATMENT AGENCIES 93

CHAPTER 5 COMMUNITY SUPERVISION 99
I. [§5.1] INTRODUCTION 101
II. [§5.2] WHO PERFORMS COMMUNITY SUPERVISION? 101
III. [§5.3] PERSONNEL REQUIREMENTS AND COMPETENCIES 104
IV. [§5.4] FUNCTIONS OF COMMUNITY SUPERVISION 104
A. [§5.5] Protecting Public Safety 105
B. [§5.6] Providing Accountability 106
C. [§5.7] Enhancing Drug Refusal Skills 106
D. [§5.8] Identifying Environmental Threats 107
E. [§5.9] Catching Impending Signs of Relapse 107
F. [§5.10] Partnering with Treatment 108
G. [§5.11] Enforcing Community Obligations 109
V. [§5.12] EFFECTIVE COMMUNITY SUPERVISION PRACTICES 109
VI. [§5.13] ACCOUNTABILITY TECHNOLOGY 110
VII. [§5.14] JURISDICTION OVER PARTICIPANTS 111
VIII. [§5.15] MEMORANDA OF UNDERSTANDING 112

CHAPTER 6 THE FUNDAMENTALS OF DRUG TESTING 115
I. [§6.1] INTRODUCTION 117
II. [§6.2] DRUG TESTING RATIONALE 117
III. [§6.3] SPECIFICITY IN THE CLIENT CONTRACT 117
IV. [§6.4] SPECIMEN OPTIONS 118
V. [§6.5] SAMPLE COLLECTION ISSUES 123
VI. [§6.6] SELECTING THE DRUGS TO BE TESTED 125

VII. [§6.7] TESTING METHODS 125
VIII. [§6.8] RESULT INTERPRETATION 128
IX. [§6.9] URINE DRUG LEVELS 132
X. [§6.10] DRUG DETECTION TIMES 133
XI. [§6.11] SPECIMEN TAMPERING 134
XII. [§6.12] CLIENT EXCUSES 137
XIII. [§6.13] ALCOHOL ABSTINENCE MONITORING ETG AND ETS 137
XIV. [§6.14] CONCLUSION 138
A. [§6.15] Ten Principles of a Good Testing Program 139

CHAPTER 7 APPLYING INCENTIVES AND SANCTIONS 141
I. [§7.1] INTRODUCTION 143
II. [§7.2] RELIABLE MONITORING 143
III. [§7.3] UNEARNED LENIENCY 145
IV. [§7.4] SCHEDULE OF STATUS HEARINGS 146
V. [§7.5] MAGNITUDE OF REWARDS AND SANCTIONS 147
VI. [§7.6] THE FISHBOWL PROCEDURE 148
VII. [§7.7] FAIRNESS 149
VIII. [§7.8] SPECIFICITY 150
IX. [§7.9] PROXIMAL VS. DISTAL GOALS 150
X. [§7.10] PHASE ADVANCEMENT 152
XI. [§7.11] SUBSTANCE ABUSE VS. DEPENDENCE 152
XII. [§7.12] NONCOMPLIANCE VS. NONRESPONSIVENESS 154
XIII. [§7.13] THE CARROT VS. THE STICK 155
XIV. [§7.14] CONCLUSION 157

CHAPTER 8 CONSTITUTIONAL AND LEGAL ISSUES IN DRUG COURTS 161
I. [§8.1] INTRODUCTION 163
II. [§8.2] FIRST AMENDMENT 163
III. [§8.3] FOURTH AMENDMENT AND RELATED ISSUES 164
IV. [§8.4] DUE PROCESS 165
V. [§8.5] DRUG TESTING AND DUE PROCESS 169
VI. [§8.6] JUDICIAL IMPARTIALITY AND DUE PROCESS 170
VII. [§8.7] DRUG COURT SANCTIONS AND DUE PROCESS 171
VIII. [§8.8] EQUAL PROTECTION 172

IX. [§8.9] RIGHT TO COUNSEL 173
X. [§8.10] DOUBLE JEOPARDY 174
XI. [§8.11] RELATED ISSUES 174
XII. [§8.12] CONCLUSION 175

CHAPTER 9 CONFIDENTIALITY 183
I. [§9.1] INTRODUCTION 185
II. [§9.2] HIPAA 185
A. [§9.3] HIPAA Order 186
B. [§9.4] HIPAA Consent Forms 186
C. [§9.5] 42 CFR PART 2 186
D. [§9.6] What Is a Program Covered by Federal Confidentiality Laws? 187
E. [§9.7] What Information Is Protected? 187
F. [§9.8] How Can Protected Information Be Shared? 188
1. [§9.9] Consent 188
2. [§9.10] Mandatory Disclosures 190
a. [§9.11] Valid Court Order 190
b. [§9.12] Child Abuse and Neglect 191
c. [§9.13] Cause of Death 191
G. [§9.14] Permitted Disclosures 191
III. [§9.15] BEST PRACTICES IN THE CONFIDENTIALITY ARENA 191
IV. [§9.16] CONCLUSION 192

CHAPTER 10 ETHICAL OBLIGATIONS OF JUDGES IN DRUG COURTS 197
I. [§10.1] INTRODUCTION 199
A. [§10.2] Integrity and Independence 199
B. [§10.3] Relations with Participants 201
C. [§10.4] Reporting Crimes and Other Misconduct 202
II. [§10.5] PRIVATE CONDUCT OF THE JUDGE 202
A. [§10.6] Providing Information and References 203
B. [§10.7] Impartiality and Decorum: Courtroom Conduct 204
C. [§10.8] Impartiality and Decorum: Conduct Outside the Courtroom 205
D. [§10.9] Ex Parte Contacts 205
E. [§10.10] Use of Nonpublic Information 206
III. [§10.11] DISQUALIFICATION AND RECUSAL OF THE JUDGE 207
A. [§10.12] Personal Knowledge of Facts 207
B. [§10.13] Extra Judicial Activities 208

IV. [§10.14] OTHER JUDICIAL ACTIVITIES 208
A. [§10.15] Publicity and Educational Activities 208
B. [§10.16] Civic Activities—Board Member of Treatment Provider . . 210
C. [§10.17] Board Member—Other Civic Organizations 210
D. [§10.18] Fund-Raising 210
E. [§10.19] Political Activity and the Drug Court 211
V. [§10.20] CONCLUSION 211

EPILOGUE LEAVING A LEGACY 215

THE TEN KEY COMPONENTS 219

PERFORMANCE BENCHMARKS 220

ABBREVIATIONS 221

Foreword

In 1998, the National Association of Drug Court Professionals (NADCP) launched its professional services branch, the National Drug Court Institute (NDCI). Since that time, NDCI has worked relentlessly to provide rigorous education, training, and technical assistance on evidence-based practices to drug court and other problem-solving court professionals.

As the original founding NDCI Director (before it was ably taken over by Carolyn Hardin), I have long wondered whether these efforts truly paid off. Do drug court professionals heed scientific information? Do they recognize the implications of that information for their daily work? And most importantly, do they adjust their practices accordingly? For more than a decade, NDCI staff members worked tirelessly on faith—at first based in blind trust, and then gradually based on firsthand observations—that drug court practitioners were, indeed, paying attention and improving their outcomes as a result.

Now, scientific research proves that our impressions were right. Research tells us that outcomes are as much as *five times better* for drug courts that provide training for all of their team members.[1] When drug court teams attended the implementation training workshops taught by NDCI and sponsored by Bureau of Justice Assistance (BJA), they have elicited an average of *fifteen times greater cost savings!* There is an old adage that if you think education is expensive, try ignorance. Knowledge is the greatest cost-savings device available to drug courts, and we at NDCI and NADCP are committed to bringing the latest and greatest knowledge to you, our constituents. We are fired up by the fact that what we do matters because what you do matters. You save thousands of lives every year, and we can take pride in the fact that we help you in your crucial work.

The *Drug Court Judicial Benchbook* represents an important step in NDCI's efforts to bring evidence-based practices to the drug court field. As drug courts "go to scale" and reach every American who needs us, we need more and more judges to join our ranks. We can no longer rely solely on a select cadre of visionaries to advance our cause. We need to instill our values and practices more broadly within the judicial system. But quantity alone is not sufficient. Every drug court must adhere to evidence-based practices and must learn from the two decades of collective experiences that our field has garnered. This benchbook presents a wealth of information for new judges considering starting a drug court, as well as for veteran judges looking to retool or tune-up their operations. Within these pages rests the collective knowledge and wisdom of thousands of judges, attorneys, treatment providers, probation officers, law enforcement officers, and research scholars. Following their recommendations will improve your drug court outcomes, increase cost savings, and provide smoother sailing for your court.

Thank you again for what you do and for allowing NDCI to continue to serve you.

C. West Huddleston, III
Chief Executive Officer
National Association of Drug Court Professionals

---

1 *See* Shannon M. Carey et al., NPC Research, Exploring the Key Components of Drug Courts: A Comparative Study of 18 Adult Drug Courts on Practices, Outcomes and Costs (2008), *available at* http://www.ncjrs.gov/pdffiles1/nij/grants/223853.pdf.

Preface

In 2000 and again in 2009, the Conference of Chief Justices (CCJ) and the Conference of State Court Administrators (COSCA) issued joint resolutions concluding that drug courts and other problem-solving courts are the most effective strategy we have for reducing drug abuse, preventing crime, and restoring families. In recognition of this fact, CCJ and COSCA called upon the justice system to extend the reach of problem-solving courts to every citizen in need, and further, to infuse the principles and practices of these proven programs throughout our system of justice.

Their conclusions echo more than two decades of rigorous scientific research establishing not only that drug courts work, but that fidelity to the Ten Key Components of the model[1] is essential for achieving the most successful and cost-effective outcomes.[2] As was originally hypothesized by the founders of the movement, research proves that the judge is, indeed, a critical ingredient for the success of drug courts[3,4]—serving, in essence, as a "leader among equals" of a multidisciplinary team of professionals that even the relentlessly addictive grasp of alcohol and other drugs cannot withstand.

But there is no magic here. Although some commentators may glibly chalk up the success of drug courts to the symbolic impact of the "black robe," or to a select group of charismatic visionaries, much, much more is required. The truth is that many judges do not perform to their potential during their first year on the drug court bench. Like any professional, it takes time and effort for judges to learn how to do their jobs most effectively.[5] It also requires considerable training and education. Judges who do not stay abreast of the research literature and do not attend specialized training do not perform very well,[6] regardless of what prestigious law school they might have attended, or whether they made law review. The truth is that the work drug courts perform requires specialized knowledge, hands-on expertise, and tireless dedication.

For this reason, I am extremely gratified to introduce this *Drug Court Judicial Benchbook* to the profession. The editors—a highly experienced drug court judge and an accomplished research scholar—have assembled a cadre of leaders in the field to synthesize and describe the latest findings on best practices and evidence-based practices. The breadth and depth of the information encompasses important and relevant topics, including but not limited to substance abuse treatment, community supervision, drug testing, judicial ethics, and constitutional law. This book is crucial reading for any drug court judge, new or seasoned, and adds considerably to the knowledge trove of our field. I know it will benefit your work, as it has benefited mine, and most importantly, it will help you to help others and to save lives. Nothing can be more important than that.

William Ray Price, Jr.
Board Chair, National Association of Drug Court Professionals
Chief Justice, Supreme Court of Missouri
Cochair, CCJ/COSCA Problem-Solving Court Committee

1 National Association of Drug Court Professionals. 1997. *Defining drug courts: The key components.* Washington, DC: Office of Justice Programs, U.S. Dept. of Justice. *Available at* www.allrise.org.

2 Carey, Shannon M., Michael W. Finigan, and Kimberly Pukstas. 2008. *Exploring the key components of drug courts: A comparative study of 18 adult drug courts on practices, outcomes and costs.* Portland, OR: NPC Research. *Available at* www.npcresearch.com.

3 Marlowe, Douglas B. 2006. Judicial supervision of drug-abusing offenders. *Journal of Psychoactive Drugs, SARC Suppl.* 3: 323–331.

4 Marlowe, Douglas B., David S. Festinger, and Patricia A. Lee. 2004. "The judge is a key component of drug court." *Drug Court Review* 4 (2): 1–34.

5 Finigan, Michael, Shannon M. Carey, and Anton Cox. 2007. *The impact of a mature drug court over 10 years of operation: Recidivism and costs.* Portland, OR: NPC Research. *Available at* www.npcresearch.com.

6 Carey, Finigan, and Pukstas, *Exploring the key components of drug courts.*

Introduction

The History of Drug Courts

Drug courts sprung out of necessity, not fashion or vogue. Just over twenty years ago when drug courts were born, the court system was in crisis. Dockets were overwhelmed with drug-related cases that rarely seemed to be resolved. Judges would sentence drug offenders to probation or incarceration, only to quickly see them back again on a revocation or new charge. The oft-cited statistics spoke loudly then and continue to speak deafeningly today: two out of three prison inmates arrested for a new offense; fifty to seventy percent of inmates reincarcerated for a new offense or parole revocation; forty to fifty percent of probationers revoked; ninety-five percent of drug offenders continuing to abuse alcohol, other drugs, or both with little pause.

Something had to give. But rather than collapse under the weight, a small group of visionaries considered what could be; what was possible but had never been tried. This required them to step out of their traditional roles and comfort zones. They would never abandon the legal and constitutional principles of our judicial system, but they would expand upon those principles and consider new ways of applying them. Neutrality, which was often used as a shield to disguise disinterest, would be transformed through the traditional plea-bargaining process into a negotiated disposition that would permit judges to talk to treatment professionals, that would require participants to speak to the judge, that would keep offenders closely supervised, and that would provide offenders with the tools they needed to get well and stay well indefinitely.

There was no magical thinking and no wish fulfillment. There was unrelenting hard work that has since been sustained for more than two decades. Rather than hide from the facts, drug courts embraced science like no other criminal justice program. They endorsed best practices and evidence-based practices, they invited evaluators to closely examine their work, and they encouraged federal agencies like the National Institute on Drug Abuse (NIDA), Bureau of Justice Assistance (BJA), National Institute of Justice (NIJ), and Center for Substance Abuse Treatment (CSAT) to issue calls to the scientific community to come see what was happening and join the fray. Some of the leading researchers in the scientific community answered those calls, first skeptically and then with great interest, and have dedicated their careers to understanding what drug courts do, how they do it, and why they work so well.

The result? More research has been published on drug courts (not to mention other problem-solving courts) than virtually all other correctional programs combined. Five independent *meta-analyses*—advanced statistical procedures conducted by rigorous scientific teams—have concluded that drug courts reduce crime and substance abuse.[1] The most conservative estimates indicate that drug courts save money for taxpayers on the order of two to four times the initial investment.[2] In short, drug courts work!

The Present For Drug Courts

But that was not the end. It was only the beginning. In 1996, a small group of drug court practitioners got together to describe the essential elements of the drug court model. Published early the following year in *Defining Drug Courts: The Key Components,* the Ten Key Components[3] identified therein quickly became the core framework not only for drug courts, but for most types of problem-solving court programs. At the time, these farsighted thinkers had little more to go on than their instincts, personal observations, and professional experiences. The research literature was still equivocal about whether drug courts worked at all and was virtually silent on the question of how they worked, for whom, and why. Now fourteen years since the Ten Key Components were published, science is catching up with professional wisdom. Research now confirms that how well drug courts accomplish their goals depends upon how faithfully they adhere to the Ten Key Components.[4]

The Ten Key Components are the building blocks of a drug court.

And science is doing more than simply validating the Ten Key Components. It is putting meat on the bones of these broad principles, in effect transforming them into practice guidelines. Armed with specific guidance about how to operationalize the Ten Key Components, drug courts can be more confident in the quality of their operations, funders can make better informed decisions about which programs to support, researchers can measure program quality in their evaluations, and trainers can identify areas needing further improvement.

Fledgling fields typically set broad and aspirational goals for themselves and resist efforts to constrain or define their practices. In the early stages of professional development, it is often best to work from the grassroots up, encouraging trial-and-error learning. However, once the knowledge base becomes sufficiently developed that it is possible to distinguish successful from unsuccessful (or worse, harmful) strategies, it is no longer defensible to permit unbridled experimentation. The only ethical and humane course of action is to begin defining acceptable practice standards and work towards bringing the field in line with those best practices.

The Future of Drug Courts: This Judicial Benchbook

Now begins the next chapter in the drug court movement. We need to continue to define best practices and assist new drug courts to recognize and adhere to those practices. This *Drug Court Judicial Benchbook* marks an important milestone in that work. The time has come to bring together much of what we know about such matters as legal and constitutional requirements in drug courts, judicial ethics, effective treatment approaches, valid drug-testing procedures, and community corrections practices. New drug court judges need a primer on these matters, and all drug court judges require a resource to

consult in their day-to-day practice. This is National Drug Court Institute's (NDCI's) effort to provide such assistance to drug court judges.

In **Chapter 1, Drug Courts: Back to the Future,** Judge Jeff Tauber (Ret.) takes a lesson from our cultural and anthropological heritage. He notes that, contrary to what many might believe, incarceration is a relatively new phenomenon, emerging substantially after our colonial history. Drug courts, it would appear, return us to our communal roots, which worked quite well to constrain antisocial conduct in premodern times. Thinking about our past might provide valuable insights into not only how drug courts work, but how we might make them even better. As the founding President of NADCP, Judge Tauber provides a fitting context for the substantive material that follows.

In **Chapter 2, Getting Started,** Carolyn Hardin and Carson Fox lay out a road map for new judges who are considering starting a drug court program. There is much to think about and much to accomplish in this regard, and these two experts plot a sequential course of action that makes the tasks seem less daunting and more manageable. As the Senior Director of the National Drug Court Institute (NDCI), Ms. Hardin routinely provides such formative guidance to new drug court programs around the country, and she is capable of teaching the material in an accessible manner. Similarly, Mr. Fox, an experienced drug court prosecutor and Chief of Operations for NADCP, has dedicated his career to training drug court professionals on how to structure their programs and carry out their functions. This chapter is a must-read for any new or current drug court judge.

Fidelity to the Ten Key Components leads to better outcomes.

In **Chapter 3, The Roles of the Drug Court Judge,** Judge Jeff Tauber (Ret.) and Judge Bill Meyer (Ret.) discuss the various roles of the drug court judge. The word *role* is cast in the plural because drug court judges serve multiple functions, either at different times or under different circumstances. These roles include overseeing the initial development of the program; serving as the team leader during case reviews and other meetings; holding entry hearings, status hearings, and termination hearings; and representing the drug court program to other members of the judiciary, the public, and the media.

In **Chapter 4, Addiction and Treatment Services,** Steven Hanson reviews the scientific research on why alcohol and other drugs can be so addictive, the behavioral and neurological effects of these substances, and treatment approaches that have proven effective for intervening against substance dependence or addiction. Recent advances in neuroscience confirm beyond dispute that prolonged exposure to these toxic chemicals can produce long-standing, if not permanent, brain changes, which may elicit cravings, withdrawal symptoms, loss of control and impulsivity. We know now that addiction is not simply a matter of will power, but is also a matter of brain damage. Armed with this knowledge, scientists and practitioners are developing effective treatments to combat the disease process, including medications, behavioral reinforcement, cognitive-behavioral counseling, motivational enhancement therapies, relapse prevention and self-help peer support groups. Mr. Hanson defines for us which treatments are *evidence-based* or reflect

best practices in the addictions field, and describes the core features of effective interventions in language that is accessible and useful for judges and other law practitioners. He also reminds us that, to be truly effective, practitioners must be proficient in and responsive to cultural and gender issues and must address co-occurring psychiatric and medical conditions.

In **Chapter 5, Community Supervision,** Helen Harberts points out that the typical drug court program can only supervise approximately ten to fifteen percent of participants' activities, leaving much of their time unaccounted for. This means that the contribution of community supervision officers is critical to the success of any drug court. Ms. Harberts, a former prosecutor and former chief probation officer, reviews best practices for community corrections officers to supervise offenders in their natural social environments; identify potential threats to their recovery and welfare; respond effectively to infractions; use field encounters to capitalize on "teachable moments"; and perhaps most importantly, catch participants doing good and reward them for their accomplishments. Research confirms that the most effective drug courts include community corrections officers on their teams, and Ms. Harberts defines for us the characteristics of an effective field officer and the essential functions to be performed by this core team member.

In **Chapter 6, The Fundamentals of Drug Testing,** Paul Cary discusses the fundamentals of effective drug and alcohol testing. Unless staff members have valid, reliable and timely information about whether participants are using alcohol or other drugs, there is no possible way to apply sanctions and incentives effectively, or to adjust clinical services accordingly. For this reason, drug and alcohol testing is, in many respects, the most basic requirement for an effective drug court program. Mr. Cary, a highly experienced laboratory scientist, reviews the strengths and weaknesses of various specimen options, including urine, blood, and sweat; the selection of specific drugs for testing; screening and confirmation procedures; the selection of drug and drug metabolite cut-off concentration levels; forensic chain-of-custody procedures; and newer approaches to alcohol testing, including ethyl glucuronide (EtG) and ethyl sulfate (EtS). To be most valid and effective, Mr. Cary concludes that drug testing should be performed randomly and at least twice per week. He also explains why drug courts should cease efforts to interpret quantitative drug or drug metabolite concentration levels, and focus instead on qualitative interpretations based on established cut-off levels.

In **Chapter 7, Applying Incentives and Sanctions,** Dr. Douglas Marlowe reviews the essential principles of behavior modification for a drug court program. To be effective, drug courts must reliably monitor participants' behaviors to ensure sanctions and incentives are applied with certainty; hold frequent status hearings to ensure consequences are imposed with immediacy; administer a gradually escalating sequence of intermediate-magnitude consequences; and ensure procedural fairness in the administration of all consequences. Dr. Marlowe further explains the basic procedures for gradually shaping participants' behaviors over time. This includes distinguishing between short-term (proximal) goals and long-term (distal) goals, and applying consequences accordingly. When conducted correctly, the shaping process reduces negative side effects, such as "learned helplessness," and increases success rates for the program. Dr. Marlowe explains

how to arrange the phase structure in a drug court program and apply contingencies within each phase to optimize outcomes.

Drug courts are, first and foremost, *courts,* and constitutional and legal requirements continue to apply to these programs, albeit with some modifications. In **Chapter 8, Constitutional and Legal Issues in Drug Courts,** Judge Bill Meyer (Ret.) reviews common constitutional and legal issues confronting drug courts. Steeped in applicable and current case law, Judge Meyer evaluates First Amendment challenges to mandatory participation in 12-step groups, which have been interpreted by the higher courts to have religious components; Fourth Amendment objections to search waivers in drug courts; due process limitations on the nonadversarial climate of drug courts; procedural due process requirements for the imposition of sanctions, including jail time, as well as termination and sentencing; evidentiary and confrontation issues related to drug testing; judicial impartiality in the "relaxed" drug court environment; equal protection in drug court admissions; and double-jeopardy challenges. Judge Meyer, a former drug court judge and chair of the committee that drafted the Ten Key Components, provides specific guidance where it can be gleaned from applicable case law, statutes, or state supreme court rules and offers recommendations for conservative practices in drug courts where guidance is currently lacking. Although not reflecting official policies of NADCP or the drug court field, these recommendations are offered in the spirit of evidence-based "risk management" from a highly experienced drug court jurist.

In **Chapter 9, Confidentiality,** Judge Meyer confronts the thorny legal and ethical issues that are encountered when addiction-related information is shared between treatment agencies and the criminal justice system. Federal and state laws related to evidentiary privileges and confidentiality may apply to certain aspects of drug court operations, as alth Insurance Portability and Accountability Act) safeguards. Judge Meyer assists drug court professionals to interpret the impact of these laws and balance due regard for the privacy and confidentiality of participants with the need to protect public safety, enforce the law, and maintain the integrity of the judicial system.

In **Chapter 10, Ethical Obligations of Judges In Drug Courts,** Judge Meyer addresses major ethical conflicts facing drug court judges. These include upholding judicial independence in light of the multidisciplinary nature of drug courts; maintaining objectivity and neutrality in light of the more direct interactions with participants; sustaining professional boundaries and courtroom decorum; managing ex parte interactions and communications; and communicating ethically with the public and potential sponsors for the drug court. Again, concrete advice is offered where specific guidance can be gleaned from applicable judicial canons or supreme court rules and recommendations are made for conservative practices where such guidance may be currently lacking.

Finally, in their epilogue, **Leaving A Legacy,** Judge Meyer and Judge Karen Freeman-Wilson (Ret.), former Chief Executive Officer of NADCP, offer inspiration and a forward-looking perspective to drug court judges and other jurists considering becoming drug court judges. Just over twenty years ago, some forward-thinkers planted seeds that took

immediate root and eventually sprouted a bounty of over 3,000 drug courts and other problem-solving courts around the U.S. and the world at-large. That work is not over; it has just begun. Drug courts are no longer new or experimental, and it is time to institutionalize our knowledge base, define our best practices, and establish our ethical principles. Much more is to come, and we invite you to join our critical mission.

Douglas B. Marlowe
William G. Meyer

---

1 David B. Wilson et al., *A Systematic Review of Drug Court Effects on Recidivism,* 2 J. Experimental Criminology 459, 459 (2006); Christopher T. Lowenkamp et al., *Are Drug Courts Effective: A Meta-Analytic Review,* J. Community Corrections, Fall 2008, at 5; Jeff Latimer et al., Dep't of Justice Can., A Meta-Analytic Examination of Drug Treatment Courts: Do They Reduce Recidivism? (2006); Deborah Koetzle Shaffer, Univ. of Nevada, Las Vegas, Reconsidering Drug Court Effectiveness: A Meta-Analytic Review 3 (2006); Steve Aos et al., Wash. State Inst. of Pub. Policy, Evidence-Based Adult Corrections Programs: What Works and What Does Not (2006).

2 Avinash Singh Bhati et al., Urban Inst., To Treat or Not to Treat: Evidence on the Prospects of Expanding Treatment to Drug-Involved Offenders 56 (2008).

3 National Association. of Drug Court Professionals & Bureau of Justice Assistance, U.S. Dep't of Justice, Defining Drug Courts: The Key Components (1997), *available at* http://www.ojp.usdoj.gov/BJA/grant/DrugCourts/DefiningDC.pdf.

4 *See* Shannon M. Carey et al., NPC Research, Exploring the Key Components of Drug Courts: A Comparative Study of 18 Adult Drug Courts on Practices, Outcomes and Costs (2008), *available at* http://www.ncjrs.gov/pdffiles1/nij/grants /223853.pdf.

Chapter 1

Drug Courts: Back to the Future

Honorable Jeffrey Tauber (Ret.)

I. [§1.1] INTRODUCTION 9
II. [§1.2] THE HISTORICAL CONTEXT 9
III. [§1.3] THE ADVENT OF DRUG COURTS 11
IV. [§1.4] THE CRITICAL PARTNERSHIP OF JUDICIAL LEADERSHIP AND COMMUNITY 13
V. [§1.5] THE IMPORTANCE OF GOING TO SCALE 14
VI. [§1.6] REENTRY DRUG COURT: THE FINAL FRONTIER 15
VII. [§1.7] WHY YOU SHOULD GET INVOLVED 16

I. [§1.1] INTRODUCTION

This introductory chapter is entitled "Drug Courts: Back to the Future" because twenty years in the drug court movement has taught us that drug courts are both forward and backward-looking. An exploration of our judicial history would surprise many who may view drug courts as a radical departure from our common-law heritage. In fact, drug courts draw heavily upon our cultural history in restoring informal, community-based sanctions to control citizens' antisocial behaviors. In a relatively short period of time—only about the past 200 years or so—our criminal justice system discovered incarceration and began to apply it as the primary tool for dealing with crime and substance abuse. And, like the proverbial carpenter who only has a hammer and therefore sees every job as requiring a nail, we have misapplied and over-applied this draconian response. Drug courts remind us of what worked previously throughout most of our history to preserve and advance our communities. In this sense, drug courts are not new, but rather newly rediscovered.

Incarceration as a criminal justice response is relatively recent.

Yet, drug courts face the very real prospect of becoming just another footnote in history; a movement whose time came and went, only to be resurrected at some future date under the guise of a new name and a new paradigm. Success comes rarely to the criminal justice system. When it does come, it must be learned from and built upon. It is incumbent on drug courts to be forward-looking, and to seize this moment of success to extend our reach throughout the justice system. You, the reader, as an innovative and committed member of the judiciary, can help to lead this charge and make extraordinary contributions to justice, law, and society. Few opportunities in your career will offer as much.

II. [§1.2] THE HISTORICAL CONTEXT

Since the beginning of recorded history, humans have lived together in communities. Primitive communities relied on what is sometimes referred to as *customary law* or the *living law,* as it was reciprocally recognized and accepted by all of those living within the community.[1] Norms of conduct were enforced not by a designated leadership class, but rather by the community as a whole. Those early communities provided the tools for supporting positive behaviors through the use of affirmation, social status, and other tangible and intangible rewards to encourage stable interactions that enhanced their chances for survival and productivity.

The community has always employed informal social sanctions to control its members' antisocial behaviors. The traditional approaches to misbehavior included admonitions, shaming, restitution (which was often the responsibility of the offender's family), shunning, and finally, banishment from the community when all else had failed. Where possible, the group typically welcomed the reformed individual back into the community

once the behavior had been corrected. The group could ill-afford to waste an individual's contribution to the community. Keeping members stigmatized created an unhealthy separation from others and prevented a healing within the community. It made far more sense to return outcasts as soon as possible to contribute to community survival.

To this day, aboriginal societies still use shunning, and in extreme cases, banishment from the group, when persons refuse to follow community norms, the breach of which could result in a destabilization of the community. It is interesting to note that, as in the drug court model, the aboriginal community is more interested in the restoration of a peaceful community than in the strict identification and punishment of the party at fault.[2]

Incarceration as a form of sanction, while considered to be conventional and even traditional today, is truly a radical departure from the past. The widespread incarceration of criminals is a comparatively recent episode in the history of Anglo-American jurisprudence, dating back to the late eighteenth to early nineteenth centuries. Before that time, incarceration was rarely used. For example, researchers have found only nineteen incidents of incarceration in the roughly 120-year period between 1691 and 1776.[3] It is generally agreed that incarceration only began to achieve widespread acceptance when societal and community-based sanctions began to lose their effectiveness. Richard Boldt, in his treatise on "Alternatives to Incarceration," states:

> [T]he American criminal justice system has responded to crime in recent decades primarily with a monolithic answer. This response contrasts to the criminal justice systems of many other countries. The peculiarity of this monolithic panacea is striking given that widespread incarceration of criminals is a relatively recent episode in the history of Anglo-American jurisprudence.[4]

Colonial America, which was made up of many small, insular, and stable communities, relied upon alternative forms of sanctions that would be considered to be community-based sanctions today. While it is true that some of those sanctions may seem unacceptable by contemporary standards (e.g., corporal punishment), others are very much a part of our criminal justice system in modern times. The use of warnings, servitude, and restoring the victim may be known by different names today (i.e., admonitions, community service, and restitution), but they share similar purposes.

A trial was an occasion for repentance and reintegration.

The primary function of criminal trials in colonial America was to accentuate and concretize this public process of penitence and redemption. According to Professor Lawrence Friedman, widely considered to be the dean of American legal history:

> This was a constant in colonial history; criminal justice as social drama. A trial was an occasion for repentance and reintegration; a ritual for reclaiming lost sheep and restoring them to the flock It was a public, open affirmation of the rules and their enforcement; a kind of divine social theater.[5]

The parallels to the drug court model could not be clearer. Living in a time when communal structures have substantially broken down, where people lead isolated lives, and where societal pressures may be fragmented or minimal, the drug court milieu provides a group structure for the drug user—offering support, rehabilitation, resources, and community—where none had existed before. This process is conducted in the public forum of a courtroom, in which the rules of social convention are emphasized and the importance of contributing to the group are ritualized and publicized. By restoring the notion of "courtroom as theater," drug courts have returned to our earliest common-law heritage. As one commentator put it:

> It is ironic and yet oddly appropriate that although eighteenth-century America turned to imprisonment because alternative punishments had lost their ability to shame, late twentieth-century America is turning to alternative punishments because imprisonment has lost its ability to deter and rehabilitate.[6]

Within the drug court community, alternative or community-based sanctions have a newfound importance. Sitting in the jury box for a day might be seen as a less humiliating equivalent of wearing a dunce cap or a scarlet letter. An admonition from the judge in front of the drug court community is a form of shaming by a community elder that most colonial citizens would readily recognize. And, upon graduation, the rehabilitated drug abuser is welcomed back into society in a very public commencement ceremony, presided over by community leaders.

Of course, colonial America was a very different place from modern America. The family, church, and community were overwhelming presences in an individual's life. Banishment, the final solution of its time, was virtually akin to a death sentence. The controls available to the community were far more effective than anything modern jurisprudence has to offer. And yet, the promise of community-based incentives and sanctions remains compelling.

In other words, there is nothing especially traditional or sacrosanct about the use of our most recent conventional sanction of choice: incarceration. It is a choice that we made in the relatively recent past, and one that we can reconsider. The historical record would suggest that the drug court model is successful because it emulates traditional community functions in its attempt to control substance abuse and crime.

III. [§1.3] THE ADVENT OF DRUG COURTS

Before the advent of the drug court movement, reform of the drug laws had been a relatively untouchable subject for decades. Many people understood that being harshly punitive was not cost-effective, productive, or humane. But, there was apparently little political interest in or concern for dealing more rationally with individuals addicted to alcohol or other drugs. Treatment was an afterthought in most cases, and generally considered to be a waste of time by criminal justice professionals and a public who did not believe it would work. Treatment providers were starved for resources and had few, if any, powerful or influential allies.

Part of the challenge was always the perception that drug abusers were different and that addiction did not occur in "good" people, families, or communities. It was a moral issue that separated those who were bad or decadent from the rest of us. Some individuals who were relatively more compassionate on this issue might have viewed drug abusers as not necessarily devoid of morals, but perhaps lacking in the maturity or strength of character that was necessary to get and stay clean and sober. Even though popular entertainers and other famous individuals such as Marilyn Monroe and Billie Holiday suffered publicly from addiction or substance abuse in the 1950s and 1960s, the disease was still largely ignored.

In 1962, the U.S. Supreme Court in the landmark case of *Robinson v. California* laid the earliest groundwork for the drug court model. In *Robinson,* Justice Stewart, speaking for the majority, held that:

> It is unlikely that any state at this moment in history would attempt to make it a criminal offense for a person to be mentally ill, or a leper, or to be afflicted with a venereal disease. A state might determine that the general health and welfare require that the victims of these and other human afflictions be dealt with by compulsory treatment, involving quarantine, confinement, or sequestration. But, in the light of contemporary human knowledge, a law which made a criminal offense of such a disease would doubtless be universally thought to be an infliction of cruel and unusual punishment in violation of the Eighth and Fourteenth Amendments.[7]

Thus, the Supreme Court found narcotics addiction to be an illness—albeit one that was unfavorably compared to leprosy or a sexually transmitted disease—whereas being in possession of illegal drugs was not a status offense and could be punished as a crime.

From *Robinson* onward, treatment rather than punishment would become more acceptable, and in some cases, the preferred approach to dealing with the drug addict. The Robinson decision spurred both the Nixon and Carter administrations to develop non-penal responses to drug offenders. In the 1970s, for example, Treatment Alternatives to Street Crimes (TASC)—later renamed Treatment Accountability for Safer Communities—a nationwide federal initiative, was created to provide a bridge between individuals addicted to alcohol and other drugs and the criminal justice system, offering treatment in lieu of punishment for many drug offenders.

Public perception was that addiction does not occur in "good" people.

The opinion in *Robinson* was the first clear precedential authority from a high court in the U.S. that the justice system was not working for addicted individuals. The criminal justice system had become a revolving door for substance-involved offenders. Parental rights were being terminated routinely for individuals whose sole problem was addiction to alcohol or other drugs. Chronic drunk drivers were ignoring court orders and creating danger on streets and highways across the nation. These conditions mandated change.

As a result of these observations, judges in the 1980s began to develop innovative approaches to the adjudication of cases. Some judges mandated that offenders submit to drug testing. Others required more frequent status reports from the probation department. Although the programs were not formalized, these individual judges recognized the relationship between addiction and criminal behavior. They also understood the chronic debilitating nature of addiction. By 1994, when the National Association of Drug Court Professionals (NADCP) was formed, there were at least a dozen drug treatment courts that had structured themselves along the lines of today's drug courts.

Now, there are more than 2,300 drug courts nationwide, located in every state and territory in the U.S. as well as in several foreign countries.[8] We have all come to recognize that drug courts are successful in reducing substance abuse and crime. The U.S. Government Accountability Office (the investigative arm of the United States Congress) has reached this conclusion.[9] Scientific research also supports the conclusion. Several meta-analyses (scientifically rigorous syntheses of the research evidence) have all determined that drug courts reduce crime.[10, 11, 12, 13, 14] A recent cost-related meta-analysis concluded that drug courts produce an average of $2.21 in direct benefits to the criminal justice system for every $1 that is invested.[15] When other types of cost offsets are also taken into account, such as savings from reduced victimization and reduced involvement in the child welfare system, studies have reported economic benefits ranging from approximately $4 to $12 for every $1 that is invested.[16, 17]

> Robinson v. California in 1962 *was the seminal case to suggest that the justice system was not working for addicted individuals.*

The Conference of Chief Justices (CCJ) and the Conference of State Court Administrators (COSCA) joined in this declaration when they passed a unanimous joint resolution in support of problem-solving courts in 2000 and most recently in 2009. They found that "drug court and problem-solving-court principles and methods have demonstrated great success in addressing certain complex social problems, such as recidivism, that are not effectively addressed by the traditional legal process."

IV. [§1.4] THE CRITICAL PARTNERSHIP OF JUDICIAL LEADERSHIP AND COMMUNITY

Dynamic judicial leadership at the inception of any drug court is essential. Virtually every drug court was initiated with the strong leadership, motivation, and commitment of a member of the judiciary. In most cases, it was the drug court judge, but in other circumstances it was the president judge or even the chief justice of the state supreme court who took the leadership role. The drive, vision, and commitment of such judges collectively had the ability to drive a drug court to short term success.

But ours has not been an entirely successful story. The original drug courts that were in existence at the time of NADCP's inception have experienced mixed results. While all of the programs had initial success, about half of those drug courts have disappeared or withered on the vine. Drug courts in St. Joseph, Michigan; Denver, Colorado; and Bakersfield and Oakland, California have undergone challenging transformations. At the same time, drug courts in Miami, Florida; Kalamazoo, Michigan; San Bernardino, California; and Las Vegas, Nevada, have matured, expanded, and thrived to the benefit of their communities.

Why did some drug courts thrive while others did not? In many respects, the answer can be attributed to the "innovator effect." This refers to the effect that strong leadership and creativity can have at the inception of any project, inspiring and motivating practitioners to heights of productivity and effectiveness. Clearly, dynamic judicial leadership at the inception of a drug court is desirable, even critical, to the program's initial success. However, while a powerful judicial presence sustains most drug courts for an initial period, when that innovator judge moves on, the drug court may have great difficulty maintaining its focus, structure, and viability. Institutionalization is then critical to maintaining the drug court structure over time. By failing to pay sufficient attention to succession planning and failing to garner widespread public and political support for their programs, the innovators may have inadvertently sown the seeds of their programs' demises.

Collaboration is central to a community-based drug court.

We know that integrating the drug court into government and community institutions is critical to the long term health of the program. Practitioners have created community-based drug courts by reaching out into the community for resources, political support, financial security, functional stability, and institutional recognition. However, doing so can be a daunting task. The most successful programs not only developed community ties, but also interconnected the various agencies that were charged with combating substance abuse and crime in their jurisdictions through unified working groups and other formal collaborative bodies. They also identified sustainable funding streams and learned to share those new resources among their constituent partners in an equitable manner that was based upon the respective allocations of resources and personnel to the drug court program.

V. [§1.5] THE IMPORTANCE OF GOING TO SCALE

Inherent in the process of institutionalization is the necessity of taking drug courts to scale. Only by treating sufficient numbers of offenders can drug courts take advantage of the economies of scale that will make their programs not only effective, but

cost-effective. Small programs cannot help but spend resources inefficiently because they must spread their initial development costs over a small number of cases, thus increasing the average cost per case. Many drug courts have been able to successfully work with a small percentage of offenders with serious substance abuse problems. However, because of the limited number of participants, those programs have not had a substantial or meaningful impact on their community's substance abuse problem. We are all aware of the resource limitations that impair a drug court program's ability to reach a large percentage of the eligible population in its community. But by successfully addressing this challenge, the drug court field can go to scale and have a lasting impact in communities across the United States and abroad. That is the primary task currently facing the drug court movement. The judge who chooses to lead the court system in accomplishing this task has a tremendous opportunity to make a real difference.

The compelling need to provide the opportunity for all to participate in drug court drives us to publish this *Drug Court Judicial Benchbook* and other documents that will assist professionals to grow existing drug courts and increase the number of new drug court programs. This sentiment is shared by our state chief justices. The CCJ and COSCA in their 2000 joint resolution committed all fifty states "to taking steps, nationally and locally, to expand and better integrate the principles and methods of well-functioning drug courts into ongoing court operations." In October of 2009, CCJ and COSCA reaffirmed their unanimous commitment to drug court, asserting that "drug courts have proven to be the most effective strategy for reducing drug use and criminal recidivism among criminal offenders with substance abuse and addiction and reuniting families broken by drug dependency."

VI. [§1.6] REENTRY DRUG COURT: THE FINAL FRONTIER

It is also time to recognize that drug courts can provide an important part of the solution to prisoners overwhelming our correctional system and ultimately, our communities. Prison populations have increased by over seven hundred percent since 1970, with over seventy-five percent imprisoned for nonviolent offenses. Over eighty percent of those inmates are drug involved and roughly one-half are clinically addicted to alcohol or other drugs. Research supports the conclusion that high-risk drug offenders—those with more severe antisocial dispositions or a history of not having responded to standard community-based treatment services—perform especially well in drug courts. The next generation of drug court structures (often called reentry courts or reentry drug courts) focuses on offenders reentering society and have the potential to help fix a prison reentry system that returns fifty percent of offenders to prison within three years of release.[18] This is our next great challenge.

About half of inmates are addicted to alcohol or other drugs.

VII [§1.7] WHY YOU SHOULD GET INVOLVED

Like the early drug court judges, you have seen that the traditional process has not served your community well. Even if you have been on the bench for many years, you have probably learned the names of only a few of the offenders who appeared before you, despite the fact that many of them undoubtedly came before you on numerous occasions for numerous violations. As an achiever in the legal community, you have a natural inclination to correct problems, but at the same time you did not go to law school to be a social worker. It is important to remember that every oath you have ever taken in the field of law and justice has entrusted you with making the system better. One reason to get involved in drug courts is the desire and mandate to improve the justice system.

Whether you have been on the bench for five years or fifteen years, service often becomes routine. Drug court is anything but business as usual. Addiction is a multifaceted disease that requires an equally diverse solution in the judicial arena. Drug courts and other problem-solving courts allow you to craft novel solutions while ensuring public safety. As a drug court judge, you will see individuals transformed daily. This provides a profound sense of satisfaction. Research proves that drug court judges are significantly more satisfied with their careers, more optimistic about the future, and feel more positive toward our system of justice. In other words, you can make a positive contribution to others, while simultaneously achieving an extraordinary feeling of personal satisfaction.

---

1 Madden, M. Stuart. 2005. "The cultural evolution of tort law." Arizona State Law Journal 37: 831.

2 Madden, "The cultural evolution of tort law."

3 Friedman, Lawrence M. 1992. Crime and punishment in American history. New York, NY: Basic Books.

4 Boldt, Richard C. 1998. "Alternatives to incarceration." Harvard Law Review 111: 1863, 1874.

5 Friedman, Crime and punishment in American history, 25.

6 Kahan, Dan. 1996. What do alternative punishments mean? University of Chicago Law Review 63: 631.

7 Robinson v. California. 1962. 370 U.S. 660, 666.

8 Huddleston, C. West, Douglas B. Marlowe, and Rachel Casebolt. 2008. Painting the current picture: A national report card on drug courts and other problem solving court programs in the United States. Alexandria, VA: National Drug Court Institute.

9 U.S. Government Accountability Office. 2005. Adult drug courts: Evidence indicates recidivism reductions and mixed results for other outcomes [No. GAO-05-219]. Washington, DC: Government Printing Office.

10 Aos, Steve, Marna Miller, and Elizabeth Drake. 2006. Evidence-based public policy options to reduce future prison construction, criminal justice costs, and crime rates. Olympia, WA: Washington State Institute for Public Policy.

11 Latimer, Jeff, Kelly Morton-Bourgon, and Jo-Anne Chrétien. 2006. A meta-analytic examination of drug treatment courts: do they reduce recidivism? Ottawa, ON: Canada Dept. of Justice, Research & Statistics Division.

12 Lowenkamp, Christopher T., Alexander M. Holsinger, and Edward J. Latessa. 2005. Are drug courts effective: a meta-analytic review. Journal of Community Corrections 28: 5–10.

13 Shaffer, Deborah Koetzle. 2006. Reconsidering drug court effectiveness: a meta-analytic review. Las Vegas, NV: Dept. of Criminal Justice, University of Nevada.

14 Wilson, David B., Ojmarrh Mitchell, and Doris L. MacKenzie. 2006. A systematic review of drug court effects on recidivism. Journal of Experimental Criminology 2 (4): 459–487.

15 Bhati, Avi, John Roman, and Aaron Chalfin. 2008. To treat or not to treat: evidence on the prospects of expanding treatment to drug-involved offenders. Washington, DC: The Urban Institute.

16 Carey, Shannon M., Michael Finigan, Dave Crumpton, and Mark Waller. 2006. California drug courts: Outcomes, costs, and promising practices: an overview of phase II in a statewide study. Journal of Psychoactive Drugs, SARC Supplement 3: 345–356.

17 Loman, L. Anthony. 2004. A cost-benefit analysis of the St. Louis city adult felony drug court. St. Louis, MO: Institute of Applied Research.

18 Tauber, Jeffrey. 2009. "A proposal for a national reentry court initiative: Four policy papers." Alexandria, VA: National Association of Drug Court Professionals.

Chapter 2

Getting Started

Carolyn Hardin, M.P.A.
Carson Fox, J.D.

I. [§2.1] INTRODUCTION 21
II. [§2.2] THE DRUG COURT TEAMS 21
A. [§2.3] STEERING COMMITTEE 21
B. [§2.4] DRUG COURT TEAM 23
C. [§2.5] EXTENDED DRUG COURT TEAM 24
III. [§2.6] DEFINING THE PROBLEM 24
IV. [§2.7] ESTABLISHING A MISSION 26
V. [§2.8] MEASURABLE GOALS AND OBJECTIVES 28
A. [§2.9] PROGRAM GOALS 29
B. [§2.10] OBJECTIVES 29
C. [§2.11] MISSION STATEMENT 29
VI. [§2.12] GATHERING RESOURCES 30
VII. [§2.13] DETERMINING ELIGIBILITY CRITERIA 31
VIII. [§2.14] SELECTING THE DRUG COURT MODEL 33
A. [§2.15] PRE-PLEA DIVERSION 33
B. [§2.16] DIVERSION WITH STIPULATION OF FACTS 33
C. [§2.17] POST-PLEA, PREADJUDICATION 34
D. [§2.18] POSTADJUDICATION, PROBATION 34
E. [§2.19] PROBATION REVOCATION 34
F. [§2.20] MIXED MODEL 34
IX. [§2.21] GRADUATION AND TERMINATION CRITERIA 35
X. [§2.22] PHASE STRUCTURE 37
XI. [§2.23] APPLYING PROGRAM CRITERIA 39
XII. [§2.24] EVALUATION 41
XIII. [§2.25] CONCLUSION 42

I. [§2.1] INTRODUCTION

Starting a drug court is a major challenge, though one that is eminently satisfying and creative. The critical issues include bringing the appropriate individuals and agencies into the planning process as early as possible and charting a clear course toward attaining the intended goals of the program. The most effective and longstanding steps that have been undertaken by the drug courts have been to take the time and effort to plan their procedures carefully in advance, to continuously monitor their operations to ensure that they were meeting their goals, and to identify and resolve any impending barriers or threats.

This chapter is intended to provide guidance on how to begin the planning and implementation process for a new drug court program. Judges who are considering starting a drug court are faced with numerous challenges and questions. Although these challenges may seem daunting and perhaps insurmountable at times, literally hundreds, if not thousands, of drug court judges have successfully negotiated the process. There is no need to "reinvent the wheel." The collective wisdom and experience of those judges and their drug court teams are available at national, regional, and state drug court conferences, as well as through training workshops and technical assistance projects provided by organizations, such as the National Drug Court Institute (NDCI). The drug court field follows what is euphemistically referred to as the C.A.S.E. method, which stands for *copy and steal everything*. Sample forms and manuals are available from hundreds of drug courts, which can serve as models upon which to develop the unique policies and procedures of any new program.

The key to a successful drug court is planning.

The pages that follow will help a new drug court judge, or a judge who is considering becoming a drug court judge, prepare for the steps that will need to be taken and the issues that will need to be resolved. These include forming the drug court team and advisory committees, clarifying the program's mission and objectives, identifying the target population for the program, specifying graduation and termination criteria, developing a phase structure, gathering community resources, and evaluating the program's operations. Considering these issues in advance will greatly streamline the development process and reduce hindrances to the founding of the program and to the making of meaningful contributions to its future participants and its community.

II. [§2.2] THE DRUG COURT TEAMS

A. [§2.3] Steering Committee

Drug courts represent a new way of doing business for the courts, and therefore, require the explicit buy-in and support of political and community leaders. It is essential to bring all of the appropriate stakeholders to the table to participate in the formative

negotiations for a drug court program. Leaving critical individuals out of the development process can sow the seeds of failure before the program has even started.

Knowing who to include in the formative process will depend upon a number of factors, many of which relate to the intended scope and authority of the drug court and to the governance structure within each state. If the intent is to situate a drug court within a limited-jurisdiction court, such as a misdemeanor district court or magisterial court, then it might be sufficient to invite local department directors operating within that court system. For example, it might be sufficient to include the county district attorney, the lead public defender for the county, the lead county agency for substance abuse services, and the local director of probation. On the other hand, if the goal is to have the drug court serve felony cases within a general-jurisdiction state court, it might be necessary to include the attorney general, the state public defender, the state probation department, and the single state agency (SSA) for substance abuse services. It is worth the time and energy to think carefully about who should be consulted during the development process.

Steering committee members:

- *Are community leaders and stakeholders*
- *Should be authorized to enter into MOUs*

The appropriate individuals should be invited to form a steering committee for the drug court program. The members of the steering committee should have the ultimate authority to enter into memoranda of understanding (MOUs) or memoranda of agreement (MOAs), in order to define the authority of the drug court and the roles and responsibilities of the respective parties. Of course, many of these professionals may not have the time to attend regular meetings or participate in all of the day-to-day planning discussions for the program. If this is the case, they can delegate to subordinates within their agencies the authority to attend the meetings and to report back to their superiors what was discussed and if there are any proposals currently on the table. Ultimately, the decision whether to sign on to such proposals will reside with the appropriate agency directors and political officials.

There will inevitably be disagreement on various issues that are based upon legitimate philosophical, legal, or political grounds. Such disagreements should not be glossed over or ignored because they are apt to rear their heads later after substantial effort and expense has already gone into developing the program, and bring the project to a screeching halt.

At times, it may seem acceptable or necessary to move forward without the explicit buy-in of a particular stakeholder agency. Such a decision should be approached with considerable caution. Researchers have clearly shown that drug courts have significantly better outcomes relating to reductions in recidivism and cost offsets when all of the relevant agencies are actively engaged in the operations of the program. For example, when representatives of the defense bar and of the prosecution, treatment providers, or law enforcement do not regularly attend staffings and status hearings, outcomes are less

favorable and more costly over the long run.[1] No agency is expendable, and all must operate in a coordinated fashion using a collaborative team approach.

If important partners are reluctant to engage collaboratively in the negotiation process, it is sometimes useful to bring in community constituents who have a stake in the process, such as local business leaders, members of the press, and members of the recovery community. Although these public stakeholders might not be regular voting members on the steering committee, they can attend meetings that are open to the public to weigh in on the importance of the program and the effects of drug-related crime in their community. This can serve to reduce grandstanding and turf battles among political leaders and lead to a more productive contribution to the founding of the program. Similarly, obtaining letters of support for the general concept of a drug court program—without necessarily endorsing any particular programmatic model—from such state officials as the mayor, governor, or supreme court justices can go a long way toward enhancing collaboration and productive activity at the county or city level.

Once the drug court program has been established, it is often important to have the steering committee continue to meet on a quarterly or semiannual basis to review how the program is performing and to address any needed changes to its policies and procedures. For example, the steering committee might review data on the program's monthly census, and make decisions about how to reduce barriers to enrollment or to obtain funding for additional slots to satisfy unmet needs in the community. Allowing the drug court to fall "out of sight/out of mind" for political leaders can lead to a gradual loss of political will and support for the program, which can seriously erode its effectiveness and viability over time.

B. [§2.4] Drug Court Team

The drug court team is the group of professionals who are primarily responsible for overseeing the day-to-day operations of the program and administering the treatment and supervisory interventions. The judge is the leader of the drug court team, and other members will commonly include a deputy or assistant prosecutor, an assistant public defender, a probation officer(s), a treatment provider(s), a case manager(s), a law enforcement officer(s), and a program coordinator. If multiple professionals within an agency will be working with drug court participants, it may be useful to appoint one or two individuals from within that agency to represent several parties during staffings or status hearings because it might be difficult, for example, to schedule numerous treatment providers or defense attorneys to attend staff meetings on a weekly basis. It might be preferable to have one public defender or one treatment case manager attend the staffings and report back to their respective agencies about the issues that were discussed and the

Drug Court Team Members

- *Judge*
- *Attorneys*
- *Probation*
- *Treatment*
- *Case managers*
- *Law enforcement*
- *Program coordination*

decisions that were reached. The decision whether to appoint such a representative(s), and whom to appoint, should rest with each agency, and should be explicitly agreed to in writing by all concerned parties. Similarly, if a substantial number of participants are expected to be represented by private defense counsel, then it may be useful to appoint a representative from the private defense bar to attend staffings and status hearings. Defense counsel should be encouraged to participate in the staffing of their clients' cases.

It is essential to keep in mind that each discipline on the drug court team has its own ethical obligations, and represents diverse professional philosophies and interests. Each team member must understand and respect the boundaries and responsibilities of other team members. The NDCI provides a core competency guide (available from the National Drug Court Resource Center) for drug court teams that outlines the respective roles and responsibilities of each drug court team member.

C. [§2.5] Extended Drug Court Team

A drug court might wish to consider having an extended team, which includes individuals who are involved in the day-to-day operations of the program, but who are not able to participate in regular staffings or court hearings. For example, some large drug courts might have one treatment coordinator who speaks on behalf of dozens of front-line counselors. In these larger programs, all of the counselors who are providing direct services to drug court participants might be included in the extended team. The extended team might meet on a bimonthly or quarterly basis to discuss concerns and observations by front-line staff, and to provide feedback to the core team about how the program is progressing and what changes might be indicated.

Extended team members may include:

- *Frontline staff from all partner agencies*
- *Business community, media, nongovernmental organizations and evaluator*

It is also a good idea to invite interested members of the public, media, and business community to attend some of the extended team meetings (perhaps once or twice per year) in order to get their input and to educate them about what the drug court is doing and what contributions it is making to their community. Research demonstrates that drug courts have far better outcomes when they maintain ongoing partnerships with other community organizations, and when they communicate regularly and effectively with those partners about how the program is performing in terms of its successes and barriers.[2]

III. [§2.6] DEFINING THE PROBLEM

Every jurisdiction needs a drug court, but not all communities may recognize this fact. Moreover, the scope of the need will vary according to a number of factors,

including the size of the arrestee population, the nature of the drug problem in that geographic region, and local community values and sentiments. The judge should depend on the steering committee, drug court team, and local community representatives to gather the necessary data to press the argument in favor of establishing a drug court. Among the data that should be collected are arrest and disposition figures and drug-use trends in the community. Prosecutors and law enforcement officials often have access to much of the relevant information, including numbers of arrests and convictions for drug-related offenses, lengths of incarceration, recidivism rates, and possibly the results of urine drug tests and blood alcohol contents (BACs) taken at arrests or at booking. Such data can be used to determine the drug trends in the community and identify the criminal activity that is related to alcohol and other drugs.

Probation departments should also have statistics on the number of referrals they make to substance abuse and mental health treatment, successful completion rates for treatment, drug-testing results, drug-related revocations, and technical violations. This information can establish the relative efficacy (or lack of efficacy) of available resources and services and can identify current supervisory interventions. Treatment providers should also have important information on local trends in drug use, including the types of substances that are being abused by their clients; diagnostic information on the degree of compulsive addiction and comorbid mental illness in the population; and the numbers of referrals to treatment coming from the criminal justice system, completion and drop-out rates, and readmission rates to treatment. Additional information may also be available regarding the levels of care existing in the community and any gaps in service availability.

Law enforcement is likely to know whether certain types of drug-related crimes have increased in the community in recent years. For example, the introduction of methamphetamine or crack cocaine to a community might be temporally associated with a concomitant increase in theft, property, or domestic violence offenses. Law enforcement should also have access to other valuable information, such as the average number of days that drug-involved arrestees remain in jail on a pretrial basis and increases in the number of occupied jail beds. Much of this information is routinely recorded and can be tracked to show growth over time.

Once these figures are collected, the judge can lead discussions with the steering committee, drug court team, and community representatives. Does a growth in drug-related crime paint a compelling picture for the need for a drug court? Are there existing programs that have been shown to be less effective? Can a lack of efficacy of certain interventions be quantified? For example, research has demonstrated that high-risk offenders—such as those who have had multiple prior treatment episodes or substantial criminal involvement—often do not perform adequately on standard pretrial supervision or probation.[3] Holding regularly scheduled judicial status hearings and providing intensive supervision in a drug court is more likely to be effective for these high-risk offenders. If the probation department or treatment agencies have data on the level of risk in their populations, this information can be marshaled to demonstrate that certain types of drug-involved offenders require a more intensive level of intervention. This can be used to make a compelling case for the need for a drug court.

For example, in jurisdictions in which pretrial intervention programs have been effective in dealing with first- or second-time drug-related offenders, or where probation has been effective in dealing with certain categories of drug offenders, the drug court may have little need to duplicate services for those subpopulations. The drug court may, however, want to look at the subpopulation that is failing pretrial supervision or probation. If certain offenders have demonstrated a need for tighter supervision, perhaps the drug court can target that subpopulation.

Make the case for a drug court:

- *Review arrest data for drug-related crimes*
- *Collect data on substance-using probationers*
- *Examine drug-use trends in the community*

Drug courts require considerable dedication and effort. Typically few, if any, team members will be assigned solely to the drug court. Judges, prosecutors, defense attorneys, and probation officers will often have caseloads outside of the drug court. Without convincing data that clearly demonstrates the community's problem with drug-related crime, persuading busy professionals to donate the time and resources needed to develop a drug court program (e.g., administering urine drug testing) will be difficult.

IV. [§2.7] ESTABLISHING A MISSION

A common definition of a *team* is a group of individuals working together toward a common goal, therefore, the new drug court team must establish its goals and mission as a basis for directing and coordinating its activities. These are the first questions to be answered by the new team: Why does the community need a drug court? Are drug-related crimes increasing? Are nonviolent drug offenders clogging court calendars? As noted above, the judge can facilitate this discussion, asking each team member to share (perhaps anonymously on paper) what he or she sees as the major purpose(s) of the drug court. The team will undoubtedly generate a list of excellent reasons, possibly including a need to reduce crime, reduce substance abuse, reunite families, protect children, reduce homelessness, and increase community safety.

There will often be considerable overlap among various team members' responses, and a consensus can usually be reached by identifying areas of common agreement and by raising additionally important impacts that some team members might not have previously considered. For example, if a team consists of six members (judge, prosecutor, defense counsel, treatment provider, probation officer, and case manager) and each team member has written two potential benefits for implementing a drug court, the initial list might look something like this:

- Reduce crime
- Improve public safety
- Provide better treatment outcomes

- Protect the community
- Reduce recidivism
- Provide drug and alcohol treatment to addicted offenders
- Provide intensive case management
- Provide job training
- Turn tax burdens into tax payers
- Improve lives of the citizens

The team can then use this initial list of ten benefits to create a more refined list of four overarching themes:

- Increase public safety
- Provide better alcohol and drug treatment
- Create tax-paying citizens
- Provide intensive case management

Finally, the judge can lead the team through the process of crafting these components into a clear, concise mission statement. The judge may want to identify and capitalize on the strengths of certain team members who have good writing skills. The judge may assign the initial drafting of the mission statement to one or two of those team members, who then bring the draft product back to the team. Finally, the team can review and revise the initial draft, making the mission a true reflection of the team's goals and the community's intent in establishing a drug court program.

From the sample list of four drug court benefits presented above, a sample mission statement might read as follows:

> The mission of the Smith County Drug Court is to enhance the effectiveness and cost-effectiveness of the county criminal justice system by providing intensive case management, treatment, and court supervision for individuals arrested for drug- or alcohol-related offenses. By holding participants accountable for their actions and providing them with access to a diverse range of needed services, participants will be equipped with the necessary tools to lead productive drug-free and crime-free lives.

When constructing a mission statement, the team should not lose sight of the importance of accountability in gauging whether it is meeting these goals. Those agencies or officials that are supporting the drug court through funding or resource reallocation, as well as the community at-large, will expect the drug court to demonstrate whether and how it has accomplished its mission. Therefore, all of the goals should be attainable and measurable. For example, a lofty goal for a drug court might be "to make the world a better place." But how would the drug court team be able to measure its success at achieving such a goal? On the other hand, "protecting public safety" can be measured through such data as incidents of new

A mission statement should clarify the goals and values of the court.

arrests while participants are in the program and after they have graduated from the program.

Upon completion of the mission statement, the team should ensure that the following critical elements have been addressed:

Purpose. Why the program exists and what it seeks to accomplish.

Business. The main methods or activities through which the program will attempt to fulfill its purpose.

Values. The principles or beliefs that guide the program's members as they pursue these aims.

V. [§2.8] MEASURABLE GOALS AND OBJECTIVES

By developing its mission statement, the team has already begun to identify the goals and objectives for the drug court. The judge can lead the team through a process of further clarifying these goals and developing measurable and attainable objectives.

At this point, there is one team member who, if he or she has not already been included in the process, should become a regular participant on the drug court team, or perhaps on the extended team—the evaluator. The evaluator will be responsible for designing the data-collection system for the program and helping the team to evaluate the effectiveness of the drug court. The evaluator will work with the team to identify clear and measurable goals and objectives. Competent evaluators can be identified by contacting departments of psychology, education, public health, social work, criminal justice, or political science at local universities or research institutions. Also, the state, county, or city administrative office of the courts may have identified a cadre of researchers who may be available to perform the drug court evaluation.

In selecting an evaluator, the judge and team should consider a number of factors. Does the evaluator have experience in evaluating drug courts, or more broadly, in evaluating criminal justice-based treatment programs? Is the evaluator willing to be part of a team approach and assist in developing the program's goals and objectives? The evaluator should have considerable experience with collecting and analyzing data and defining variables. Copies of past evaluation reports and published articles should be reviewed by the team for clarity, sophistication, and usefulness. Inquire as to whether the evaluator has been published in peer-reviewed journals. Another excellent resource for selecting an evaluator is NDCI. NDCI staff can provide excellent guidance on what to look for in an evaluator.

The team will need to carefully consider what type of information to gather in the evaluation. Much of the information will be collected from participants throughout their enrollment in the program. Information will also be collected from various other sources, including the court, treatment agencies, and probation. This information must be accurate, accessible, and quantifiable if it is to be of any value. The evaluator can use this information to educate the team about whether the program is working, and more importantly, on what particular components of the program are effective or perhaps deficient.

How to structure a data-collection system, what data elements to collect, and how to conduct an evaluation are beyond the scope of this chapter and benchbook; however, excellent resources are readily available to the drug court judge, team, and evaluator. In 2005, NDCI published a monograph entitled, *Local Drug Court Research: Navigating Performance Measures and Process Evaluations,* which can be downloaded at no cost from the NDCI website at www.ndci.org. This publication addresses the fundamentals of drug court evaluation, including the critical questions every drug court team should answer when implementing their drug court program. Remember, every drug court team will be asked to demonstrate whether the drug court is meeting its goals and objectives. No drug court program is a success if that success cannot be demonstrated through clear, convincing evidence. Evaluators should be able to assist the team in identifying a data-collection system, along with ensuring that the team collects the necessary information to permit meaningful evaluation results down the road.

The team should review the mission statement, goals, and objectives to ensure that the following critical issues are met. These are not intended to be exhaustive.

A. [§2.9] Program Goals

Program goals should do the following:

- Focus on public health, public safety, and personal responsibility
- Improve utilization of community resources
- Be cost effective on the criminal justice system
- Show high rates of treatment retention and completion
- Improve functioning of individuals
- Address access and fairness issues

B. [§2.10] Objectives

Program objectives should be as follows:

- Clearly stated with realistic end results
- Quantifiable with measurable outcomes
- Responsive to participant, stakeholder, and community needs
- Attainable given program design and available resources

C. [§2.11] Mission Statement

Address critical program goals in a concise, understandable way that captures the spirit and motivations of the team and its stakeholders.

VI. [§2.12] GATHERING RESOURCES

A community determines that it needs a drug court because there is a drug-involved population within the criminal justice system that needs additional services, above and beyond what the court, treatment, and supervision programs are currently providing. It is incumbent upon the drug court team to determine what additional resources will be needed to effectively intervene with this population. As previously stated, research has shown that certain high-risk populations require closer supervision by a judge. But what about more intensive case management services, home contacts, drug testing, and evidence-based treatment? Having defined the problem, the judge must now lead the team through a process of gathering the necessary information and resources to craft the solution.

In identifying and building resources for the drug court, the judge will want to turn to the community. Service identification and development for a drug court is too great a job for any one person, or even for one drug court team. The more people who are involved in this process, the more successful the program is likely to be. The judge should ask team members to brainstorm about whom to include in an advisory capacity. Advisors harness the knowledge of the community and bring skills and resources to the drug court. Traditionally, these advisors have included the core drug court team; the extended team (if applicable); members of the faith community; members of the recovery community; representatives from local schools, universities, vocational agencies, and health agencies; the business community; and many others.

Use the National Drug Court Resource Center: http://www.ndcrc.org/

The judge may call a meeting and send letters of invitation to each person that the team has identified for this advisory function. At the meeting, the judge and team should describe the problem, review the mission, goals, and objectives of the drug court, and then list the resources that will be needed to tackle the problem. The judge may decide to accomplish a few basic tasks at the initial advisory meeting, such as educating the larger group, dividing into subcommittees to address various tasks, and selecting a time to reconvene.

One tool that drug courts often use in identifying resources is community mapping. An example of a community mapping chart can be found on the National Drug Court Resource Center website. The judge may want to distribute a copy of the community map to all of the advisors, perhaps partially completed by the core team, and then ask the advisory members to identify additional resources. Furthermore, the judge may ask the advisors to brainstorm on other resources that the drug court may need to access, which may not have been identified in the community map or by the core team.

Resource identification is critical. Often, resources may exist in a community but are unknown to the main players in the criminal justice system. The drug court may need to access a variety of resources, including, but not limited to, substance abuse treatment, medical treatment, housing, transportation, educational and vocational training, and

drug testing. Recognizing what resources do not exist is as important as identifying those that do. If, for example, General Educational Development (GED) assistance is not available in a given community, requiring drug court participants to acquire a GED equivalency diploma may be unreasonable. But can the drug court advisory committee create those resources by, for example, purchasing GED tutorial materials for the drug court program? Similarly, if no detoxification facilities are available in a jurisdiction, yet the jurisdiction has a demonstrated need for such facilities, the advisory committee may be able to advocate for the development of such a resource.

By dividing the advisory committee into subcommittees (and designating committee chairs to coordinate the ongoing work and report out), the judge can avoid overwhelming the group with the tremendous task of harnessing community resources, while also enlisting community buy-in and support for the new drug court.

VII. [§2.13] DETERMINING ELIGIBILITY CRITERIA

Now that the team has defined the problem, established its mission and objectives, and begun gathering resources, it must turn its attention to developing its policies and procedures. First, the team must decide on objective eligibility criteria for the drug court. The team may consider certain offenses to be eligible and others to be prohibited. For example, drug possession offenses might be eligible, whereas violent offenses might be excluded. Similarly, the team may decide that certain offender-level characteristics will make individuals ineligible for participation. For example, individuals who have serious medical conditions might be denied entry to the drug court. The program must have well-defined eligibility criteria to ensure a clear understanding about who can and cannot enter the drug court. If eligibility criteria are left too vague, this can lead to unintentionally disparate treatment for certain groups of citizens, such as racial or ethnic minorities, or can create a perception that the program is unfair in its selection of candidates. This could also lead to due process or equal protection challenges.

Clear, objective, and specific eligibility criteria are critical.

Throughout this process, as team leader, the judge should encourage the team to be as inclusive as is reasonably possible, while also respecting each team member's legitimate concerns. Factors to consider in drafting eligibility criteria may include, but are not limited to, the nature of the current offense, past offense history, type of drug, residency, history of violence, and whether treatment resources are reasonably available to serve the offender's needs. There may also be statutory considerations, given that several states have enabling legislation for drug courts that define the limits of entry criteria. Other statutory provisions may also govern the availability of nonincarcerative sentences or diversion opportunities for certain types of offenses. Finally, there may be funding considerations because certain federal grants have restrictions on using resources to treat individuals with records of physical violence or gun possession.[4]

Other important considerations in selecting the target population for a drug court include the level of prognostic risk and criminogenic need presented by the offender.[5] *Prognostic risk* refers to those characteristics of offenders that generally predict poorer outcomes in standard rehabilitation programs. Examples include an early onset of substance abuse or delinquency, prior felony convictions, previously unsuccessful attempts at treatment, a coexisting diagnosis of antisocial personality disorder (APD), and a preponderance of antisocial peers or affiliations (e.g., gang affiliations). Importantly, in this context, the term "risk" does *not* necessarily refer to a risk for violence or dangerousness, but rather to a risk of failing to respond to standard interventions, and thus for continuing to engage in the same level of drug abuse and crime as in the past. *Criminogenic needs* refer to clinical disorders or functional impairments that, if ameliorated, substantially reduce the likelihood of continued engagement in crime. The most common examples include drug or alcohol addiction and serious psychiatric disorders.

Research now shows that drug courts tend to have the most powerful effects for drug offenders who are both high risk and high need, meaning that they have serious substance abuse disorders and also have a history of a poor response to standard treatment and/or antisocial personality traits.[6,7] On the other hand, low-risk and low-needs offenders who do not have these characteristics tend to perform just as well in less intensive programs, such as standard probation or pretrial diversion.[8] These findings suggest that, when possible, drug courts should attempt to target their services to more serious types of drug offenders who can be safely managed in the community. If a drug court focuses on low-severity offenders, it is less likely to achieve meaningful cost savings for its community that would justify the additional expense and effort of the program.

Of course, practical and political realities will dictate whether a drug court can reach a more serious drug offender population. If, for example, the prosecution is unwilling to offer drug court to recidivist offenders, this may be a "rate-limiting factor" that prevents the program from reaching the more severely addicted offender population, at least in the short term. If the prosecutor cannot be swayed from this position, it might be advisable to begin targeting less severe offenders to get the drug court off the ground and then to advocate over time for widening the eligibility criteria as experience with the program demonstrates its safety and effectiveness.

Drug courts work best for offenders who are both high risk and high need.

The judge must lead the team through these decisions, making every effort to define the criteria in a clear and objective fashion, and establishing concrete methods for team members to reliably assess each person's suitability for the program. For example, if the team decides to exclude violent offenders, the judge should assign certain team members, such as the prosecutor and defense counsel, to work together to define what constitutes a violent offender and who is responsible for screening each case for a violence history. Once the eligibility criteria and screening procedures are established, they should be clearly specified in the policy and procedure manual and should be disseminated to all interested stakeholders and potential referral sources.

VIII. [§2.14] SELECTING THE DRUG COURT MODEL

It is essential to determine what legal model a drug court will follow. For example, will it be a diversion program, in which graduates have their charge(s) dismissed or vacated? Or will the program target only probation revocation cases, in which case graduates may have their probationary conditions reduced? Will admission to the program require the judge to formally enter a judgment of guilt and sentence the offender to the program, or will the plea be held in abeyance pending graduation or termination? The basic types of drug court models addressed below.

A. [§2.15] Pre-Plea Diversion

From 1989 until the mid-1990s, many drug courts were pre-plea. Participants entered the program, perhaps as part of a pretrial intervention, with the understanding that upon successful completion, the charges would be dismissed. In this model, the participant's case is held in abeyance until program completion or termination. Charges are dismissed upon successful completion, but the case continues through the system upon unsuccessful termination. One perceived advantage of a diversionary drug court is faster case processing because preliminary hearings and discovery are typically not necessary. Perceived weaknesses include the case possibly going "cold" if the participant fails drug court several months after admission. For example, witnesses and officers might not still be available to testify. Another perceived weakness is that more seriously addicted offenders might be denied an opportunity for treatment because prosecutors will be less likely to offer diversion to offenders with more serious offense histories, and in some states there are statutory exclusions for certain types of offenders or offenses.

Models include:

- *Pre-plea diversion*
- *Diversion with stipulated facts*
- *Post-plea, preadjudication*
- *Postadjudication probation*
- *Probation revocation*
- *Mixed models*

B. [§2.16] Diversion with Stipulation of Facts

This model aims to tackle the perceived proof problems presented by standard diversion. Upon program entry, the participant, with advice of counsel, signs a stipulation of facts, essentially confessing to the events as stated in the police report. This model satisfies prosecutors who fear that cases might go cold while defendants bide their time in the drug court program.

C. [§2.17] Post-Plea, Preadjudication

This model, sometimes referred to as "Deferred Entry of Judgment," offers prosecutors the opportunity to put more "teeth" into the diversion program. Participants enter a formal guilty plea, which is then held in abeyance. Upon successful completion, the participant may face a lighter sentence in some jurisdictions, such as a probationary sentence when jail time was a realistic probability. Alternatively, the graduate might have the ability to withdraw the guilty plea and have the charges dismissed. Upon unsuccessful termination, the participant faces regular sentencing. Perceived strengths of this model include the fact that cases do not go cold, and that more serious offenders may have the opportunity for program participation. Perceived weaknesses include the increased time that may be needed for due process hearings to take place, including preliminary hearings, discovery, and other defense preparations.

There is no clear evidence that one model is superior to another.

D. [§2.18] Postadjudication, Probation

This model requires participants to plead guilty and receive a sentence of probation, with the term of probation requiring compliance with the drug court. As in other post-plea models, the case will not get old, but the additional time that is needed for court preparation and entries of judgment often delay treatment entry. Prosecutors may more readily recommend serious offenders for this model because a final judgment of guilt has been entered. Upon successful completion, the participant may have his or her probation terminated successfully or reduced, or the "carrot" may simply be a recommendation for probation rather than prison at the final sentencing disposition.

E. [§2.19] Probation Revocation

This model takes individuals who are already on probation, and who are up for a violation and possible revocation. The violation typically involves drug use, such as positive urine drug tests, detection of contraband, or additional drug charges. Rather than possibly having their probation revoked, the participants are offered drug court. If they successfully complete the drug court, their probation may be terminated successfully or shortened, or they may avoid a jail or prison sentence.

F. [§2.20] Mixed Model

Some drug courts use multiple models, or have multiple tracks. This gives the judge, prosecution, and defense counsel the option to target several levels of offenders, and therefore, to offer drug court to the largest possible criminal justice population.

Which model is best? There is no one clear answer to this question, but a few findings are known. First, research suggests that outcomes tend to be better when drug courts can apply some degree of coercive leverage over participants to keep them engaged in

treatment.[9,10] If there is little consequence for failing to complete the program, outcomes tend to be poorer. Thus, pre-plea diversion models tend to have less impressive effects because participants who are terminated are essentially put back in the same position, legally speaking, as when they were first arrested.

Second, applying one consistent model, rather than mixing populations in different models, tends to produce better results.[11] It is not entirely clear why this is the case, but presumably it is due to the fact that mixed-model programs might not have developed separate policies and procedures to deal with the diverse needs of a heterogeneous population. Perhaps if mixed-model programs developed separate tracks specifically tailored to the needs of different populations, the results would be better. More research is needed to better understand this issue.

Apart from these two findings, there is no clear evidence regarding whether one model is superior to another. In many respects, comparing outcomes between different drug court models raises the question of whether an evaluator is really comparing "apples to oranges," because the populations are likely to be so different. For example, a probation-revocation drug court might have relatively poorer outcomes than a diversion drug court simply because it is likely to be treating a more severe offender population to begin with. The most practical advice would be for jurisdictions to develop drug court models that serve the pressing needs of the criminal justice system within their communities.

IX. [§2.21] GRADUATION AND TERMINATION CRITERIA

Once the eligibility criteria are defined and the drug court model is selected, the team must decide on graduation/commencement and termination criteria. In other words, what does a drug court participant need to accomplish in order to graduate from the program, and what can lead to a participant's termination from the program?

Many factors may be considered in determining graduation criteria. The most common criteria include a specified duration of "clean" time (i.e., a consecutive interval of sobriety as confirmed by negative urine drug screens). Evidence suggests that ninety days of consecutive sobriety is minimally necessary to predict sustained abstinence, but many programs require four to six months or more of sobriety to increase the confidence that participants will maintain their gains over the long term. In addition, graduation requirements often include payment of victim restitution and court fines or fees (if applicable), successful completion of all treatment requirements, obtaining a job or pursuing an education, and securing a stable residence. With all of these requirements, the team must ensure that

The most common graduation criterion is "clean time" monitored by urine tests. A minimum of ninety days or as long as six months may be required.

adequate resources are available and accessible in the community to make obtaining these goals possible. No drug court should set its participants up for failure by making unreasonable demands.

Many drug courts have additional requirements for program completion that relate to other problems commonly confronted by drug offenders. For instance, homelessness, joblessness, financial debt, illiteracy, health problems, and family problems are typical issues confronted by drug court participants. As the team builds program resources, it will also be looking ahead to what the program will require for graduation. For example, if the typical drug court participant in a program lacks a basic education, the team might elect to require a GED equivalency diploma for graduation. The team will need to assess whether each participant needs such and whether he or she is capable of obtaining one during the limited time available for enrollment in the drug court. Then, the team must add that requirement to that participant's case management plan and follow-up with the participant at appropriate intervals in the program, since obtaining a GED equivalency diploma requires multiple steps, including study, test scheduling, and possibly retesting. Again, if the team requires a GED equivalency diploma for graduation, resources for completing it, such as study guides, tutors, and test sites, should be available at no cost or reduced cost to the participants.

When balancing the reasonableness of drug court requirements, the team will need to consider the required length of the program and whether the graduation requirements can be reasonably accomplished during that period of time. Research has indicated that programs with set lengths of roughly twelve to sixteen months tend to have higher success rates than programs of lesser or greater duration, and those of unstated duration.[12, 13] It may help the team to map out the time requirements on a calendar to gain a clear visual of what the drug court demands. If drug court participants are required to hold down full-time jobs, attend twelve to sixteen hours of treatment per week, meet with their case managers, provide two or more unscheduled urine specimens per week, and attend court sessions, this may not be realistically possible. To make matters more complicated, many participants may not have a driver's license, may have child care responsibilities, and may not be able to rely on family support. The best way to balance requirements is to have some responsibilities decrease over time while others increase over time. For example, as participants move through the program, the amount of probation supervision and court appearances might begin to decrease, thus making room in their schedules for new obligations, such as earning a GED equivalency diploma or obtaining a job.

Termination criteria may include behaviors that threaten public safety or staff welfare; however, termination would be the last sanction for continued substance use.

The team must also decide upon termination criteria for the program. Failing to specify the grounds for termination up front can lead to a due process challenge because participants could be facing a loss of liberty without adequate notice. The first issue is whether there are any behaviors that can lead to immediate termination from the drug

court. Behaviors that jeopardize public safety or threaten the welfare of staff members or other participants might be grounds for immediate termination. Examples might include driving while impaired (DWI), dealing drugs to other participants in the program, or threatening staff. By contrast, less serious infractions, such as continued drug use, are typically punished on a graduated or escalating basis, in which the magnitude of the sanction increases over successive infractions. For example, participants might receive steadily increasing sanctions for each drug-positive urine result. Termination would ordinarily be the last sanction on the graduated schedule to be applied when all else has failed.

A number of infractions are in the middle ground between being considered serious violations and routine violations. For example, drug courts may apply higher-magnitude sanctions, which fall short of termination, for participants who falsify a drug test, abscond from the program, or are arrested for a new nonviolent drug-possession offense. Such infractions might elicit higher-magnitude sanctions (such as community service or brief jail detention) during the early phases of the program, but stop short of outright termination. If the team begins by administering higher-magnitude sanctions from the beginning for such infractions, termination can occur more rapidly if those behaviors continue to occur.

Less serious infractions may trigger graduated sanctions such as community service.

Importantly, research indicates that outcomes in drug courts tend to be substantially better when participants are given clear advance notice about the types of behaviors that can elicit a sanction, and the types and range of sanctions that may be imposed for various types of infractions.[14] Concrete information about infractions, sanctions, and grounds for termination should be clearly described in a policies and procedures manual, which should be widely distributed to all participants, their attorneys, and other stakeholders of the program.

X. [§2.22] PHASE STRUCTURE

Drug courts are virtually always structured into phases. The court and treatment program may have identical or different phase structures, but in either case, movement from one phase to another should be dependent upon the completion of objective criteria. Selecting the criteria and developing a system to measure their completion is up to the team. Many drug court teams have a list of specific benchmarks that must be achieved to attain phase advancement. Others may use a scoring system, in which a certain number of points are allotted for the completion of various tasks. Once a participant has accumulated a preset number of points, the participant can move on to the next phase.

There is no one correct sequence or number of phases, and drug courts should develop their own phase structure based upon the clinical needs and prognostic risk in their population. The phase structure should focus on progressive goals for the client as

treatment moves forward. Generally speaking, the first phase often focuses on stabilization and induction into treatment. Phase advancement might require the participant to complete all applicable clinical assessments, regularly attend treatment sessions (say, a ninety percent attendance rate for at least two months), obtain stable living arrangements, and obtain a self-help group sponsor. The second phase might focus more directly on the initiation of abstinence, requiring a minimum number of days of consecutive drug-negative urine samples, and perhaps completion of community service obligations or other probationary requirements. The third phase might focus on the development of prosocial healthy behaviors, such as obtaining employment, working toward a GED equivalency diploma, or attending vocational or parenting classes. Finally, the last phase often focuses on relapse prevention and aftercare preparation. At this juncture, requirements within the drug court have been substantially reduced in terms of attendance at treatment sessions, probation appointments, and court hearings. This allows room for a time commitment to school or work and for attendance in aftercare services such as self-help group meetings and alumni association meetings.

As participants successfully move from one phase to another, the drug court may wish to recognize those successes with a formal ceremony, presentation of a certificate, or at least an explicit acknowledgement from the bench. When a participant graduates from the program, the team should formally recognize that graduation with a ceremony in the courtroom unless the participant objects. Graduation ceremonies in drug courts are as individualized as the courts themselves. At some ceremonies, the arresting officer may attend to witness the defendant's transformation and close the circle on the original arrest. Local dignitaries, such as the mayor, attorney general, or chief of police, might also attend and deliver speeches and personal congratulations to the graduates, welcoming them back into the community. Some ceremonies are formal with caps and gowns. Others are simply worked into the regular drug court docket, with applause and congratulations from the bench. The judge, with input from the team, should decide on what type of graduation ceremony works best for his or her drug court.

Consequences should be clearly written into court policies and procedures manuals and participant handbooks.

At this point in the drug court planning, the judge may ask the team to begin developing an entry flow chart. The entry flow chart is basically a diagram of what happens from the drug court participant's initial infraction (arrest, probation violation, etc.) through completion of or termination from the drug court program. At each stage in the diagram, every team member should clearly understand his or her role in the process, and the judge should organize the team so that all procedures are recorded in the drug court policies and procedures manual. The drug court needs an institutional memory of the procedures to pass on to new team members. If possible, a copy of every form the court uses during the drug court proceedings should be included in the policies and procedures manual. Also, the judge should encourage each agency represented on the team to sign an MOU or MOA agreeing to the policies and procedures set out in the manual, so that

the team is not in the position of renegotiating policies each time a team member transitions. The policies and procedures manual should be so inclusive that the entire team could change in one day, and a new team could pick up the manual and run the program (assuming, of course, that they have completed the applicable trainings on drug court implementation and best practices).

Finally, once the policies and procedures have been established, the judge should lead the team through the documentation of clear expectations for the participants themselves. Research shows that clear expectations aid in behavior modification. All team members should work together on a contract and participant handbook that outline exactly what the drug court requires of participants, including the benchmarks for phase advancement, graduation, and termination criteria and possible sanctions and rewards. Through this client contract, participants should receive a clear understanding of what benefits and burdens they are undertaking by entering the program. Many drug courts have each participant and his or her attorney sign the agreement before entering the drug court.

Developing a flow chart mapping participant entry through graduation is helpful.

XI. [§2.23] APPLYING PROGRAM CRITERIA

The judge should then lead the team through the process of developing the concrete, day-to-day procedures for applying the program criteria. For example, the team will need to decide how it will educate referral sources, such as attorneys and law enforcement, about the eligibility criteria for the program. It will also need to decide how referrals to the drug court will be received, and who will determine legal eligibility for the program. States may have specific statutes that outline entry criteria. Legal eligibility refers to whether applicants are legally permitted to enter the program; for example, whether they have any disqualifying offenses that are pending or on their record. The individual or agency that determines legal eligibility is essentially the gate keeper for the referral process. Often, this function is assumed by the prosecution.

Similarly, there must be procedures for determining clinical eligibility for the drug court. Typically, offenders must meet diagnostic criteria for drug abuse or dependence, and there must be some evidence that their substance abuse problem is fueling or exacerbating their criminal activity. Often, this determination must be made by a clinician or clinical case manager who may work for the court, probation department, or local treatment program. Once an applicant is found to be eligible for the program, procedures are needed for scheduling an entry hearing and ensuring that the defendant provides a knowing and voluntary waiver of his or her relevant rights and consents to enter the program.

As part of this process, the court will lead a discussion on a variety of related topics, including the number of drug court hearings to be held each month during the various

Procedures checklist should include:

- *How will referral sources be educated about the program?*
- *What are the legal and clinical program eligibility criteria?*
- *How often must the participant report to court?*
- *Who attends staffings and drug court status hearings?*
- *How often are they held?*
- *What is the type and form of information received by the judge? Who prepares it? With whom is it shared?*
- *Are appropriate waivers in place?*
- *What is the final case disposition for successful and unsuccessful participation?*

phases of the program. The court must decide whether drug court participants will attend status hearings weekly, biweekly, or monthly. Research indicates that biweekly status hearings should generally be held during at least the first phase of the program.[15, 16, 17] Once participants have begun to initiate abstinence and demonstrate a commitment to treatment, the schedule of court hearings is often decreased over subsequent phases in the program. The team will need to decide on this phase structure in advance.

Drug court status hearings are typically preceded by team meetings, often called *staffings*, during which the team gathers to discuss each participant's progress since the last status hearing. At the staffings, the various team members provide the judge with accurate and timely information about participants' progress in the program, and make recommendations to the judge about incentives, sanctions, or therapeutic consequences that might be imposed. Ultimately, the judge will make the final decision about what consequences to impose, after giving due consideration to the expert advice of all team members. Then, the team might work together to script the court proceedings, including the order in which participants will be called before the judge. This is done to increase the educational value of the hearings and to enhance the "courtroom as theater" value of the drug court. Careful attention is paid to all aspects of the court hearings to continuously drive home a therapeutic message to the participants about what is expected of them and how they should apply themselves in the program.

One critical issue for the judge to resolve with the team concerning staffings is the manner in which information will be shared with the court. The judge may have only a few hours or days each week to preside over the drug court. If the judge is to see many dozens of drug court participants each week and establish a therapeutic relationship with each participant, the judge must have accurate information that is easy to navigate. Many drug courts have one-page reports for the judge's file, which may include drug test results, compliance issues, treatment progress, information gathered during home contacts, and relevant personal information, such as birthdays.

Finally, the judge must lead a discussion about what happens to participants after graduation or termination. Depending on participants' legal status in the program, successful graduates might have their charges dismissed, receive a reduced sentence, or have their probation terminated early. It is essential that the procedures for entering these dispositions be clearly specified and communicated to the participants and their defense counsel. More thorny issues are presented by terminated cases. Some commentators have taken the position that drug court judges should not sentence participants who are terminated from their programs because they have a heightened familiarity with the case, and thus may not be adequately neutral. Others take the position that drug court judges are most likely to understand the nature of addiction and to impose the most appropriate sentences in such cases. The safest position is to offer the offender the option to be sentenced by the drug court judge or by another neutral magistrate, and to entertain petitions for recusal if they are proffered by either the defense or prosecution. (For additional information, refer to Chapter 8, "Constitutional and Legal Issues in Drug Courts," of this benchbook.)

XII. [§2.24] EVALUATION

Evaluation is a critical tool for maximizing productivity in drug court. It provides a mechanism to understand what works, what doesn't, and why. It is the greatest management tool available. As an administrative tool, it allows drug court teams to better allocate resources and further sustain their program in the future. Evaluation should not be considered an add-on but an integral part of the planning process. To that end, early evaluator engagement strengthens program design and planning.

It is essential that drug courts engage their stakeholders in the development of the evaluation design. Stakeholders include funders, project managers, team members, line staff, collaborating partners, and persons served or affected by the program. Failure to engage stakeholders increases the probability that findings will be ignored, criticized, or resisted because the evaluation did not address their concerns or values.

Process evaluation and performance measurement are two aspects of drug court research that form the foundation for any national claims of drug court efficiency and efficacy. Drug courts should consider national, state, and local variables that need to be regularly captured to evaluate drug court performance. The NDCI publication entitled *Local Drug Court Research: Navigating Performance Measures and Process Evaluations* provides a set of model research questions with the means for answering them, a list of minimum data-elements that should be collected and maintained, and a sample evaluation plan.

Every drug court team member should understand the essential differences between a *process evaluation*, which evaluates the operations of the program itself, and an *outcome evaluation*, which evaluates the program's impacts on its participants. Process evaluations tell the team what is and isn't working in the day-to-day operations of the drug court. For example, are drug test results available in a timely and reliable manner? How many participants are being screened for the program? How soon after referral are participants

being screened, and if found eligible, entering the program? By contrast, an outcome evaluation measures how effective the program is. For example, what is the graduation rate and recidivism rate for participants? Both process and outcome evaluations should reflect whether the goals and objectives of the drug court (discussed earlier in this chapter) are being met. For either to be reliable, the drug court must collect accurate, accessible data from program inception, track participants and graduates, and use a knowledgeable evaluator.

XIII. [§2.25] CONCLUSION

Drug courts represent a collaborative team approach to judicial, prosecutorial, criminal defense, and clinical decision making. This collaborative orientation must begin at, or before, the inception of the drug court program. Dozens of critical decisions must be negotiated among various parties, clearly resolved, and memorialized in written form. There is no substitute for the team committing itself to engaging in this painstaking, but ultimately satisfying and enlightening, process. The time and effort that it takes to plan the parameters of the program in advance will pay dividends many times over in terms of more efficient and effective operations once the program opens its doors. The more effort that is made to bring all of the relevant stakeholders into the process and to gain buy-in and support from community leaders and constituents, the more effective and enduring the program will be. There is no doubt that the most productive and longstanding drug court programs, nationally, all share in the fact that they worked actively and continuously to enlist partners at multiple levels within their jurisdictions.

And remember that the NDCI can be an important asset to you as you embark on this important journey. Planning and implementation workshops are available to bring your team together in a problem-solving mode to develop your policies and procedures, enhance mutual trust and support among team members, and learn about the most effective and cost-effective best practices for your programs. Research demonstrates that attendance at implementation workshops produces better outcomes and greater satisfaction among team members.[18] Allow this proven training to work for the benefit of you and your drug court team, just as you will work for the benefit of your clients and your community.

The National Drug Court Institute is here to help.
www.ndci.org

1 Carey, Shannon M., Michael W. Finigan, and Kimberly Pukstas. 2008. *Exploring the key components of drug courts: A comparative study of 18 adult drug courts on practices, outcomes and costs.* Portland, OR: NPC Research. *Available at* www.npcresearch.com.

2 Carey,. Finigan, and Pukstas.. *Exploring the key components of drug courts.*

3 Marlowe, D. B., Festinger, D. S., Lee, P. A., Dugosh, K. L., & Benasutti, K. M. (2006). Matching judicial supervision to clients' risk status in drug court. Crime & Delinquency, 52, 52–76.

4 Omnibus Crime Control and Safe Streets Act of 1968 § 2953(a)(1), 42 U.S.C. § 3797u-2(a)(1), amended by Second Chance Act of 2007, Pub. L. No. 110-199, 122 STAT. 657.

5 Marlowe, Douglas B. 2009. Evidence-based sentencing for drug offenders: An analysis of prognostic risks and criminogenic needs. *Chapman Journal of Criminal Justice,* 1: 167–201.

6 Marlowe, Douglas B. 2006. Judicial supervision of drug-abusing offenders. *Journal of Psychoactive Drugs, SARC Suppl. 3:* 323–331.

7 Marlowe, Douglas B., David S. Festinger, Karen L. Dugosh, Patricia A. Lee, and Kathleen M. Benasutti. 2007. "Adapting judicial supervision to the risk level of drug offenders: Discharge and six-month outcomes from a prospective matching study." *Drug & Alcohol Dependence* 88 (Suppl 2): 4–13.

8 DeMatteo, David S., Douglas B. Marlowe, and David S. Festinger. 2006. Secondary prevention services for clients who are low risk in drug court: A conceptual model. *Crime & Delinquency* 52: 114–134.

9 Goldkamp, John S., Michael D. White, and Jennifer B. Robinson. 2001. Do drug courts work? Getting inside the drug court black box. *Journal of Drug Issues* 31: 27–72.

10 Longshore, Doug L., Susan Turner, Suzanne L. Wenzel, Andrew R. Morral, Adele Harrell, Duane McBride, et al. 2001. Drug courts: A conceptual framework. *Journal of Drug Issues* 31: 7–25.

11 Shaffer, Deborah Koetzle. 2006. *Reconsidering drug court effectiveness: A meta-analytic review*. Las Vegas, NV: Dept. of Criminal Justice, University of Nevada.

12 Latimer, Jeff, Kelly Morton-Bourgon, and Jo-Anne Chrétien. 2006. *A meta-analytic examination of drug treatment courts: do they reduce recidivism?* Ottawa, ON: Canada Dept. of Justice, Research & Statistics Division.

13 Shaffer, Deborah Koetzle, *Reconsidering drug court effectiveness.*

14 Carey, Finigan, and Pukstas, *Exploring the key components of drug courts.*

15 Carey, Finigan, and Pukstas, *Exploring the key components of drug courts.*

16 Marlowe et all, Matching judicial supervision to clients' risk status in drug court.

17 Marlowe et al, Adapting judicial supervision to the risk level of drug offenders.

18 Carey, Finigan, and Pukstas, *Exploring the key components of drug courts.*

Chapter 3

The Roles of the Drug Court Judge

Honorable William G. Meyer (Ret.)
Honorable Jeffrey Tauber (Ret.)

I. [§3.1] INTRODUCTION 47
II. [§3.2] JUDGE AS LEADER. 48
III. [§3.3] JUDGE AS COMMUNICATOR 50
IV. [§3.4] JUDGE AS EDUCATOR 53
V. [§3.5] JUDGE AS COMMUNITY COLLABORATOR 54
VI. [§3.6] JUDGE AS INSTITUTION BUILDER 58
VII. [§3.7] CONCLUSION 59

I. [§3.1] INTRODUCTION

The eminent legal scholar and Federal Circuit Court Judge Richard Posner described judges as follows:

> My analysis and the studies upon which it builds find that judges are not moral or intellectual giants (alas), prophets, oracles, mouthpieces or calculating machines. They are all-too-human workers, responding to the conditions of the labor market in which they work.[1]

Drug courts grew out of a grass roots movement, when judges and other criminal justice practitioners "responding to the conditions of the labor market in which they work," realized that traditional criminal justice interventions of incarceration, probation, or supervised parole did not stem the tide of drug use among criminals and drug-related crimes in America.[2] The National Drug Court Institute (NDCI) has identified nine core competencies that describe the role of the drug court judge:[3]

Core Competency 1. Participates fully as a drug court team member, committing him or herself to the program, mission and goals, and works as a full partner to ensure their success.

Core Competency 2. As part of the drug court team, in appropriate non-court settings (i.e., staffing), the judge advocates for effective incentives and sanctions for program compliance or lack thereof.

Core Competency 3. Is knowledgeable of addiction, alcoholism, and pharmacology generally and applies that knowledge to respond to compliance in a therapeutically appropriate manner.

Core Competency 4. Is knowledgeable of gender, age, and cultural issues that may impact the offender's success.

Core Competency 5. Initiates the planning process by bringing together the necessary agencies and stakeholders to evaluate the current court processes and procedures and thereafter collaborates to coordinate innovative solutions.

Core Competency 6. Becomes a program advocate by utilizing his or her community leadership role to create interest in and develop support for the program.

Core Competency 7. Effectively leads the team to develop all the protocols and procedures of the program.

Core Competency 8. Is aware of the impact that substance abuse has on the court system, the lives of offenders, their families and the community at-large.

Core Competency 9. Contributes to education of peers, colleagues, and judiciary about the efficacy of drug courts.

NDCI uses these core competencies to deliver training to jurisdictions that want to implement a drug court; the core competencies provide guidance and structure for discussing the role of the drug court judge. The drug court judge must possess or acquire skills as a leader, communicator, educator, community collaborator, and institution builder. Each of the core competencies is addressed under those topic headings.

II. [§3.2] JUDGE AS LEADER

The author Ken Kesey observed: "you don't lead by pointing and telling people some place to go. You lead by going to that place and making a case."[4] While putative leaders imagine that leadership can provide power, control, or perks, the actual role of a leader consists of empowering others, helping others fix problems, and serving others.[5] At least three core competencies directly relate to the judge as leader. The cornerstone of the drug court is a team of professionals, which is led by the drug court judge.[6] As a team member, the drug court judge is fully committed to the program mission and goals and works as a full partner to ensure program success. (Core Competency 1) As part of the planning process the judge should:

- Select team members from each discipline and extend an invitation to take part in drug court;
- Schedule planning meetings conducive to the schedule of each drug court team member;
- Develop with team members the structure of the program mission, along with goals and objectives, during planning process meetings;
- Assure all agreed-upon terms of the program structure are memorialized;
- Maintain role as team leader while promoting a productive work environment, in which each team member can participate without fear.[7]

As the court becomes operational, the judge must continue the development and implementation of the drug court program. For the operational drug court, the judge should:

- Continue to schedule regular meetings focused on program structure;
- Regularly revisit program mission, goals, and objectives with team to assure their efficacy and application;
- Schedule team-building activities designed to promote and encourage team members.[8]

A drug court judge is:

- *A leader*
- *A communicator*
- *An educator*
- *A community collaborator*
- *An institution builder*

The judge should require that all team members participate in staffings. Excuses of budget limitations and caseload are often used to justify either the prosecutor's or defense counsel's absence from staffings. Without full representation at staffing, the court will be subject to receiving ex parte communications.[9] Recent drug court research reports that the participation of both the prosecution and defense counsel at staffings and court review hearings had a significant positive impact on drug court participant graduation rates and costs.[10] Similarly, treatment providers, probation and law enforcement should be members of the team and attend staffings and court hearings.[11] It should never be a question of inability to financially afford attendance at staffings and court hearings because the research demonstrates that the prosecution and defense counsel and other team members cannot afford to not attend these sessions.

The role of the judge at staffings and in the courtroom is being the first among equals. Core Competency 2 requires that the judge be at the forefront in identifying appropriate sanctions during the planning stage and in selecting and delivering motivational consequences during the operational stage. At the planning stage the judge should:

A judge is a judge and is always a judge even in drug court. Neither judicial independence nor judicial discretion are diminished by being a drug court judge.

- Discuss with the team when staffings will convene;
- Participate in client staffings;
- Preside over court sessions;
- Learn science-based principles regarding the development and use of incentives and sanctions;
- Explore, along with the team, community resources available for the imposition of incentives (e.g., gift certificates for local businesses) and sanctions (e.g., community service at local animal shelter);
- Participate in the development of incentives and sanctions to be used in the drug court program.

Once the court becomes operational, the judge should:

- Participate in scheduled staffings to review progress of participants;
- Preside over court sessions;
- Solicit information regarding the participant's progress from every team member in attendance;
- Remain abreast of research regarding behavior modification techniques and the imposition of incentives and sanctions;
- Impose incentives and sanctions that are consistent while considering the individual needs of each drug court participant;
- Establish separate meetings to ensure that policy and staffing issues are discussed;
- Deliver coordinated response to participants in the courtroom.

Drug courts, in general, and drug court judges, in particular, have come under sharp criticism for allegedly giving up their independence and sacrificing judicial decision making in favor of the team approach.[12] Such contentions are from the misinformed. Although drug court judges work collaboratively with team members, they neither give up their discretion nor their independence. As noted by respected Drug Court Judge Peggy Hora:

> One concern that may be voiced by drug treatment court detractors is the softening of the traditional focus on an adversarial relationship between the prosecution and defense. In using a problem-solving approach, drug treatment courts do not purport to "trump" traditional and respected doctrines such as due process, equal protection, and judicial independence, which may conflict with therapeutic considerations. On the contrary,

> the approach suggests how the adversarial process might be "reinvigorated or supplemented" by new psychological and sociological insight. The defining principles of the drug treatment court movement explicitly are altered.[13]

Drug court judges simply do not give up their discretion or independence. Ultimately, when a consequence has to be imposed due to a drug court participant's noncompliant behavior, it is the judge's decision, after giving due consideration to the merits of the other team members' input.

Critics also assert that judges should not be doing social work.[14] Such a contention is well rebutted by New York Judge Juanita Bing Newman:

> [T]he process of judging, where judges use their authority to form an informed response to social problems, is simply not new, it is not unusual. It is what we do. *Brown v. The Board of Education*, for example, comes to my immediate mind. And so, just as it is appropriate for judges to have informed responses to public macro issues, I think it is similarly appropriate for us to have those informed responses to micro personal issues, such as drug addiction for individuals, particularly when we know that it has [an] effect in the public milieu.[15]

Effective drug court judges also work with their team to develop written protocols that document the policies and procedures of the drug court program and Core Competency 7 requires such memorialization.[16] As part of the planning process, the drug court judge should:

- Schedule regular meetings with team members to create written protocols and procedures;
- Promote dialogue among team members to create protocols and procedures that address the concerns of each discipline.

Once the drug court becomes operational the drug court judge should:

- Regularly review protocols and procedures to assure their continued applicability and effectiveness;
- Monitor drug court processes to ensure protocols and procedures are utilized.

This attention to formalization and documentation will assist the drug court in becoming institutionalized and ensure that routine procedures are implemented and followed.

III. [§3.3] JUDGE AS COMMUNICATOR

Several of the core competencies touch on the needed communication skills of the judge, including Competency 2: the judge as sanction and incentive advocate, and Competency 6: the judge as program promoter. Deserving of singular attention is the relationship between the judge and the drug court participant. Some have described it as therapeutic.[17] Detractors complain that drug court judges are acting as amateur

psychiatrists.[18] What separates drug court judges from traditional judges is training in addiction, understanding how to motivate behavior change, and simple empathy.[19] Drug court judges do not act as therapists or amateur psychiatrists. However, the relationship between the drug court participant and the judge is a significant factor in recovery. As psychiatrist Sally Satel reported in a study entitled "Observational Study of Drug Court Dynamics":

> In some cases, when participants tell evaluators that the judge "really cares," the true meaning of this superficial endorsement is not always clear. In optimal instances, this means that the judge is genuinely engaged with the participants and has become a central and respected figure in their drug court and recovery experience. In these situations, motivation to succeed may stem partly from a desire to "make the judge proud of me." A participant in the Denver Drug Court told evaluators that, "[When] the judge recognized that I've been here so long it was like he was proud, it was strange, like a father kinda. There's no doubt in my mind that this is different [from other court experiences]. When I relapsed and got disciplined, he said, 'well, you still owe me a day.' But he didn't do it out of vindictiveness, you know, like a spanking or something. Actually, it was what I needed."[20]

Similarly, a survey conducted by the Drug Court Clearinghouse at American University reported: "Eighty percent of [drug court] participants [surveyed] indicated they would not have remained if they did not appear before a judge as part of the process."[21]

It is not only the type and magnitude of the consequence for (non)compliance that shapes a drug court participant's behavior in the future.[22] The court's interaction with the participant and the delivery of the response also impact a participant's subsequent performance. People interacting with the judiciary believe they will be treated fairly because such treatment will produce an equitable result.[23] The touchstone of the court's interface with the drug court participant should be procedural fairness. Individuals who receive a negative outcome in court are much more likely to accept the result if they perceive they were treated fairly by the court.[24] The keys to procedural fairness are fourfold:

Voice. The ability to participate in the case by expressing their viewpoint.

Neutrality. Consistently applied legal principles, unbiased decision makers, and a "transparency" about how decisions are made.

Respectful Treatment. Individuals are treated with dignity and their rights are plainly protected.

Trustworthy Authorities. Authorities are benevolent, caring, and sincerely trying to help the litigants. This trust is garnered by listening to individuals and by explaining or justifying decisions that address each litigant's needs.[25]

The importance of procedural fairness is aptly illustrated in the Center for Court Innovation's recent study on participants' perspectives on the drug court judge. In general, in the courts surveyed, participants were positive about their interaction with

the drug court judge. However, negative comments were directed toward one judge who did not give participants the opportunity to express themselves, seemed arbitrary, and "made his own rules."[26]

Additionally, the judge must be cognizant of the audience of drug court participants. Drug courts frequently use court progress hearings to illustrate lessons to audience participants who are waiting to have their case called. Perceived unfairness impacts not only the recipient but also those who observed the alleged injustice.[27] To avoid an appearance of unfairness, it is critical that the drug court judge explain the basis for the decision. Initially, the judge should discuss various factors during the staffings when selecting a particular sanction or incentive, such as the severity of the participant's addiction, mental illness, criminal background, response to treatment and program compliance or noncompliance. Advanced trainings by NDCI on sanctions and incentives recommend that when the judge delivers a consequence, the court should review with the offender the severity of their substance abuse problem; the behavior being responded to; how that particular behavior is temporally important in their recovery; and why the particular sanction and magnitude were selected.[28]

Courts have better outcomes when judges spend three minutes or more per participant.

Explanations should not just be given at the time consequences are imposed. Providing the offender with explicit behavioral instructions, the range of sanctions for noncompliance and the rewards for achievement can avoid a helplessness syndrome where the participant becomes defiant, despondent, or drops out when consequences are imposed.[29] Moreover, court procedures should be described such as why cases are being called in a certain way[30] or how phase advancement is achieved.

Furthermore, empirical research is unequivocal that the judge is a key component in drug court for individuals whose background reflects a high probability of rehabilitative program failure coupled with significant clinical disorders or functional impairments, like substance dependence which, if addressed, reduce the likelihood of future recidivism.[31] For these offenders, the court should require status hearings every two weeks.[32] Offenders who are low risk and that do not possess these characteristics might be assigned to an alternative, less intensive track or possibly referred to a different program altogether.[33]

Not surprisingly, the drug court judge who is assigned to the drug court for two years or indefinitely has better participant drug court graduation rates and lower outcome costs than those courts that yearly rotate judges in and out of the drug court.[34] Finally, the length of time that the judge spends with the offender during status hearings can result in positive cost savings, and the use of "courtroom as classroom" may influence the participant's programmatic progress. NPC Research[35] reports that judges who spend three or more minutes with the participant during status hearings have greater programmatic outcome savings than those courts where the judges spent less time.[36] Also reported is the "audience effect," by which drug court participants acknowledge

that by sitting in the gallery and watching the proceedings as others receive incentives and sanctions sends the message "it could be me," which assists them in keeping clean.[37]

Thus, to be an effective communicator, the drug court judge need not only consider what is communicated to the drug court participant, but how it is stated and when it is conveyed. The judge should be particularly attentive to according the participant the elements of procedural fairness.

IV. [§3.4] JUDGE AS EDUCATOR

At least three core competencies are implicated when discussing the drug court judge as educator. The drug court judge must self-educate so that she or he is familiar with addiction, evidence-based treatment, drug testing, and motivational strategies. Core Competency 3 requires that the drug court judge be "knowledgeable of addiction, alcoholism, and pharmacology generally and apply that knowledge to respond to compliance in a therapeutically appropriate manner."[38] During the planning process, the well informed drug court judge should:

- Select a treatment provider who is knowledgeable and informed;
- Participate in the creation of a memorandum of understanding reflecting the mutual agreements between all drug court team members including the treatment provider;
- Learn about psychopharmacology and addiction;
- Learn about scientific and evidence-based treatment modalities and interventions for the target population;
- Learn about strengths-based approaches.[39]

As the drug court becomes operational, the drug court judge should:

- Participate in regular cross-trainings with the treatment team;
- Employ evidence-based practices and focus on strengths-based approaches.[40]

Familiarity with appropriate treatment and testing protocols is insufficient without the judge also being conversant about the population being served. Core Competency 4 contemplates that the drug court judge be knowledgeable of gender, age, and cultural issues that may impact the offender's success. As part of the planning process, the drug court judge should:

- Emphasize the importance of cultural competency for all team members, making sure that all are familiar with the population from which drug court participants will be selected;
- Engage in cultural competency training.

As the drug court becomes operational, the drug court judge should:

- Participate in ongoing cultural competency training;
- Promote cultural competency among the entire team through outside and cross-training activity.[41]

As the elements of the core competencies are contemplated, the judge should self-educate as well as participate with team members in ongoing cross-training. Current research supports such ongoing education because drug courts that provide preimplementation training for staff members have higher graduation rates and greater outcome cost saving when compared to drug courts that do not.[42] Similarly, where new hires had formal training or orientation, cost savings were realized, and where all members of the drug court team had ongoing training both cost savings and higher graduation rates were achieved.[43]

Core Competency 9 obliges the drug court judge to "contribute to [the] education of peers, colleagues and judiciary on the efficacy of drug courts."[44] Therefore, as part of the planning process, the drug court judge should:

- Inform the judiciary and local bar association about drug court;
- Seek public speaking opportunities to inform the public about drug courts;
- Discuss drug courts with their colleagues.

As the drug court becomes operational, the responsibilities of the drug court judge continue in this area because the judge must:

- Oversee the integrity of the drug court program through quality assurance;
- Disseminate information about drug court as frequently as possible.[45]

The failure to inform judicial colleagues presents two potential problems for the drug court judge. First, it inhibits the necessary political buy-in from fellow judges, which is necessary for ongoing drug court operations. Second, such lack of communication impairs the development of a succession plan.[46]

Therefore, the educated drug court judge must (1) become trained on addiction, pharmacology, drug testing, and the population served; (2) ensure that all team members receive timely and ongoing cross-training; and (3) routinely disseminate information about the drug court program to colleagues, stakeholders, and the community.

V. [§3.5] JUDGE AS COMMUNITY COLLABORATOR

As a community collaborator, the drug court judge initiates the planning process by bringing together the necessary agencies and stakeholders to evaluate the current court processes and procedures and, thereafter, collaborates to coordinate innovative solutions.[47] High judicial visibility in the community is not novel. One notable criminal justice expert commented on the historical antecedents of judges in rural communities:

> …judges are key sources of energy for community justice, given the breadth of their judicial experience, their strong feeling of connection to and responsibility for the people in their respective counties, their belief that progress is possible, and their willingness to gather people to solve local problems.[48]

In the planning stage, the drug court judge will:

- Identify agencies and stakeholders in the community who can assist with the development and implementation of the program;
- Schedule meetings to bring together all potential agencies and stakeholders;
- Participate in open dialogue with community agencies and stakeholders;
- Assist in the establishment of memoranda of understanding (MOUs) with agencies and stakeholders.

In the operational stage, the drug court judge should act as a mediator to:

- Develop and maintain resources;
- Improve interagency linkages.

The drug court judge marshals the participation and resources of agencies and organizations. Some agencies are accustomed to working closely with or under the supervision of the court. Others have no knowledge of the court system. Some agencies have difficulty cooperating with each other; others operate at different ends of the social or political spectrum (e.g., police and treatment; prosecutors and public defenders). The drug court judge must not only bring these diverse agencies together, but obtain their collaboration in formulating MOUs. The judge can help address issues as disparate as how to handle a participant who admits substance use while in the program or what action should be taken to increase a treatment agency's capacity for drug court participants. The drug court judge can use his or her position to gain the support of agency heads such as mayors, county supervisors, police, and probation chiefs and service agency executives. Relationships with agency heads will also assist the drug court judge in dealing with challenges in the program that relate to those agencies or their representatives on the drug court team.

Closely related to Core Competency 5 is the drug court judge's obligations under Core Competency 6, which requires the drug court judge to "becomes a program advocate by utilizing his or her community leadership role to create interest in and develop support for the program."[49] Under this competency, the planning process contemplates that the judge should:

- Share information regarding the efficacy of drug courts with local civic organizations, other members of the judiciary, and the community at-large;
- Seek opportunities to illuminate media sources about drug court.

During the operational phase, the drug court judge would act as a spokesperson for the drug court at various community events. Drug court judges have the political influence, relationships within government, moral authority, perceived fairness and impartiality, and the expertise and focus to lead a coordinated antidrug effort in communities. The drug court judge is often a valuable member of the greater community. The drug court judge is a great ambassador for drug court to service organizations such as the Elks, Lions, and Rotary. Although the drug court judge and court staff cannot solicit donations from community organizations, other members of the drug court team can enlist volunteers to sponsor events (graduations, picnics, banquets), provide mentors for participants, or

provide tangible incentives for use by the drug court. Community entities can be a valuable source of educational, employment, and housing opportunities for participants.

While the drug court judge may have originally started the program because of the revolving door for drug-involved offenders in the criminal justice system, the judge needs to not only be aware of the impact of substance abuse on the court system, but also the influence of substance abuse on the lives of offenders, their families, and the community at-large.[50] Key to this core competency is the collection and dissemination of accurate data on the results of the drug court program. During the planning stage, the drug court judge should:

- Assist in collection of data regarding the offender population;
- Seek a competent evaluator as a key team member who will identify relevant data and disseminate to the team.

Once the court becomes operational, the drug court judge should:

- Assist in collection of data regarding drug court's impact on the offender population;
- Request and review process evaluation, ensuring reference to original goals and objectives when doing so;
- Request and review outcome evaluation, share positive information and address negative information.

The proper use of the collected data and evaluation results enhances program effectiveness, reduces costs, and provides a justification for continued funding. Data collection is an essential part of institutionalization. The drug court judge and team must be fully apprised of all substantial aspects of the participant's compliance (including drug test results, treatment session attendance, and other objective criteria of compliance). Technology now facilitates the collection, sharing, and analysis of information in the drug court arena. This information is essential to the success of participants and the program. All team members must participate in sharing information and collecting data to benefit participants and the program.

Reliable data also provide the basis for evaluations that support the program's efficacy. Data necessary for evaluation must be identified during the planning stages. A logical source for research professionals are local universities and think tanks dedicated to the study of the judicial system. Evaluations can often be supported through collateral funding sources such as government and foundation grants. Research demonstrates that electronic data collection and use of evaluation feedback improves outcomes and saves money. NPC Research[51] reports:

> Programs that used evaluation feedback and their own internal statistics to modify their program process showed substantial benefit in improved outcome costs. It is always possible that a poor evaluation could either lead to inappropriate modifications, or result in the program choosing not to make modifications. Among the programs included in this study, however, those that made modifications based on feedback had better outcomes. In addition, programs that participated in more than one

> evaluation showed improved outcome costs. This illustrates the importance of the use of feedback based on program-specific data to modify and enhance drug court operations. The use of paper files to manage data important to monitoring participant progress and to conducting program evaluation was associated with higher investment costs, lower graduation rates and less improvement in outcome costs. This demonstrates the cost effectiveness of electronic databases in tracking participant progress as well as performing evaluation.[52]

The drug court judge is in a unique position to lead the team in the acquisition of funding. Armed with positive outcome statistics, the appeal for funding is enhanced. Without such data, the drug court cannot justify its existence. By using knowledge of agencies, county and state institutions, and national drug court leaders, the drug court judge can lead the team to resources for the program. Judges can request justice funding from the state supreme court, legislature, and other governmental entities directly responsible for funding the court system. Judges can also share their drug court experience with foundation heads, corporate CEOs, and service organizations so that team members, who are not governed by the judicial canons, can request drug court funding. It's important to note that the judge must be circumspect and judicious in making such disclosures.

Judges are often hesitant to be visible in the community, believing that community participation is a violation of the Canons of Judicial Conduct. Nothing could be further from the truth. As one legal ethics scholar observed:

> It is frequently said that impartial judges should be neutral and detached, but this does not mean that judges have to isolate themselves, devoid of any contact with the community at-large. … Moreover, to place judges in a monastery or an ivory tower would diminish their judicial ability. Judges need to keep in contact with the outside world. Involvement in the outside world enriches the [judiciary], and enhances a judge's ability to make difficult decisions. As Justice [Oliver Wendell] Holmes once said: "[The] life of the law has not been logic: it has been experience." [53]

The drug court judge must be willing to communicate with members of the media. Because drug court presents a different view of the court system, the court will automatically attract media attention. The judge is also the best media contact because of the media and general public's respect for members of the judiciary. This is useful in calls to newsrooms, editorial boards, and station managers when attempting to get coverage for your drug court. In serving in this capacity, it is helpful to get pointers from individuals or training guides about media relations. This includes writing releases, identifying newsworthy topics, use of true-life stories, cameras in the courtroom (when permissible by the state supreme court and after obtaining appropriate confidentiality waivers), and best media to maximize the message. It is critical for the drug court team to discuss the issue of media contact when planning its program. Some team member agencies may already have policies in place for media contact, and the entire team must be aware of these policies. Having a written plan that is part of the program's policy and

procedure manual and that covers who will speak to the media and what information can and will be shared is crucial to effective operation.

At budget time and when opportunities for growth appear, the media can be an ally. It should also be noted that when something untoward occurs in drug court, the media will cover the event. A preexisting relationship with members of the media encourages understanding of the drug court program and the relapsing nature of the disease of addiction.

VI. [§3.6] JUDGE AS INSTITUTION BUILDER

The drug court judge understands and recognizes the benefits and pitfalls of institutionalization.[54] The development of standardized written policies and procedures is crucial to the long-term success of drug court programs. However, bureaucratic rules and procedures can sometimes impede programs. It is important to consistently review program processes, rules, and procedures to ensure that they add to the viability and success of the program and the ultimate goals of drug court: participant recovery and public safety.

Judges who transfer into existing drug courts also have a role in the continuation and growth of that institution. To achieve success, it is important to tread lightly. In some jurisdictions, judicial assignments change as frequently as once a year.[55] Other team members have the historical perspective, institutional history, and commitment to the program. Do not initiate changes solely to create your imprint. Any changes should be designed to strengthen the program. New drug court judges must carefully balance the authority of their position with the fragility of their new position as a drug court team member. At the same time, the position as a new team member should not require relinquishment of the leadership role in the drug court.

A judicial policy committee or an informal gathering of former drug court judges and other interested judges can provide advice, consultation, and assistance in the continuity of the program. Former drug court judges (and other judicial officers) will very likely welcome an invitation to actively support the drug court program. Their assistance and advice can be critical in understanding both the structural and organizational history of the program, as well as providing a framework for future restructuring. Additionally, any countywide judicial committee can exert considerable influence on both the court and county's political infrastructure. In general, it is also important to invite all members of the judiciary to attend drug court graduations, status hearings, pre-court staffing sessions, and training conferences. Over the long term, this judicial support will greatly benefit the drug court.

The drug court judge who plans for the future looks for a successor at the beginning of his or her drug court tenure. This recruitment can be accomplished with invitations to graduations, status sessions, and planning meetings or informal discussions with colleagues. It may also require active solicitation and encouragement to find the right replacement.

Efforts to secure the future of the drug court program should ensure that the workload is manageable. Because drug court responsibilities are often added to traditional dockets, it is important to ensure an equitable work assignment. A realistic assessment of drug court duties and work schedule is necessary to minimize a workload that will result in burnout and discourage a potential successor. Some presiding and chief judges do not support drug court or view it as "real judges' work." This often leads to the assignment of a full calendar along with drug court responsibilities. The drug court sometimes is used as a dumping ground for cases other judges would prefer not to handle. It is important to address these challenges directly by sharing drug court research and other information that will enlist the presiding or chief judge's support. As the drug court becomes institutionalized, such problems diminish, but the drug court judge must still be vigilant to thwart institutional pressures that impair drug court operations.

VII. [§3.7] CONCLUSION

The drug court judge leads the establishment of a new institution within the court system. For judges who are starting a court, this represents an exciting and challenging time. As described in Chapter 2, "Getting Started," the planning and implementation of a drug court is an extraordinary process. For many judges who lead their teams from the beginning, the planning process seems like a marathon meeting, with intervals for food and restroom breaks. For others, the planning period seems much shorter. Most judges who persevere in the drug court find immeasurable gratification. In fact, job satisfaction for drug court judges far exceeds that of other judges handling nonproblem-solving court dockets.[56] In the end, it is not the time that counts, but the care associated with the development of processes that stand the test of time and adapt to new and improved information.

The drug court judge's influence extends from the courtroom and justice system to the offender, the offender's family, and the community. The effective drug judge acts as leader, communicator, educator, community collaborator, and institutional builder.

Assuming these diverse roles requires that the judge step out of the traditional judicial job functions, yet be constrained by the Canons of Judicial Conduct. The course of the judge, in both the planning and the operation of a drug court is aptly characterized by the following quote:

"Do not follow where the path may lead. Go, instead, where there is no path and leave a trail."

~ Ralph Waldo Emerson

1 Richard A. Posner, How Judges Think 7 (2008).

2 Peggy Fulton Hora,et al. *Therapeutic Jurisprudence and the Drug Treatment Court Movement: Revolutionizing the Criminal Justice System's Response to Drug Abuse and Crime in America,* 74 Notre Dame L. Rev. 439, 439 (1999).

3 *See* Bureau of Justice Assistance, Core Competencies Guide Adult DCPI Trainings, http://www.dcpi.ncjrs.gov/dcpi/pdf/ndci-core-competencies.doc.

4 Quoted in Chris Brady & Orrin Woodward, Launching a Leadership Revolution xiv (2007).

5 *Id.* at 7.

6 Am. Bar Ass'n, Road Map to Problem Solving Courts 9 (2008).

7 *See* Bureau of Justice Assistance, *supra* note 4.

8 *Id.*

9 *See infra* ch. 9.

10 Shannon M. Carey et al., NPC Research, Exploring the Key Components of Drug Courts: A Comparative Study of 18 Adult Drug Courts on Practices, Outcomes and Costs 9 (2008), *available at* http://www.ncjrs.gov/pdffiles1/nij/grants /223853.pdf.

11 *Id.* at 23.

12 See, e.g., Morris B. Hoffman, *Therapeutic Jurisprudence, Neo-Rehabilitationism, and Judicial Collectivism: The Least Dangerous Branch Becomes Most Dangerous,* 29 Fordham Urb. L.J. 2063, 2063 (2002); Richard C. Boldt, *Rehabilitative Punishment and the Drug Treatment Court Movement,* 76 Wash. U. L. Q. 1205, 1205 (1998).

13 Peggy Fulton Hora & Theodore Stalcup, Drug Treatment Courts in the Twenty-First Century: The Evolution of the Revolution in Problem-Solving Courts, 42 Ga. L. Rev. 717, 790 (2007). See also Greg Berman & John Feinblatt, Good Courts: The Case for Problem-Solving Justice 109-122 (2005).

14 Morris B. Hoffman, The Drug Court Scandal, 78 N.C. L. Rev. 1437, 1479 (2000); Morris B. Hoffman, supra note13, at 2063. One judicial commentator characterizes the Hoffman critique of drug courts as follows:

> Of course, there is a small minority of commentators for whom meaningful discussion is foreclosed by a fundamentalist adherence to the a priori validation of punitivism. Because such an approach discards inconvenient empiricism in its ideological insistence on philosophical dominance, it is no match for logic: properly managed, treatment courts are demonstrably effective on many offenders.
>
> Michael H. Marcus, Conversations on Evidence-Based Sentencing, 1 Chap. J. Crim. Just. 61, 64 (2009).

15 Greg Berman & John Feinblatt, Ctr. for Court Innovation, Judges and Problem-Solving Courts 13 (2002).

16 See Bureau of Justice Assistance, supra note 4.

17 Joyce A. Wheeler, Witness for the Client: A Judge's Role in Increasing Awareness in the Defendant, 9 Gestalt Rev. 144, 144-161 (2005).

18 The Drug Court Scandal, supra note 15, at 1479.

19 William G. Meyer & A. William Ritter, Drug Courts Work, 14 Fed. Sent'g Rep. 179, 183-184 (2002).

20 Sally L. Satel, Observational Study of Courtroom Dynamics in Selected Drug Courts, 1 Nat'l Drug Ct. Inst. Rev. 43, 56, 69 (1998).

21 Drug Court Clearinghouse & Tech. Assistance Project, U.S. Dep't of Justice, Summary Assessment of the Drug Court Experience (1996). See also Donald J. Farole, Jr. & Amanda B. Cissner, Ctr. for Court Innovation, Seeing Eye to Eye?: Participant and Staff Perspectives on Drug Courts 8 (2005).

22 See infra Ch. 7.

23 Robert J. MacCoun, Voice, Control, and Belongings: The Double-Edged Sword of Procedural Fairness, 1 Ann. Rev. L. Soc. Sci. 171, 171(2005).

24 Kevin Burke & Steve Leben, Procedural Fairness: A Key Ingredient in Public Satisfaction, 44 Ct. Rev. 4, 6 (2007).

25 Id.

26 Farole & Cissner, supra note 22, at 9. See also Scott Senjo & Leslie A. Leip, Testing Therapeutic Jurisprudence Theory: An Empirical Assessment of the Drug Court Process, 3 W. Criminology Rev. 1-21 (2001), available at http://wcr.sonoma.edu/v3n1/senjo.html (noting that a supportive judicial style appeared more effective).

27 Blackwell Handbook of Social Psychology: Intergroup Processes 349 (Rupert Brown & Sam Gaertner eds., 2003).

28 National Drug Court Institute, Incentives and Sanctions: Rethinking Court Responses to Client Behavior, http://www.ndci.org/trainings/advanced-subject-matter-training.

29 Douglas B. Marlowe & Kimberly C. Kirby, Effective Use of Sanctions in Drug Courts: Lessons from Behavioral Research, 2 Nat'l Drug Ct. Inst. Rev. 1, 1-31 (1999).

30 Some courts call all the good reviews first to reward these participants by letting them leave first. Other courts require new participants to stay the entire court session, thereby instilling in them court expectations and educating them on court responses.

31 Individuals with a high probability of rehabilitative program failure are defined as being a high prognostic risk, and those offenders with significant clinical disorders or functional impairments are defined as having high criminogenic needs. See infra Ch. 7.

32 Douglas B. Marlowe et al., Adapting Judicial Supervision to the Risk Level of Drug Offenders: Discharge and Six-Month Outcomes from a Prospective Matching Study, 88 Drug & Alcohol Dependence S4, S4 (2007) (finding high-risk drug offenders performed better in drug court when required to attend frequent, biweekly status hearings); Douglas B. Marlowe et al., Matching Judicial Supervision to Clients' Risk Status in Drug Court, 52 Crime & Delinq. 52, 52 (2006) (finding that high-risk drug offenders do better in drug court when mandated to attend frequent, biweekly status hearings); David S. Festinger et al., Status Hearings in Drug Court: When More Is Less and Less Is More, 68 Drug & Alcohol Dependence 151, 151 (2002).

33 Douglas B. Marlowe, Evidence-Based Sentencing for Drug Offenders: An Analysis of Prognostic Risks and Criminogenic Needs, 1 Chap. J. Crim. Just. 167, 167-201 (2009) (delineating appropriate sentencing elements and response magnitude for programmatic noncompliance depending upon the offender's prognostic risk and diagnostic need assessment). Without correlating for risk or needs there is some evidence to suggest that drug courts that require attendance at least once per month in the final phase had greater cost savings and better graduation rates. See Carey et al., supra note 11, at 16.

34 Carey et al., supra note 11, at 16.

35 NPC Research is a well-respected research organization that has performed numerous evaluations of drug and other problem solving courts around the country.

36 See supra note 33.

37 Farole & Cissner, supra note 22, at iii.

38 See Bureau of Justice Assistance, supra note 4.

39 Id.

40 Id. Evidence-based approaches can be found through the National Registry of Evidence-Based Programs and Practices established by Substance Abuse and Mental Health Services Administration (SAMHSA) of the Department of Health and Human Services at NREPP, Find an Intervention, http://www.nrepp.samhsa.gov/.

41 See Bureau of Justice Assistance, supra note 4.

42 Carey et al., supra note 11, at 19.

43 Id.

44 See Bureau of Justice Assistance, supra note 4.

45 Id.

46 See Aubrey Fox, Ctr. for Court Innovation, Lessons Learned Ch. 2 (forthcoming) (discussing why the initial design of the Denver Drug Court failed, attributing such failure in part to founder's self-admitted inadequate colleague communication and succession plans).

47 See Bureau of Justice Assistance, supra note 4, at 3 Competency 5.

48 Walter J. Dickey & Peggy McGarry, U.S. Dep't of Justice, Community Justice in Rural America: Four Examples and Four Futures (2001).

49 See Bureau of Justice Assistance, supra note 4 Competency 6.

50 See Bureau of Justice Assistance, supra note 4 Competency 8.

51 See supra note 36.

52 Carey et al., supra note 11, at 18.

53 James J. Alfini et al, Judicial Conduct and Ethics § 1-3 (4th ed. 2007).

54 Virtually all of the Core Competencies apply to this role. See Bureau of Justice Assistance, supra note 4. Although directed toward applying collaborative justice techniques to conventional courts, the publication by the Center for Court Innovation entitled Collaborative Justice in Conventional Courts: Opportunities and Barriers is instructive on the institutional opportunities and barriers facing a drug court. Donald Farole et al., Ctr. for Court Innovation, Collaborative Justice in Conventional Courts: Opportunities and Barriers (2004).

55 Such short tenure is unwise. A judge's rotation in drug court should be at least two years. Longer judicial tenure produces better outcomes and saves money. Carey et al., supra note 11, at 15.

56 Deborah J. Chase & Peggy Fulton Hora, The Best Seat in the House: The Court Assignment and Judicial Satisfaction, 47 Family Ct. Rev. 209-238 (2009); Peggy Fulton Hora & Deborah J. Chase, Judicial Satisfaction When Judging in a Therapeutic Key, 7 Contemporary Issues L. (2003/2004).

Chapter 4

Addiction and Treatment Services

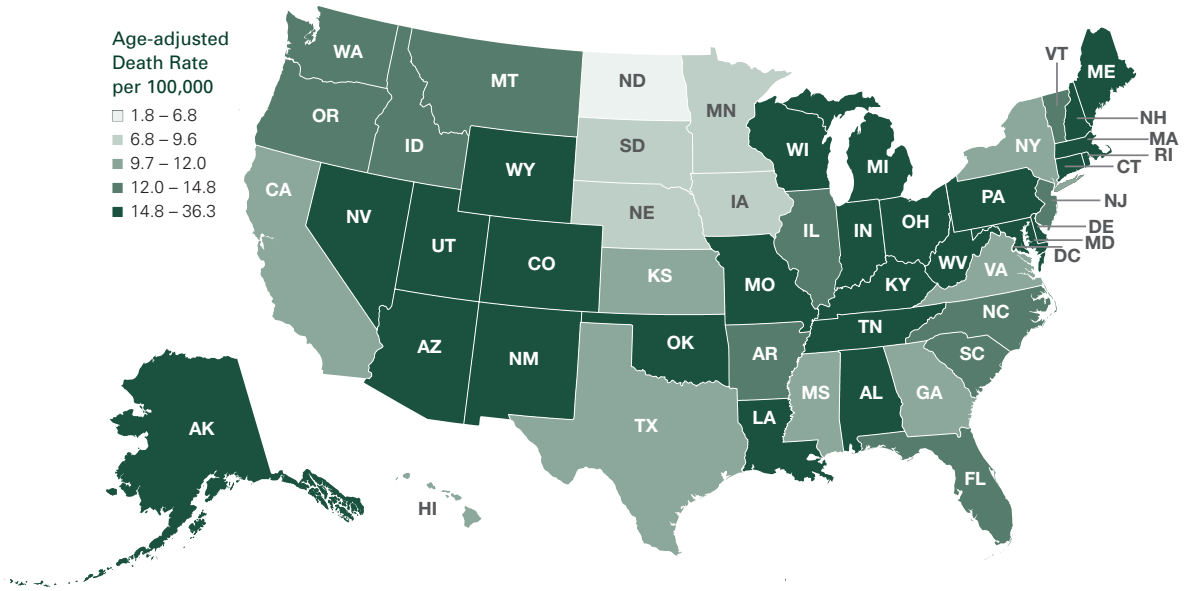
Steve Hanson, M.S.Ed, LMHC, CASAC

I. [§4.1] INTRODUCTION 65
II. [§4.2] DEVELOPMENT OF ADDICTION 67
III. [§4.3] COGNITIVE EFFECTS OF DRUGS AND ALCOHOL 69
IV. [§4.4] WHAT DOES TREATMENT DO? 71
A. [§4.5] Motivation 72
B. [§4.6] Insight 72
C. [§4.7] Behavioral Skills 72
V. [§4.8] EVIDENCE-BASED PRACTICES AND BEST PRACTICES 73
A. [§4.9] Motivational Enhancement Therapy and Motivational Interviewing 74
B. [§4.10] Cognitive Behavioral Therapy 74
C. [§4.11] Contingency Management 75
D. [§4.12] Relapse Prevention Therapy 75
E. [§4.13] Self-Help Recovery Programs 76
VI. [§4.14] ADDICTION MEDICATIONS 77
VII. [§4.15] LEVELS OF CARE 79
A. [§4.16] Detoxification 80
B. [§4.17] Inpatient Rehabilitation 80
C. [§4.18] Residential Treatment Programs 81
D. [§4.19] Intensive Outpatient Treatment or Day Treatment 81
E. [§4.20] Outpatient Treatment 82
F. [§4.21] Recovery Services 82
VIII. [§4.22] THE ROLE OF THE JUDGE IN DETERMINING THE LEVEL OF CARE 82
IX. [§4.23] TREATMENT PLANNING 83
X. [§4.24] CULTURAL AND GENDER ISSUES 85
XI. [§4.25] SUBSTANCE USE DIAGNOSES 87
XII. [§4.26] CO-OCCURRING MENTAL HEALTH DISORDERS 88
A. [§4.27] Hallucinations 89
B. [§4.28] Delusions 89
C. [§4.29] Negative Symptoms 90
D. [§4.30] Affective Disorders 90
E. [§4.31] Anxiety Disorders 91
F. [§4.32] Attention Deficit Disorder (ADD) 92
G. [§4.33] Personality Disorders and Learning Disabilities 92
XIII. [§4.34] SELECTING AND WORKING WITH TREATMENT AGENCIES . 93

I. [§4.1] INTRODUCTION

Substance abuse has been an issue in the United States for a long time. Problems with alcohol consumption in the late 1800s and early 1900s led to Prohibition from 1920 to 1933. Since then, the country has seen a number of different drugs rise to prominence. Marijuana, cocaine, benzodiazepines, heroin, methamphetamine, and hallucinogens have all had turns as the "drug of the day." Since 2010, two types of drugs have dominated the landscape. Opioids, both prescription painkillers and illegal heroin, and new synthetics based on marijuana and amphetamine analogs have been in the news. Opioids have taken a particular toll on the country. Fatal overdoses from opioids have risen dramatically. The Centers for Disease Control reported that 28,647 people died from opioid-related overdoses in 2014.[1] Many of those with an opiate addiction started with painkillers prescribed for a medical condition (chronic pain, postsurgical pain, etc.). The overdose prevalence rates identify that rural parts of the country frequently have the highest rates of overdose deaths, as shown in the map.[2]

Age-adjusted Death Rates for Drug Poisoning by State, 2014



Source: National Center for Health Statistics, Centers for Disease Control and Prevention.

The second class of drugs causing significant concern is synthetics. Created in laboratories both in the United States and abroad, these drugs are made to mimic certain effects from marijuana or stimulant-based drugs called cathinones. The illicit manufacturing results in many different formulas (making these drugs hard to detect). Synthetics can have a serious impact on the physical and mental health of the user.

Substance use is prevalent in the criminal justice system. Approximately four out of every five adult offenders (eighty percent) have some level of substance involvement, meaning they (1) were charged with a drug- or alcohol-related offense, (2) were intoxicated at the time of their offense, (3) reported committing their offense to support a drug habit, or (4) have a significant history of substance use treatment.[3] Just under one-half (forty-five percent) of adult inmates satisfy official diagnostic criteria for substance dependence, which is also commonly referred to as addiction.[4,5]

Offenders who continue to abuse alcohol or other drugs are at approximately two to four times greater risk of engaging in recidivist criminal activity than those who abstain.[6] Fortunately, substance use treatment works to substantially cut the risk of criminal reoffending. Criminal recidivism is reduced by approximately one-third for offenders who receive a sufficient amount of substance use disorder treatment,[7] and the effects have been shown to last for at least five years.[8]

The goal of the judge is to use the court's authority and drug court procedures to ensure compliance with treatment and program obligations.

Unfortunately, drug offenders are notorious for failing to comply with their conditions to attend substance use treatment. Unless they are intensively supervised by the court, approximately twenty-five percent of drug offenders who have been ordered to attend substance use treatment will fail to enroll in treatment, and among those who do arrive for treatment, approximately one-half will drop out of treatment prematurely.[9]

A primary goal, therefore, of effective correctional programming is to ensure that drug offenders comply with their treatment obligations. Although it was once believed that addicted individuals could not be coerced into treatment with effective results, research indicates that individuals who enter substance use treatment under the threat of a legal sanction perform at least as well as, and often appreciably better than, those who enter treatment voluntarily.[10,11] The important issue appears not to be why they enter treatment, but rather how long they remain in treatment and whether the services they receive are effective and evidence based.

This chapter reviews the scientific evidence on why alcohol and other drugs can be so addictive, the effects these substances have on the people who abuse them, and treatment approaches that have been proven to be effective for combating this serious behavioral and neurological disorder.

II. [§4.2] DEVELOPMENT OF ADDICTION

"Drug dependence is less a failure of will than a miscarriage of brain chemistry."

~ Geoffrey Cowley

Many people are puzzled by addiction. They may find it difficult to understand why anyone would risk ruining his or her life for a brief period of euphoria or intoxication. They may know people in their personal lives or hear about people in the news who went to treatment only to be arrested shortly thereafter when they relapsed. Why do they not just stop? Do they not care what it is doing to them and to their families and friends?

Recent scientific advances are teaching us that it is not simply a matter of willpower for an addicted individual to stop using alcohol or other drugs. Neurological changes in the brain, ingrained behavioral habits, and/or co-occurring emotional and psychiatric disorders may contribute to substance use and addiction, making it very difficult for an addicted individual to stop abusing these substances.

All drugs of abuse (including alcohol and nicotine) act primarily by mimicking the effects of neurotransmitters that are naturally found in the mammalian brain.[12,13] Neurotransmitters are chemicals that stimulate (or in some cases inhibit) the action of brain cells and act as signals between different brain cells. When there is a surge of a particular neurotransmitter called dopamine in a part of the brain called the nucleus accumbens, the result can be intense feelings of euphoria and pleasure. For this reason, the nucleus accumbens, along with other parts of the brain, including the ventral tegmentum, is referred to as the reward system. As part of our evolutionary history, our brain developed this reward system to make certain activities so pleasurable that we will continue to engage in them repetitively. Behaviors that are critical to our survival, such as eating, drinking, and reproducing, are naturally rewarded by our brain with pleasurable feelings so that we will continue to engage in those behaviors and thus survive as individuals and as a species

Addiction is a hijacking of the brain by powerful chemicals.

It is important to recognize, however, that substances of abuse can activate these brain regions as much as three times (as in the case of powder cocaine) to ten times (as in the case of methamphetamine) above normally occurring levels.[14] The subjective feeling is often extremely pleasurable and may invoke a strong and persistent desire to repeat the experience. Over time, unfortunately, this process can severely interfere with the brain's natural production of, and sensitivity to, neurotransmitters. Prolonged exposure to artificially high levels of illicit drugs can cause the brain to begin to manufacture lower levels of its own neurotransmitters or to reduce its cells' ability to receive those neurotransmitters. The result is that the brain may eventually

become dependent on the artificial substances for some of its essential functions. These brain changes can be long lasting and in some instances permanent.

Subsequently, when the individual stops ingesting alcohol or other drugs, the brain may find itself in a depleted state with insufficient levels of necessary neurotransmitters. This represents one of the critical physical manifestations of addiction. With insufficient levels of dopamine, for example, the individual may no longer experience pleasure from basic life activities, such as eating, having sex, or spending time with loved ones. Feelings of boredom, lethargy, and anhedonia (the inability to experience pleasure or gratification) may become the individual's new baseline state. Only by taking high levels of the drug may the individual be capable of experiencing pleasure, or at least of not experiencing depression and boredom.

In addition, this depleted state of the brain can invoke severely uncomfortable withdrawal symptoms, such as muscle and bone aches, nausea, agitation, anxiety, and profuse sweating. Only by taking the drug can the individual make those extremely unpleasant symptoms stop. This can lead to a perpetually reinforcing cycle of extreme discomfort when levels of the substance decline in the bloodstream, followed by relief and euphoria when the drug is taken, and then by a resumption of discomfort leading to further drug taking.

Intense cravings for drugs can be triggered after years of sobriety. It's about people, places, and things.

Research with laboratory animals has demonstrated that whenever a specific behavior, such as pulling a lever, stimulates the brain's reward center, an animal will persevere extensively at that behavior. In fact, studies have shown that after repeated exposure to certain drugs, such as cocaine or opiates, laboratory animals may persevere at drug seeking such that they neglect essential activities like eating, drinking, or sleeping to the point of near death. This helps to explain how illicit drugs and alcohol can literally take over some people's daily lives and crowd out adaptive, healthy behaviors.

Although many people who experiment with alcohol or other drugs will eventually be capable of walking away from these substances, others will want or need to do it over and over again. These are the people who can become addicted. They may repeat the behavior so often that they do not even have to consciously think about it. The behavior may become so ingrained that the individual performs it almost automatically. The difficulty with such automatic behaviors is that they are very hard to stop. Part of the reason that such behaviors are hard to change is that the neural pathways that lead to the behavior become myelinated. The more often neural pathways are used, the more myelin or insulation may be wrapped around the neurons along that pathway. This process makes the pathways more salient and efficient, and speeds up their conduction of neural impulses. An analogy would be trampling a path across a grassy field. The more frequently the path is traveled, the clearer, flatter, and easier to traverse it becomes. This increases the likelihood that future travelers will also follow that same path as opposed to taking alternate routes.

When an individual wishes to quit alcohol or other drugs, he or she must develop alternate neural pathways that can compete against substance use. This takes considerable time and practice in order to myelinate the alternative pathways to an equivalent degree as the drug-related pathways. If it took months or years to lay down drug-related pathways, it could be expected to take months or years to lay down newer pathways that can compete effectively against drug or alcohol abuse.

III. [§4.3] COGNITIVE EFFECTS OF DRUGS AND ALCOHOL

Individuals who have abused alcohol or other drugs may demonstrate significant deficits in brain functioning long after the abuse has ceased. The figure on this page depicts positron emission tomography (PET) scans of the brain of a cocaine abuser as compared to the brain of a nonuser. PET scans measure the degree of glucose metabolism in various regions of the brain. The brain metabolizes glucose (a type of sugar) as it performs cognitive tasks; therefore, greater glucose metabolism reflects greater brain activation. Brighter areas indicate substantial brain activity, whereas darker areas indicate diminished brain activity.

The PET scans on the top row of the figure show normal levels of brain activity. The lighter areas indicate that the brain is metabolizing glucose to allow it to perform cognitive tasks. The second row shows the activity level of the brain of a cocaine abuser following ten days of sustained abstinence. Note that there are very few bright areas of activity. Most notably, there is little activity in the frontal lobe (the top of the scan) and the limbic system (the center of the brain). The frontal lobe is the part of the brain that is associated with judgment and reasoning. The limbic system is the seat of emotions. Ten days after the last use, these regions of the brain are still substantially impaired. The third row shows that the impairments remain present one hundred days after the use has stopped. That is more than three months of residual effects.

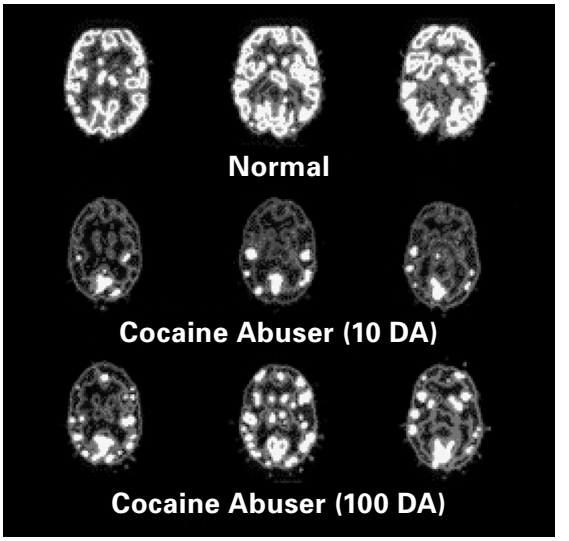


Photo courtesy of Nora Volkow, Ph.D. Volkow ND, Hitzemann R, Wang G-J, Fowler JS, Wolf AP, Dewey SL. Long-term frontal brain metabolic changes in cocaine abusers. Synapse 11:184-190, 1992; Volkow ND, Fowler JS, Wang G-J, Hitzemann R, Logan J, Schlyer D, Dewey S, Wolf AP. Decreased dopamine D2 receptor availability is associated with reduced frontal metabolism in cocaine abusers. Synapse 14:169-177, 1993. http://www.nida.nih.gov/pubs/teaching/Teaching5/Teaching3.html

This finding is consistent with the observations of clinicians. Professionals who work with addicted individuals know how difficult the first three months of treatment can be. These individuals frequently manifest serious errors in judgment, emotional instability, and poor attention spans throughout much of this time frame. These symptoms of cognitive dysfunction can make it very difficult to engage them in treatment and maintain their attention long enough for them to learn new skills to support their abstinence. As a result, it may be necessary in some cases to lower one's expectations and focus predominantly on keeping these individuals safe and stable until cognitive functions begin to recover. After a few months, the brain of a cocaine abuser may begin to return to normal. For the serious methamphetamine addict, it may take up to two years to return to baseline levels of brain functioning. Abusers of designer drugs such as Ecstasy may never regain use of affected brain cells, which may be permanently damaged or destroyed by exposure to this highly toxic compound.[15]

Anhedonia is an inability to experience pleasure without the drug. It often takes a long time to recover the ability to have fun without drugs.

Chronic drug use may also change how the brain responds to nondrug stimuli. It has been demonstrated, for example, that cocaine addicts may become overly sensitive to cocaine-related images, such as pictures of cocaine, paraphernalia (e.g., crack pipes), or drug-using accomplices.[16] These stimuli can become paired in the brain with memories of the intense euphoria associated with cocaine intoxication. As a result, the individual might experience severe cravings or even anticipatory euphoria when confronted with these stimuli. This is one reason why addicted individuals are repeatedly warned in treatment to stay away from the people, places, and things that are associated with their former drug use. Any contact with such people, places, or things may evoke intense neurological arousal akin to intoxication, cravings, or withdrawal.

It has further been demonstrated that addicted individuals may become less responsive to stimuli in their environment that would ordinarily be perceived as naturally pleasurable or arousing.[17] For example, they may show diminished brain reactivity in response to sexually erotic stimuli or to pictures of gourmet foods or vacation spots. In essence, the drug reprioritizes what the brain perceives as salient or important to the individual. The drug has essentially hijacked the brain. As a result, the addicted person may no longer find pleasure in events that would previously have been highly satisfying, such as eating a good meal, spending time with loved ones, winning a contest, or receiving a job promotion. Such events may no longer be able to compete with the lost pleasures of the drug. This anhedonic state can lead to relapse because the individual may seek to regain those lost feelings of happiness or pleasure. One important focus of treatment, therefore, is to help the client tolerate feelings of anhedonia or boredom long enough for normal brain functioning to begin to return. Clients need to be reassured that the ability to take pleasure from normal life activities is likely to recuperate over time.

Cravings are also commonplace in the disease of addiction.[18] The brain makes an association between certain people, places, and things and the experience of euphoria. Thus, a seemingly innocuous cue, such as a picture of the street corner where the individual previously purchased drugs, might trigger a memory that causes an increase in activity in parts of the brain associated with reward (nucleus accumbens) and action/drive (amygdala). As these two parts of the brain become more active, the brain experiences stress. This stress may cause the emotional centers to overwhelm the parts of the brain that are associated with judgment (i.e., the frontal lobe). This may result in an impulsive decision to use drugs without adequate consideration of the consequences of that action. The cravings can become so powerful that the person may feel that he or she has little choice but to give in to them. Another vital part of treatment, therefore, is to train the individual to manage his or her cravings and call upon his or her frontal lobe to think before acting. Treatment will involve applying techniques such as relapse prevention, motivational enhancement, and cognitive behavioral therapy (CBT) (which are briefly described later) to help the client manage his or her cravings, consider the negative consequences of continued drug or alcohol use, and maintain a firm commitment to recovery.

Although many brain functions do begin to return over time, some of the damage from repeated exposure to alcohol or other drugs can be chronic or permanent. Therefore, to be in recovery is to recognize that for the vast majority of people there is no cure for addiction. To be cured would mean that the person could use alcohol or other drugs and not experience new problems as a result. Addiction is a chronic relapsing disease that needs to be managed over the long term, much like diabetes, asthma, or hypertension.[19] Many medical patients with these conditions are not cured of their disease, but rather can learn to manage their symptoms and reduce the negative consequences of the illness by making healthy lifestyle choices. So too can addicted persons learn to manage this illness and reduce or eliminate the negative effects.

IV. [§4.4] WHAT DOES TREATMENT DO?

Addiction is a chronic disease that is prone to relapse. Managing this chronic condition requires major changes in one's behaviors, cognitions, and feelings. Substance use treatment addresses several areas that are essential to help the addicted individual through this process. The three main foci of substance use treatment are as follows:

- Motivation
- Insight
- Behavioral skills

A. [§4.5] Motivation

Motivation is always a key concern in substance use treatment. As was noted earlier, the large majority of substance use patients drop out of treatment prematurely. Intense cravings, withdrawal symptoms, impaired impulse control, and anhedonia may conspire to overwhelm their commitment to sobriety and drive them into relapse. Initiating and maintaining a significant life change requires substantial levels of sustained motivation. As anyone who has ever been on a diet knows, maintaining motivation is the key issue. Treatment works, in part, by developing and maintaining a person's motivation for change.

If a treatment program does not have specific interventions in mind for enhancing clients' motivation, improving their insight, and developing their behavioral drug-refusal skills, then it may be time to find a new treatment program.

Drug courts can be very effective at helping people find motivation. This is because motivation is not necessarily synonymous with an internal desire for change. People may be quite motivated to change their behavior simply because they want to get out of trouble (e.g., to avoid imprisonment).[20] Such external motivation might, indeed, be all that is maintaining many drug offenders in treatment during the first few months after their arrest. The important point here is that external motivation is far better than no motivation. If the threat of a legal sanction is sufficient to keep someone in treatment, then so be it. Over time, however, the important goal is to move that individual from an external to an internal state of motivation.[21] As the client begins to experience the natural benefits of sobriety, such as improved health and better family relationships, he or she will hopefully begin to develop an internal commitment to sustain and extend those improvements.

B. [§4.6] Insight

Insight is about knowing why and what to change. Just because people wish to improve their lives does not mean they know how to go about implementing the necessary changes. Self-knowledge becomes important for maintaining recovery over the long haul. For example, some individuals might abuse drugs as a way to avoid feelings of depression or anxiety, or as a means to feel more socially competent in interpersonal situations. Recognizing one's own triggers for drug use (e.g., depression, anxiety, or loneliness) is the key to avoiding relapse in the future. Effective substance use treatment focuses on helping clients recognize their own triggers and develop more adaptive means for dealing with those triggers when they arise.

C. [§4.7] Behavioral Skills

Behavioral skills are necessary to walk the walk of recovery. Knowing what one is supposed to do does not necessarily translate into knowing how to do it. Avoiding drugs, managing cravings, and responding appropriately to triggers takes skill and practice. The simple art

of saying *no* to an offer of drugs may take a great deal of trial-and-error learning, with multiple experiences of failure before success is achieved. Recall that the neural pathways associated with drug use have become well myelinated for many addicted offenders, and these individuals may be accustomed to saying *yes* to drugs before conscious thought has had a chance to be factored into the equation. Practice helps the person to make new adaptive behaviors similarly automatic, so that it is no longer necessary to stop and think consciously about the best way to react to problematic situations.

Effective treatment programs incorporate all three of these critical factors (motivation, insight, and behavioral skills) into their treatment regimens and include concrete interventions that are designed to address each of these factors in clients' written treatment plans. If a treatment program does not have specific interventions in mind for enhancing clients' motivation, improving their insight, and developing their behavioral drug-refusal skills, then it may be time to find a new treatment program.

V. [§4.8] EVIDENCE-BASED PRACTICES AND BEST PRACTICES

Over approximately the past ten years, the field of substance use treatment has determined that evidence-based practices and best practices should form the foundation of effective treatment. An evidence-based practice (EBP) is one that has been proven through tightly controlled research studies to be effective in helping people recover from substance dependency. With regard to medications and certain medical devices, the Food and Drug Administration (FDA) generally requires proof of effectiveness through at least two randomized, controlled experimental studies. Comparable criteria for EBPs have recently been endorsed for behavioral interventions, including addiction counseling. A list of EBPs is maintained by the Substance Abuse and Mental Health Services Administration (SAMHSA) on its National Registry of Evidence-Based Practices and Programs (NREPP) website. This website is updated regularly as new research findings uncover additional approaches to evidence-based treatment.

The National Registry of Evidence-Based Practices and Programs (NREPP) maintains a list of evidence-based practices. http://www.nrepp.samhsa.gov/

Best practices (BPs) are those that have not necessarily been proven to be effective in tightly controlled experiments but tend to be implemented by the most effective treatment programs. For example, effective programs usually focus on elements that engage and retain clients in the program. These elements can include how welcoming the environment is, staff interactions with the clients, and focus on the client's perspective of the problem.

Examples of evidence-based practices (EBPs) that are commonly utilized in substance abuse treatment programs include motivational enhancement therapy (MET), cognitive behavioral therapy (CBT), contingency management (CM), and relapse prevention therapy (RPT).

Some examples of EBPs and BPs that are commonly used in substance use treatment programs include CBT, motivational enhancement therapy (MET), contingency management (CM), relapse prevention therapy (RPT), and self-help recovery groups. Each of these interventions is briefly described in the sections that follow, and a bibliography of relevant resources is provided at the end of this chapter. An important issue to bear in mind is that these are well-standardized interventions that have been carefully described in treatment manuals or other reference books. The manuals often include sample scripts that help counselors communicate most effectively with their clients; exercises and homework assignments that teach clients how to apply the relevant skills; and assessment tools that indicate how well clients are actually learning the skills and progressing in their treatment. If a treatment program is not following such manuals or applying standardized procedures, it is *not* engaged in EBP.

A. [§4.9] Motivational Enhancement Therapy and Motivational Interviewing

MET and motivational interviewing are nondirective counseling strategies that focus on moving addicted individuals along a hypothetical continuum of motivation from what is called the *precontemplation* stage to what are called the *contemplation* and *action* stages. Individuals who are in the precontemplation stage are often unaware or unconvinced that they have a problem, or they may feel unprepared or disinterested in making a change. By rolling with the resistance rather than confronting it head-on, the counselor gently assists the client to recognize how alcohol or other drugs have interfered with the client's life goals. Recognizing the negative effects of addiction moves the client toward contemplation about the importance of becoming abstinent and finally toward taking concrete action steps to deal with the problem. Use of these procedures has been demonstrated to significantly increase treatment retention and engagement among addicted individuals.[22,23]

B. [§4.10] Cognitive Behavioral Therapy

CBT is one example of an insight-focused technique that has been demonstrated to improve outcomes among substance abusers.[24] CBT points out that our maladaptive behaviors are often caused by misinterpretations of events, rather than by the events themselves. Frequently, our interpretations are faulty, resulting in behavior that is not productive . . . or worse. For example, an individual who has been passed up for a job

promotion might overreact and conclude that he or she is no good and will never amount to anything. Given such a catastrophic and fatalistic interpretation of events, it might seem justified to just give up and use drugs. Helping the client to realize that job promotions may be denied for all sorts of reasons, some of which might have nothing to do with his or her abilities, can go a long way toward preventing self-pitying and forestalling self-destructive substance use. It also points toward an action plan that may actually help the client land a promotion in the future. For example, perhaps he or she needs to take an additional class to learn new skills that are required for a higher-level position. Rather than overestimating the seriousness of the event and giving up, the individual is helped to put the event in perspective and take concrete actions to make the future better.

C. [§4.11] Contingency Management

CM—also referred to as operant conditioning, motivational incentives, or positive reinforcement—is a standardized procedure for rewarding clients with tangible incentives for engaging in desired behaviors that lead to recovery. In a drug court, the target behaviors will typically include abstaining from drug use, attending treatment, and perhaps obtaining a job or completing an educational curriculum.[25] By being rewarded for these target behaviors, the client learns and adopts the behaviors more quickly. Research has proven that CM programs can be quite effective in reducing substance use, increasing treatment retention, and increasing prosocial behaviors.[26] Various methods have been used to reward participants for their positive behaviors. Examples of rewards in drug courts might include verbal praise from the bench, movie tickets, prize drawings, and coupons or vouchers that are redeemable for items in a prize store.[27] As was noted previously, it is important to apply CM procedures and other EBPs in a standardized manner. Research has shown that some CM programs are considerably more effective and more cost-effective than others, and it is a good idea to model one's program after those CM programs that have been proven to work. For example, CM programs are substantially more effective when substance use is monitored several times per week, when clients are eligible to earn rewards on at least a weekly basis, and when the rewards are contingent upon single, well-defined behaviors, such as cocaine-negative urine specimens.[28,29]

Caution: mandating attendance at AA or NA without a secular alternative implicates First Amendment issues.

D. [§4.12] Relapse Prevention Therapy

RPT is a structured intervention that helps clients to identify their own personal triggers for relapse and the process by which they tend to lead themselves down the road toward substance use. By recognizing the early warning signs of an impending relapse, clients will have time to change course and avert disaster. Examples of steps that might be taken

to avert relapse include avoiding the people, places, and things that are associated with substance use; reality testing one's overly optimistic assumptions about the ability to use drugs with impunity; and reconsidering one's overly favorable expectations about the positive effects of alcohol or other drugs. For example, instead of fantasizing about how good intoxication is expected to feel, it may be more adaptive to remember how bad the withdrawal symptoms and cravings actually felt during previous episodes. Teaching these behavioral skills to clients has been demonstrated to extend abstinence considerably and to reduce the likelihood of relapse following a treatment episode.[30]

E. [§4.13] Self-Help Recovery Programs

Self-help recovery programs are peer-support groups that do not involve professional staff members. These groups offer huge advantages because they are free, available in the large majority of communities, and held several days per week and at various times of the day. Many of the groups are open, meaning that virtually anyone may attend who has a legitimate interest in doing so. The groups typically emphasize total abstinence as opposed to controlled or reduced substance use, and most strongly endorse members' progression through the 12-steps that form the philosophical foundation of programs such as Alcoholics Anonymous (AA) and Narcotics Anonymous (NA). The 12-steps include recognizing one's loss of control over the addiction, asking for assistance from a higher spiritual power, taking a moral inventory of one's personal failings, and making amends for one's maltreatment of others. Participants are also typically paired at some point in time with a sponsor who has achieved a sustained period of sobriety and who is available to provide support and assistance twenty-four hours per day.

Twelve-step programs are the first to acknowledge that they are not treatment in the formal sense, but rather are continuing-care, peer-support groups. Although it has been difficult to conduct the type of controlled research on these programs that would be necessary to establish them as an EBP, referral to these groups is clearly a BP for addicted individuals. That is, the most effective treatment programs develop close relationships with the local 12-step community and rely heavily on that community to provide continuing care for their patients, both during treatment and after they have been discharged from treatment. The research evidence is quite clear that the longer addicted individuals remain actively involved in peer-support groups, the greater their chance for achieving sustained and long-term sobriety.[31]

One important concern about 12-step programs is that they do rely on recognition of a higher spiritual power, which has been interpreted by appellate courts to have religious significance that may trigger First Amendment objections. Appellate courts have held that the State cannot mandate attendance in these groups unless it also offers a secular alternative.[32] There are several secular alternatives that may be offered to drug court participants. For example, Smart Recovery (http://www.smartrecovery.org) and Save Our Selves (SOS) (http://www.sossobriety.org/) have a scientific or cognitive orientation as opposed to a spiritual or religious orientation.

VI. [§4.14] ADDICTION MEDICATIONS

Addiction medications are grossly underutilized in the criminal justice system. Evidence supporting the effectiveness of several addiction medications is incontrovertible, and there is no empirical justification for denying them to addicted offenders. With many opiate users dying from overdose, it is imperative that courts use every tool available to help save lives. The National Institute on Drug Abuse (NIDA) has published a guiding document, entitled *Principles of Drug Abuse Treatment for Criminal Justice Populations*, which states:

> Medications can be an important component of effective drug abuse treatment for offenders. By allowing the body to function normally, they enable the addict to leave behind a life of crime and drug abuse. Opiate agonist medications, which work by replacing neurotransmitters in brain cells that have become altered or desensitized as a result of drug abuse, tend to be well tolerated and can help an individual remain in treatment. Antagonist medications, which work by blocking the effects of a drug, are effective but often are not taken as prescribed. Despite evidence of their effectiveness, addiction medications are underutilized in the treatment of drug abusers within the criminal justice system. Still, some jurisdictions have found ways to successfully implement medication therapy for drug abusing offenders.[33]

Failing to heed the medical research literature and the recommendations of leading scientific organizations such as NIDA may be tantamount to engaging in substandard clinical practice. The time has come for the criminal justice system and the substance use treatment system to apply EBPs, which include the administration of appropriately prescribed medications. Addiction medications have great potential to assist clients by:

- Providing relief from withdrawal symptoms
- Blocking the effects of illicit drugs
- Reducing cravings
- Precipitating aversive reactions when clients take illicit alcohol or other drugs

Using medically assisted treatment is an evidence-based practice supported by the National Association of Drug Court Professionals.

One class of addiction medications, called *agonists*, stimulates the central nervous system (CNS) in much the same manner as illegal drugs. For example, methadone is a prescription opiate that works similarly to illicit opiates, such as heroin. However, because the effects of methadone are considerably longer, more gradual, and less intense than those of heroin, an addicted individual can continue to function safely and effectively without euphoria on this medication while performing daily chores and routines. A newer medication, called buprenorphine, has what are called *partial agonist* properties because it does not stimulate the CNS to the same degree.

For offenders who are addicted to opiates, agonist medications can control or eliminate cravings and withdrawal symptoms and, at sufficient dosages, can make it difficult or impossible for the offender to become intoxicated by ingesting illicit opiates. There is a substantial body of research spanning several decades demonstrating that the appropriate and medically supervised administration of methadone can significantly reduce crime, drug abuse, and health-risk behaviors and contribute to better adaptive functioning among opiate-addicted individuals.[34,35] Comparable evidence is now amassing in favor of buprenorphine.[36] Importantly, recent studies demonstrate that these positive effects hold just as well for addicted criminal offenders.[37,38,39,40] In light of these demonstrative research findings, the National Drug Court Institute (NDCI) explicitly endorses the use of appropriately prescribed evidence-based medications in drug court programs.[41,42,43]

Unfortunately, some drug courts may consider prescription treatment with methadone or buprenorphine to be an exclusion criterion for the program. Offenders may be denied entry into the drug court or may be prevented from graduating successfully if they do not taper completely off of the medication. There is no scientific or empirical justification for this across-the-board exclusion, and it is inconsistent with the literature on EBPs.

Drug courts must, of course, always keep an eye out for clients who may doctor-shop in order to obtain prescriptions for medications that they want but do not necessarily require. For example, some patients may receive prescriptions for methadone not as a treatment for addiction, but rather as a treatment for pain. In fact, the majority of overdoses and other negative reactions to methadone are attributable to its use in pain management rather than for the treatment of addiction.[44] There are at least two courses of action open to drug courts to address potential instances of doctor shopping:

- The drug court judge may subpoena the prescribing physician to testify in court or respond to written inquiries concerning the client's need for the prescription medication. In many instances, doctors may not even be aware that the client has a drug dependency, and the mere fact of being subpoenaed to drug court can alert the physician to this issue. Also, such an approach may put unscrupulous physicians on notice that they should desist from reckless prescribing practices, at least with regard to the current case.
- The drug court judge also may have the option of ordering a medical reevaluation of the client by a competent and trusted physician—ideally one who has been specially trained in addiction psychiatry—if there is a significant question about the appropriateness of a medication regimen. If the judge then relies upon the advice of the expert in requiring a discontinuation of the prescription, the judge cannot be accused of "practicing medicine without a license" or deviating from accepted standards of care. Rather, the decision has been made by a competent medical doctor applying appropriate standards of practice.

Another class of addiction medications, called *antagonists*, works very differently from agonist medications in that they do not stimulate the CNS in the same manner as illicit drugs. Rather, they block the effects of illicit drugs while providing no intoxication of their own. For example, a medication with the generic name naltrexone (product names include ReVia and Vivitrol) binds to opiate receptors in the brain and prevents opiates from getting through to those blocked nerve cells. As a result, the individual cannot

Antagonist medications block the effects of certain drugs and assist recovery.

become intoxicated on opiates. At the same time, naltrexone is nonaddictive, is nonintoxicating, and has minimal side effects. Although naltrexone has been approved for the treatment of opiate and alcohol addiction for decades, it is infrequently used in clinical practice because addicted individuals rarely comply with the regimen. Although naltrexone does somewhat reduce addicts' cravings and withdrawal symptoms, it tends to be resisted by some patients unless it is coupled with evidence-based treatment and case management and, in some cases, ingestion monitoring. However, a long-acting version called Vivitrol has now been developed that provides a thirty-day blockade with a single injection. This mode of delivery substantially reduces problems with medication noncompliance.[45]

It is important to remember that one medication may not be right for all patients. Some may respond better or worse to any of the medications. It is the role of the doctor to determine what the best course of medication treatment should be, not the court.

Many relapses may be brought about by intense cravings. Cravings involve high stress that can impair judgment. In such circumstances, being able to reduce the stress related to craving will help improve the chances of staying abstinent. Acamprosate (Campral) has been shown in some but not all studies to reduce cravings for alcohol. Other medications such as Chantix and baclofen are also being studied for their ability to reduce cravings for nicotine and cocaine, respectively.

Finally, some medications can precipitate extremely aversive and unpleasant reactions whenever a client ingests alcohol or certain other drugs. Disulfiram (Antabuse) is a nonaddictive medication that causes an uncomfortable physical reaction in individuals who imbibe alcohol. Reactions may include heart palpitations, diffuse sweating, and severe skin flushing. As with naltrexone, compliance with disulfiram tends to be poor among alcohol-addicted individuals but might be considerably better for those who are in a drug court and thus subject to sanctions for noncompliance.

VII. [§4.15] LEVELS OF CARE

All of the pharmacological and counseling treatments described here may be delivered to clients within any one of several levels or modalities of care, ranging from a few hours per week of outpatient counseling to twenty-four-hour, medically monitored inpatient treatment in a hospital setting. The level of care that an individual requires is typically determined according to standardized Patient Placement Criteria (PPC) promulgated by the American Society of Addiction Medicine (ASAM).[46] These criteria give due consideration to several critically important factors, including the patient's withdrawal risk, the presence of medical conditions that may be complicated or exacerbated by substance use, any co-occurring psychiatric or emotional disorders, the

patient's readiness for change, and the patient's relapse potential. For example, an individual who is at risk for severe withdrawal symptoms might be considered appropriate for treatment in a detoxification program. By contrast, an individual who is at minimal risk for withdrawal, has no co-occurring medical or psychiatric conditions, and has access to a supportive recovery environment might be considered appropriate for outpatient treatment. Additionally, most states have specific definitions of these levels of care with criteria that indicate the length and frequency for each.

Treatment placement should be based on an objective clinical assessment and may include:

- *Detoxification*
- *Inpatient rehabilitation*
- *Residential treatment*
- *Intensive outpatient treatment/day treatment*
- *Outpatient treatment*

The various levels of care are described briefly in the sections that follow.

A. [§4.16] Detoxification

Detoxification (detox) is a medical procedure for a specific medical problem—severe withdrawal symptoms that may, at times, be life-threatening. For example, individuals who are detoxifying from chronic alcohol abuse or sedative abuse may suffer life-threatening seizures, such as delirium tremens (DTs). Addressing these serious symptoms is critical to helping the individual stabilize medically and make it safely through the first week or so of abstinence. The detoxification program is often administered in a hospital or hospital-like setting, with frequent monitoring of the patient by medical staff; however, some patients may be suited to detoxification on an outpatient basis. The decision as to the most appropriate setting for detoxification is a medical one that must be made only by a physician. Medications may be used to treat some of the symptoms of withdrawal, including antiseizure and antianxiety medications. Detoxification stays are typically in the range of three to five days. Importantly, detoxification is *not* the same as treatment for addiction. It is merely a procedure for medical stabilization. Patients who are discharged from detoxification without intensive follow-up addiction care are at great risk for relapse.[47] Such an approach is not consistent with EBP and falls below the accepted standard of care for the field.

B. [§4.17] Inpatient Rehabilitation

Inpatient rehabilitation (rehab) is designed to provide a safe, structured, and drug-free environment for patients who have not been able to remain abstinent in the community. It is also suited for individuals whose health or mental health is at significant risk if they do not remain drug free. Inpatient stays are usually in the range of seven to thirty-five days, with the twenty-eight-day program perhaps the most common. The role of inpatient rehabilitation is to prepare the patient for outpatient care. Providing inpatient treatment without adequate outpatient follow-up is highly unlikely to lead to sustained abstinence

and is inconsistent with EBP.[48] In addition to medication management, inpatient programs often include educational lectures; individual and group therapies; recreation or occupational therapy; medical, dental, and mental health care; and preparation for and initiation of self-help group involvement. Inpatient rehabilitation programs can be relatively expensive as compared to outpatient care; however, for individuals who require physical and emotional stabilization, or who live in high-risk environments, inpatient treatment can be more effective and more cost-effective in the long run. Offering lower levels of care than patients actually require is unlikely to lead to sustained abstinence, and can contribute to an expensive pattern of repetitive, revolving-door admissions that eat up more treatment-related resources over the long term.

C. [§4.18] Residential Treatment Programs

Residential treatment programs are typically longer term, but lower in intensity, than inpatient rehabilitation programs and do not provide around-the-clock medical supervision. Residential treatment programs include halfway houses, supportive living communities, and therapeutic communities. (Some recovery houses provide formal substance use treatment services and thus may be classified as residential treatment programs, whereas others simply offer a supervised and financially subsidized place to live and thus are not formally recognized or licensed as residential treatment programs.) Residential treatment programs help the individual by providing a safe and supportive environment for an extended period of time. In some programs, the residents work or go to school during the day and return to the facility afterward. The programs typically offer on-site community meetings, professional counseling sessions, self-help meetings, and transportation assistance to attend other outpatient treatment programs or vocational or educational programs in the community. Residential programs may last from three months to one year, with some therapeutic community programs lasting two years. The per-diem rates for residential programs are lower than those for inpatient rehabilitation, which usually allows for longer lengths of stay needed to stabilize clients during early recovery. Some residential treatment programs may preclude outside employment, and clients who have jobs or caretaking responsibilities for children or their families may have difficulty participating in some residential programs.

A judge should not decrease a client's level of care as a reward for good behavior or increase the level of care as a punitive sanction for bad behavior.

D. [§4.19] Intensive Outpatient Treatment or Day Treatment

Intensive outpatient treatment or day treatment programs typically meet three to five days per week for several hours each visit. Day treatment is essentially an intensive outpatient program that meets four to five days per week with sessions lasting all or most of the day. Intensive outpatient treatment helps clients in early recovery receive the support and structure they require. As their recovery gets stronger, the number of visits will decrease.

Intensive outpatient treatment is a common level of care for new drug court participants. Clients may stay one to three months in intensive outpatient treatment, followed by a step-down to outpatient treatment (described in the next section). Intensive outpatient treatment provides a less expensive alternative to inpatient treatment for clients whose environment and stabilization needs are such that they can remain in the community.

E. [§4.20] Outpatient Treatment

Outpatient treatment is the most common level of addiction care. Clients live at home or in a community residence and attend sessions at the program. Traditionally, regular outpatient treatment will involve one or two visits per week, lasting approximately one to two hours per visit. Clients attend group and individual counseling sessions while participating in the program. Outpatient care should almost always be included in continuing-care plans for clients who are leaving higher levels of care. Clients may stay in outpatient care for three to twelve months or more, depending upon their individual needs.

F. [§4.21] Recovery Services

Jail time is not a substitute for detoxification or inpatient rehabilitation.

A growing understanding that recovery from addiction is a process that extends after a treatment episode has ended has resulted in an increase in recovery support services offered to individuals. Recovery services can include recovery centers, places where people in recovery can congregate, recreate, receive educational/vocational programming, and get other supports. The use of certified peer specialists is a growing mechanism for providing recovery supports. These supports increase the likelihood of success and enhance the quality of life for individuals in recovery.

VIII. [§4.22] THE ROLE OF THE JUDGE IN DETERMINING THE LEVEL OF CARE

Determining the appropriate level of care for a particular client must always be done by a duly trained and licensed or certified clinician, such as an addiction counselor, social worker, psychologist, or physician. Under no circumstances should a judge or other nonclinically trained criminal justice professional order a higher or lower level of care than has been determined to be necessary by an ASAM placement or comparable assessment (assuming that the indicated level of care is realistically available). To do so would, in essence, be akin to practicing medicine or another clinical specialty without a valid license.

Similarly, it is inappropriate for a judge to decrease a client's level of care as a reward for good behavior, or to increase the level of care as a punitive sanction for bad behavior. Such actions may give the inadvertent message to clients that treatment is aversive and

thus something to be avoided. It also risks wasting scarce treatment resources on the wrong types of clients for the wrong reasons. For example, if residential treatment is used as a sanction for noncompliance with outpatient treatment, then costly residential services might be focused on clients who do not require that level of care, who desire those services the least, and who are least likely to take advantage of the opportunities. The decision about whether to increase or decrease a client's level of care should always be based upon a professional clinical assessment of each client's treatment needs and prior response to treatment.

Of course, if a client is not responding adequately to a particular level of care, it is always appropriate for the judge to order a reassessment of the client to determine whether a change in the treatment plan might be indicated. Under such circumstances, the judge is not substituting his or her judgment for that of the clinicians, but rather is requesting additional information from the clinicians to assist in deciding how best to proceed with the case.

Finally, it is never appropriate for the criminal justice system to use inpatient or residential treatment as a partial substitute for incarceration. Because many offenders are diverted into drug court as an alternative to jail or prison, there may be a concern that these individuals could pose a threat to public safety. It might seem like a fair trade-off to place an offender in a residential treatment program as a means of ensuring twenty-four-hour supervision and restricting his or her freedom of action. However, clinicians are not trained as correctional officers. Clinicians do not have law enforcement powers, they might not have received substantial training in the management of criminality or violence, and their physical facilities usually are not sufficiently secure to hold individuals who pose a serious flight risk. Putting clinicians in the role of correctional officers not only poses unacceptable risks to their programs and to the other patients, but also has the potential to disrupt the therapeutic relationship. If clinicians are forced to be responsible for "policing" their clients' misbehavior, they may have insufficient time, resources, and credibility remaining to focus on ameliorating their clients' symptoms and teaching them drug-refusal strategies.[49] If an offender truly needs to be held in a restrictive setting to protect the public, treatment services should be delivered in a corrections-based program, such as an in-jail treatment program, correctional halfway house, or correctional day-reporting center.

IX. [§4.23] TREATMENT PLANNING

Substance use clients present with a wide range of needs for various types of treatments and other services. A one-size-fits-all approach does not work and is inconsistent with EBPs or BPs. At the most basic level, each client should receive an individualized treatment plan. Treatment plans should not all look alike and should not all include the same interventions. If all clients in a particular treatment program attend the same groups and receive identical services, it may become necessary for a drug court to reconsider partnering with that treatment program.

Individualized treatment plans should take into account general factors related to each client's (1) clinical needs, (2) prognostic risks, and (3) personal strengths and resources. The assessment of *clinical needs* should include, at a minimum:

- The severity and nature of the client's substance use problem, including a diagnosis of substance use or dependence (discussed later)
- Co-occurring psychiatric disorders that might require treatment (discussed later)
- Functional impairments that might require rehabilitation services, such as brain injuries or physical disabilities
- Limitations in basic adaptive abilities that might require remediation, such as illiteracy, lack of job skills, or poor life skills

Each need that is identified should be noted in the treatment plan and accompanied by a remedial plan and anticipated timetable for resolution. Importantly, if referrals must be made to outside agencies for some of the needed services, the client's attendance at those programs and progress in treatment should be carefully documented in the treatment plan. The primary agency (i.e., the agency that is directly contracted with the drug court program and that is making the referral) should remain continuously responsible for monitoring clients' performance in outside programs and for reporting on their progress in those programs to the drug court team at status hearings and case staffings.

The assessment of *prognostic risks* should include any issues that are likely to impede the client's progress in treatment. Examples of prognostic risks might include the absence of an adequate social support system or a safe recovery environment. For example, if the client's family members or close friends are active substance users, alternative arrangements might need to be made for that client to live in a safe and drug-free environment, such as a recovery house or residential treatment program.

Finally, the treatment plan should include a consideration of each client's *personal strengths and resources*. For example, a client might have family members who are themselves in recovery, and who perhaps could serve as a helpful resource for reinforcing the material that is taught in the counseling sessions. Similarly, a client might have marketable job skills, thus making it possible to fill his or her day with healthy, productive employment activities. When such strengths or resources are available, the treatment plan should capitalize on them to the client's advantage.

Treatment plans should always be developed with input from the client.

Importantly, treatment plans should always be developed with input from the client himself or herself. This is critical for getting the client's buy-in to the treatment. The treatment plan should be written in language that the client can understand and recall. A simply worded treatment plan that the client can remember and describe is far preferable to a complex plan that is written in professional jargon and that the client cannot comprehend or explain. A simple treatment plan also has a far better chance of actually being implemented.

For clients who are attending multiple treatment programs, it is also important to reconcile or blend together the various treatment plans across agencies. Frequently, different treatment providers may set their own agendas and priorities for the case. As a result, the client might receive mixed messages or an overload of expectations. For example, if the substance use treatment agency is requiring the client to attend several counseling sessions per week, but the vocational training agency is attempting to get the client a full-time day job, this could create an irreconcilable scheduling conflict. The best way to resolve such conflicts is to have all of the participating agencies provide input into one integrated treatment plan, which all of the parties sign off on.

The drug court team should coordinate the various treatment plans to ensure that all of the agencies are working toward the same goals and that their expectations for the participant are reasonable. One way to ensure this is to review the weekly service schedule that the participant must follow. Does the participant have enough time to meet all of the requirements in the plan? Are there potential transportation issues? Can some of the appointments be combined or staggered on alternate weeks to make compliance easier? Addressing such basic scheduling conflicts can go a long way toward reducing stressors on the client and increasing the odds that the client will successfully complete the drug court program.

X. [§4.24] CULTURAL AND GENDER ISSUES

Cultural sensitivity and cultural competence are important aspects of treatment planning. Staff members are considered to be culturally *sensitive* when they recognize the importance of race, ethnicity, and nationality in clients' lives and are respectful of the cultural differences between people. Research indicates that simply being interested in, and respectful of, other people's cultures can go a long way toward enhancing the therapeutic relationship and improving outcomes in treatment.[50]

Cultural COMPETENCE indicates that staff have specialized knowledge of their clients' cultures.

Cultural *competence* indicates that staff members have completed special training in the unique features of their clients' cultures and are skilled at responding to their clients in culturally familiar ways using culturally appropriate words and gestures. Importantly, simply being of the same race, ethnicity, or nationality as one's clients does *not* mean that one is culturally sensitive or competent. Although cultural competence is certainly desirable, many programs may not be capable of employing staff members who are sufficiently familiar with all of the cultural backgrounds of their clients. At a minimum, therefore, it is essential to communicate to clients that staff members respect their cultural backgrounds and are open to learning about their experiences as treatment moves forward.

Gender issues are also critically important for treatment. Research indicates that holding separate treatment groups for men and women tends to produce better outcomes, especially for the women.[51] There are many possible reasons for this. Women and men may have

Women do better in women-only treatment groups.

different dynamics or histories related to their addictions that may make it difficult for them to address their problems in mixed groups. For example, men are more likely to be introduced to drugs by friends, whereas women are more likely to be introduced to drugs by intimate partners. As a result, men and women might need to employ different strategies for avoiding relapse situations in the future. Women might, for example, need to consider ways to change their dating behaviors, whereas men might need to change their recreational activities or hobbies. Gender-specific groups can focus more specifically on the types of strategies that have been shown to be most successful for men versus women. In addition, most women in addiction treatment have been the victims of physical abuse, sexual abuse, or domestic violence. Discussing such matters in the presence of male peers may be embarrassing or may make them feel unsafe. Similarly, many males may not want to discuss comparable experiences of victimization in front of women for fear of appearing weak.

Another concern related to mixed-gender treatment is the phenomenon of the "rehab romance." As clients struggle through their early recovery, they may mistake intense emotional reactions or attachments that are often triggered in treatment groups for a romantic interest or compatibility. In reality, rehab romances frequently do not work out, often resulting in relapse for one or both of the parties. And lastly, some substance use clients are relationship predators, and treatment groups may offer an easy opportunity for them to prey upon emotionally vulnerable or unstable individuals. It is incumbent upon the counselors, therefore, to strongly caution clients not to spend unsupervised time with each other, especially romantically, outside of the treatment groups.

Cultural SENSITIVITY recognizes the importance of race, ethnicity, and nationality and respects cultural differences.

Of course, it is not always possible for treatment programs to hold gender-specific groups. Some programs might not, for example, have large enough censuses to support parallel groups. This does not, however, absolve any program from the duty to anticipate and deal with the issues just described. It is clinically and ethically incumbent upon every program to be prepared for such matters and to take concrete steps to address them when and if they do arise. For example, staff members need to monitor their treatment groups for evidence of rehab romances and periodically remind their group members not to fraternize with each other outside of the program. It might also be necessary to set aside individual, trauma-informed counseling sessions for clients with histories of victimization to process that material outside of mixed-gender groups. It would not be a defense against poor clinical practice for any program to simply assert that it does not have sufficient resources to deal effectively with these issues, which are highly foreseeable and commonly confronted in addiction treatment.

XI. [§4.25] SUBSTANCE USE DIAGNOSES

The fifth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5) published by the American Psychiatric Association (APA)[52] describes the official diagnostic criteria for psychiatric disorders in the United States. The DSM- 5 presents some critical changes to the diagnosis of substance abuse compared to DSM-IV. First, DSM-5 eliminated the dependency versus abuse distinction. Reflecting an improved understanding of addiction, DSM-5 now identifies substance use disorders (SUD) as the main category of diagnosis. The individual diagnosis is based on two main characteristics: the drug of choice and the severity. DSM-5 identifies ten separate classes of drugs: alcohol, caffeine, cannabis, hallucinogens, inhalants, stimulants, opioids, sedatives/hypnotics/anxiolytics, tobacco, and other (unknown) substances. The manual recommends that when rendering the diagnosis, the specific substance used should be listed. For example, cocaine use disorder should be listed instead of stimulant use disorder.

The second dimension relates to the severity of the condition. Instead of a simple distinction between abuse and dependence, DSM-5 recognizes a continuum of severity. It identifies the severity as being mild, moderate, or severe based on the number of critical symptoms demonstrated by the individual. There are twelve critical symptoms:

1. The drug is often taken in larger amounts or over a longer period than was intended.
2. A persistent desire or unsuccessful efforts to cut down or control drug use.
3. A great deal of time is spent in activities necessary to obtain the drug, use the drug, or recover from its effects.
4. Craving or a strong desire or urge to use the drug.
5. Recurrent drug use resulting in a failure to fulfill major role obligations at work, school, or home.
6. Continued drug use despite having persistent or recurrent social or interpersonal problems caused or exacerbated by the effects of the drug.
7. Important social, occupational, or recreational activities are given up or reduced because of drug use.
8. Recurrent drug use in situations where it is physically hazardous.
9. Drug use is continued despite knowledge of having a persistent or recurrent physical or psychological problem that is likely to be caused or exacerbated by the drug.
10. Tolerance as defined by either of the following:
    a. A need for markedly increased amounts of the drug to achieve intoxication or desired effect.
    b. A markedly diminished effect with continued use of the same amount of the drug.
11. Withdrawal, as manifested by either of the following (note: this symptom does not apply to certain substances that lack an identified withdrawal syndrome):
    a. The characteristic withdrawal syndrome for the drug.
    b. Another drug is taken to relieve or avoid the withdrawal symptoms.

Severity is determined as follows:

Mild: Presence of two or three symptoms

Moderate: Presence of four or five symptoms

Severe: Presence of six or more symptoms

State laws and regulations relative to "scope of practice" identify who may render a diagnosis in the same way that they identify who may practice law. Only individuals who meet the state requirements of licensure or certification may render the diagnosis. The list of those authorized usually includes medical doctors, licensed psychologists, licensed social workers or mental health counselors, credentialed substance abuse counselors, and registered nurses. Check with your state to determine who is included on the list.

Interventions for mild substance use disorders may be different from those for moderate and severe cases. For example, rather than focusing on ameliorating cravings or withdrawal symptoms, or avoiding relapse triggers, interventions for mild substance use disorders might focus more on providing psychoeducation about the dangers of substance use or having clients spend more time in healthy and productive recreational activities. It is also less likely that treatment for mild substance use disorder would need to be provided in a residential or inpatient setting, whereas individuals with severe substance use disorder may need to begin their treatment in an inpatient or detoxification setting in order to stabilize their symptoms, medical conditions, or emotional functioning.

It should be evident, therefore, that a treatment program cannot develop a competent individualized treatment plan for a client without first rendering a diagnosis of substance abuse versus substance dependence. Many crucial treatment considerations should flow from this initial determination. If a treatment program provides similar interventions for all clients irrespective of their substance use diagnosis, the program is not engaged in EBPs.

XII. [§4.26] CO-OCCURRING MENTAL HEALTH DISORDERS

"[Co-occurring mental health and substance use disorders] are the expectation, not the exception."

~ Dr. Ken Minkoff

Research indicates that approximately twenty to fifty percent of participants in drug courts are likely to have a co-occurring mental health disorder.[53] Effective treatment for such individuals requires that *both* the substance use and the mental health symptoms be addressed simultaneously.[54] If a particular treatment program is of the belief that one or the other of these disorders should be treated first, that program is not engaged in EBPs or BPs, and the drug court should consider seeking an alternative provider with whom to partner.

Addiction reflects a compulsive use of alcohol or other drugs, whereas substance abuse reflects a repetitive misuse of alcohol or other drugs.

Drug courts should determine what mental health services are available within their jurisdictions and what types of clients the programs are prepared to serve. Many substance use treatment programs will offer some degree of mental health counseling within their own agencies. However, this may vary from providing only basic psychoeducation about how to handle emotional concerns to offering intensive psychiatric services including medications. Mental health problems are complex and run a wide gamut in terms of the severity of the disorders and types of symptoms that may be manifested. In some cases, substance use treatment providers might not have sufficient resources within their own agencies to meet mentally ill clients' needs. It may become necessary for such programs to refer those clients out for conjoint or adjunctive psychiatric treatment in addition to their substance use treatment. Alternatively, it may become necessary to refer them out to receive all of their services from specialized programs that focus specifically on the integrated treatment of comorbid substance use and mental health disorders.

It is beyond the scope of this chapter to describe in detail all of the psychiatric disorders that might be confronted in drug courts or the treatments that are indicated for those disorders. This section will briefly familiarize drug court judges with some of the terminology and conditions that they are likely to confront in their work.

The most common significant psychiatric problems include psychotic disorders, affective disorders, and anxiety disorders. *Psychotic disorders* are among the most severe and chronic of the mental health disorders. They are categorized as thought disorders because they involve some major disruption in the thought processes of the individual. Schizophrenia is one example of a psychotic disorder. The thought problems that may appear in psychotic disorders include the following.

A. [§4.27] Hallucinations

Hallucinations are false perceptions that may be auditory, visual, tactile (touch), or olfactory (smell). Auditory and visual hallucinations tend to be the most common among psychiatric patients; however, addicted individuals are also more likely to experience false tactile perceptions, such as bugs crawling on their skin (termed *formication*) or false olfactory smells. These latter hallucinations can be serious because they may reflect severe withdrawal symptoms or incipient brain damage from chronic substance use.

B. [§4.28] Delusions

Delusions are false beliefs that may or may not be integrated into a cohesive belief system. Often the beliefs revolve around the themes that other people are out to harm the patient (paranoia or persecution), or that the patient is unusually important or special in some

way (grandiosity). Paranoid delusions are not uncommon in substance users, especially those who have been abusing stimulants, such as amphetamines, methamphetamine, or cocaine. Drug-induced delusions tend to be relatively short-lived in duration (measured in hours or perhaps days), unless the drug has triggered an underlying psychiatric disorder. When the delusions are bizarre (i.e., they could not possibly have any basis in reality), they are more likely to reflect a schizophrenic-spectrum syndrome rather than be the direct effects of substance use. For example, if a client believes that alien forces are implanting thoughts in his or her head through the TV, this would be more suggestive of a schizophrenic syndrome than of a substance-induced state.

Psychotic symptoms include hallucinations and delusions.

C. [§4.29] Negative Symptoms

Hallucinations and delusions are sometimes referred to as positive symptoms because they reflect novel clinical features. On the other hand, psychotic patients may also develop negative symptoms, in which they lose functions that they previously had. Common examples of negative symptoms include social withdrawal, cognitive decline, and blunted or nonreactive emotions. Generally speaking, the more severe and chronic the course of a psychotic disorder, the greater the severity and prevalence of negative symptoms.

The primary intervention for the psychoses includes antipsychotic medications. Many of the symptoms (especially the positive symptoms) of psychotic disorders are thought to be caused by the overactivity of certain neurotransmitters in the brain. The medications help to decrease this overactivity. Zyprexa and Risperdal are two commonly prescribed antipsychotic medications. Haldol, Mellaril, and Thorazine are some of the older medications that may still be in use. One problem with these medications is that their effectiveness can be difficult to maintain, with frequent dosage adjustments sometimes being called for. Side effects are also a serious concern and can include permanent and life-threatening syndromes.

For these reasons, encouraging faithful compliance with the medication regimen is critically important for these individuals. Failure to follow the medication regimen can lead to serious side effects, and can cause the psychotic symptoms to become more entrenched and impenetrable to future treatment regimens. However, when clients are adequately stabilized on antipsychotic medications, they can be effectively managed in many substance abuse treatment programs.

D. [§4.30] Affective Disorders

Affective disorders include major depression and bipolar disorder (formerly known as manic depression). Depression may occur as the result of a negative life event (e.g., the death of a loved one or loss of a job), a neurochemical imbalance in the brain, or both. Depression can often contribute to a chemical dependency as the person seeks to

Affective disorders include bipolar disorder and major depression.

self-medicate the depressive symptoms. Frequently there is a chicken-or-egg issue, as it is hard to determine which of the two conditions occurred first. Addressing the addiction and depression at the same time is essential because treating only one of the conditions usually results in the other condition worsening, and thus to an eventual return of the symptoms of both conditions in the end.

Depression may be treated with medication. Selective serotonin reuptake inhibitors (SSRIs) are often the first line choice in the medical management of depression. These include Prozac, Zoloft, and Paxil. If these prove ineffective, other types of antidepressant medications, such as tricyclics, may be prescribed. For some patients, electroconvulsive therapy (ECT) may also be a helpful treatment. As it is practiced today, ECT is very different from what was represented in movies such as *One Flew over the Cuckoo's Nest*. It is a relatively safe procedure that is often administered on an outpatient basis. In fact, ECT can be among the more effective and quick treatments for depression, as medications often take more than a month to reach effective levels of action.

Bipolar disorder is a condition in which a person's neurotransmitters are not stabilized, resulting in wide mood swings over a significant period of time (frequently weeks or months). The manic phase of the illness is often marked by fast or pressured speech, a diminished need for sleep, and binges or sprees of activity that may focus on work, sex, or substance use. Many people with bipolar illness also have a chemical dependency. The alcohol or other drugs are often used to self-medicate the depressive symptoms, accentuate the manic high, or both. The primary treatment for bipolar disorder is medication, including lithium. Lithium can cause significant side effects (e.g., cognitive slowing, acne, and weight gain) that often lead patients to stop taking the medication. Not surprisingly, the symptoms then reemerge and can become more treatment-resistant as a result. Lithium can also become toxic if blood levels get too high.

As is the case for psychotic disorders, it is extremely important for patients with affective disorders to faithfully adhere to their medication regimens. Although the potential side effects generally tend to be less serious than those of antipsychotic medications, some antidepression medications can be hoarded and taken all at once in a suicide attempt or gesture. In addition, failure to comply with the medication regimen can cause the symptoms to become more treatment-refractory and resistant to improvement in the future.

E. [§4.31] Anxiety Disorders

Anxiety disorders are common among substance use patients. For many, alcohol or other drugs may be used to self-medicate anxiety symptoms. Phobias (i.e., irrational and debilitating fears of certain objects or situations), posttraumatic stress disorder (PTSD), panic disorder, and generalized anxiety disorder (GAD) are examples of anxiety disorders. The medications commonly used to treat these disorders (benzodiazepines) can be abused themselves because of their sedative properties and can become habit-forming.

This may present a major challenge to drug courts and treatment programs because some stress relief may be necessary for the individual to maintain recovery; however, the medications can be addictive and intoxicating in and of themselves.

As was discussed earlier with regard to addiction medications, the decision as to whether to prescribe antianxiety medications is a medical one that should be made by a qualified psychiatrist. It is not appropriate for a drug court to have an across-the-board policy prohibiting participants from receiving medically prescribed treatments. If a drug court is concerned that a client has been doctor-shopping or has received a sedative prescription in error, the judge may question the physician concerning the justification for the prescription, or may order an independent evaluation to be performed by a qualified addiction psychiatrist. Under such circumstances, the judge is not substituting his or her judgment for that of medical experts, but rather is relying on expert opinions in choosing the most appropriate disposition for the case.

F. [§4.32] Attention Deficit Disorder (ADD)

Attention deficit disorder (ADD) is a syndrome that typically has a childhood onset and is characterized by distractibility and sometimes excessive restlessness or hyperactivity. It is relatively common among substance use patients, in part because untreated ADD in childhood may predispose some children to develop substance use problems later in life. A minority of children with ADD may also continue to have symptoms of distractibility (and, considerably less often, hyperactivity) into adulthood. The frontline medical treatment for ADD is the use of stimulant medications, such as Ritalin. Stimulant medications can have a paradoxical effect in children (and sometimes in adults) who have ADD, in which the medication acts to slow down thoughts and actions as opposed to speeding them up, which is their more typical characteristic effect.

Because stimulant medications are themselves potentially addictive and can cause intoxication or euphoria at higher doses, their use is controversial among substance use patients. As has already been discussed, the decision as to whether or not to prescribe such medications must be made by a qualified physician. If a drug court is concerned that a stimulant prescription might not be warranted for a given client, the judge may request information to justify the prescription or seek an independent evaluation by a qualified addiction psychiatrist.

G. [§4.33] Personality Disorders and Learning Disabilities

Individuals with antisocial personality disorder (APD) perform better in drug courts.

Personality disorders and learning disabilities typically have a childhood onset and tend to follow a chronic course. They, too, are relatively common among substance use patients and may complicate the clinical picture. Certain types of personality disorders in particular, such as antisocial personality disorder (APD), are generally associated with a more severe and chronic course of both substance use and

delinquent or criminal activity. Individuals with APD engage in frequent illegal activity, display a lack of remorse for their misbehavior, and may show little or no empathy for other people. Importantly, individuals with APD tend to perform *better* in drug courts than in other types of substance use treatment programs.[55] The additional structure, monitoring, and consequences for misbehavior that are provided in drug courts are especially valuable and helpful for individuals with APD.

XIII. [§4.34] SELECTING AND WORKING WITH TREATMENT AGENCIES

Selecting competent treatment providers is a critically important task for any drug court program. In deciding whether or not to partner with a given treatment agency, drug courts are strongly encouraged to carefully consider the factors discussed here relating to EBPs and BPs. If, for example, a particular treatment program does not conduct individualized treatment planning, does not have access to medications or mental health services, or does not provide gender and culturally sensitive treatment services, it is unlikely to be engaged in EBPs or BPs and might not be a suitable partner for a drug court program.

Admittedly, some communities might not have reasonable access to effective treatment programs that provide EBPs and BPs. The substance use treatment field has, unfortunately, been relatively slow to adopt new and validated interventions,[56] and there may not be meaningful consumer choice in a given jurisdiction. Under such circumstances, however, it is incumbent upon the drug court team to work diligently to encourage the eventual adoption of EBPs and BPs going forward. There is no justification for permitting poor-quality or unvalidated treatment services to continue to be administered unabated, with the excuse that criminal justice professionals are not qualified to judge the quality of those treatment services. Although it is inappropriate for judges, lawyers, or probation officers to engage in clinical practice, they can and must learn to become competent consumers of clinical practices. Where necessary, a drug court may need to enlist its own cadre of experienced clinicians to serve as consultants to the program on EBPs and BPs, or may need to obtain technical assistance and training from national, regional, or state organizations, such as NDCI.

One important step that a drug court should take is to partner with as many different treatment programs as is necessary to ensure access to the full range of levels of care, from detoxification services to residential services to outpatient services. A drug court should also attempt to ensure sufficient access to any adjunctive services that may be needed for its population, such as mental health services or vocational services. Importantly, research indicates that outcomes tend to be best when one treatment program serves as the primary or central case management agency for the drug court and coordinates referrals to the other programs.[57] This primary case management program should remain responsible for documenting clients' progress in the other programs and reporting on their progress to the drug court team at staffings and status hearings.

Partner with as many agencies as are necessary to provide a full range of services and levels of care.

Some levels of care, such as inpatient treatment, might not be available in a given jurisdiction. If such services are available in a nearby county, reaching out to those programs and developing standard referral procedures or contractual arrangements can be extremely helpful. If, however, the services are not realistically available within a travelable range, the drug court might not, in good conscience, be capable of accepting clients who are in need of such services. Providing lesser levels of care than clients actually require is associated with poorer outcomes and could lead to more severe legal consequences in the event of treatment failure.

However, if the only practical alternative facing an individual is incarceration or no treatment at all, it might be worth the effort to attempt to treat that individual in whatever level of care is realistically available. Under such circumstances, it is important to guard against administering high-magnitude sanctions to the client in the event of treatment failure, because the responsibility for failure could be attributable to the treatment regimen rather than to the client himself or herself. At a minimum, if treatment does fail, the client should not be any worse off and should not face more severe legal consequences than if he or she had never attempted a treatment-oriented disposition.

A research-based guide, Principles of Drug Abuse Treatment for Criminal Justice Populations, *may be found at https://www.drugabuse.gov/publications/principles-drug-abuse-treatment-criminal-justice-populations/principles.*

Regardless of whether and how a drug court chooses to operate over the short term in the face of inadequate treatment resources, it is not justifiable for that drug court to remain content indefinitely with substandard levels of practice. The ultimate responsibility of any drug court is to advocate for improvements in the quality of treatment services for addicted individuals living within its own community. In this way, drug courts can serve as the tide that raises all ships within both the criminal justice system and the substance use treatment system.

RECOMMENDED READINGS AND RESOURCES

Understanding Addiction (Websites)

National Institute of Drug Abuse, http://www.nida.nih.gov/

National Institute of Drug Abuse. High school curriculum, The Brain: Understanding Neurobiology Through the Study of Addiction. http://www.nida.nih.gov/Curriculum/HSCurriculum.html

National Institute on Alcohol Abuse and Alcoholism, http://www.niaaa.nih.gov/

Treatment Approaches (Websites)

Motivational interviewing, http://www.motivationalinterviewing.org/

National Registry of Evidence-Based Practices and Programs (NREPP), http://www.nrepp.samhsa.gov/

Treatment Approaches (Books)

Miller, William R., and Stephen Rollnick. 2012. *Motivational interviewing: Helping people change*. 3rd ed. New York: Guilford Press.

National Institute on Drug Abuse. 2006. *Principles of Drug Abuse Treatment for Criminal Justice Populations*. Available at https://www.drugabuse.gov/publications/principles-drug-abuse-treatment-criminal-justice-populations/principles.

Treatment Manuals

Center for Substance Abuse Treatment. 2005. *Substance abuse treatment for adults in the criminal justice system*. Treatment Improvement Protocol (TIP) Series 44. DHHS Publication No. (SMA) 05-4056. Rockville, MD: Substance Abuse and Mental Health Services Administration. *Available* at https://www.ncbi.nlm.nih.gov/books/NBK64137/.

Center for Substance Abuse Treatment. 2005. *Substance abuse treatment for persons with co-occurring disorders*. Treatment Improvement Protocol (TIP) Series 42. DHHS Publication No. (SMA) 05-3922. Rockville, MD: Substance Abuse and Mental Health Services Administration. Available at https://www.ncbi.nlm.nih.gov/books/NBK64197/.

Center for Substance Abuse Treatment. 1999. *Treatment for stimulant use disorders*. Treatment Improvement Protocol (TIP) Series 33. DHHS Publication No. (SMA) 09-4209. Rockville, MD: Substance Abuse and Mental Health Services Administration. Available at https://www.ncbi.nlm.nih.gov/books/NBK64333/.

National Institute for Drug Abuse. 2009. *Principles of drug addiction treatment: A research-based guide*. 2nd ed. Bethesda, MD: NIH Publication No. 09-4180. Available at http://www.drugabuse.gov/PODAT/PODATindex.html.

Carroll, Kathleen M. 1998. *A cognitive-behavioral approach: Treating cocaine addiction*. NIH Publication No. 98-4308. Bethesda, MD: National Institute on Drug Abuse. Available at http://www.drugabuse.gov/TXManuals/CBT/CBT1.html.

Mercer, Delinda E., and George E. Woody. 1999. *An individual drug counseling approach to treat cocaine addiction: The collaborative cocaine treatment study model*. NIH Publication No. 99-4380. Bethesda, MD: National Institute on Drug Abuse. Available at http://www.drugabuse.gov/TXManuals/IDCA/IDCA1.html.

Daley, Dennis C., Delinda E. Mercer, and Gloria Carpenter. 1999. *Counseling for cocaine addiction: The collaborative cocaine treatment study model*. IH Publication Number 99-4380. Bethesda, MD: National Institute on Drug Abuse. Available at https://archives.drugabuse.gov/TXManuals/DCCA/DCCA1.html.

Stages-of-Change Model

DiClemente, Carlo C. 2006. *Addiction and change: How addictions develop and addicted people recover*. New York: Guilford Press.

Contingency Management

Budney, Alan J., Stephen Higgins, Delinda E. Mercer, and Gloria Carpenter. 1998. *A community reinforcement approach: Treating cocaine addiction*. Therapy manuals for drug abuse: Manual 2. NIH Publication No. 98-4309. Bethesda, MD: National Institute on Drug Abuse. Available at http://archives.drugabuse.gov/TXManuals/CRA/CRA1.html.

Petry, Nancy M. 2000. A comprehensive guide to the application of contingency management procedures in clinical settings. *Drug and Alcohol Dependence* 58 (1–2): 9–25.

Principles of Drug Abuse Treatment for Criminal Justice Populations, http://www.atforum.com/addiction-resources/documents/PODAT_CJ.pdf.

1 Rudd, Rose A., Noah Aleshire, Jon E. Zibbell, and R. Matthew Gladden. 2016. Increases in drug and opioid overdose deaths—United States, 2000–2014. Centers for Disease Control and Prevention, *Morbidity and Mortality Weekly Report (MMWR)* 64(50);1378–1382.

2 Rossen, L. M., B. Bastian, M. Warner, D. Khan, and Y. Chong. 2016. *Drug poisoning mortality: United States, 1999–2014*. National Center for Health Statistics, Centers for Disease Control and Prevention.

3 Belenko, Steven, and Jordan Peugh. 1998. *Behind bars: Substance abuse and America's prison population*. New York: Center on Addiction and Substance Abuse at Columbia University.

4 Fazel, Seena, Parveen Bains, and Helen Doll. 2006. Substance abuse and dependence in prisoners: A systematic review. *Addiction* 101(2): 181–191.

5 Karberg, Jennifer C., and Doris J. James. 2005. *Substance dependence, abuse, and treatment of jail inmates, 2002*. NCJ 209588. Washington, DC: Bureau of Justice Statistics, U.S. Dept. of Justice.

6 Bennett, Trevor, Katy Holloway, and David Farrington. 2008. The statistical association between drug misuse and crime: A meta-analysis. *Aggression and Violent Behavior* 13(2): 107–118.

7 Holloway, Katy R., Trevor H. Bennett, and David P. Farrington. 2006. The effectiveness of drug treatment programs in reducing criminal behavior: A meta-analysis. *Psicothema* 18(3): 620–629.

8 Gossop, Michael, Katia Tradaka, Duncan Stewart, and John Witton. 2005. Reductions in criminal convictions after addiction treatment: Five-year follow-up. *Drug and Alcohol Dependence* 79(3): 295–302.

9 University of California at Los Angeles. 2007. *Evaluation of the substance abuse and crime prevention act: Final report*. UCLA Integrated Substance Abuse Programs.

10 Kelly, John F., John W. Finney, and Rudolf Moos. 2005. Substance use disorder patients who are mandated to treatment: Characteristics, treatment process, and one- and five-year outcomes. *Journal of Substance Abuse Treatment* 28(3): 213–223.

11 Perron, Brian E., and Charlotte Bright. 2008. The influence of legal coercion on dropout from substance abuse treatment: Results from a national survey. *Drug and Alcohol Dependence* 92(1-3): 123–131.

12 Baler, Ruben D., and Nora D. Volkow. 2006. Drug addiction: The neurobiology of disrupted self-control. *Trends in Molecular Medicine* 12(12): 559–566.

13 Chandler, Redonna K., Bennett W. Fletcher, and Nora D. Volkow. 2009. Treating drug abuse and addiction in the criminal justice system. *JAMA* 301(2): 183–190.

14 Di Chiara, Gaetano, and Assunta Imperato. 1988. Drugs abused by humans preferentially increase synaptic dopamine concentrations in the mesolimbic system of freely moving rats. *Proceedings of the National Academy of Sciences* 85(14): 5274–5278.

15 Schmidt, Christopher J. 1989. *Pharmacology and toxicology of amphetamine and related designer drugs*. NIDA Monograph No. 94. Bethesda, MD: National Institute on Drug Abuse.

16 O'Brien, Charles P., Anna Rose Childress, Ronald Ehrman, and Steven J. Robbins. 1998. Conditioning factors in drug abuse: Can they explain compulsions? *Journal of Psychopharmacology* 12(1): 15–22.

17 Baler and Volkow, Drug addiction.

18 O'Brien et al., Conditioning factors in drug abuse.

19 McLellan, A. Thomas, David C. Lewis, Charles P. O'Brien, and Herbert D. Kleber. 2000. Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *JAMA* 284(13): 1689–1695.

20 Marlowe, Douglas B., David J. Glass, Elizabeth P. Merikle, David S. Festinger, David S. DeMatteo, Geoffrey R. Marczyk, et al. 2001. Efficacy of coercion in substance abuse treatment. In *Relapse and recovery in addictions*, edited by Frank M. Tims, Carl G. Leukefeld, and Jerome J. Platt, 208–227. New Haven, CT: Yale University Press.

21 Conner, Bradley T., Douglas Longshore, and M. Douglas Anglin. 2009. Modeling attitude towards drug treatment: The role of internal motivation, external pressure, and dramatic relief. *Journal of Behavioral Health Services and Research* 36(2): 150–158.

22 Burke, Brian L., Hal Arkowitz, and Marisa Menchola. 2003. The efficacy of motivational interviewing: A meta-analysis of controlled clinical trials. *Journal of Consulting and Clinical Psychology* 71(5): 843–861.

23 Rubak, Sune, Annelli Sandbaek, Torsten Lauritzen, and Bo Christensen. 2005. Motivational interviewing: A systematic review and meta-analysis. *British Journal of General Practice* 55(513): 305–312.

24 Morgenstern, Jon, and Richard Longabaugh. 2000. Cognitive-behavioral treatment for alcohol dependence: A review of evidence for its hypothesized mechanisms of action. *Addiction* 95(10): 1475–1490.

25 Marlowe, Douglas B., and Conrad J. Wong. 2008. Contingency management in adult criminal drug courts. In *Contingency management in substance abuse treatment*, edited by Stephen T. Higgins, Kenneth Silverman, and Sarah H. Heil, 334–354. New York: Guilford Press.

26 Prendergast, Michael M., Deborah Podus, John Finney, Lisa Greenwell, and John Roll. 2006. Contingency management for treatment of substance use disorders: A meta-analysis. *Addiction* 101(11): 1546–1560.

27 Marlowe, Douglas B., David S. Festinger, Karen L. Dugosh, Patricia L. Arabia, and Kimberly C. Kirby. 2008. An effectiveness trial of contingency management in a felony preadjudication drug court. *Journal of Applied Behavior Analysis* 41(4): 565–577.

28 Kirby, Kimberly C., Douglas B. Marlowe, David S. Festinger, Richard J. Lamb, and Jerome J. Platt. 1998. Schedule of voucher delivery influences initiation of cocaine abstinence. *Journal of Consulting and Clinical Psychology* 66(5): 761–767.

29 Lussier, Jennifer Plebani, Sarah H. Heil, Joan A. Mongeon, Gary J. Badger, and Stephen T. Higgins. 2006. A meta-analysis of voucher-based reinforcement therapy for substance use disorders. *Addiction* 101(2): 192–203.

30 Carroll, Kathleen M. 1996. Relapse prevention as a psychosocial treatment: A review of controlled clinical trials. *Experimental and Clinical Psychopharmacology* 4(1): 46–54.

31 McCrady, Barbara S., and William R. Miller. 1993. *Research on Alcoholics Anonymous: Opportunities and alternatives*. New Brunswick, NJ: Rutgers Center of Alcohol Studies.

32 *Americans United v. Prison Fellowship*. 2007. 8th Cir. 509 F.3d 406.

33 National Institute on Drug Abuse. 2006. *Principles of drug abuse treatment for criminal justice populations: A research-based guide*. NIH Publication No. 06–5316: 22–23. Bethesda, MD: Author.

34 Kleber, Herbert D. 2008. Methadone maintenance four decades later: Thousands of lives saved but still controversial. *JAMA* 300(19): 2303–2305.

35 Platt, Jerome J., Mindy Widman, Victor Lidz, and Douglas B. Marlowe. 1998. Methadone maintenance treatment: Its development and effectiveness after 30 years. In *Heroin in the age of crack-cocaine*, edited by James A. Inciardi and Lana D. Harrison, 160–187. Thousand Oaks, CA: Sage Publications.

36 Strain, Eric C., and Michelle R. Lofwall. 2008. Buprenorphine maintenance. In *Textbook of substance abuse treatment*, edited by Marc Galanter and Herbert D. Kleber, 309–324. Washington, DC: American Psychiatric Press.

37 Gordon, Michael S., Timothy W. Kinlock, Robert P. Schwartz, and Kevin E. O'Grady. 2008. A randomized clinical trial of methadone maintenance for prisoners: Findings at six months post-release. *Addiction* 103(8): 1333–1342.

38 Dolan, Kate A., James Shearer, Bethany White, Jialun Zhou, John Kaldor, and Alex D. Wodak. 2005. Four-year follow-up of imprisoned male heroin users and methadone treatment: Mortality, re-incarceration, and hepatitis C infection. *Addiction* 100(6): 820–828.

39 Kinlock, Timothy W., Michael S. Gordon, Robert P. Schwartz, and Kevin E. O'Grady. 2008. A study of methadone maintenance for male prisoners: Three-month postrelease outcomes. *Criminal Justice and Behavior* 35(1): 34–47.

40 Magura, Stephen, Joshua D. Lee, Jason Hershberger, Herman Joseph, Lisa Marsch, Carol Shropshire, and Andrew Rosenblum. 2009. Buprenorphine and methadone maintenance in jail and post-release: A randomized clinical trial. *Drug and Alcohol Dependence* 99(1-3): 222–230.

41 National Drug Court Institute. 1999. *Buprenorphine in the treatment of opioid addiction*. Practitioner Fact Sheet. Alexandria, VA: Author.

42 National Drug Court Institute. 2002. *Methadone maintenance and other pharmacotherapeutic interventions in the treatment of opioid dependence*. Practitioner Fact Sheet Vol. III, No. I.. Alexandria, VA: Author.

43 Shuster, Charles R., and Charles O'Brien. 2008. Medication-assisted treatment for participants in drug court programs. Monograph Series No. 9. In *Quality improvement for drug courts: Evidence-based practices*, edited by Carolyn Hardin and Jeffrey N. Kushner, 33–42. Alexandria, VA: National Drug Court Institute.

44 Sims, Shannon A., Laverne A. Snow, and Christina A. Porucznik. 2007. Surveillance of methadone-related adverse drug events using multiple public health data sources. *Journal of Biomedical Informatics* 40(4): 382–389.

45 O'Brien, Charles P., and James W. Cornish. 2006. Naltrexone for probationers and parolees. *Journal of Substance Abuse Treatment* 31(2): 107–111.

46 American Society of Addiction Medicine. 2000. *Patient placement criteria for the treatment of substance-related disorders*. 2nd ed. Chevy Chase, MD: Author.

47 McLellan, A. Thomas. 2008. Evolution in addiction treatment concepts and methods. In *Textbook of substance abuse treatment*, edited by Marc Galanter and Herbert D. Kleber, 93–108. Washington, DC: American Psychiatric Press.

48 McLellan, Evolution in addiction treatment concepts and methods.

49 Schottenfeld, Richard S. 1989. Involuntary treatment of substance abuse disorders—impediments to success. *Psychiatry* 52(2): 164–176.

50 Westermeyer, Joseph, and Daniel L. Dickerson. 2008. Minorities. In *Textbook of substance abuse treatment*, edited by Marc Galanter and Herbert D. Kleber, 639–651. Washington, DC: American Psychiatric Press.

51 Brady, Kathleen T., and Sudie E. Back. 2008. Women and addiction. In *Textbook of substance abuse treatment*, edited by Marc Galanter and Herbert D. Kleber, 555–564. Washington, DC: American Psychiatric Press.

52 American Psychiatric Association. 2013. *Diagnostic and statistical manual of mental disorders*. 5th ed. Arlington, VA: American Psychiatric Press.

53 Ross, Stephen. 2008. The mentally ill substance abuser. In *Textbook of substance abuse treatment*, edited by Marc Galanter and Herbert D. Kleber, 537–554. Washington, DC: American Psychiatric Press.

54 Drake, Robert E., Kim T. Mueser, and Mary F. Brunette. 2004. A review of treatments for people with severe mental illnesses and co-occurring substance use disorders. *Psychiatric Rehabilitation Journal* 27(4): 360–374.

55 Marlowe, Douglas B., David S. Festinger, Karen L. Dugosh, Patricia A. Lee, and Kathleen M. Benasutti. 2007. Adapting judicial supervision to the risk level of drug offenders: Discharge and six-month outcomes from a prospective matching study. *Drug and Alcohol Dependence* 88 (Suppl 2): 4–13.

56 Taxman, Faye S., Matthew L. Perdoni, and Lana D. Harrison. 2007. Drug treatment services for adult offenders: The state of the state. *Journal of Substance Abuse Treatment* 32(3): 239–254.

57 Carey, Shannon M., Michael W. Finigan, and Kimberly Pukstas. 2008. *Exploring the key components of drug courts: A comparative study of 18 adult drug courts on practices, outcomes, and costs*. Portland, OR: NPC Research. Available at www.npcresearch.com

Chapter 5

Community Supervision

Helen Harberts, M.A., J.D.

I. [§5.1] INTRODUCTION 101
II. [§5.2] WHO PERFORMS COMMUNITY SUPERVISION? 101
III. [§5.3] PERSONNEL REQUIREMENTS AND COMPETENCIES 104
IV. [§5.4] FUNCTIONS OF COMMUNITY SUPERVISION 104
A. [§5.5] Protecting Public Safety 105
B. [§5.6] Providing Accountability 106
C. [§5.7] Enhancing Drug Refusal Skills 106
D. [§5.8] Identifying Environmental Threats 107
E. [§5.9] Catching Impending Signs of Relapse 107
F. [§5.10] Partnering with Treatment 108
G. [§5.11] Enforcing Community Obligations 109
V. [§5.12] EFFECTIVE COMMUNITY SUPERVISION PRACTICES 109
VI. [§5.13] ACCOUNTABILITY TECHNOLOGY 110
VII. [§5.14] JURISDICTION OVER PARTICIPANTS 111
VIII. [§5.15] MEMORANDA OF UNDERSTANDING 112

I. [§5.1] INTRODUCTION

Consider this simple fact: the typical drug court program can only supervise approximately ten to fifteen percent of participants' activities. Assume, for example, that a drug court requires its participants to attend twelve hours per week of addiction counseling, three hours per week of court hearings, two hours of probation appointments, one hour of urine collection, and four hours of adjunctive vocational training sessions (twenty-two hours of total services). With 168 hours in a week, that leaves eighty-seven percent of the participants' time unsupervised and largely unaccounted for. This is where community supervision comes in.

Managing drug-involved offenders is not a desk job or an office job. These individuals are generally not at risk for using drugs or committing crimes while they are attending court hearings or sitting in a probation office or treatment clinic. The risks they face are in their natural social environment, where they are often confronted with drugs, drug-using associates, and the stresses of their daily lives. A drug court must be able to extend its influence into the natural settings in which its clients live and function.

Research confirms that the most effective drug courts provide community supervision services within their programs. Not only are outcomes significantly better for drug courts that include community corrections officers or law enforcement officers on their teams, but those programs are also nearly twice as cost-effective.[1] The up-front costs of community supervision are offset several times over by the fact that participants commit fewer new crimes, engage in fewer technical violations, spend less time incarcerated, graduate sooner, and consume fewer resources while they are in treatment. Like any wise investment, community supervision pays multiple dividends over the long run. This chapter reviews the appropriate roles for community supervision officers in drug court programs, including personnel requirements and critical job tasks.

In any given week, the majority of a participant's time may be unsupervised.

II. [§5.2] WHO PERFORMS COMMUNITY SUPERVISION?

One goal of a drug court program is to build partnerships in order to maximize its beneficial impacts over the lives of participants and the community as a whole. Therefore, community supervision should be conducted by as many parties and agencies as possible. Although probation departments are typically the primary community supervision agencies for drug courts, they are not the only possible partners in community supervision efforts. No single agency is capable of monitoring offenders around the clock. Properly informed police officers, sheriff's deputies, highway patrol officers, dispatchers, and jail personnel can make an invaluable contribution to the effectiveness of community supervision and improve the outcomes of a drug court. Therefore, building solid partnerships with all

levels of law enforcement is essential. Examples of such partnerships might include, but are by no means limited to, the following:

- Informing local police or sheriff dispatchers about who is enrolled in the drug court and requesting that they inform both the police officer and drug court team whenever there is a law enforcement contact. Because drug court participants often have a Fourth Amendment search and seizure waiver as a condition of their drug court participation, the police officer or sheriff's deputy will be alerted to make additional inquiries and, if warranted, perform a search pursuant to the conditions of the drug court program.
- Alerting highway patrol officers to watch out for drug court participants who might be driving on a suspended license or while impaired.
- Requesting that police officers drive by designated homes to monitor curfews.
- Expediting drug court warrants so that absconded participants are brought quickly back into the system.
- Requesting back-up and assistance by the police, where needed, for home contacts, warrant sweeps, curfew checks, and monitoring of area restrictions.
- Soliciting the police or sheriff's department to donate abandoned or unclaimed bicycles to drug court participants who have no driver's license or other means of transportation. This can be especially effective in DWI courts.
- Inviting police officers or sheriff's deputies to attend drug court graduation ceremonies to publicly recognize the accomplishments of individuals who they previously arrested and to let the officers or deputies know which citizens have made meaningful strides towards reforming their behavior.

To develop these effective partnerships, law enforcement officers need to know what the drug court program does and what it wants for its participants. First, it is essential to dispel any myths or misperceptions that drug courts are soft on crime or eschew the essential functions of policing. Drug courts, like other criminal justice programs, believe in the importance of holding people accountable for their actions and protecting the public from unlawful or dangerous conduct. In this way, their goals are very much in line with those of other criminal justice agencies. Second, the drug court team should provide in-service education to law enforcement on how the drug court operates and how it performs its essential functions. Because drug court supervision practices are actually quite similar to those of other community policing and problem-oriented policing techniques, there is a clear connection between what a drug court wants and what most law enforcement agencies are capable of delivering. However, specialized training on drug court-specific procedures is also important. At the simplest level, law enforcement officers require clear guidance on how they should respond to violations by drug court participants, and how they should transmit information about drug court participants to the primary case managers working in the drug court program. For example, they need to know, at a minimum, the name and contact information for the drug court coordinator or the probation officer(s) who are supervising the drug court participants.

Law enforcement's involvement in drug court is cost effective and produces better outcomes.

It is also important for law enforcement to recognize the value of catching participants doing something right and informing the drug court team about accomplishments and appropriate behaviors. Many law enforcement officers may not be trained or encouraged to report good news as well as bad news. Having a police officer see and report on good behavior can be a powerful tool for behavioral change and can enhance the power of the drug court team. Most drug court participants have never heard "good job" from the police and are likely to be extremely influenced by such an encounter. This can be especially powerful if that encouragement is later reaffirmed by the drug court team and the judge. This sends two important messages to the drug court community: (1) it rewards the participant's specific behavior, and (2) it lets all participants in the program know that the drug court team and its partners are closely watching their behavior and responding accordingly. It also strengthens support for the drug court by law enforcement.

Officers should be comfortable with both the public safety side and the public health side of their profession.

Probation officers are ordinarily the primary case managers for the criminal justice system. In some states, probation officers are peace officers with concomitant law enforcement powers, and in other states they may rely on their law enforcement partners to carry out that function. Some probation departments may place limits on the duties their agents are permitted to perform, such as disallowing home contacts or vehicle searches. In addition, the law in some jurisdictions might not permit such activities on the part of probation. It is essential for the drug court team to understand what range of probationary services is available to their program. Where gaps exist in needed services, it is essential to build partnerships that can extend the community supervision component as close as possible to a 24-hour, 7-days-per-week monitoring system. Depending upon the role and authority of a particular probation department, it may be necessary to add supplementary services. For example, some private probation agencies are basically focused on monitoring attendance, collecting fees, and performing drug testing. Although these services are certainly critical, they are not on par with the performance of field services, such as conducting home contacts and searches, bar sweeps, and employment confirmations.

Community supervision is the "eyes and ears" of drug court.

No matter who has the ultimate responsibility for such functions, field services and searches must be performed in a professional and respectful manner, consistent with the role-modeling that we expect from supervision professionals. Participants learn their expected behaviors, in part, from watching the conduct of professionals. Tossing them or their homes (i.e., performing intrusive and aggressive searches) does not model the type of behavior that we expect from law abiding citizens. One important byproduct of drug court can be a new appreciation for law enforcement as a valuable resource for the community.

III. [§5.3] PERSONNEL REQUIREMENTS AND COMPETENCIES

Drug courts are best served by experienced officers who have had comprehensive training in community supervision skills and how to work in a drug court environment. Officer safety, good field services skills, and the ability to work independently are essential traits for the job. It is also necessary to maintain a balanced attitude about the appropriate role of community supervision, which includes not only protecting public safety but also assisting offenders to function more competently and providing objective and useful information to treatment professionals to assist them in their clinical tasks. Officers should be comfortable with both the public safety side and the public health side of their profession, which includes helping offenders to make good decisions and develop appropriate adaptive skills. Probation officers and others in the community corrections field are experts in what they do, however in the drug court setting it is crucial that they also possess a firm understanding of addiction and recovery, psychopharmacology, and co-occurring disorders as well.

Drug Courts are best served by experienced officers with comprehensive training.

Some probation agencies or police departments may assign their least experienced officers to drug court because it is viewed (wrongly) as dealing with a relatively low-risk population. This practice is not warranted. It requires considerable experience, skills, and maturity to intervene effectively with drug-addicted individuals, who often present with a host of other disorders and problems in their lives. Experience yields the ability to flexibly assess each situation and determine how best to address violations of a court order. Not all violations are serious enough to require an arrest or revocation, and overreacting can make a bad situation considerably worse. Although the community supervision officer should never ignore noncompliance, sometimes infractions present an excellent opportunity for instruction and intervention. Knowing how to discern the difference between a "teachable moment" and a serious threat to public safety requires judgment and insight on the part of the officer. Conversely, some infractions might seem fairly innocuous, but are potentially quite serious given the particular background of an offender. For example, finding over-the-counter cold medicine in an offender's home could be a serious warning sign if he or she has a history of manufacturing methamphetamine. Again, knowing how to read a situation requires experience and judgment and should not be delegated to junior officers unless they are being closely supervised and mentored by senior instructors.

IV. [§5.4] FUNCTIONS OF COMMUNITY SUPERVISION

Drug courts make promises to their communities, their partners, and their participants that they will promote public safety, hold people accountable for their actions, acknowledge success, and follow evidence-based practices to maximize results. Program

integrity rests on fulfilling these promises. Failure to provide appropriate levels of community supervision not only breaches the public trust but calls program effectiveness into question for the participants themselves. When a drug court instructs participants to do something, they are held accountable for failing to meet those obligations. It is essential for the same level of accountability to apply to the drug court program and team. If the drug court promises to conduct field visits, then it must deliver. Staff members must follow through on what they say they will do. Otherwise, every participant will come to recognize that the court has "no teeth" and cannot be relied upon to do what it says. Drug court judges must hold treatment providers, community supervision agents, case managers, drug-testing agencies, and all other members of the team to a high standard of professional care and performance.

Field services and searches are critical and must be done respectfully and professionally.

While in the field, community supervision officers can identify and intervene in risky behaviors, correct errors before they become serious, and catch participants doing something right. All of these functions are critical elements of drug court interventions. A drug court cannot apply behavior modification principles to undetected behavior—both good and bad. Detection is the key. Without consistent and rapid detection, application of the principles of behavior modification becomes ineffective. Below is a brief description of some of the many critical functions that are served by community supervision officers.

A. [§5.5] Protecting Public Safety

A primary aim of community supervision is to protect public safety. If not for the drug court program, many of these individuals might be in custody. Some drug court participants may pose a threat of driving while impaired (DWI), domestic violence, or the commission of other crimes. Moreover, individuals who abuse alcohol or stimulant drugs such as methamphetamine or cocaine may be at risk for spontaneous aggression against others, and those who abuse narcotics such as opiates might be at risk for experiencing a fatal overdose.

As was noted earlier, these risks typically occur within offenders' community of origin and not while they are appearing in court or attending a treatment program. Therefore, they need to be monitored within their own community to ensure that they stay away from high-risk locations and avoid high-risk behaviors. For example, enforcing home curfews and area restrictions can go a long way toward reducing drug court participants' access to illicit substances and keeping them away from drug-using accomplices. Similarly, installing and monitoring supervision technologies, such as ignition interlock devices or anklet monitors, can go a long way toward preventing these offenders from committing infractions and endangering the public.

B. [§5.6] Providing Accountability

Court orders have little meaning or effect if they are not enforced. Each time an offender gets away undetected with a violation, the program loses valuable credibility. Worse still, the odds are substantially increased that the offender will repeat that infraction in the future. Research demonstrates that punishment tends to be least effective when it is applied infrequently or intermittently.[2] For punishment to be effective, it must be certain. Therefore, on one hand, failing to detect or respond to an infraction is not simply a lost opportunity to intervene. It can make the offender worse because it invites future efforts to beat the system once again. On the other hand, when an offender is caught in the act of a transgression, or soon thereafter, and receives an immediate and appropriate consequence, the likelihood of repeating the transgression is reduced, and the effect of treatment is enhanced several fold.

In addition to certainty, punishment must also be swift if it is to effectively change offenders' behavior.[3] Catching transgressions in the field greatly reduces the time delay between the infraction and its detection, and therefore enhances the effects of the program. For example, even if drug use is detected through urine drug testing at the drug court, the time lag between the drug use and the positive test result could be several days. If, instead, a probation officer detected the drug use during a home contact, the delay could be only a matter of hours. Responding in a shorter period of time is apt to make the consequences substantially more meaningful and effective in stopping future episodes of drug use.

C. [§5.7] Enhancing Drug Refusal Skills

Community supervision officers should:

- *Protect public safety*
- *Provide accountability*
- *Enhance drug refusal skills*
- *Identify environmental threats*
- *Catch impending signs of relapse*
- *Partner with treatment*
- *Enforce community obligations*

Many drug court participants are seriously deficient in drug-refusal skills. Even if they truly desire to remain sober, they may not know how to say *no* in a manner that is effective. There are at least two critical aspects to saying *no* in an effective manner to an offer of drugs. First, the refusal must come across as definite. Drug-using associates and dealers are accustomed to tentative refusals that can be easily overcome with a little persistence. A bit of cajoling is often sufficient to change a *no* into a *yes*. Second, the refusal must come across as respectful and nonjudgmental. Appearing to criticize or insult an individual who is offering drugs could lead to confrontation or recrimination.

The fact that a supervision agent could check up on the participant at any time offers a convenient and legitimate excuse for turning down an offer of drugs. Drug court participants can simply respond that an officer might show up at their home and urine test them without notice, and therefore they cannot risk engaging in any usage. During the early stages of recovery, when participants' commitment to sobriety may still be fragile and their drug-refusal skills are not yet well developed, relying on this external reason for declining drugs may be all that stands between them and an impending relapse.

D. [§5.8] Identifying Environmental Threats

By conducting field visits, officers can identify threats to participants' recovery and personal safety. Many drug court participants have problems or burdens that they cannot realistically assess or that they may feel uncomfortable talking about. For example, some participants may have insufficient food, their electricity or phone service might have been shut off, or they may be essentially homeless. Often, they may feel too ashamed or embarrassed to acknowledge these problems during an office interview. Making a home contact may be the only way for the drug court team to identify such problems and intervene effectively.

Similarly, some drug court participants may be the victim of domestic violence and may be too ashamed or fearful to ask for help. By making unannounced home visits, supervision agents can identify such threats and order the offending individual to leave the premises. This takes the burden off of the participant, who is then not the one who is blameworthy for calling the problem to the attention of authorities.

Finally, some drug court participants may be living with other people who still use drugs, and may not want those individuals to leave the home. For example, a boyfriend or parent may be abusing drugs, but the drug court participant may feel that this is the only person he or she can depend upon for support or closeness. It could be unrealistic to expect the participant to report this fact during an office interview. Only by conducting home contacts would such a dynamic be brought to the attention of the drug court team.

E. [§5.9] Catching Impending Signs of Relapse

The community supervision officer should never ignore noncompliance.

Community supervision officers can intervene early in the relapse process, preventing a serious episode by detecting the warning signs of an impending relapse before actual usage occurs. By monitoring the recovery environment in the home, school, and at work, officers can detect subtle changes that signal improvement or deterioration in the participant's lifestyle. The ability to detect such changes early and pass that information on to the treatment team can make the crucial difference between success and failure.

Although relapse to drug abuse may often seem to be spontaneous and unforeseeable, in fact, it usually develops over time according to familiar sequences of events. A chain of behavior typically leads the individual down the path toward substance abuse. For example, some drug court participants may begin to seek out old acquaintances or spend time in old surroundings that were associated with substance abuse. Although they might not be consciously aware of it, they are placing themselves at serious risk for experiencing cravings and gaining ready access to drugs. Unfortunately, it is unlikely that participants will voluntarily report such early warning signs to their counselors during office visits. Rather, it is often incumbent upon community supervision officers to go into the field to discover the fact that participants are visiting restricted areas or spending time with restricted individuals.

Similarly, some drug court participants might abuse alcohol or other drugs as a means of coping with symptoms of depression or psychosis. By conducting home contacts, community supervision officers can determine whether participants are keeping up with their basic activities of daily living, such as cleaning their home, maintaining personal hygiene, and paying bills. Failing to keep up with such basic responsibilities may signal the return of depressive or psychotic symptoms and the possibility of an impending relapse to substance abuse. Again, participants may be reluctant or unable to accurately report such symptoms to their counselors during office sessions. Only by going out into the field and directly observing their behaviors may it be possible to detect deterioration in their functioning and prevent a full-blown relapse episode from occurring.

F. [§5.10] Partnering with Treatment

Community supervision officers and treatment professionals should be in constant communication with each other. The most reliable information and effective interactions with clients come from a seamless relationship between these two professional disciplines.[4] Drug court judges should support and encourage this beneficial relationship. These are not agencies that have historically worked well together, but with the proper waivers and information sharing agreements, they can greatly enhance the outcomes of any drug court program.

Treatment professionals must generally rely on self-reported information from their clients and their own clinical intuition to monitor participants' progress. Probation officers can objectively observe participants' relationships, homes, places of employment, and associates. This information can be used by treatment professionals to address deception, minimization, manipulation, or triangulation in treatment sessions. For example, if a participant denies engaging in substance abuse, but the probation officer found empty beer bottles in his or her trashcan, the counselor can use this information to confront the lying and begin a productive dialogue about how the relapse occurred and how to avoid it in the future. If, instead, the counselor is forced to accept the participants' false denial at face value, there is no basis for intervening, and the counselor loses valuable credibility by falling for the deception.

Catch them doing something right.

Conversely, the observations of probation officers can be used to congratulate and encourage participants for engaging in positive and productive behaviors. For example, informing participants during counseling sessions that their probation officer called to inform the treatment team that things are going well at home accomplishes two goals: (1) it reaffirms the positive feedback and incentive, and (2) it alerts others in the program that the supervision team watches them closely and communicates its findings to the treatment team.

G. [§5.11] Enforcing Community Obligations

Office services are also important. In an office setting, probation officers can monitor participants' completion of community service hours and review their activity logs to confirm that they have been attending self-help groups, meeting with their self-help sponsors or mentors, and complying with their medication regimen. Office visits are also an excellent place for planned confrontations or participant-centered staffings. For example, some drug court participants may engage in what is called *splitting*, in which they tell very different stories to their probation officer than to their treatment provider, or they may attempt to create a disagreement between the treatment provider and the probation officer. To deal with this issue, the probation officer and treatment provider might meet together with the participant to confront the distortions and manipulations.

Similarly, a probation officer might meet with a participant and his or her family members or significant others to address problematic situations at home. For example, if a participant has been stealing money from a family member to purchase drugs, the probation officer and family member could confront this issue together and the probation officer could impose a consequence or sanction for the transgression. This provides invaluable support and backup to family members as they learn to deal more effectively with misbehavior at home.

V. [§5.12] EFFECTIVE COMMUNITY SUPERVISION PRACTICES

It is important to develop a specialized set of terms and conditions for probation and community supervision; this may be part of the drug court contract or part of the overall case plan for the participant. These terms and conditions should be clearly written down and should be reviewed with participants at regular intervals. Participants are unlikely to recall what has been said or read to them during the early stages of recovery. For the first few months after an extended period of drug abuse, individuals are apt to have serious problems with memory, attention, and concentration. Therefore, it is necessary to repeat statements to them numerous times, to write things down, and to have the participants repeat back what was said to ensure that they truly understood the message.

It is also important to bear in mind that many people are fearful after an arrest and may be too anxious to understand and remember what was said during court. Therefore, it is very important for probation officers to review with participants what orders and decisions were reached by the judge, and the reasons for them. Although many

drug court participants may be represented by defense counsel, once they have entered the program, they may have more frequent interactions with their probation officers than with their attorneys. It therefore may be left up to the probation officer, as a practical matter, to keep participants informed of their obligations and responsibilities in the program.

It is often useful to provide participants with drug court handbooks that have been written at or below the sixth grade reading level. It is also helpful to provide them with written behavioral contracts and handouts to remind them about their responsibilities, to hang up reminder posters on the walls of the probation office, and to have the participants complete quizzes about the terms and conditions of probation.

VI. [§5.13] ACCOUNTABILITY TECHNOLOGY

There are continuing advances in monitoring technologies that can make community supervision substantially more effective. One obvious technology that continues to improve is drug testing. Hair, saliva, and sweat have now joined urine testing and blood testing as part of the testing continuum. It is, of course, essential to evaluate the research supporting the validity of these technologies (that research is reviewed in Chapter 6, "The Fundamentals of Drug Testing"). Keep in mind, however, that experience in the field has shown that sometimes a new technology does not meet the claims that were made when the product was first introduced by the developer. Although a technology might be shown to be effective and efficient in controlled laboratory settings, it might turn out to be much less useful and reliable in the real world of criminal justice. It is often a very good idea for the judge and drug court team to seek information from the supervision officer about his or her experiences with a particular technology.

There are some tried-and-true tools that have been upgraded or downsized to make them easier to use. For example, portable breath testers are now simpler to operate, smaller, and cheaper than ever before. These devices are critical tools for all types of drug court programs. Alcohol is a disinhibitor, and the risk of relapsing on one's drug of choice (e.g., cocaine) is considerably increased with every drink of alcohol.[5] Portable breath tests should, therefore, be used at every point of contact with drug court participants.

Drug testing is a key component of drug courts:

- *Urine, hair, saliva, and sweat can be tested*
- *Portable breath-testing machines are useful*
- *24-hour monitoring devices such as SCRAM can reduce use*

There are also transdermal detection devices that can offer 24-hour monitoring of alcohol ingestion. For example, the Secure Continuous Remote Alcohol Monitor (SCRAM) is an anklet device that can detect alcohol vapors in sweat and transmit the data wirelessly to a remote monitoring facility. Research shows that such devices can reduce alcohol use among DWI offenders and drug offenders.[6] They are also good tools to augment

drug-refusal skills and support early recovery because they provide a constant reminder to the participant about the risk of detection. The participant can also use the device as an excuse to resist a "friend's" offer of alcohol.

There are various versions of home-monitoring equipment that rely on telephone technology. If participants have phones, they can be called on a random basis or during curfew hours, and a photograph plus a breath sample can be immediately taken and the results transmitted to the probation department. Similar kiosk systems exist and can be placed in public access locations such as police stations, courthouses, or treatment clinics. Global Positioning Systems (GPS) can be used to monitor area restrictions and document whether a participant was in a restricted location, such as a bar, alcohol beverage store, or drug house.

Each new generation of ignition interlocks gets better. However, the human imagination is boundless, and for every machine there will be someone who finds a way around it. For this reason, human supervision should not be suspended in lieu of machine detection. For example, anecdotes abound relating to efforts to beat interlock devices. One such anecdote concerns a woman who used a glove compartment-sized tire pump to "breathe" alcohol-free air into the device. Police reportedly only learned about this practice from a jailhouse informant. This suggests that there is no substitute for old fashioned supervision in ensuring that these monitoring technologies are being used correctly and effectively. Even with all the available technology, the best supervision is done by probation and community supervision officers in the field, during nongovernmental hours, enforcing the orders of the court and building offender accountability.

VII. [§5.14] JURISDICTION OVER PARTICIPANTS

Drug court judges must always consider who will be conducting supervision of participants who live outside of the immediate jurisdiction where the offense occurred and the case was prosecuted. It may be necessary to consider transferring probation supervision of such participants to another jurisdiction, if possible. The county of residence might be willing to accept the transfer and perform what is referred to as "courtesy supervision." Under such circumstances, however, it is essential to ensure that the supervision and other drug court services such as treatment will be at the desired level and intensity for a drug court. Other issues must also be considered and resolved. For example, how will the drug court deal with violations of probation or remands in another county? Which agency will pay to transport the arrested participant back to the drug court? It is for these for reasons that many drug courts exclude those who live outside the jurisdiction.

Although transfers of jurisdiction and courtesy supervision are often possible within a given state or commonwealth, there may be practical hindrances that must be overcome. If multiple supervision agencies are available locally to assist, then the matter may be fairly simple to accomplish. In some instances, however, the transfer may be to a remote or rural area that has few supervision services available. If adequate services are not available, the drug court may need to consider denying the transfer request.

Transfers between different states must be accomplished in accordance with the Interstate Compact. The Interstate Compact was created in 1937 and renewed in 2001. Forty-seven states belong to the Interstate Compact. This is a difficult and time-consuming process. Interstate Compact staff members are generally overwhelmed with requests and are chronically short staffed. It is a difficult job under the best of circumstances. For more information, www.interstatecompact.org provides local representative contacts, regional information, forms, and the history of the Interstate Compact. Many border cities and counties resolve such matters quietly on a local level, by simply calling a nearby drug court and asking for a local transfer between courts by courtesy supervision. However, serious concerns can erupt if a major crime is committed by an out-of-state probationer.

Be aware of opportunities for shared or transferred jurisdiction if the participant does not live within the court's jurisdictional boundaries.

VIII. [§5.15] MEMORANDA OF UNDERSTANDING

It should be apparent from the foregoing discussion that community supervision is a multifaceted and critical service for drug court programs. As with all team-member agencies, the best practice is for a drug court to create a memorandum of agreement (MOA) or memorandum of understanding (MOU) with each of the relevant community supervision agencies concerning the required level of training and experience of the officers, work hours, caseload sizes, and a clear description of the services to be rendered, including the scope of field services and searches to be performed. This allows all parties to be clear about the duties and responsibilities of the supervision team. Without an MOA or MOU, it is difficult to measure performance against clear expectations. Because community supervision is such a central and critical component of an effective drug court, it is essential that all parties' expectations be clearly defined and enforceable. This will ensure that the program is providing the appropriate degree of service and accountability that is rightfully expected by the program's stakeholders and partners, the participants themselves, and the community at-large.

RECOMMENDED READINGS AND RESOURCES

Harberts, Helen. 2007. Probation Strategies. In *Drug Courts: A New Approach to Treatment and Rehabilitation,* edited by James E. Lessenger, and Glade F. Roper, 355–376. New York, NY: Springer Science and Business Media, LLC.

Marlowe, Douglas B. 2003. Integrating substance abuse treatment and criminal justice supervision. National Institute of Drug Abuse (NIDA), *Science & Practice Perspectives* August: 4–14.

Reinventing Probation Council, Center for Civic Innovation. 1999. *'Broken Windows' Probation: The Next Step in Fighting Crime* (Civic Report No. 7). New York: The Manhattan Institute.

Taxman, Faye S., Eric S. Shepardson, and James M. Byrne. 2004. *Tools of the trade: A guide to incorporating science into practice.* U.S. Department of Justice, National Institute of Corrections.

1 Carey, Shannon M., Michael W. Finigan, and Kimberly Pukstas. 2008. *Exploring the key components of drug courts: A comparative study of 18 adult drug courts on practices, outcomes and costs*. Portland, OR: NPC Research. *Available at* www.npcresearch.com.

2 Marlowe, Douglas B., and Conrad J. Wong. 2008. Contingency Management in Adult Criminal Drug Courts. In *Contingency Management in Substance Abuse Treatment,* edited by Stephen T. Higgins, Kenneth Silverman, and Sarah H. Heil, 334–354. New York: Guilford Press.

3 Marlowe, Douglas B. 2008. Application of Sanctions [Monograph Series No. 9]. In *Quality Improvement for Drug Courts: Evidence-based Practices,* edited by Carolyn Hardin & Jeffrey N. Kushner, 107–114. Alexandria, VA: National Drug Court Institute.

4 Taxman, Faye S. 1999. Graduated sanctions: Stepping into accountable systems and offenders. *The Prison Journal* 79: 182–204.

5 McKay, James R., Arthur I. Alterman, Megan J. Rutherford, John S. Cacciola, and A. Thomas McLellan. 1999. The relationship of alcohol use to cocaine relapse in cocaine dependent patients in an aftercare study. *Journal of Alcohol Studies* 60: 176–180.

6 Flango, Victor E., and Fred L. Cheesman. 2009. Effectiveness of the SCRAM Alcohol Monitoring Device: A preliminary test. *Drug Court Review* 6: 113–144.

Chapter 6

The Fundamentals of Drug Testing

Paul Cary, M.S.

I. [§6.1] INTRODUCTION 117
II. [§6.2] DRUG TESTING RATIONALE 117
III. [§6.3] SPECIFICITY IN THE CLIENT CONTRACT 117
IV. [§6.4] SPECIMEN OPTIONS 118
V. [§6.5] SAMPLE COLLECTION ISSUES 123
VI. [§6.6] SELECTING THE DRUGS TO BE TESTED 125
VII. [§6.7] TESTING METHODS 125
VIII. [§6.8] RESULT INTERPRETATION 128
IX. [§6.9] URINE DRUG LEVELS 132
X. [§6.10] DRUG DETECTION TIMES 133
XI. [§6.11] SPECIMEN TAMPERING 134
XII. [§6.12] CLIENT EXCUSES 137
XIII. [§6.13] ALCOHOL ABSTINENCE MONITORING ETG AND ETS 137
XIV. [§6.14] CONCLUSION 138
A. [§6.15] Ten Principles of a Good Testing Program 139

I. [§6.1] INTRODUCTION

Effective abstinence monitoring of drug court clients through the use of drug-detection procedures is essential for program success. Drug testing provides an objective means of determining recent drug use. As the drug court judiciary works to define behavioral expectations by establishing compliance boundaries required for continued client participation, drug testing serves to monitor participant behavior so that the court may direct intervention strategies that promote an abstinent lifestyle. In order for case adjudication to be appropriate, consistent, and equitable, drug detection procedures must produce results that are scientifically valid and forensically defensible. This section will highlight some of the fundamental components necessary for developing and maintaining a successful drug-testing program.

II. [§6.2] DRUG TESTING RATIONALE

Key Component 5 of the Ten Key Components (included on page 217 of this benchbook) states: "Abstinence is monitored by frequent alcohol and other drug testing."[1] The benefits of drug testing in a therapeutic court environment are numerous. Drug testing:

Drug testing can provide courts with the data to aid clients in achieving recovery goals.

- Provides a deterrent to future drug usage—a therapeutic tool as participants develop and refine their coping and refusal skills aimed at rejecting new drug use opportunities;
- Identifies clients who are remaining abstinent and guides incentives or rewards;
- Identifies drug court participants who have relapsed, allowing for (1) rapid intervention, and (2) effective utilization of finite court resources by targeting those participants who most need assistance;
- Provides incentive, support, and accountability;
- Serves as an adjunct to treatment.

Achieving success in overcoming substance abuse often focuses on guiding clients up and out of despair while at the same time assisting them in avoiding a disastrous relapse. Successful abstinence monitoring via drug testing can provide drug courts with the requisite data to aid in attaining these recovery goals.

III. [§6.3] SPECIFICITY IN THE CLIENT CONTRACT

Defining client expectations in a drug court setting begins before the first sample is ever collected. The client contract should serve as an instructional instrument—both detailing the court's benchmarks and the participant's obligations associated with

the drug-testing process. The following examples are designed to provide greater specificity to the language of the drug court client contract as it relates to abstinence monitoring. Sample contract language includes the following:

Establish clear, written rules for drug testing.

> *I understand I will be tested for the presence of alcohol and other drugs in my system on a random basis according to procedures established by the drug court team and/or my treatment provider.*
>
> *I understand that I will be given a location and time to report for my test.*
>
> *I understand that it is my responsibility to report to the assigned location at the time given for the test.*
>
> *I understand that if I am late for a test, or miss a test, it may be considered as a positive test for alcohol or other drugs and that I may be sanctioned.*
>
> *I understand that if I fail to produce a urine specimen or if the sample provided is not of sufficient quantity, it may be considered as a positive test and that I may be sanctioned.*
>
> *I have been informed that the ingestion of excessive amounts of fluids can result in a diluted urine sample, and I understand that my urine sample will be tested to ensure the sample is not diluted.*
>
> *I understand that if I produce a diluted urine sample it may be considered as a positive test for alcohol or other drugs and that I may be sanctioned.*
>
> *I understand that substituting or altering my specimen or trying in any way to modify my body fluids or other specimens for the purposes of changing the drug-testing results will be considered as a positive test for drugs/alcohol and will result in sanctioning and may be grounds for immediate termination from drug court.*

Clearly establishing the court's ground rules in advance and communicating those expectations to participants (and staff) promotes compliance, reduces confusion, and mitigates concerns over potential sanction inequalities.

IV. [§6.4] SPECIMEN OPTIONS

Rapid technological advances in drug testing over the last decade have resulted in the development of reliable and accurate testing methods in a variety of specimens. The types of specimens that can routinely be used for court-mandated drug detection purposes are numerous. However, each specimen is unique and offers a somewhat different profile of a client's drug-use behavior over time. In addition, each specimen has distinct strengths and weaknesses when used in a criminal-justice

environment. Table 1 illustrates some of the major characteristics associated with common drug-testing specimens.

Table 1. Advantages and Disadvantages of Drug-Testing Specimens

Specimen	Detection Period	Advantages	Disadvantages
Urine	Provides a profile of both current and recent past substance usage. Detection time generally calculated in days for most drugs (excluding alcohol). See Table 4 which outlines additional detection window estimates.	• Provides detection for both recent and past usage. • Sample is generally available in large quantities for testing. • Drug and metabolites are highly concentrated; therefore easily detectable using both laboratory-based and on-site testing devices. • Numerous inexpensive testing options including on-site testing. • Uniform forensic criteria supported by years of court/legal case law and adjudication. • Established cutoffs.	• Invasive "witnessed" collection procedures required—necessitates same gender observed collections. • Specimen is susceptible to tampering via dilution or adulteration. • Drug concentration influenced by fluid intake; savvy clients may consume copious fluids to alter testing results. • Sample collection process can be time consuming. • Urine drug levels provide no interpretive data (no dose/concentration relationship).
Sweat (Patch)	Measures current (ongoing) drug use following patch application; past exposure not detected. Patch is FDA approved to be worn for up to 7 days.	• Ability to monitor 24/7 for extended periods, which provides a significant adjunct to the therapeutic process. • Relatively client tamper-proof. • Use has participant acceptability due to noninvasive approach. • Increased deterrent to drug use. • Cross-gender collections.	• Cannot detect prior drug exposure. • Limited collection devices and testing laboratories. • Potential risk of contamination during patch use. • Can be removed. • Limited number of drugs detected. • No on-site testing.
Oral Fluid (Saliva)	Provides recent usage detection. Many drugs cannot be detected beyond 24 hours after use.	• Noninvasive, cross-gender collections. • Specimen tampering reduced. • Data may relate to behavior/performance. • On-site testing available (but not recommended).	• Short detection window. • Specimen collection can be time consuming. • Limited collection devices and testing facilities. • Cutoffs not well established. • Limited number of drugs detected. • On-site testing devices pose forensic concerns regarding accuracy and reliability.

Specimen	Detection Period	Advantages	Disadvantages
Hair	Provides past drug usage only; detection period up to 90 days. Does not provide recent drug-use information (hair required to grow out of scalp prior to sample acquisition).	• Extended detection period. • Noninvasive, cross-gender sample collection. • Reduced specimen tampering. • No biohazard issues. • No poppy seed interference.	• Increased cost per sample tested. • Inability to detect recent drug usage. • Limited number of testing facilities. • No on-site testing. • Continuing concerns regarding ethnic, hair-color bias. • Use of "body" hair forensically controversial. • Testing may not detect single drug use event. • Date of drug use cannot be assessed.
Blood	Detects very recent usage of abused substances; detection time often measured in hours following use.	• Results both qualitative and quantitative may provide behavior/performance data in select circumstances such as driving while impaired (DWI). • Specimen tampering eliminated.	• Invasive sample collection—venipuncture required by medical staff. • No on-site testing. • Traditional urine-testing methods not applicable to blood analysis. • Limited sample volume can be obtained. • Detection of abused drugs in blood difficult for many laboratories due to low levels of drug. • High potential for false negative results. • Specimen not recommended for drug court abstinence monitoring.
Eye Scanning/ Pupilometer Instruments	Designed to determine impairment, recent use monitoring client only. Detection time measured in hours.	• No specimen collection. • On-site devices, immediate results. • Ease of operation.	• Monitors impairment rather than abstinence. • Short detection window. • May require additional specimen collections to confirm positives. • Not peer reviewed. • Devices may detect client fatigue as "positive."

There is no perfect drug-testing specimen—each has advantages and disadvantages, and each provides a somewhat different picture of a client's drug use history. Despite the variety of specimen types, urine remains the specimen of choice for drug court abstinence monitoring. With its longstanding history, urine is accepted as the gold standard for drug testing. In addition to the advantages listed in Table 1, most of the published scientific literature and legal/court precedence associated with drug testing has been established with urine. Further, its widespread use in workplace testing has resulted in standardized certification of urine-testing laboratories that has culminated in recognized quality practices. Urine has taken on additional importance with the advent of alcohol metabolite testing, such as ethyl glucuronide (EtG) and ethyl sulfate (EtS), which is discussed in greater detail later in this chapter.

Although urine may represent the specimen of choice for drug testing, sweat, oral fluids, and hair have also been accepted as alternative or complementary specimens for criminal justice applications. Transdermal alcohol detection devices (worn as ankle bracelets) have also demonstrated effectiveness for both detection and deterrence. Some of these alternative specimens have acknowledged benefits over urine particularly in their reduced susceptibility to tampering and the elimination of direct observation of collections (which require same-gender collectors). But, as noted in Table 1, there are also disadvantages associated with alternative specimens that the entire drug court team must take into account.

Factors to be considered in selecting a drug-testing specimen include goals of the monitoring program; personnel collecting the sample (level of training); volume of testing (which often influences the cost per test); list of drugs to be screened (not all drugs can be easily detected in every specimen type); turnaround time for results (critical for effective therapeutic intervention); and availability of testing. The overall cost associated with drug testing can vary widely between specimen types and between laboratory-based versus on-site testing devices. The adage "you get what you pay for" is especially relevant to drug testing. Drug courts should evaluate cost-benefit differences closely before choosing a specimen type or a testing method. Those courts relying on a lowest bid request for proposals (RFP) should develop those requests with sufficient detail and safeguards to ensure the integrity of the testing. The ability to access drug-testing results quickly and obtain expert technical assistance in addressing questions or concerns should not be overlooked.

When selecting a method of testing, consider:

- *Program monitoring goals*
- *Personnel availability and training*
- *Volume*
- *Drugs to be tested*
- *Report time*
- *Cost*

The choice of a drug-testing specimen must be veiwed in both a forensic and therapeutic context. Obviously, the court wants to ensure that drug-testing results are valid and legally defensible. But in a problem-solving court, the judiciary also needs to make certain that a

drug-testing specimen is *therapeutically* beneficial—a result that will support recovery. It is not sufficient for a specimen (or test) to simply provide an accurate profile of a client's drug use. It must also provide those results in a time frame that allows for rapid intervention using therapeutic measures in order to maximize behavioral change.

As an example of this therapeutic imperative, consider the advantages and disadvantages of hair as a specimen for drug testing in a drug court environment. While the ability of this specimen to extend the detection window back ninety days is a significant advantage, this benefit is tempered by the fact that hair testing does not have the ability to detect recent drug usage. Depending on the client, it may take anywhere from seven days to two weeks for head hair to grow out of the follicle (the part of the scalp that grows hair by packing old cells together) and obtain sufficient length for sampling. In other words, drugs cannot be detected or tested in a hair sample until approximately two weeks after the use of the drug. Consequently, if the goal of drug court is rapid therapeutic intervention in order to successfully modify behavior, hair testing does not serve this purpose well. Sanctioning a client several weeks after the prohibited drug use event likely promotes little behavioral change. The client's ability to link the offending behavior and the court-directed consequence is undoubtedly limited; therefore, the therapeutic value of a sanction (or incentive) is significantly diminished.

Oral fluid drug testing in the criminal justice environment has received considerable attention because the collection of this specimen is noninvasive, eliminates the need for same-gender collectors, and specimen tampering is significantly reduced. However, here again, the therapeutic aspects of oral fluid drug testing must be considered. While promotional efforts to market oral fluid testing may suggest otherwise, the scientific literature generally concludes that the drug detection window for abused substances in oral fluids is approximately twenty-four hours. Put another way, if a client smokes marijuana on a Monday morning, cannabinoids will likely not be detectable on Tuesday afternoon using oral-fluid-detection approaches. This limited detection window constrains the court's ability to provide a surveillance strategy that effectively monitors long-term abstinence and may hamper the use of meaningful incentives and sanctions.

The judiciary has relied on blood-testing data for decades in making sentencing decisions, most notably, the interpretation of blood alcohol concentrations for the purposes of establishing intoxication and impairment. However, blood testing for abused substances is generally *not* recommended and should be avoided for client surveillance in a drug court environment. Unlike urine testing, which tests primarily for drug metabolites using a longer detection window, blood analyses often attempt to identify the parent (unmetabolized) drug compound. For many abused substances, the parent drug is only detectable for a matter of hours, rendering blood testing not amenable to an abstinence monitoring program. Blood also represents a rather dirty specimen because it contains protein, blood cells, lipids, etc., and is obtainable in only limited quantities, making blood a much more challenging drug-detection matrix. The use of traditional urine assays to screen blood samples is strongly discouraged because urine cutoffs are not appropriate for the concentrations of drugs in blood (producing many false negative results). Blood drug testing is more commonly employed in medical examiner death investigations or in driving while impaired by drugs (DWI-D) cases.

V. [§6.5] SAMPLE COLLECTION ISSUES

Particularly for urine, sample collection procedures may represent the single most important component of a credible drug court abstinence monitoring program. Failure to collect a valid sample puts at risk the court's confidence that the testing accurately reflects client drug-use behavior. If clients, in order to avoid detection of surreptitious drug use, tamper with their sample, then procedures and provisions put in place to ensure quality results may be rendered useless. Requiring two essential elements can significantly enhance valid urine sample collections: random client selection and witnessed collections.

For testing to correctly assess the drug use patterns of program participants, it is crucial that samples be collected in a random, unannounced manner. The more unexpected and unanticipated the collection regime, the more accurately the testing results will reflect the actual substance use of a drug court client population. Drug courts need to appreciate the value of the element of surprise from an abstinence monitoring standpoint (relapse detection). If clients never know when they are going to be tested, then opportunities for them to use drugs during known testing gaps are reduced. As a result, unexpected collections have a better chance of identifying new use if it has occurred. Further, if clients never know when they are going to be tested, opportunities for them to engage in sample tampering strategies to avoid detection are also reduced. Some testing protocols mistake frequency for thoroughness. In other words, believing that testing three to four times per week (e.g., Monday, Wednesday, Friday) is equally sufficient and effective coverage may be erroneous because it is on a predictable schedule. Courts that relinquish the element of surprise do so at their own risk and may fall victim to creative clients who may find opportunities to subvert the program's objectives.

Test as often as you can afford, but twice a week is the minimum.

Another strategy that diminishes the opportunity for participants to engage in sample tampering tactics is limiting the time period between client notification of a drug test and the time that the sample collection actually occurs. While there are numerous factors that constrain the court's sample collection timing and a client's ability to travel to the collection site, it is important to limit the interval between notification and collection. The more effective a court is at shrinking this time period (should be no longer than a few hours), the greater the success of the program's deterrent and monitoring efforts.

Developing multiple and evolving techniques to randomize the sample collection process is essential. The use of code-phone or automated call-in systems and surprise home contacts are just two techniques to further randomize the sample collection process. The American Probation and Parole Association's drug-testing guidelines state: "The greatest weakness of scheduled collections is that clients may also schedule their drug use to escape detection."[2] Similarly, the Drug Court Clearinghouse and Technical Assistance Project at American University, funded by the Office of Justice Programs, recommends as follows: "Random testing prevents participants from planning ahead and avoiding detection."[3]

The importance of witnessed collections (for urine monitoring) cannot be overemphasized. Urine collections that are not witnessed (direct frontal observation) may be of little or no assessment value in determining a client's recent drug use history. Courts must understand the nature of the disease that is substance abuse. The ramifications of a positive drug test (sanction, imprisonment, etc.) combined with the denial component of substance abuse are sufficient motivations for clients covertly using drugs to tamper with their sample to produce a false negative finding. The success of testing procedures is predicated on a valid specimen. The most successful guarantee that clients will produce a legitimate specimen is direct observation of collections. Drug courts can employ the best testing methods available; however that testing may be worthless if the sample has been tampered with by the participant prior to the analysis. Courts should be creative in establishing evolving procedures designed to create multiple sample collection schemes. For example, this may involve altering the days and times of the week for collection, collecting a client sample early in the day and another unscheduled sample later that same day, collecting samples on sequential days, or collecting samples during surprise home contacts. When reviewing progress reports prior to drug court, a judge should be mindful of whether testing dates appear to be consistent with predetermined testing schedules.

A witnessed urine collection necessitates same-gender observation. It is understood that this obligation can pose a hardship for some programs with a disproportionate number of male clients and female staff or vice-versa. However, because of the importance of direct observation, court programs should be committed to developing appropriate solutions. Support agencies (treatment, law enforcement, schools, healthcare providers, etc.) should be enlisted to assist court staff with problematic collection situations. Many drug courts have a primary collection agency such as probation or treatment. These collection services can be augmented, by agreement or contract, with other agencies to increase the number of collections or aid in same-gender collections. In any case, when more than one agency is collecting samples for drug court, it is important for the program to review collection protocols carefully to ensure consistency.

The frequency of court-mandated drug screening is largely dependent upon specimen type, but is also dictated by client compliance, program phase, and court resources. Drug testing should be performed as often as the court budget will allow, particularly in the early stages of the program—when the court is establishing client expectations and boundaries. For comprehensive surveillance, urine drug testing should be performed at least twice per week. Not all drug court participants require testing at the same frequency. Individuals suspected of tampering and those clients with behaviors that suggest relapse should be tested more often (progressive testing strategies). Programs should strive to design testing patterns that fit the drug use profiles of the individuals being tested. All drug court clients are different—drug of choice, duration of use, motivation to succeed in the program, access to therapeutic resources, life skills, etc. It is useful to incorporate these unique aspects in creating client-specific testing regimens. For example, if a client's drug of choice is cocaine (a drug with a rapid elimination profile), that participant may require drug testing at an increased frequency in order to maintain sufficient abstinence surveillance. Consultation with drug court team members can provide valuable insights when developing client testing schedules.

The recognition that drug court samples represent forensic evidence necessitates appropriate specimen handling and possession protocols. Correctly annotated custody and control documents, tamper-evident sample seals, and locked storage compartments should be compulsory. Laboratory results are often called into question not because of scientific-related deficiencies, but because of the inability to establish a simple chain of custody.

VI. [§6.6] SELECTING THE DRUGS TO BE TESTED

The drugs included in abstinence monitoring detection should be a reflection of the substances being abused or used within the community or jurisdiction of the court. While laboratories and on-site vendors will offer predesigned drug-testing panels, the court should evaluate the population being tested and determine the most appropriate substances to be screened. Seeking input from law enforcement and treatment professionals can aid in the development of a suitable drug screening list. At a minimum, drug courts should consider screening for amphetamines, barbiturates, benzodiazepines, cannabinoids (marijuana), cocaine, opiates, and alcohol. Certain substances, such as steroids, inhalants, and hallucinogens, are difficult to detect using routine methods, or the testing can be cost prohibitive.

VII. [§6.7] TESTING METHODS

The drug detection methods used for drug court proceedings should meet three important criteria. The drug tests should be:

- Scientifically valid (utilize methods that employ proven technologies accepted by the scientific community and evaluated in peer-reviewed journals);
- Legally defensible (able to withstand legal challenge and have an established court track record that has undergone legal/judicial scrutiny);
- Therapeutically beneficial (able to provide an accurate profile of clients' drug use, produce rapid results for appropriate court responses, and quick treatment intervention as required to change behavior and support recovery).

The analytical process used by most forensic drug-testing programs utilizes a 2-step approach. The preliminary step (screening) is designed to differentiate samples that contain no detectable drugs from those samples that produce a reaction in the initial testing phase. Using urine as the sample for drug testing, this screening can be performed on-site (utilizing rapid test devices or instrumentation) or via laboratory-based testing. Samples that produce an initial positive determination (usually conducted by an immunoassay-based test) are often referred to as "presumptively positive." However, given that structurally similar substances can produce a positive test reaction in the absence of the target compound (actual drug being assayed), it is necessary to validate positive screening results in order to rule out the potential of a false positive by performing a confirmation procedure.

The second step, confirmation, is the process by which the positive results of the screening test are authenticated by reanalysis of the sample by an alternative testing method. Put another way, samples that are positive by the screening assay are double-checked using a second, *different* test to ensure that the first test was indeed accurate. Gas chromatography-mass spectrometry (GC-MS) provides chemical fingerprint identification of drugs and is recognized as the definitive confirmation technology. Confirmation of a presumptive positive test is one of the surest techniques to eliminate false positive results. A confirmation policy adds a greater level of fairness and certainty to the drug-testing process, while at the same time minimizing potential legal issues concerning the validity of test results. Unless a client admits to using the drug identified by the screening procedure (whether on-site or laboratory-based), confirmation of presumptive positive tests should be mandatory.

The imposition of sanctions can be traumatic for clients and can even be disturbing for court professionals with vested interests in their clients' success, particularly if there are concerns about the validity of the test results. A positive drug test is often the stimulus for court-imposed consequences. Doubts regarding the accuracy and reliability of drug-testing procedures can exacerbate those concerns over participant punishment. The confirmation of positive test results provides a large measure of confidence to the court's decision-making process and allows the judiciary to sanction clients without fear of wrongful or inappropriate penalties.

Client excuses or explanations for a positive drug test often include claims that over-the-counter (OTC) medications are the source of the "erroneous" results. And indeed, some OTC products can result in cross-reactivity or interference with testing that relies primarily on immunoassay methods. Regrettably, there is no master list that compiles all of the known medications and their propensity to cause false positive drug-testing results. Each drug method, from each manufacturer, has its own unique specificity toward potentially interfering compounds. As previously stated, confirmation of positive results resolves nearly all of these concerns. Questions related to cross-reactivity and specificity on screening tests should be directed to the drug test manufacturer. But beyond that, no drug court client should be allowed to consume OTC medications, poppy seeds, homeopathic preparations, vitamins, or supplements without express approval from the court. In addition, the prohibition of these products should be included in the drug court client contract.

It is understood that confirmation testing can represent an additional cost to the court. However, many programs shift this burden to the drug court participant. Clients' willingness to pay for their own confirmation procedure may indicate the sincerity of their denial. Making drug court clients pay for confirmation may also provide therapeutic leverage to break the denial process by encouraging admission of use of prohibited substances. This leverage can often be enhanced by program policies that increase the severity of imposed sanctions associated with a confirmed positive result (i.e., client is informed that sanctions will be doubled if usage is denied and the screening result is subsequently confirmed as positive). The cost of confirmation testing may be waived or reimbursed to clients in the event of a failure to confirm the result. Confirmation,

however, should not be withheld because a client cannot pay up front; find alternative forms of "payment" such as volunteer work. All clients should have equal access to confirmation and should clearly understand that they will be responsible for the cost if it is indeed positive.

Uncertainty in testing results can have a devastating effect on a drug court's ability to create lasting behavioral modifications in clients and can be discouraging to drug court personnel responsible for treatment, case management, and sanction imposition (judges). When drug testing is performed on site, within the purview of the court, it becomes the responsibility of the court, and ultimately the judge, to guarantee that the testing is accomplished in a forensically acceptable manner. Vigilance is required to ensure that quality testing products are used, that competently trained staff members perform the testing, and that resources for confirmation are readily available.

Regardless of the skill level of drug court personnel, the accuracy and reliability of results using on-site drug-testing procedures will likely not be equivalent to results obtained from a qualified forensic drug-testing laboratory. Research studies evaluating on-site testing versus laboratory-based analysis support this conclusion. This is not to suggest that on-site drug testing is somehow inherently imprecise and unreliable. The value of near-instant results is undeniable. The ability of the court to swiftly respond in an effort to enhance behavioral change is well recognized. However, precautions need to be taken to make certain that the client does not suffer untoward consequences because of the court's desire to achieve speedy results. The importance of confirmation of on-site positive tests cannot be overstated; however, it should again be noted that an on-site positive test might result in the client admitting to recent drug use. The use of effective on-site testing devices that have demonstrated accurate and reliable characteristics is also very important. Table 2 lists the advantages and disadvantages of on-site versus laboratory-based drug testing.

Judges should be aware of the significant concerns posed by drug testing performed outside the purview of the court. In an effort to refute court-mandated drug-testing results, on occasion, clients may attempt to obtain testing from alternative sources not under the court's control or supervision. Client advocates who believe (rightly or wrongly) that the court's procedures are flawed may encourage these alternative tests. The admission of these client-generated drug test results should only rarely be allowed into court proceedings as exculpatory evidence, and only under clearly defined conditions. The court rarely has insight into how these alternative tests were performed, under what circumstances the samples were collected, or even whether the sample tested belongs to the client in question. If the court requires independent validation of a positive test, the retesting should always be conducted on the original specimen—not one collected at a later time. Therefore, the court should arrange for all positive samples to be retained under proper custody and control procedures for some finite period of time following testing. Frozen or refrigerated sample retention, either by the off-site laboratory or by on-site testing personnel, for several weeks should allow sufficient time for independent testing to be requested, if necessary.

Table 2. On-Site Versus Laboratory-Based Drug Testing

Type	Advantages	Disadvantages
On-Site Drug Testing	• Rapid result turn-around time (quick reward for drug-free behavior or quick justification for sanctions). • Ease of use technology. • Potential for reduced testing costs. • No capital equipment expenditures. • Reduced training costs. • Elimination of specimen transport and storage issues.	• Increased cross-reactivity and interference (potential false positive results). • On-site testing often does not include quality control. • On-site testing often does not include testing for diluted samples (creatinine) and adulteration testing. • Testing personnel competency is often not assessed. • Reduced flexibility in testing panels (limited number of drugs tested). • Potential privacy or conflict-of-interest concerns.
Laboratory-Based Drug Testing	• Testing often provided by professionally trained technologists. • Use of approved scientific methods. • Integrated quality assurance. • Confirmation testing more readily available. • Creatinine and adulteration testing more readily available. • Toxicology expertise/forensic competency. • Established custody and control procedures.	• Increased result turn-around time (compared to on-site testing). • Additional sample handling and shipment required. • Potential increased cost per test. • Difficulty in accessing data and information from large corporate laboratories.

VIII. [§6.8] RESULT INTERPRETATION

The drug court judiciary should recognize that there is often a gap between the questions that legal professionals would like to have answered by drug testing and the answers that the scientific community can legitimately provide. All too often court personnel draw unwarranted or unsupportable conclusions from drug-testing results that would not withstand scientific challenge or legal scrutiny. While it may be unnecessary for a drug court judge to be knowledgeable about the arcane analytical aspects of the procedures employed to detect substance use, it is critical that the bench serve as a gatekeeper for the proper interpretation of drug-testing results. Failure to maintain a forensic evidentiary standard with regard to the use of drug-testing results invites controversy, challenge, and criticism.

Drug-testing cutoff levels represent an important safeguard designed to ensure the reliability of testing results. Simply put, there is no drug-testing procedure that can determine whether there is a single molecule of a drug in a client's system and each drug and each drug test has a limit of detection. Below that limit, the test cannot accurately discriminate between samples that are absolutely drug free and samples that may have a

trace amount of drugs present. In other words, at concentrations below the cutoff, drug tests can become unreliable at detecting the presence (or absence) of drugs. As a result of these analytical limitations, the goal of achieving a true zero-tolerance drug-testing program is unattainable.

A search for standardized drug-testing cutoff levels designed specifically for criminal justice programs will yield few results. Most drug-testing products (for laboratory and on-site use) use testing cutoffs that comply with workplace drug-testing mandates. While not explicitly intended for drug courts, employment-related cutoff levels routinely work well for criminal justice applications. It is recommended that drug courts utilize standardized drug-testing cutoffs. Remember, these cutoff levels were not established to frustrate the judiciary. Standardized cutoffs serve as an important safeguard both in terms of maintaining evidentiary standards and protecting client rights. These cutoffs represent an important legal and technological benchmark designed to ensure that drug testing is both scientifically accurate and legally defensible.

The court must maintain a forensic evidentiary standard for drug test results.

Every day drug courts grapple with two seemingly disparate imperatives—the need for rapid therapeutic intervention (sanctioning or incentivizing designed to produce behavioral change) and the need to ensure that the evidentiary standards, crafted to protect client rights, are maintained. Although administrative decision making in a drug court environment (or a probation revocation hearing) may not necessitate the same due process requirements and protections that exist in criminal trials, as professionals we are obliged to ensure that court decisions have a strong evidentiary foundation. Lowering cutoffs in an effort to catch clients using drugs covertly can produce unintended consequences for your program.

Commonly accepted drug-testing cutoff levels for use with drug court clients are outlined in Table 3. Note that confirmation cutoffs that utilize GC-MS methods are generally lower than those of the initial screening method. By design, confirmation is more sensitive and selective than screening techniques.

Isn't any amount of drug in a client's sample a violation worthy of sanction? This question provides clear delineation between the *punishment* model of drug testing and the *therapeutic* model. In the punishment model, the goal of testing is to identify client behaviors that require some form of retribution-type consequences (e.g., probation revocation, incarceration). By contrast, the therapeutic model is designed to enhance behaviors that lead to recovery. Learning to grapple with addiction is a gradual process. The step-wise reduction and eventual elimination of client resistance to change is critical. Given that drug testing is a large component of the drug court experience, its perceived fairness is also critical to outcomes. Unfortunately, drug testing has the potential to build resistance, particularly if a client is falsely accused by a test (or court policy) that stresses a zero tolerance approach. From a therapeutic perspective, it may be better to let a client get away with one, rather than risk a false accusation that could lead to the reestablishment of client resistance. The result of resistance may be learned helplessness and the loss

of engagement by the client with the drug court process. This is not to suggest that clients should not be held responsible for contractual violations. Consequences for prohibited behavior are also critical to outcomes. But, the prudent use of drug-testing results can certainly enhance the path to recovery.

Table 3. Commonly Accepted Drug Testing Cutoff Levels

Drug	Screening Cutoffs (in ng/mL)	Confirmation Cutoffs (in ng/mL)
Amphetamines	500 or 1000	500
Barbiturates	200 or 300	100–300
Benzodiazepines	200 or 300	100–300
Cannabinoids	20–50	15
Cocaine Metabolite	150 or 300	150
Opiates[4]	300	100–300
Phencyclidine (PCP)	25	25
Alcohol	variable	10 mg/dL

Drug-testing results reported as *none detected* or *negative* indicate that no drugs or their breakdown products (metabolites) were detected in the analyzed sample at the cutoff level of the test. This does not necessarily indicate that there are no drugs present. A negative drug test may not always indicate abstinent behavior. It is not uncommon for an individual's urine to contain a level of drug below the cutoff point. In other words, negative does not mean zero—thus samples yielding a drug concentration below the cutoff level of the test are defined as "negative" or "none detected" because the test may not be capable of reliably detecting the drug at concentrations below the cutoff. Generally speaking, a reported negative test result should not be interpreted in any manner other than negative. Attempting to evaluate results below the cutoff (e.g., borderline negatives) is fraught with pitfalls and may have untoward forensic consequences. Based on a negative test result, two interpretations are possible:

- The client is not using a drug that can be detected by the test;

OR

- The client may be using one of the drugs detected by the test *but*:
  - is not using a sufficient dose to be detected;
  - is not using the drug frequently enough to be detected;
  - the urine is being collected too long after drug use (i.e., the drug has been eliminated from the body);
  - the urine sample tested was diluted or otherwise tampered with;
  - the drug test was not sufficiently sensitive to detect the drug's presence;
  - the client is using a drug not on the list of substances being tested.

Because of the many potential interpretations of negative test results that are inconsistent with client abstinence, negative tests should always be assessed in the context of a client's overall program compliance (or lack thereof). It is not necessary for the court to

second-guess every negative sample or to withhold incentives and other positive reinforcement for encouraging behaviors. But the court is reminded that drug testing is a tool. It is not and should not be the sole assessment instrument of client conduct or the only determiner of therapeutic measures such as rewards and sanctions.

Establish a baseline of abstinence.

Positive urine drug test results indicate that a drug or its metabolite has been detected. In other words, the drug was present at a concentration at or above the cutoff level of the testing method. If the preliminary screen is positive for one or more drugs, confirmation is highly recommended prior to the imposition of sanctions unless the participant acknowledges the use.

Negative results produced by one specimen type (i.e., oral fluid) that are in conflict with another specimen type (i.e., positive urine test) require careful examination. While seemingly at odds, a positive and a negative test result on the same client, with samples collected in close proximity but using two different specimen types, may indeed be consistent depending upon each specimen's window of detection. Consultation with a toxicologist or qualified laboratory personnel may alleviate potential confusion associated with apparently disparate results.

The concept of a client's abstinence baseline is useful in a therapeutic court context. The abstinence baseline can either be a point at which a client has demonstrated his or her abstinence from drug use via sequentially negative testing results (*actual* baseline), or a court-established time limit after which a client should not test positive if that client has abstained from drug use (*scientific* or *theoretical* baseline). Each baseline has importance in a court-mandated drug monitoring program and can be used to establish compliance benchmarks. Drug court participants may be deemed to have reached their actual abstinence baseline when they have produced two consecutive urine drug tests both yielding negative results. Any positive drug test result following the achievement of an actual baseline indicates new drug exposure. The scientific or theoretical approach uses a court-established detection window for those drugs being screened. This scientific or theoretical baseline can be established using reference detection window databases such as in Table 4. Individuals who continue to produce positive drug test results beyond the established detection window maximums are subject to sanction for failing to remain abstinent during program participation.

A negative drug test may not always indicate abstinent behavior.

By establishing abstinence baseline parameters through consensus with drug court team members, and by alerting clients to the court's expectations, many potential benefits can be realized. These include operating procedures with a definitive result interpretation policy; reducing court indecision associated with clients who continue to produce positive results; increasing drug court team agreement on confounding cases; administering consistent consequences across the court's docket; and reducing

implausible client excuses. No abstinence baseline should replace the utilization of client-specific facts for case adjudication. Drug test results are only one of many assessment tools available to the drug court team. Courts should continue to critically evaluate a client's level of compliance on a case-by-case basis using all of the behavioral data available to the court in addition to testing results.

IX. [§6.9] URINE DRUG LEVELS

Drug detection methods used by drug courts are *qualitative*. That means that the purpose of the test is to determine the presence or absence of a drug in the sample being tested. Either a drug test is positive (drug presence at or above the cutoff concentration) or negative (none detected; drug level below the cutoff concentration). Most drug detection methods are not designed to produce *quantitative* results—i.e., how *much* drug is present in the sample. It is recognized that in the criminal justice system, the use of urine drug levels to evaluate client drug use patterns may be widespread and longstanding. However, because courts rarely have the necessary toxicology or pharmacology expertise, the routine use of urine drug levels by court personnel in an effort to define substance abuse behavior and formulate appropriately measured sanctions is a practice that can result in inappropriate, factually unsupportable conclusions and a decision-making process that lacks a sound scientific foundation.

The scientific rationale for discouraging the use of urine drug levels is both technical (issues associated with the testing methodologies) and physiological (how the human body processes drugs). First, technical: qualitative drug tests, particularly immunoassays, are not linear. Therefore, the urine drug concentrations reported by these screening tests are likely not very accurate or precise. Second, many initial screening tests detect both the presence of parent drugs and their metabolites simultaneously, meaning the numeric result reported represents a total concentration of the mixture of similar drug components. Therefore, attempting to evaluate a urine drug level based upon a total drug concentration measurement (of continually changing concentrations) is not possible.

The interpretive challenges associated with a client's physiology are equally daunting. Drug concentrations in the urine are present in proportion to the total amount of liquid in the sample tested. If the urine is diluted, the concentration of the drug is reduced, and when the urine is more concentrated, the drug concentration is increased. Urine volume or output is highly variable and is influenced by a variety of factors. Urine drug levels may vary widely within a day or between days even with no additional drug exposure as a result of fluid intake alone. As mentioned in the previous paragraph, initial screening tests for drugs detect both the presence of parent drugs and their metabolites concurrently. These drugs are eliminated from the body at differential rates, thus varying the overall test response, making any attempt to evaluate these changing urine drug levels to assess patterns extremely problematic.

Simply put, urine drug concentrations are of little or no interpretive value in assessing a client's past drug history or current use behavior. The interpretation of urine drug levels is highly complex and even under the best of circumstances, provides only limited information

regarding a participant's drug use. Further, such interpretations can be a matter of disagreement even between forensic experts with the requisite knowledge and training to render such opinions. Therefore, in order to maintain a solid evidentiary standard, drug court programs routinely interpreting urine drug levels are encouraged to transition to a strictly qualitative result format (i.e., results simply reported as positive or negative).

While the transition to a nonnumerical drug report format may be difficult, there are benefits. First and foremost, the court moves forward secure in the knowledge that its rulings have a strong scientific basis and are forensically sound. Second, the court no longer has to attempt to interpret data that is not interpretable. Third, courts that have eliminated the use of urine drug concentrations have reported greater confidence in their decision-making process. Making decisions based entirely on either positive or negative reports removes the judicial ambiguity associated with manipulating numbers that few individuals, if any, in the court environment are trained to understand. Lastly, the use of urine drug test results that do not rely on concentrations adds additional fairness and equity to the rewards and sanctions process of the drug court. By removing the unpredictable urine drug levels from the decision-making equation, courts eliminate the unsupportable foundation on which these interpretations are based.

Attempting to extract information from a drug test result in order to develop conclusions about urine drug concentrations, however well-intentioned, cannot be supported by the science and represents an adjudication practice that is simply not forensically defensible. It is not possible to fully explore the many aspects of this critical issue within the confines of this manual. However, a detailed examination of this issue is available.[5]

X. [§6.10] DRUG DETECTION TIMES

The length of time a specific drug can be detected in a sample is difficult to predict and varies between individuals. The drug detection window is dependent upon a number of factors including chemical/pharmacological properties of the drug itself, the specimen being analyzed, individual client characteristics, duration and frequency of drug use, dosage or concentration of exposure, time between drug use and sample collection, and the sensitivity and specificity (cutoff) of the testing method. The impact of these factors undoubtedly explains the wide variations that can be seen in tables purportedly showing the detection window of drugs in urine. With all of these variables (unknowns), it is not easy to calculate with certainty the detection time of any specific drug in a particular individual. Nonetheless, certain generalities can be advanced. These generalities are based on a synthesis of scientific information and published data and are presented in Table 4 for urine as the specimen. (Detection times by specimen type are presented in Table 1.)

Because of fat solubility and subsequent delayed elimination from the body, marijuana poses unique sanctioning challenges related to continued positive cannabinoid test results (i.e., continued excretion from prior usage vs. recent reexposure). Prolonged cannabinoid positive results can impede therapeutic intervention, thwart timely judicial sanctioning, and foster the denial of marijuana usage by drug court participants.

Establishing a reasonable and pragmatic detection window for cannabinoids can assist court professionals in reducing the complexities associated with marijuana-testing results. For a complete review of these issues refer to National Drug Court Institute's "The Marijuana Detection Window."[6]

Table 4. Drug Detection Windows

Drug	Approximate Drug Times in Urine
Amphetamines	1–4 days
Barbiturates	1–7 days
Benzodiazepines	1–7 days
Cannabinoids[7]	At 50 ng/mL cutoff: • up to 3 days for single event/occasional use • up to 10 days for heavy chronic use At 20 ng/mL cutoff: • up to 7 days for single event/occasional use • up to 21 days for heavy chronic use
Cocaine Metabolite	1–3 days
Opiates	1–4 days
Phencyclidine (PCP)	1–6 days
Alcohol (as ethyl alcohol) ————————- **as alcohol metabolites EtG/EtS**	variable, usually measured in hours ————————- at the 500/100 ng/mL cutoff: 24–48 hours

XI. [§6.11] SPECIMEN TAMPERING

The ramifications of a positive drug test (sanction, program expulsion, imprisonment, etc.), combined with the denial component of substance abuse, often create circumstances whereby clients feel the need to "beat the drug test" by tampering with the sample. Sample tampering represents a significant challenge to the court's mission and can threaten to undermine the legitimacy of the court's policies and procedures, as well as its decisions. Savvy drug court clients are constantly gleaning information about drug testing from a variety of sources in an explicit effort to thwart the monitoring efforts of the court. Table 5 outlines the basic urine tampering approaches and control strategies.

While witnessed sample collections can significantly reduce tampering, it is recommended that all urine samples tested for drug court purposes include testing for creatinine. Sample dilution is by far the most common tampering technique. Diluting urine is simple and cheap and is designed to produce a sample that has a watered down drug concentration that will fall below the drug testing cutoff, thus fabricating a false negative

Table 5. Urine Tampering Approaches and Control Schemes

Type	Method Description	Control Strategy
Precollection Dilution	Consumption of large volumes of fluid just prior to sample collection in an effort to dilute urine drug concentrations to below the screening test cutoff, thus producing false negative results (flushing, water loading, hydrating).	Perform creatinine levels on all drug court samples to assess specimen validity. Samples with creatinine concentrations of less than 20 mg/dL are generally considered dilute and test results do not accurately reflect a client's drug use history.
Postcollection Dilution	Addition of liquid (water, colored fluid) to sample post collection in an effort to dilute urine drug concentrations to below the screening test cutoff, thus producing false negative results.	Direct observation/witnessed collection should preclude most postcollection dilution and determine creatinine levels.
Adulteration	Addition of chemical agents (liquids or powders) to sample (postcollection) designed to disrupt testing procedures or to mask the presence of drugs.	Specimen validity testing (SVT)[8] are specialized tests capable of detecting chemical adulteration agents. Available from most drug-testing laboratories; on-site "instant" SVT devices are also available.
Substitution	Replacing client urine sample with a substitute "look-a-like" sample: • Biological substitution (e.g., another person's "clean" urine, dog urine) • Nonbiological substitution. (e.g., replacing urine with apple juice, Mountain Dew, water with food coloring)	Use of SVT combined with creatinine testing; most nonbiological samples will result in minimal creatinine concentrations.

result. Creatinine is a biological waste material that is produced by muscle metabolism. The measurement of creatinine allows the determination of the strength or concentration of a client's urine sample.

Dilute urine samples (with creatinine levels less than 20 mg/dL) are not normal occurrences. It is unusual for a healthy individual to produce a sample with a creatinine level of less than 20 mg/dL. Therefore, urine samples from drug court clients that yield a creatinine concentration of less than 20 mg/dL should be considered as *dilute* samples. Because the sample is dilute (more like water than urine), the drug test is not able to detect the presence of drugs that may be present because the drugs have been diluted to below the cutoff point of the assay. In cases of dilute samples, *negative* or *none detected* results should not be interpreted as indicating no drug use or abstinent behavior. Positive drug test results from a dilute sample, however, are considered valid because the donor was apparently not able to dilute the sample sufficiently to deceive the test.

A 2005 study that assessed over 22,000 subjects (with urine samples taken from adults and children, different ethnic groups, and at various times throughout the day) determined that the average, normal urine creatinine in the U.S. is 130 mg/dL. While the incidence of dilute urine samples is not commonplace in the general population, in populations known to be drug tested (e.g., criminal justice), the incidence of low

creatinine levels increases significantly. The diluting of urine samples by consuming large volumes of fluid is easy and common in drug court populations; therefore, many courts sanction accordingly for repeat dilute samples. Drug courts are also advised to place a dilute sample prohibition into participant contracts and inform participants that diluted samples are considered unacceptable.

The rapid (over a period of sixty to ninety minutes) intake of two to four quarts of water or other liquid beverages is sufficient to produce urinary creatinine levels of less than 20 mg/dL and result in a sufficiently watered down specimen that no longer reflects recent drug usage behavior. But this is a general guideline because the exact amount of fluid necessary to produce a dilute urine sample is dependent upon many variables, including a person's metabolism, amount of fluids regularly consumed, dietary habits, and occupation.

The important concept is that a creatinine level of less than 20 mg/dL associated with a drug test is *nearly always* an attempt by the donor to avoid drug-use detection, regardless of how much liquid was consumed in order to achieve this result. While it is possible for an individual to unintentionally consume sufficient liquid to produce a diluted sample, this should be viewed as the exception rather than the rule. For clients who work outside (e.g., construction workers) in hot, summer weather and ingest large amounts of fluid, the court should consider testing these clients before they go to work or on their days off.

The bottom line is that the court cannot allow clients (new or veterans) to continue to produce low creatinine samples without some sort of escalating sanction. There is no standardized response to diluted samples. Rather, there is a wide spectrum of judicial responses. Adjudicating a diluted sample as a positive result is one common approach. Some programs allow a single diluted sample per phase (or per quarter) without sanction. Other programs treat a diluted sample as more egregious than a positive sample because it is often indicative of intentional tampering. However a court decides to handle the diluted sample issue, programs should also respond with additional therapeutic interventions when diluted samples are identified.

Participants should receive a sanction for water loading and other attempts at tampering with the test.

Urine creatinine level patterns can also be used to uncover ongoing sample tampering. Normal urine creatinine levels do not demonstrate extreme fluctuation. Therefore, clients producing rapidly changing and significantly high and low urine creatinine levels from day to day (or from collection to collection) are indicative of potential specimen tampering. If a client is capable of producing a sample with normal urine creatinine levels some of the time and subsequently exhibits low creatinine levels on other occasions, this suggests that the dilute collections are not associated with a disease-related problem. Other tampering control measures that can be used by the court include:

- Developing challenging collection strategies (e.g., minimize access to water sources, require hand washing *prior* to sample donation, require the removal of outer clothing (coats), no backpacks, purses, hats, etc., pockets turned inside out);
- Instituting unannounced/random collections;

- Observing collections directly (full-frontal witnessed);
- Training collection staff to be observant (inspect sample);
- Measuring sample temperature (reject if not 90°–100° F);
- Keeping staff abreast of tampering techniques;
- Employing specimen validity tests designed to identify sample adulteration.

XII. [§6.12] CLIENT EXCUSES

Every judge will hear a myriad of client excuses offered to explain why a drug-testing result is positive. Many of these excuses will have a "dog ate my homework" quality. Clients offer implausible excuses for many reasons: denial as part of the disease process, the learned behavior of chronic dishonesty, risk taking or manipulative behavior, paranoia (co-occurring disorder issues), threat of court sanctions, or resistance to change. First, in response to client excuses associated with a positive drug test, courts should not assume the role of excuse evaluators (i.e., attempting to determine if every client excuse has legitimacy). Clients need to be held responsible for their behavior and for maintaining a drug-free physiology. If the drug testing is performed appropriately and confirmation is used to validate screening results, how or why the drug got into the client's sample is largely irrelevant. A positive drug test puts the participant in violation and sanctions should be imposed. As a practical matter, the court does not have the time or resources to evaluate every excuse or to argue with each client who concocts an inventive story.

Second, while assessing each excuse for authenticity is not recommended, evaluating client excuses for therapeutic progress may be useful. Client explanations that include self-admissions such as "I accidentally used" may represent signs of behavioral change—self-reporting versus complete denial. Some excuses may also suggest mental health issues (paranoia, hallucinations) and potential co-occurring disorders.

XIII. [§6.13] ALCOHOL ABSTINENCE MONITORING ETG AND ETS

A new approach to monitoring client alcohol abstinence offering an extended detection window involves urine testing for two compounds: EtG and EtS. EtG and EtS are ethyl alcohol metabolites (biomarkers) that allow the detection of recently consumed alcohol in persons who have agreed to abstain from drinking. Both of these metabolites remain in the body considerably longer than alcohol itself. While methods measuring alcohol in breath, urine, saliva, and blood provide a detection window only for a matter of hours, EtG/EtS testing can extend the detection window of recently consumed alcohol to a couple of days. This extended detection window is especially useful for alcohol abstinence monitoring by DWI courts.

EtG/EtS testing is becoming increasingly available from drug-testing laboratories and represents a major breakthrough in alcohol abstinence monitoring. However, because alcohol is ubiquitous in our environment, concerns have been raised about the ability to

differentiate between purposeful alcohol consumption (in violation of compliance standards) and unintended alcohol exposure. In other words, has the capability to employ this highly sensitive testing procedure to detect recent ethyl alcohol exposure outpaced the ability to appropriately interpret test results in a forensically defensible manner? These concerns are not unlike similar drug-testing issues associated with passive inhalation of marijuana smoke or positive urine opiate results from poppy seed ingestion.

Therefore, establishing appropriate EtG/EtS cutoff levels is critical. A cutoff for EtG/EtS should be considered inversely proportional to a program's willingness to consider alternative sources of alcohol exposure other than covert ingestion in violation of program rules (i.e., lower cutoffs for programs with considerable flexibility in handling positive results, and higher cutoffs for courts with strict, unyielding sanctioning policies in response to EtG/EtS positives).

Because the concerns associated with incidental, environmental, casual, or inadvertent alcohol exposure (producing measurable EtG/EtS urine levels) are the source of much current research, there is no universally accepted urine EtG/EtS cutoff. At present, the general consensus is that a 500 ng/mL cutoff for EtG and a 100 ng/mL cutoff for EtS avoids false detections from nearly all known incidental exposures. It is further recommended that drug courts utilize specific EtG/EtS client contracts. These contracts can serve to educate, alert, and advise drug court clients of the unintended sources of alcohol that could produce positive urine EtG/EtS test results. It can also list the numerous commercial products that contain ethyl alcohol and provide a catalog of substances that should be avoided while in a drug court program.

XIV. [§6.14] CONCLUSION

The law is not black and white and neither is science. Negative drug test results do not guarantee that a drug court client is abstinent (impossible to prove a negative), even if that client continues to produce negative tests. Positive drug-testing results can document prohibited substance use by clients in violation of court-mandated agreements, but confirmation is required to obtain the certainty required for appropriate sanction. The drug court model is built upon a foundation that provides maximum flexibility to team members as they apply innovative strategies designed to succeed where other legal remedies have failed. While this flexibility is an important client-management tool, basic evidentiary standards for the admissibility of scientific data into the court's proceedings must be maintained. Unfortunately, as drug courts experiment with a variety of therapeutic interventions and struggle with sanction and incentive decisions, this evidentiary foundation may become compromised. This is particularly true of the drug-testing component utilized by problem-solving courts.

It is understood that the court cannot be expected to fully comprehend all of the technical nuances associated with the multitude of drug detection modalities. Nor can the court be expected to apply the many physiological variables associated with the pharmacology of abused drugs in the human body. However, by using drug-testing results in a forensic context, the drug court judge assumes and accepts the responsibilities (and liabilities)

associated with that scientific knowledge—its use and misuse. Therefore, it is incumbent upon each judge to determine the appropriateness of the drug tests results and their interpretation in dispensing justice.

The court must trust the drug-testing results in order to function in a fair and impartial manner.

The court is urged to recognize that drug testing, as an abstinence monitoring strategy, is a *tool*. And, that drug testing is but a single assessment option available to the court. Too often, courts become myopic regarding drug-testing results—leading to incentive and sanction decisions that are driven exclusively by whether a drug test is positive or negative. The court would be wise to consider all of the behavioral data available from the drug court team members. While drug testing itself is an analytical endeavor, the judiciary must consider the therapeutic ramifications of these results when adjudicating to support recovery.

Providing an accurate, reliable, and effective drug-testing program, combined with the therapeutic utilization of results designed to change behavior and support recovery, represents the bookends of judicial responsibility in a drug detection program.

A. [§6.15] Ten Principles of a Good Testing Program

The ten most important principles of a successful drug-testing program can be summarized as follows:

1. Design an effective drug detection program, place the policies and procedures of that program into written form (drug court manual), and communicate the details of the drug detection program to the court staff and clients alike.
2. Develop a client contract that clearly enumerates the responsibilities and expectations associated with of the court's drug detection program.
3. Select a drug-testing specimen and testing methodology that provides results that are scientifically valid, forensically defensible, and therapeutically beneficial.
4. Ensure that the sample-collection process supports effective abstinence monitoring practices including random, unannounced selection of clients for sample collection and the use of witnessed/direct observation sample-collection procedures.
5. Confirm all positive screening results using alternative testing methods unless participant acknowledges use.
6. Determine the creatinine concentrations of all urine samples and sanction for creatinine levels that indicate tampering.
7. Eliminate the use of urine levels for the interpretation of client drug-use behavior.
8. Establish drug-testing result interpretation guidelines that have a sound scientific foundation and that meet a strong evidentiary standard.
9. In response to drug-testing results, develop therapeutic intervention strategies that promote behavioral change and support recovery.
10. Understand that drug detection represents only a single supervision strategy in an overall abstinence-monitoring program.

If universally adopted, these ten principles will sustain drug courts as models of effective and appropriate jurisprudence far into the future.

---

1 National Association of Drug Court Professionals. 1997. Defining drug courts: The key components. Washington, DC: Office of Justice Programs, U.S. Dept. of Justice. Available at www.allrise.org.

2 American Probation and Parole Association. 1988. *Drug Testing Guidelines and Practices for Adult Probation and Parole Agencies* (p.33). Washington, DC: Bureau of Justice Assistance, U. S. Department of Justice.

3 Robinson, Jerome J., and James W. Jones. 2000. *Drug Testing in a Drug Court Environment: Common Issues to Address* [NCJ #181103, p.10]. Washington, DC: Office of Justice Programs, Drug Court Clearinghouse and Technical Assistance Project at American University. Available at http://www.ncjrs.gov/pdffiles1/ojp/181103.pdf.

4 Federally mandated workplace testing guidelines provide for an opiate cutoff level of 2000 ng/mL, which is not recommended for abstinence monitoring programs. At a cutoff level of 2000 ng/mL, opiate relapse may be difficult to identify. Consult your laboratory or on-site vendor to ensure an appropriate opiate cutoff is being used.

5 National Drug Court Institute. 2004. *Urine Drug Concentrations: The Scientific Rationale for Eliminating the Use of Drug Test Levels in Drug Court Proceedings* [Drug Court Practitioner Fact Sheet, Vol. IV, Issue 1]. Alexandria, VA: Author.

6 National Drug Court Institute. 2006. *The Marijuana Detection Window: Determining the Length of Time Cannabinoids Will Remain Detectable in Urine Following Smoking: A Critical Review of Relevant Research and Cannabinoid Detection Guidance for Drug Courts* [Drug Court Practitioner Fact Sheet, Vol. IV, Issue 2, April 2006]. Alexandria, VA: Author.

7 The only timeframe in which an individual's chronic marijuana use (possibly leading to extended cannabinoids elimination) is relevant is during a client's admission into the drug court program. Following the initial detoxification phase, the extent of a client's past chronic marijuana usage does not influence the cannabinoid detection window as long as appropriate supervision and drug monitoring for abstinence continues on a regular basis. Therefore, the consequences of chronic marijuana usage on cannabinoid detection are effectively limited to the initial entry phase of the program. Detailed cannabinoid detection information available in NDCI Fact Sheet, Volume IV, Issue 2, April 2006

8 Specimen validity tests (SVT) are specialized analyses designed to identify chemical substances the presence of which is inconsistent with normal human urine.

Chapter 7

Applying Incentives and Sanctions

Douglas B. Marlowe, J.D., Ph.D.

I. [§7.1] INTRODUCTION 143
II. [§7.2] RELIABLE MONITORING 143
III. [§7.3] UNEARNED LENIENCY 145
IV. [§7.4] SCHEDULE OF STATUS HEARINGS 146
V. [§7.5] MAGNITUDE OF REWARDS AND SANCTIONS 147
VI. [§7.6] THE FISHBOWL PROCEDURE 148
VII. [§7.7] FAIRNESS 149
VIII. [§7.8] SPECIFICITY 150
IX. [§7.9] PROXIMAL VS. DISTAL GOALS 150
X. [§7.10] PHASE ADVANCEMENT 152
XI. [§7.11] SUBSTANCE ABUSE VS. DEPENDENCE 152
XII. [§7.12] NONCOMPLIANCE VS. NONRESPONSIVENESS 154
XIII. [§7.13] THE CARROT VS. THE STICK 155
XIV. [§7.14] CONCLUSION 157

I. [§7.1] INTRODUCTION

In the social and psychological sciences, few findings have been so reliably demonstrated that they may qualify as "laws" of human behavior. The principles of operant conditioning or contingency management are one such set of laws. These principles have been proven time and again across numerous settings to the degree that they are no longer the subject of legitimate scientific dispute. The basic techniques for effective implementation of operant conditioning are reviewed in the pages that follow. For more in-depth discussions of the topic, a list of recommended readings is provided at the conclusion of this chapter.

Put simply, if one's goal is to improve adaptive functioning and reduce antisocial behavior on the part of drug offenders, then it is essential to closely monitor their conduct and impose certain and immediate rewards for achievements and sanctions for infractions. Failing to punish misfeasance inevitably makes behavior worse, and failing to reward accomplishments makes those accomplishments less likely to recur. Although the proper administration of incentives and sanctions is by no means the be-all and end-all of drug court programs, it will be the rare drug court that can effect positive change without it.

II. [§7.2] RELIABLE MONITORING

The success of every intervention in a drug court depends, ultimately, on the reliable monitoring of participants' behaviors. Research indicates that the most important factor influencing the success of any behavioral intervention is certainty. Certainty is often expressed as a ratio of infractions to sanctions, or as a ratio of achievements to rewards. For example, if drug court participants are sanctioned every time they fail to attend a treatment session, then the ratio of infractions to sanctions is 1:1, and this is called a fixed ratio-1 (or FR1) schedule. If they are sanctioned for every two missed sessions, this would be an FR2 schedule, and so forth. The scientific evidence is unambiguous on this point: the smaller the ratio, the better the effects for initiating a new behavior.

Nothing spells disaster more for a drug court than failing to detect and redress negative behaviors or failing to recognize and reward positive accomplishments.

If the drug court judge does not have accurate information about whether a participant is being compliant or noncompliant in the program, there is no possible way to apply incentives or sanctions correctly or to adjust treatment and supervision services accordingly. Nothing spells disaster more for a drug court than failing to detect and redress negative behaviors or failing to recognize and reward positive accomplishments. The worst case scenario is to apply the wrong consequence. For example, if a participant is wrongly applauded for doing well in the program, when in fact he or she is surreptitiously continuing to abuse drugs, the practical effect is to reward the participant's deception and

destroy any credibility the program might have had. Once credibility is lost, it is exceedingly difficult to reclaim.

Recommended procedures for monitoring participants' behaviors are discussed in other sections of this benchbook, including Chapters 5 and 6 on community supervision and drug-testing (respectively); however, a few evidence-based pointers are worth underscoring here:

- Urine drug testing should be performed no less frequently than twice per week, at least during the first phase of the program.[1] Because the detectible metabolites of most drugs of abuse stay in the system for only about forty-eight to seventy-two hours, less frequent testing leaves an unacceptable gap during which participants can abuse drugs without being detected.
- Urine drug testing should be performed on a random basis. If participants know in advance when they will be drug tested, they can adjust their usage accordingly. They can also front-load on water consumption or take other countermeasures to beat the tests. If drug testing is unannounced, participants will have less time to prepare for such countermeasures.

Best practice would be to continue monitoring substance use throughout the court process.

- Urine drug testing should be the last supervisory burden that is lifted, and ordinarily only during the last phase of the program, if at all. Drug courts typically ratchet down the intensity of treatment and supervision services as participants make progress in the program. There is always the risk that participants will relapse as those services are reduced. Therefore, urine drug testing should continue unabated in order to be certain that relapse is not occurring when other adjustments are being made to the treatment plan.
- Urine drug testing should be performed, at least occasionally, on weekends. Participants are very attentive to when they are being tested and they know when testing will not occur. Giving them a predictable 48-hour reprieve from testing invites efforts to get away with undetected drug use.
- Alcohol is one of the most common substances of abuse among drug court participants, yet many testing technologies do not do a good job of detecting alcohol consumption. Breathalyzers, for example, detect only a very small time window of recent alcohol use. Technologies should be employed that have longer detection windows, such as ethyl glucuronide (EtG), ethyl sulfate (EtS) or SCRAM (Secure Continuous Remote Alcohol Monitor) anklet devices. (These technologies are discussed in Chapter 6, "The Fundamentals of Drug Testing.")
- Most misconduct by participants occurs during off-hours, when they are not physically present at the drug court program. It is essential, therefore, for community supervision officers to observe participants in their natural social environments. This includes conducting unannounced home contacts, verifying employment and school attendance, enforcing area and place restrictions, monitoring compliance with curfews, and performing bar sweeps, where relevant.

It bears repeating that naiveté is inconsistent with competent professional practice and effective behavior modification. To borrow a phrase from former President Ronald Reagan: "trust but verify."

III. [§7.3] UNEARNED LENIENCY

Some drug court professionals may feel ambivalent about administering punishment. They may view their role as providing treatment and not policing misconduct. Although such sentiments may be appropriate for certain team members, such as defense counsel or clinicians, it is not appropriate for the drug court team as a whole. A critical function of any drug court is to closely monitor offenders and hold them meaningfully accountable for their behavior. The public at-large is a legitimate consumer of drug court services and has a right to expect drug courts to fulfill their obligations to public safety and to the integrity of our legal system.

This has important implications for the practice of giving participants second chances. Assume, for example, that a participant delivers a drug-positive urine specimen, but the judge elects not to administer a sanction because the judge was in a good mood that day. This would have the practical effect of increasing the ratio of infractions to sanctions. For example, it might shift the participant from an FR1 schedule to an FR2 schedule. This would be likely to reduce the efficacy of the program, no matter how well intentioned it might have been.

Consider a different example, however, in which the participant used drugs, but then felt guilty about it, spontaneously acknowledged the drug use to his or her counselor, and sought further treatment to avoid a continued relapse. In this example, it would be appropriate to withhold the sanction as an incentive for the client being truthful and seeking treatment on his or her own volition. In behavioral terms, this would be an example of what is called *negative reinforcement*, in which a sanction is withheld as an incentive for honesty and help-seeking behavior. The point here is that second chances can be appropriate, but only when they have been earned. Mistakes happen, and participants need to learn how to deal with the aftermath of their mistakes. If a participant behaves in a responsible manner following a relapse, then that responsible behavior may be seen as canceling out the impending sanction for drug use. This should not be misconstrued; participants cannot continue to use drugs again and again, knowing that as long as they are honest afterwards they will avoid a sanction. This would be something that would primarily happen in the early stages of treatment.

Sanctions for drug use might be suspended to reward honesty and help-seeking behavior.

This process can at times be applied prospectively as well. For example, a sanction might be imposed for an infraction, such as failing to attend a counseling session, but then held in abeyance pending subsequent corrective action. If the participant attends, say, the next five counseling sessions in a row, the sanction might be formally withdrawn.

However, failure to attend the next five sessions would elicit two sanctions—one for the original absence and another for the new one. In essence, the participant is offered an opportunity for "double or nothing."

In short, when a sanction is withheld to reward corrective efforts, it is in the best interests of the participant and is an example of effective behavior modification. When, however, it is withheld because it makes the professional feel more personally comfortable, it is not effective behavior modification and is apt to make the participant worse off in the long run.

IV. [§7.4] SCHEDULE OF STATUS HEARINGS

After certainty, the second most important element of effective behavior modification is immediacy, sometimes referred to as *celerity*. The unfortunate reality is that the effects of rewards and sanctions begin to decline within only a few hours or days after a participant has engaged in a target behavior. One explanation for this precipitous decline in efficacy is that there is interference from new behaviors. Assume, for example, that a participant uses drugs on Monday, but then is abstinent and compliant with treatment for the remainder of the week. If that same individual is sanctioned on Friday for the instance of drug use that occurred on Monday, it should be evident that the desirable behaviors transpiring on Tuesday through Thursday are actually closer in time to the sanction than the drug use. This explains why the effects of sanctions decline precipitously. New behaviors occur more recently in time, and behavior modification works, in part, by proximity in time. In this example, the practical effects of the sanction could be, paradoxically, to punish the good behaviors that occurred most recently.

This finding has important implications for establishing an effective schedule of status hearings in drug courts. Most drug courts apply incentives and sanctions during court hearings, after the team has had an opportunity to review the case in a staffing and agree upon a suitable consequence. The ultimate decision about what consequence to impose is determined by the judge, but is based upon a consideration of the relevant evidence and expertise contributed by the various team members. The longer the time interval between staffings and between status hearings, the longer the delay will be between participants' accomplishments and the imposition of rewards, and between their infractions and the imposition of sanctions.

Initially, Drug court participants should appear for court sessions at least every two weeks.

Fortunately, research provides clear indications about when to schedule status hearings. Outcomes in drug courts appear to be optimized when participants appear in court no less frequently than every two weeks, at least during the first three to six months of the program.[2,3,4,5] Requiring participants to appear in court at least every two weeks permits the team to respond to their accomplishments and infractions in a reasonably short interval of time, which is necessary to modify their behavior effectively.

This is not to suggest that holding status hearings on a weekly basis is harmful or undesirable. Rather, there is no clear indication from the research that the additional expense and inconvenience of weekly hearings (for both the participants and staff) is warranted based upon the relative differences in outcomes. It also remains unclear whether this finding applies equally to populations other than adult drug offenders, such as mentally ill offenders or juvenile delinquents. More research is needed to determine how frequently status hearings should be scheduled for other populations. The best advice that can be offered at this juncture is that biweekly status hearings appear to be a reasonable and evidence-based schedule to follow in a drug court program.

There is no clear indication yet from the research evidence about when it is appropriate to ratchet down the frequency of status hearings. Most drug courts reduce the schedule of court hearings as participants move through the various phases of the program. If advancement through the phases is based upon objective evidence of progress in treatment (which it should always be), and if participants continue to be reliably tested for substance abuse and other relevant behaviors, then it appears suitable to gradually reduce the frequency of court hearings over time. More research is needed to determine how quickly those adjustments can and should be made.

V. [§7.5] MAGNITUDE OF REWARDS AND SANCTIONS

There is a common misconception that rewards and sanctions are most effective at high magnitudes. In fact, evidence reveals that rewards can be quite effective at low to moderate magnitudes. For example, positive outcomes have been achieved with low-magnitude rewards, such as verbal praise, diplomas, certificates of progress, transportation passes, and gift cards to local stores or restaurants.

Punitive sanctions tend to be the least effective at the lowest and highest magnitudes, and most effective within the moderate range. Sanctions that are too weak in magnitude can precipitate what is called *habituation*, in which the individual becomes accustomed to being sanctioned. The problem with habituation is not only that low-magnitude sanctions may fall below an effective threshold—of greater concern, they can make it less likely for higher-magnitude sanctions to work in the future because they can raise the participant's tolerance for being sanctioned. This may account for the "been-there, done-that" attitude that many drug offenders exhibit in response to threats of punishment. Over time, they may become desensitized to repeated threats of inconsequential sanctions; therefore, they may be apt to push the limits to the point of no return (e.g., to the point of imprisonment, overdose, or death).

Moderate magnitude responses can be quite effective at producing behavioral change.

At the other extreme, sanctions that are too high in magnitude can lead to *ceiling effects*, in which further escalation of punishment is impracticable. Once a participant has been

incarcerated, for example, the drug court may have used up its list of sanctions. At this point, future efforts to improve that offender's behavior could be futile. High-magnitude sanctions are also apt to precipitate a host of negative side effects. Individuals who are exposed to high-magnitude sanctions will often do everything in their power to avoid the sanctions, such as absconding from the program, lying, or tainting their urine specimens. As a result, staff members spend much of their time attempting to overcome participants' deceptions rather than conducting therapy. In addition, participants who receive severe sanctions may become depressed, angry, or despondent, which can interfere with their therapeutic alliance with staff members.

For these reasons, successful drug courts craft a wide and creative range of intermediate-magnitude rewards and sanctions, which can be ratcheted upward or downward in response to participants' behaviors. For example, participants may receive writing assignments, fines, community service, or brief intervals of jail detention for failing to comply with treatment. Conversely, they may receive verbal praise, token gifts, or reduced supervisory obligations for complying with treatment. The sanctions and rewards are administered on an escalating or graduated gradient, in which the magnitude increases progressively in response to each successive infraction or accomplishment in the program. This can enable a drug court to navigate between habituation and ceiling effects by altering the magnitude of punishment in response to successive infractions. It also permits the criminal justice system to offer a substantially richer and more effective range of rewards than is ordinarily available to offender populations.

The success of any drug court will depend largely on its ability to apply a meaningful range of intermediate rewards and sanctions. Just like the story of "Goldilocks and the Three Bears", those programs that are too lenient will be apt to elicit habituation and make outcomes stagnant; whereas those that are too harsh will be apt to elicit resentment, avoidance, and ceiling effects. Those programs that are "just right" will tend toward the best results.

VI. [§7.6] THE "FISHBOWL" PROCEDURE

Many drug courts are stretched for resources and may not have much money available to purchase concrete rewards. One economical way to deal with this limitation is to use what is sometimes referred to as the *fishbowl procedure*. Participants earn opportunities to draw from a fishbowl or other lottery-like container as a reward for various accomplishments in the program, such as attending treatment sessions and providing drug-negative urine specimens. Most of the draws might earn only a written declaration of success in the program (e.g., a certificate of accomplishment for the week signed by the judge). Others might elicit small prizes of roughly $5 to $15 value (e.g., transportation passes or gift certificates to

An effective and inexpensive reward system allows everyone who has done well to participate in a lottery for prizes.

fast food restaurants). Finally, a small proportion of the draws might elicit larger prizes, such as DVDs or a portable CD player.

Research indicates that the fishbowl procedure can bring about comparable, or even better, outcomes than providing participants with rewards for every achievement.[6, 7] The excitement of possibly winning a higher-magnitude reward appears to compensate for the reduced chances of actual success. This can enable drug courts to offer effective positive reinforcement for their clients at a reduced cost to the program. It also introduces some entertainment value into the process. Importantly, concerns that such a procedure might trigger gambling behavior on the part of some participants are not warranted and have been disproven in research studies.[8] In addition, concerns that participants might exchange their rewards for drugs or other inappropriate acquisitions have also proven unwarranted.[9, 10, 11] To the contrary, providing concrete rewards is associated with reductions in drug use, higher success rates, and greater satisfaction with the drug court program.

VII. [§7.7] FAIRNESS

Certainty, immediacy, and magnitude relate to how rewards and sanctions are actually imposed. However, *perceptions* of rewards and sanctions are also very important. One issue relates to the concept of procedural justice. Evidence from cognitive psychology reveals that individuals are more likely to perceive a decision as being correct and appropriate if they believe that fair procedures were employed in reaching that decision.[12, 13] In fact, the perceived fairness of the procedures exerts a greater influence over participants' reactions than does the outcome of the decision. Specifically, participants will be most likely to accept an adverse judgment if they feel they (1) had a fair opportunity to voice their side of the story, (2) were treated in an equivalent manner to similar people in similar circumstances, and (3) were accorded respect and dignity throughout the process.[14] When any one of these factors is absent, behavior not only fails to improve, but may get worse, and participants may sabotage their own treatment goals.[15]

Rewards and sanctions must be perceived as fair to be effective.

This does not mean that participants should necessarily get what they want. The important point is that they should be given a fair chance to explain their side of the story, and they should be offered a clear-headed explanation about how and why a particular decision was reached. If staff members have difficulty articulating a defensible rationale for why a participant is being treated a given way, then perhaps the team should rethink its response. Most importantly, it is never appropriate to be condescending or discourteous. Even the most severe sanctions, such as jail detention or termination, should be delivered in a dispassionate and even-handed manner, with no suggestion that the judge or other staff members enjoy meting out punishment. It should be clear that the sanction is intended to address the participant's misconduct, and is not being imposed because the participant is a bad person or intrinsically deserves to be punished.

Research indicates that drug courts tend to have better outcomes when they clearly specify their policies regarding incentives and sanctions in a written program handbook or manual.[16] Prior to entering the program, participants should be clearly informed in writing about the program's rules; the specific behaviors that may trigger sanctions or rewards; the types of sanctions and rewards that can be imposed; the criteria for graduation or termination from the program; and the consequences that may ensue from graduation and termination. Prior to waiving their legal rights, this material in the handbook should be verbally reviewed by defense counsel with the participants and should perhaps also be the subject of a formal colloquy between the judge and each participant. Such procedures help to ensure that participants understand the rights they are giving up and the risks they are assuming by entering the program. This will serve to increase participants' perceptions of fairness and predictability in the program, which will make them more likely to accept negative sanctions should they need to be imposed.

VIII. [§7.8] SPECIFICITY

Ambiguity undermines the effects of sanctions and rewards. If participants do not have clear advance notice about the specific behaviors that may trigger sanctions or rewards, and the types of sanctions and rewards that may be imposed, they will be apt to view the imposition of sanctions and rewards as unfair. This will be unlikely to improve their behavior and may actually make their behavior worse.

Vague terms such as "irresponsible behavior" and "immaturity" are open to differing interpretations and should be scrupulously avoided. Infractions and achievements should be clearly defined in objectively measurable behavioral terms, such as drug-positive urine specimens or unexcused absences from counseling sessions. Criteria for phase advancement and graduation should similarly be clearly stated, such as a specified number of drug-negative urine specimens or a specified attendance rate at counseling sessions. As noted previously, these criteria should be memorialized in a written manual or handbook, carefully discussed with participants prior to entry, and periodically reviewed with participants over time.

IX. [§7.9] PROXIMAL vs. DISTAL GOALS

Distal goals are the desired behavior that may take time to achieve.

When it comes to modifying habitual or ingrained behaviors, it is essential to draw a distinction between proximal and distal behavioral goals. This process is referred to as shaping. Proximal goals are behaviors that (1) participants are already capable of engaging in, and (2) are necessary for long-term objectives to be achieved. Examples might include attendance at counseling sessions, attendance at court hearings, or delivery of urine specimens. Distal goals are the behaviors that are ultimately

desired, but may take participants some time to accomplish. Examples might include gainful employment or improved parenting skills.

As will be discussed in greater depth below, the shaping process has important implications for responding to positive urine drug screens from individuals who are substance abusers as opposed to those who are compulsively addicted to alcohol or other drugs. Abstinence, on one hand, is relatively easier to achieve (and thus is a proximal goal) for individuals whose drug use is under voluntary control and has not progressed very far in severity. On the other hand, abstinence is a distal goal for individuals who are seriously addicted to alcohol or other drugs. Thus, as will be discussed, sanction and incentive schedules may need to be different for addicted individuals as opposed to substance abusers.

Although it is always appropriate to administer a sanction for every infraction, the magnitude or severity of the sanction should be higher for proximal behaviors and lower for distal behaviors. If a participant receives low-magnitude sanctions for failing to fulfill easy obligations, this will almost certainly lead to habituation. However, if a participant receives high-magnitude sanctions for failing to satisfy difficult demands that are beyond his or her capabilities, this will almost certainly lead to depression, hostility, or a disruption of the therapeutic relationship.

Telling the truth is always a proximal goal. Sobriety or total abstinence may be a distal goal.

Thus, for example, a participant who fails to show up for counseling sessions or delivers tampered urine specimens might receive a substantial sanction, such as community service or a brief period of jail detention. On the other hand, if that same participant failed to find a job or to enroll in an educational program during the early phases of the program, he or she might receive a lesser consequence, such as a verbal reminder or writing assignment. As will be discussed, distal goals eventually become proximal goals as participants make progress in the program. At some point in time, finding a job or enrolling in an educational program will become a proximal goal, and the participant should receive higher-magnitude consequences for failing to fulfill these obligations as well.

The converse applies to rewards. Low-magnitude rewards should generally be administered for proximal behaviors, and high-magnitude rewards for distal behaviors. For example, participants might receive verbal praise and encouragement for attending counseling sessions, but might receive more substantial rewards, such as reduced supervision requirements, for engaging in prosocial behaviors like returning to school. Again, distal behaviors will eventually become proximal behaviors over time. At some point in time, verbal praise might become a sufficient response to attendance at school.

Of course, some behaviors that represent an immediate threat to public safety or to program integrity, such as the commission of a new crime, driving while impaired (DWI), or dealing drugs to other clients, are necessarily conceptualized as proximal because they cannot be permitted to continue. Offenders who fail to refrain from these behaviors

might be considered to be poor candidates for drug court or may need to be confined and treated in a correctional halfway house, residential facility, or prison or jail setting.

X. [§7.10] PHASE ADVANCEMENT

Phase advancement recognizes that distal goals have become proximal.

Defining proximal and distal goals has important implications for designing the phase structure of a drug court program. The primary purpose of phase advancement is to let participants know that what was previously considered to be a distal goal has now become a proximal goal. For example, phase one in many drug courts focuses on stabilization of the client and induction into treatment. The emphasis might be placed on completing clinical assessments, establishing a routine of attending treatment sessions in a timely manner, abiding by a home curfew, and obtaining a self-help group sponsor. Participants might not, however, be required (or even encouraged) to find a job or return to school at this early stage in their recovery.

Once a participant has become stabilized and developed a proper routine, he or she might then be advanced to phase two, in which other goals such as employment or education would become more salient. Thus, failing to attend job training during phase one might receive no consequence or only a minimal consequence, whereas failing to attend job training during phase two or three might elicit a more substantial consequence. A distal goal becomes a proximal goal over subsequent phases of the program, and the consequences for failing to achieve that goal increase accordingly.

Each time a participant is advanced to a higher phase in the program, the drug court team should take that opportunity to underscore for all of the participants what was required for the advancement to occur, and what new challenges now await the individual. Ideally, the judge should repeatedly review the process of phase advancement in open court and explain to all participants the implications of moving from one phase to another. This way, there will be no surprises when participants find that the program's expectations for their behavior have increased and the consequences for their misbehavior have been enhanced accordingly.

XI. [§7.11] SUBSTANCE ABUSE vs. DEPENDENCE

It is unwarranted to assume that merely because an individual has been arrested for a drug-related offense, he or she must be an addict or in denial about being an addict. In fact, research indicates that approximately thirty to forty percent of drug court participants do not have a serious addiction problem.[17]

There are three prototypical symptoms for determining whether an individual is addicted to or dependent on alcohol or other drugs:

- Any introduction of the substance into the bloodstream precipitates a binge pattern. For example, the individual intends to have just one beer, but drinking that beer triggers a several-hour bender.
- The individual experiences intense cravings or compulsions for the substance, which are extremely difficult to resist and which steadily build in intensity during prolonged intervals of abstinence.
- The individual suffers severely uncomfortable or debilitating withdrawal symptoms when levels of the substance decline in the bloodstream.

Further discussion of the diagnostic criteria for substance abuse and dependence may be found in Chapter 4, "Addiction and Treatment Services."

As was noted previously, for participants who are exhibiting one or more of these hallmark features of dependence, abstinence should generally be considered a distal goal. Substance use is compulsive for such individuals and they may be expected to require time and effort in order to achieve abstinence. If a drug court team were to impose high-magnitude sanctions on these individuals for drug use early in treatment, the odds are high that the team would hit a ceiling effect quite soon, and the participant could fail out of the program. This would have the paradoxical effect of making the most drug-dependent individuals ill-fated for success in drug court programs. Instead, high-magnitude sanctions should be reserved during the early phases of the program for proximal, treatment-related behaviors, such as attending counseling sessions, appearing at status hearings, and submitting urine specimens. Positive urine screens should still be met with certain and swift sanctions; however, the magnitude of those sanctions should be relatively low, thus permitting ample opportunities for the team to ratchet up the magnitude of the sanctions over time.

For substance abusers, sobriety is a proximal goal, and they should receive relatively high magnitude sanctions for drug use. This is not necessarily true for those who are substance dependent.

By contrast, for participants who are not addicted to alcohol or other drugs, abstinence should be considered a proximal goal. Because substance use is not compulsive for these individuals, they are capable of stopping their usage relatively quickly. Applying low-magnitude sanctions for substance use would essentially allow them to continue their use with minimal consequences. This could lead to habituation effects, which would make outcomes worse. Instead, higher-magnitude sanctions should be applied for drug use from the outset, so as to put a rapid end to this misbehavior.

It should be evident from the foregoing discussion that sanction and incentive schedules and phase structures should ordinarily be different for participants who are substance abusers as opposed to those who are dependent or addicted. For example, substance abusers might be required to initiate abstinence during phase one of the program, and

might receive relatively high-magnitude sanctions for drug use in phase one, whereas such a requirement could be unrealistic for those who are compulsively addicted to alcohol or other drugs. For addicted individuals, the emphasis during phase one might, instead, be on learning to follow a structured routine, attending treatment sessions on time, completing applicable clinical assessments, and obtaining a self-help group sponsor. It might be more realistic to reserve a major emphasis on the initiation of abstinence for addicted individuals until phase two of the program. After an addicted participant has developed a productive routine and begun to engage meaningfully in treatment, then abstinence might become a proximal goal, and higher-magnitude sanctions would ensue for drug use.

This practice could require some drug courts to develop separately stratified tracks or dockets for participants who are drug-dependent as opposed to those who are abusers. Separate tracks could help to avoid perceptions of unfairness when some participants are treated more leniently than others for what appears on the surface to be the same behavior (i.e., drug use). Of course, for rural drug courts or those with low censuses, separate tracks might not be practical. Staff members in those programs will need to be able explain to participants why they are being treated differently from other clients based upon their clinical needs. Having a prepared script on hand to provide this explanation could help to reduce perceptions of unfairness.

XII. [§7.12] NONCOMPLIANCE VS. NONRESPONSIVENESS

Related to the distinction between proximal and distal goals is the distinction between noncompliance and nonresponsiveness. Drug court participants are jointly supervised by the criminal justice system and the substance abuse treatment system, which can lead to apparent (though not actual) role conflicts between different team members. Criminal justice professionals are primarily charged with protecting public safety and are empowered to respond to misconduct with enhanced supervision or punitive sanctions. Treatment professionals, by contrast, are primarily charged with improving the health and functioning of their clients and may intensify a client's treatment plan in furtherance of these goals. It is not always immediately apparent whether a punitive sanction or a change to the treatment plan is called for in a given instance. Distinguishing between noncompliance and nonresponsiveness addresses this issue squarely.

Increased treatment should not be used as a sanction.

If, for example, a participant fails to show up for counseling sessions or to deliver urine specimens when directed to do so, he or she is arguably engaged in willful noncompliance, assuming that the absences were unexcused and avoidable. Under such circumstances, it would be appropriate to apply a punitive sanction or to increase the participant's supervision requirements. On the other hand, if the participant was attending all of his

or her required sessions but was not responding to the clinical interventions, the fault might lie not with the participant but with the treatment plan. Rather than apply a punitive sanction, it would be preferable to alter the treatment plan. For example, the participant might require intensive clinical case management services to address a co-occurring psychiatric problem. In other words, noncompliance refers to a failure to engage in treatment, whereas nonresponsiveness refers to a failure to benefit from the treatment that is being offered. The former is willful (and proximal) and the latter is non-willful (and distal). Thus, the former should result in a sanction, and the latter should result in an alteration of the treatment plan. Recent research suggests that making this important distinction when applying consequences has the potential to significantly improve outcomes in drug court programs.[18, 19]

Distinguishing between noncompliance and nonresponsiveness addresses an important problem that is commonly encountered in drug courts. Some judges or probation officers may suggest increasing treatment requirements as a consequence of misconduct in the program. However, as noted in Chapter 4, "Addiction and Treatment Services," this practice not only risks wasting scarce treatment slots, it may give the inadvertent message to participants that treatment is aversive and thus something to be avoided. It is only appropriate for a judge or criminal justice professional to order a change to the treatment plan or level of care in response to noncompliance when it is clinically indicated after reassessment by a treatment professional. If, however, a participant is being compliant in treatment, but is not getting better, then it is certainly appropriate for the court to order a clinical reevaluation of the case by treatment professionals and to solicit recommendations from the treatment professionals about the best course to pursue. Under such circumstances, the judge would be relying upon expert advice in ordering a change to treatment, rather than practicing a clinical specialty without a license or adequate training or expertise.

XIII. [§7.13] THE CARROT VS. THE STICK

There is a serious concern that some drug courts may place an inordinate emphasis on squelching undesired behaviors to the detriment of reinforcing desired behaviors. Although drug courts can be quite effective at reducing crime and drug use while participants are under the supervision of the judge, these effects should not be expected to endure unless the participants receive alternative rewards and sanctions in their natural social environments that help to maintain the effects over time. For instance, participants who find a job, develop hobbies, or improve their family relationships will be more likely to be continuously rewarded for prosocial behaviors (e.g., with praise, social prestige, or wages) and punished for drug-related behaviors (e.g., by being ostracized from peers or fired from a job). By contrast, participants who simply return to their previous habits and routines will most likely find themselves back in an environment that rewards drug use at the expense of prosocial attainments. The community reinforcement approach (CRA)[20] is one counseling strategy that seeks to capitalize on natural systems of rewards and sanctions in clients' social environments to compete with the drug-using lifestyle.

To maintain treatment effects over time, it is essential that drug courts not merely punish crime and drug use, but also reward productive activities that are incompatible with crime and drug use. A critical task facing drug court practitioners is to use more positive reinforcement in their work and to select behavioral goals for their clients that can take the place of drug use and crime.

As was discussed earlier, sanctions have been associated with a host of negative side effects that can make outcomes worse, rather than better. For example, sanctions have been associated with avoidance responses, learned helplessness, anger, despondency, and ceiling effects. Positive reinforcement has also been associated with negative side effects; however, those side effects tend to be considerably less problematic than those of punishment. For example, some participants may become complacent or feel entitled if they come to expect something for nothing. That is, if participants are continuously rewarded for mediocre or substandard performance, this will not only fail to improve their performance, but can lead them to feel resentful or despondent if expectations for acceptable performance are subsequently increased. This problem can be easily avoided by increasing one's expectations for participants over time. As participants move through the various phases of the program, the requirements for the program should steadily increase (i.e., distal goals should become proximal goals). If expectations for appropriate behavior are continuously heightened, there should be little concern that participants' conduct will become stagnant.

Reward productive activities that are incompatible with crime and drug use.

There is also some suggestion from the research literature that artificial, extrinsic rewards can undermine clients' intrinsic motivation for change.[21] Importantly, however, these findings relate to detrimental effects on individuals who were already intrinsically motivated. Intrinsic motivation is often conspicuously absent among drug abusers and criminal offenders. If participants are not motivated to begin with, then it is difficult to envision how their motivation could be interfered with. For unmotivated individuals, it is not only acceptable to use extrinsic rewards to get them started on a course towards abstinence, but it may be minimally necessary to do so.[22] After they have experienced a sustained interval of sobriety, then participants will begin to experience the natural rewards that come with abstinence. For example, they will start feeling physically and emotionally healthier, may regain the respect of family members or friends, and may become gainfully employable. Then, and perhaps only then, will they begin to develop the intrinsic motivation that is necessary to maintain abstinence over the long run.

Perhaps the most enduring objection to rewards is one of equity. Citizens are not ordinarily given tangible incentives for abstaining from drugs and crime. Therefore, it may seem inequitable to reward some people for doing what is minimally expected of others—particularly when those being rewarded may be seen as the less desirable elements of society, such as drug addicts and criminal offenders. Because this objection is based upon sentiment and is not related to the actual effects of the intervention, it cannot be empirically disputed. It is an unavoidable policy objection that can make it

High-risk, antisocial drug abusers respond very well to positive reinforcement programs.

difficult for drug court professionals to conduct their work most effectively. The best recourse is to explain to stakeholders why positive reinforcement is so necessary to achieve long-term gains among drug offenders, and why it may be among the most effective and cost-effective strategies to employ with these individuals. Perhaps data can answer some of the objections that are often raised against the use of positive rewards with offenders.

In fact, numerous studies have found that high-risk, antisocial drug abusers tended to respond exceptionally well to positive reinforcement programs.[23, 24, 25] Many of these individuals are reinforcement-starved, meaning they rarely received praise or positive incentives for good behaviors in their past, including during their childhoods when incentives are especially influential. Because they may have been denied positive reinforcement during many of their formative years, they may crave positive attention to a degree beyond that of most adults. Although they may make every effort to act as if they do not care about rewards, their actions often suggest otherwise. Some studies in drug courts suggest that the more severe an offender's criminal background, the more responsive he or she may be to earning rewards for good behaviors.[26]

XIV. [§7.14] CONCLUSION

At its core, the criminal justice system is a contingency management intervention designed to reduce crime and rehabilitate offenders. Traditionally, however, rewards and sanctions have rarely been applied in a systematic manner that could produce meaningful or lasting effects. Dissatisfied with this state of affairs, a group of criminal court judges set aside special dockets to provide closer supervision and greater accountability for drug-abusing offenders. Wittingly or unwittingly, these judges devised programs highly consonant with scientific principles of operant conditioning. Specifically, they:

- Introduced greater certainty, celerity, and fairness into the process of imposing criminal justice sanctions;
- Crafted a range of intermediate-magnitude incentives and sanctions that could be ratcheted upward or downward in response to offenders' conduct;
- Developed a phased program structure that separates proximal from distal goals, and thus helps to shape behavior most effectively;
- Introduced more positive reinforcement and therapeutic goals into the business of the courts.

As a result, outcomes from drug courts have substantially exceeded those typically achieved by other programs for drug-involved offender populations. Drug courts are certainly far from perfect and more research is needed to fine-tune the behavioral components of these programs. Clearly, however, drug courts represent the best behavior modification intervention, to date, that has been applied on a systemic scale for drug-involved offenders.

RECOMMENDED READINGS

Arabia, Patricia L., Gloria Fox, Jill Caughie, Douglas B. Marlowe, and David S. Festinger. 2008. Sanctioning practices in an adult felony drug court. *Drug Court Review* 6 (1): 1–31.

Burdon, William M., John M. Roll, Michael L. Prendergast, and Richard A. Rawson. 2001. Drug courts and contingency management. *Journal of Drug Issues* 31: 73–90.

Harrell, Adele, and John Roman. 2001. Reducing drug use and crime among offenders: The impact of graduated sanctions. *Journal of Drug Issues* 31: 207–32.

Higgins, Stephen T., Kenneth Silverman, and Sarah H. Heil (Eds.). 2008. *Contingency management in substance abuse treatment*. New York: Guilford.

Lindquist, Christine H., Christopher P. Krebs, and Pamela K. Lattimore. 2006. Sanctions and rewards in drug court programs: Implementation, perceived efficacy, and decision making. *Journal of Drug Issues* 36: 119–146.

Marlowe, Douglas B. 2007. Strategies for administering rewards and sanctions. In *Drug Courts: A New Approach to Treatment and Rehabilitation,* edited by James E. Lessenger, and Glade F. Roper, 317–336. New York, NY: Springer.

Marlowe, Douglas B. 2008. Application of Sanctions [Monograph Series No. 9]. In Quality Improvement for Drug Courts: Evidence-based Practices, edited by Carolyn Hardin & Jeffrey N. Kushner, 107–114. Alexandria, VA: National Drug Court Institute.

Marlowe, Douglas B., and Kimberly C. Kirby. 1999. Effective use of sanctions in drug courts: lessons from behavioral research. *National Drug Court Institute Review* 2: 1–31.

Marlowe, Douglas B., and Conrad J. Wong. 2008. Contingency Management in Adult Criminal Drug Courts. In *Contingency Management in Substance Abuse Treatment,* edited by Stephen T. Higgins, Kenneth Silverman, and Sarah H. Heil, 334–354. New York: Guilford Press.

Petry, Nancy M. 2000. A comprehensive guide to the application of contingency management procedures in clinical settings. *Drug & Alcohol Dependence* 58 (1–2): 9–25.

Stitzer, Maxine L. 2008. Motivational incentives in drug courts. In *Quality Improvement for Drug Courts: Evidence-based Practices,* edited by Carolyn Hardin & Jeffrey N. Kushner, 97–105. Alexandria, VA: National Drug Court Institute.

---

1 Carey, Shannon M., Michael W. Finigan, and Kimberly Pukstas. 2008. *Exploring the key components of drug courts: A comparative study of 18 adult drug courts on practices, outcomes and costs.* Portland, OR: NPC Research. *Available at* www.npcresearch.com.

2 Carey, Finigan, and Pukstas. *Exploring the key components of drug courts.*

3 Festinger, David S., Douglas B. Marlowe, Patricia A. Lee, Kimberly C. Kirby, Gregory Bovasso, and A. Thomas McLellan. 2002. Status hearings in drug court: When more is less and less is more. *Drug & Alcohol Dependence* 68: 151–157.

4 Marlowe, Douglas B., David S. Festinger, Patricia A. Lee, Karen L. Dugosh, and Kathleen M. Benasutti. 2006. Matching judicial supervision to clients' risk status in drug court. *Crime & Delinquency* 52: 52–76.

5 Marlowe, Douglas B., David S. Festinger, Karen L. Dugosh, Patricia A. Lee, and Kathleen M. Benasutti. 2007. Adapting judicial supervision to the risk level of drug offenders: Discharge and six-month outcomes from a prospective matching study. Drug & Alcohol Dependence 88 (Suppl 2): 4–13.

6 Petry, Nancy M., Jessica M. Peirce, Maxine L. Stitzer, Jack Blaine, John M. Roll, Allan Cohen, et al. 2005. Effect of prize-based incentives on outcomes in stimulant abusers in outpatient psychosocial treatment programs. *Archives of General Psychiatry* 62: 1148–1156.

7 Sigmon, Stacey C., and Maxine L. Stitzer. 2005. Use of a low-cost incentive intervention to improve counseling attendance among methadone-maintained patients. *Journal of Substance Abuse Treatment* 29: 253–258.

8 Petry, Nancy M., Ken B. Kolodner, Rui Li, Jessica M. Peirce, John M. Roll, Maxine L. Stitzer, et al. 2006. Prize-based contingency management does not increase gambling. *Drug & Alcohol Dependence* 83: 269–273.

9 Festinger, David S., Douglas B. Marlowe, Jason R. Croft, Karen L. Dugosh, Nicole K. Mastro, Patricia A. Lee, et al. 2005. Do research payments precipitate drug use or coerce participation? *Drug & Alcohol Dependence* 78: 275–281.

10 Festinger, David S., Douglas B. Marlowe, Karen L. Dugosh, Jason R. Croft, and Patricia L. Arabia. 2008. Higher magnitude cash payments improve research follow-up rates without increasing drug use or perceived coercion. *Drug & Alcohol Dependence* 96: 128–135.

11 Roll, John M., Michael L. Prendergast, Keeli Sorenson, Sharlyn Prakash, and Joy E. Chudzynski. 2005. A comparison of voucher exchanges between criminal justice involved and noninvolved participants enrolled in voucher-based contingency management drug abuse treatment programs. *American Journal of Drug & Alcohol Abuse* 31: 393–401.

12 Burke, Kevin, and Steve Leben. 2007. Procedural fairness: A key ingredient in public satisfaction. *Court Review* 44: 4–24.

13 Thibaut, John W., and W. Laurens Walker. 1975. *Procedural Justice: A Psychological Analysis*. Hillsdale, NJ: Erlbaum.

14 Tyler, Tom R. 1994. Psychological models of the justice motive: Antecedents of distributive and procedural justice. *Journal of Personality & Social Psychology* 67: 850–63.

15 Sherman, Lawrence W. 1993. Defiance, deterrence, and irrelevance: A theory of the criminal justice sanction. *Journal of Research on Crime & Delinquency* 30: 445–73.

16 Carey, Finigan, and Pukstas. *Exploring the key components of drug courts.*

17 DeMatteo, David S., Douglas B. Marlowe, David S. Festinger, and Patricia L. Arabia. 2009. Outcome trajectories in drug court: Do all participants have serious drug problems? *Criminal Justice & Behavior* 36: 354–368.

18 Marlowe, Douglas B., David S. Festinger, Patricia L. Arabia, Karen L. Dugosh, Kathleen M. Benasutti, Jason R. Croft, and James R. McKay. 2008a. Adaptive interventions in drug court: A pilot experiment. *Criminal Justice Review* 33: 343–360.

19 Marlowe, Douglas B., David S. Festinger, Patricia L. Arabia, Karen L. Dugosh, Kathleen M. Benasutti, and Jason R. Croft. 2009. Adaptive interventions may optimize outcomes in drug courts: a pilot study. *Current Psychiatry Reports* 11: 370–376.

20 Sisson, Robert W., Nathan H. Azrin. 1989. The community reinforcement approach. In *Handbook of Alcoholism Treatment Approaches: Effective Alternatives,* edited by Reid K. Hester, and William R. Miller, 242–258. Elmsford, NY: Pergamon.

21 Deci, Edward L., Richard Koestner, and Richard M. Ryan. 1999. A meta-analytic review of experiments examining the effects of extrinsic rewards on intrinsic motivation. *Psychological Bulletin* 125: 627–668.

22 Ledgerwood, David M., and Nancy M. Petry. 2006. Does contingency management affect motivation to change substance use? *Drug & Alcohol Dependence* 83: 65–72.

23 Messina, Nena, David Farabee, and Richard Rawson. 2003. Treatment responsivity of cocaine-dependent patients with antisocial personality disorder to cognitive-behavioral and contingency management interventions. *Journal of Consulting & Clinical Psychology* 71: 320–329.

24 Marlowe, Douglas B., Kimberly C. Kirby, David S. Festinger, Stephen D. Husband, and Jerome J. Platt. 1997. Impact of comorbid personality disorders and personality disorder symptoms on outcomes of behavioral treatment for cocaine dependence. *Journal of Nervous and Mental Disease* 185: 483–490.

25 Silverman, Kenneth, Conrad J. Wong, Annie Umbricht-Schneiter, Ivan D. Montoya, Charles R. Schuster, and Kenzie L. Preston. 1998. Broad beneficial effects of cocaine abstinence reinforcement among methadone patients. *Journal of Consulting & Clinical Psychology* 66: 811–824.

26 Marlowe, Douglas B., David S. Festinger, Karen L. Dugosh, Patricia L. Arabia, and Kimberly C. Kirby. 2008b. An effectiveness trial of contingency management in a felony pre-adjudication drug court. *Journal of Applied Behavior Analysis* 41: 565–577.

Chapter 8

Constitutional and Legal Issues in Drug Courts

Honorable William G. Meyer (Ret.)

I. [§8.1] INTRODUCTION 163
II. [§8.2] FIRST AMENDMENT 163
III. [§8.3] FOURTH AMENDMENT AND RELATED ISSUES 164
IV. [§8.4] DUE PROCESS 165
V. [§8.5] DRUG TESTING AND DUE PROCESS 169
VI. [§8.6] JUDICIAL IMPARTIALITY AND DUE PROCESS. 170
VII. [§8.7] DRUG COURT SANCTIONS AND DUE PROCESS 171
VIII. [§8.8] EQUAL PROTECTION 172
IX. [§8.9] RIGHT TO COUNSEL 173
X. [§8.10] DOUBLE JEOPARDY 174
XI. [§8.11] RELATED ISSUES 174
XII. [§8.12] CONCLUSION 175

I. [§8.1] INTRODUCTION

The legal and constitutional issues arising in drug courts are pervasive and complex: from First Amendment Establishment Clause prohibitions, to the scientific reliability of drug-testing results, and to the due process rights of drug court participants in termination proceedings and during the sanctioning process.

This chapter does not attempt to collect and analyze all the relevant law from each drug court jurisdiction. By highlighting significant issues, the author gives a starting point from which to begin the research applicable to that court. Additionally, the author is advocating certain best legal practices for operational drug courts. While all these practices may not be required in a particular jurisdiction, they reflect a standard of practice that merges the therapeutic benefits of drug court procedure and the highest legal standard of due process.

II. [§8.2] FIRST AMENDMENT

As an adjunct to treatment, drug courts frequently refer drug court participants to 12-step programs such as Alcoholics Anonymous (AA) or Narcotics Anonymous (NA). The treatment provider or the court expect the participant to "work" or complete the 12-steps of the program. While these 12-step programs declare a tolerance for each person's personal vision of God, the writings of AA and NA encourage the participant to commit to the existence of a Supreme Being.[1]

Citing the Establishment Clause[2] of the First Amendment to the Constitution, courts have consistently held that requiring an individual to participate in an AA or NA program is unconstitutional.[3] Ironically, courts have not accorded evidentiary privilege protection to communications by attendees in such programs.[4]

Although court-mandated participation in AA and NA may run afoul of the First Amendment, such referrals are not prohibited where there are alternatives available. The Establishment Clause is violated when the state coerces the participant to engage in a religious activity.[5] Where there are other 12-step or secular self-help groups to which the drug court participant can readily be referred, use of AA or NA groups is constitutional for those individuals who do not object.[6] For offenders who do object to the deity-based 12-step programs, placement in a secular program is appropriate.[7]

Ordering AA or NA without secular alternatives violates the First Amendment.

Thus, where 12-step referrals are used, the author recommends that the drug court judge should ensure that the team surveys the community for the availability of secular 12-step or other self-help programs and provides the drug court participant a secular alternative when requested.[8]

Drug court practices also implicate the First Amendment Freedom of Speech and Association Clause.[9] As a condition of program enrollment, judges often prohibit drug court participants from being in certain geographic locales (area restrictions) or associating with certain individuals (association restrictions). Area restrictions have survived constitutional attack when they are narrowly drawn.[10] The factors often used in determining whether the restriction is reasonable include whether the defendant has a compelling need to go through or to the area, a mechanism for supervised entry into the area, the geographic size of the restricted area, and the relationship between the restriction and the rehabilitation needs of the offender.[11]

To be Constitutional, area and association restrictions must be narrowly drawn and reasonably related to the rehabilitation needs of the participants.

Similarly, the courts have routinely upheld association restrictions as a condition of supervision. Constitutional attacks on such provisions are unavailing when the conditions are reasonably related to the purposes of probation, the prevention of crime, and protection of the public.[12]

III. [§8.3] FOURTH AMENDMENT AND RELATED ISSUES

Under the Fourth Amendment, individuals cannot be arrested nor have their person and property searched without probable cause. Drug court participation is often contingent upon a defendant's agreement to execute a search waiver, by which the participant consents to a physical and property search, often without cause, day or night.

However, searches of probationers without a warrant are upheld based upon reasonable suspicion,[13] and because of the distinctions between jurisdictions, including state and federal differences, every judge and team must be aware of the terms of the waiver. Probable cause is not required because probation is a form of criminal sanction which subjects the probationer to reasonable restraints on liberty and the states' need to control the risk for recidivism that probationers present.[14] The U.S. Supreme Court recently upheld a search solely based upon a parolee's execution of a search waiver.[15] Previously, several states have found that a search waiver alone justifies a suspicionless, warrantless search—at least as it relates to cases where the offender's status is as a probationer or parolee.[16] The constitutionality of a search solely based upon a search waiver for offenders on bond or other nonconvicted status is in doubt.[17]

The validity of search conditions may depend on the status of the participant—on probation, preadjudication, or on bond.

This same distinction arises when mandating random drug testing as a condition of probation or parole,[18] contrasted with orders requiring drug testing as a condition of

pretrial release.[19] A condition of bond or pretrial release which requires drug testing implicates the Fourth Amendment and must be reasonable, based upon an individualized assessment that a person may use drugs during pretrial release.[20] The individualized suspicion can be based upon drug convictions or self-reported drug use.[21]

Related to the drug-testing issue as a condition of release or sentence is a court order prohibiting the drug court participant from consuming a legal substance—alcohol. Where the defendant has been convicted, the alcohol abstinence condition must be reasonably related to the defendant's reformation or protection of the public.[22] As noted in one case:[23]

> Presumably for this very reason, the vast majority of drug treatment programs, including the one Beal [the appellant] participates in as a condition of her probation, require abstinence from alcohol use (Am. U. Sch. Pub. Affairs, 1997 Drug Court Survey Report: Executive Summary, p. 49). Based on the relationship between alcohol and drug use, we conclude that substance abuse is reasonably related to the underlying crime and that alcohol use may lead to future criminality where the defendant has a history of substance abuse and is convicted of a drug-related offense.

In the pretrial release context, alcohol prohibition clauses have been held to be valid as long as reasonably related to assuring the defendant's future appearance in court.[24]

IV. [§8.4] DUE PROCESS

"[Nor] shall any state deprive any person of life, liberty, or property without due process of law."

~ U.S. Constitution[25]

Because drug courts utilize nonconfrontational, often streamlined procedures, the danger exists that drug court offenders will not be fully accorded their due process rights. In fact, commentators have cited the nonadversarial nature of drug courts as promoting a tension with participants' due process rights.[26] Despite certain informalities, and cooperation between counsel, drug courts must adhere to Key Component 2 of the Ten Key Components (included on page of this 217 benchbook):

> Using a nonadversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights.[27]

Procedural protections are due under the Due Process Clause when the defendant will potentially suffer impairment to a recognized liberty or property right under the Fourteenth Amendment.[28] If due process applies, the question remains, what process is due?[29] Due process is flexible and requires the procedural protections that the situation demands.[30] Procedural due process obligations in drug court are usually identified with revocation of probation, termination from drug court, and the imposition of sanctions, which often involve an individual's liberty rights.[31]

Termination from drug court can involve the enforcement of preenrollment agreements by which the participant consents to a court trial based solely upon the police complaint. If the consent is knowingly, voluntarily, and intelligently given, the stipulated fact trial does not violate due process.[32] However, a stipulation to a trial based solely upon the police report does not relieve the prosecution from its obligation to prove the charge beyond a reasonable doubt before the accused can be found guilty.[33] The same standards of a knowing intelligent waiver are applicable to a drug court participant foregoing, as part of a plea agreement, the right to appeal,[34] the right to contest a search,[35] or even the right to forgo incarceration credit when jail is a sanction and program participation is revoked and a prison sentence is imposed.[36] The obligation of all counsel and judges to educate themselves about drug courts, so as to properly advise clients, was addressed by Judge May in *Smith v. State*:[37]

The court can and should prohibit drinking alcohol while in the program.

> Drug courts have been in existence since 1989, originating from the creativity, hard work, and ingenuity of Chief Judge Gerald T. Wetherington and Judge Herbert M. Klein. Since then the concept has spread throughout this country and the world. There are currently drug courts in forty-eight of our fifty states, and in England, Canada, Australia, South America, Bermuda, and the Caribbean. There are currently seventy-four drug courts (thirty-eight adult, twenty-two juvenile, twelve dependency, and two reentry) in the State of Florida. It is essential that lawyers educate themselves as to the availability, requirements, and appropriateness of drug court programs. Only then can they effectively advise their clients. It is equally important for the institutions that educate future lawyers, as well as those that educate the other disciplines that play vital roles in the drug court process to incorporate drug courts into their curricula. For lawyers to do otherwise is for them to become legal dinosaurs. To ignore the need to learn about the drug court process is to ignore the evolution of the justice system. The sooner the Bar educates itself, the sooner the issue raised in this case will become extinct.

Usually, terminations from drug court require notice, a hearing, and a fair procedure.[38] However, a participant who self-terminates from drug court is not entitled to a pretermination hearing.[39] Many drug court participants are not on formal probation, but are on a diversion, deferred prosecution, deferred judgment, or deferred sentencing status. The consequences of termination from drug court are comparable to those sustained in a probation revocation. Consistent with several state rulings on this issue, the author concludes that the best practice is to accord drug court participants the same due process rights enjoyed by probationers.[40] In *Gagnon v. Scarpelli*, the U.S. Supreme Court required a probationer be accorded a preliminary and final revocation hearing.[41] Before the preliminary hearing, the probationer must be notified of the hearing, its purpose and the alleged violation, the limited right to confront and call witnesses, and the probationer's right to be present, as well as given a written report of the hearing.[42] At

the probation revocation hearing, similar elements are required including (1) written notice of the violation;[43] (2) disclosure of the evidence against the probationer; (3) an opportunity to be present and testify; (4) the right to confront and cross-examine adverse witnesses; (5) a neutral magistrate; and (6) a written finding of the evidence relied upon and the reasons for revocation. [44] Jurisdictions are divided on whether the drug court defendant can waive some or all of these rights, in advance, by signing a contract.[45] In *Staley v. State*, a panel of the Florida Court of Appeals held that a drug court participant, upon entry to the drug court, could not contractually waive the substantive due process rights attendant to a revocation hearing.[46]

The law in this area is very much in a state of flux. Recent decisions from the state of Idaho are a good example. In *State v. Rogers*,[47] the Idaho Court of Appeals held that the terms of the drug court contract governed the process by which termination would occur. Holding that the full panoply of due process rights present in a probation revocation hearing were not required in a drug court revocation proceeding, if the limitation was voluntarily agreed to by the defendant, the Idaho appellate court recommended the trial court nonetheless grant the drug court participant the same rights accorded a defendant facing revocation of probation.[48] In October 2007, the Idaho Supreme Court reversed, holding that protections akin to those given a probationer should be accorded a drug court defendant who has pled guilty but is on deferred sentence diversionary status.[49] Recognizing that the procedures in drug courts may differ, the Idaho Supreme Court held that different due process safeguards may be appropriate for other jurisdictions:

Best practice is to apply probation revocation standards of due process for drug court terminations.

> As a preliminary matter, a short discussion of Idaho's drug court program is warranted. The introduction of the problem-solving approach in the courts has given rise to innovative diversion efforts such as drug court programs. In 2001, the Idaho legislature enacted the Idaho Drug Court Act, by 2005 amendment now known as the Idaho Drug Court and Mental Health Court Act (the "Act"). I.C. §§ 19-5601, *et seq.* The Act provides, *inter alia,* that the district court in each Idaho county may establish a drug court. I.C. § 19-5603. With the exception of eligibility standards, *see* I.C. § 19-5604, the Act itself provides no guidance on the inner workings or procedures to be followed by a drug court. Instead, the Act authorized the Idaho Supreme Court to establish a Drug Court and Mental Health Court Coordinating Committee and vested it with responsibility for establishing standards and guidelines and providing ongoing oversight of the operation of drug courts. I.C. § 19-5606. Effective September 26, 2003, the Committee has adopted guidelines for adult drug courts. *See* Idaho Adult Drug Court Guidelines for Effectiveness and Evaluation. These guidelines do not specify exactly how a drug court program must be run and, as specifically stated therein, the guidelines "are not rules of procedure and have no effect of law." In addition, effective August 15, 2005, the Idaho

> Supreme Court adopted an administrative rule to provide additional direction for the development, establishment, operations, and termination of drug courts and mental health courts. *See* Idaho Court Administrative Rule 55. As relevant to the instant appeal, the rule addresses primarily how a drug court is created and it does not mandate that a drug court program must be operated in any particular way.
>
> As of January 2006, Idaho had forty-four drug courts in operation spread out over approximately twenty-three counties and at differing levels of the judicial system within some counties. From the above discussion, it must be assumed that each drug court in Idaho operates uniquely and, therefore, the analysis in this case might not be applicable to any other particular drug court program in the state.[50]

The recent case, *People v. Kimmel,*[51] held that in a mental health/drug court, the defendant was not entitled to a hearing per se, but was entitled to make a statement and have counsel present arguments on why the defendant should not be removed from the program where he failed to appear for over eight months. Contrary to *Kimmel* are recent decisions from Indiana and Virginia appellate courts, holding that drug court participants are entitled to hearings because drug court termination affect liberty interests and therefore the Due Process Clause.[52] The author recommends that the termination process from drug court include the full panoply of rights accorded a probationer facing a revocation of probation petition. Of course, assuming there are no jurisdictional, statutory, or ethical barriers, there is no reason that the termination and revocation hearings cannot be combined.

Specimen testing must meet evidentiary standards.

Conspicuously absent from federal due process requirements is the right to counsel at probation preliminary and revocation hearings. Although the federal constitution does not mandate the right to counsel at probation preliminary and revocation hearings,[53] many states accord probationers facing revocation such a right.[54] The author endorses the right to counsel for drug court participants facing revocation or program termination, where the underlying crime is a felony or where the potential penalty may include a jail sentence.[55]

At the probation revocation hearing, the full constitutional procedural protections do not apply.[56] There is no jury trial right[57] and double jeopardy does not apply[58] to a revocation hearing. In certain circumstances, the probationer cannot attack the underlying conviction or guilty plea.[59] In most jurisdictions, the Fourth Amendment does not apply to probation revocation proceedings,[60] and the Fifth Amendment[61] and *Miranda*[62] are not fully applicable to probation revocation proceedings. Additionally, revocation allegations usually need not be proven beyond a reasonable doubt.[63] Finally, the rules of evidence do not apply at a probation hearing and hearsay is admissible.[64]

Despite the lessened procedural requirements for termination from drug court or probation revocation hearings, due process requires that these proceedings be conducted according to the Fourteenth Amendment's concept of fundamental fairness.[65] For

example, in an opinion involving a drug court, a five-part test was adopted to determine whether the evidence supporting termination from a treatment program was sufficiently reliable to meet due process requirements.[66] The factors the court considered included the following:

- Whether a hearsay report by the treatment provider was corroborated
- The reliability of the source of the information and, if provided by unnamed informants, the reason for identity nondisclosure
- The provision of a hearing with opportunity to fully cross-examine adverse witnesses
- Whether a preponderance of the evidence supported termination
- The disparity of the sentence upon completion and noncompletion

Issues of reliability are not just centered on the admission of hearsay evidence at termination/revocation proceedings. Frequently, termination/revocation is based upon the results of drug testing.

V. [§8.5] DRUG TESTING AND DUE PROCESS

The reliability of drug test results under the Federal Rules of Evidence (FRE) is dependent upon the witness being qualified to opine about the matter at issue and whether the scientific testing meets the standards of *Daubert v. Merrell Dow Pharmaceuticals*.[67] While some states have adopted *Daubert*, others rely upon Daubert's predecessor *Frye v. United States*.[68] Some other states use an analysis based upon FRE 702,[69] or they have devised their own formulation.[70]

The purpose of this section is not to be an exhaustive dissertation on the reliability of drug-testing techniques, but rather to highlight some of the reliability issues and their potential impact on due process. The most common modalities of drug detection in drug court include testing samples from urine, hair, and sweat.[71]

Urine drug-detecting testing is usually done by instrumented testing or nonlaboratory, on-site testing or a combination of both. One common methodology for urine testing is the enzyme multiple immunoassay technique (EMIT). The EMIT test does not measure the amount of drugs in the urine but instead measures the reaction of an enzyme to a particular drug.[72] EMIT results have been found to be reliable when confirmed with a second EMIT test.[73] Contentions that the EMIT results must be confirmed with an independent method of drug testing before the results meet due process reliability standards have been rejected.[74] As noted in Chapter 6, "The Fundamentals of Drug Testing," this is not a best practice since whatever cross-reaction may be occurring will not be resolved by a second test using the same analysis method. Other urine testing such as the fluorescein polarization immunoassay test (FPIA) and thin layer chromatography have been found to be reliable, at least where the proponent has established the necessary foundation.[75]

If they deny use, participants may be charged the cost for confirmed tests.

To conserve costs and obtain rapid results, many drug courts rely upon noninstrumented on-site test cups or dip sticks. The reliability of such testing instruments has been the source of considerable debate,[76] particularly in the area of methamphetamine.[77] If on-site, noninstrumented testing is used and the drug court participant denies such use, the author recommends the urine specimen should be retested by instrumented testing, preferably by gas chromatography/mass spectrometry (GC-MS).[78] If the retest returns another positive result, the drug court participant may be assessed the retest cost[79] and sanctioned for lack of candor.[80] A word of caution: drug courts must be aware of the cutoff levels of both the on-site test and the instrumented test, since differing results could be attributed to different cutoff levels. As noted in Chapter 6, in almost all cases the cutoff levels used in confirmation will be lower than those of the presumptive or noninstrumented tests. This will help to avoid misinterpretations.

Some drug courts are employing the sweat patch to determine drug usage. The patch is composed of an absorbent pad with an outer membrane which is placed on the wearer's back or forearm. The patch is designed to collect the wearer's sweat and any drug or drug metabolite over the period that patch is attached—approximately one week.[81] Although generally held to be reliable, there is evidence that the patch can test positive from contamination or exposure to drugs not ingested by the wearer.[82]

Hair is also analyzed to determine drug usage. The obvious problem with hair testing for drug usage is the high potential for environmental contamination, and the reliability of the methodology used to determine the presence of drugs or drug metabolites in the hair specimen.[83]

Another test finding favor in drug courts is a test for Ethyl Glucuronide (EtG), which is a metabolite of alcohol. The presence of EtG in urine reportedly provides proof of prior alcohol consumption, even after the alcohol itself has been eliminated from the body.[84] EtG results have been questioned, and using a cut-off level that is sufficiently high is critical because of the real possibility of incidental or environmental exposure to alcohol.[85]

As a preface to establishing the general reliability of the testing methodology to meet due process guarantees, the proponent must connect the specimen collected and tested to the person against whom it is offered.[86] Although hearsay is admissible at the revocation/termination/disciplinary hearing, due process requires that the proffered hearsay evidence have sufficient indicia of reliability before it can be relied upon to discipline.[87]

VI. [§8.6] JUDICIAL IMPARTIALITY AND DUE PROCESS[88]

Due process requires that a judge possess neither actual nor apparent bias[89] in favor of or against a party. The standard for determining the appearance of bias or partiality is an objective one.[90] Usually the basis of recusal is due to partiality or bias acquired outside the context of the proceedings—or from an "extrajudicial source."[91]

Additionally, a judge should recuse where the court has personal knowledge of disputed facts.[92]

Judges sitting in drug court often have substantial information about drug court participants—some of which was gained through on-the-record colloquies and pleadings, as well as informal staffings with defense counsel, the prosecutor, the treatment provider, and probation. The Oklahoma Supreme Court[93] recognized the potential for accusations of bias against a drug court judge for information obtained in the court's supervisory role and recommended an alternate judge handle termination proceedings:

> However, we recognize the potential for bias to exist in a situation where a judge, assigned as part of the drug court team, is then presented with an application to revoke a participant from drug court. Requiring the district court to act as drug court team member, evaluator, monitor, and final adjudicator in a termination proceeding could compromise the impartiality of a district court judge assigned the responsibility of administering a drug court participant's program.
>
> Therefore, in the future, if an application to terminate a drug court participant is filed and the defendant objects to the drug court team judge hearing the matter by filing a motion to recuse, the defendant's application for recusal should be granted and the motion to remove the defendant from the drug court program should be assigned to another judge for resolution.

Recent decisions have held that a drug court judge does not violate the defendant's due process rights by presiding over the termination or the revocation hearing.[94] Although not necessarily required, the author recommends that the drug court judge give the defendant the opportunity to recuse the judge, and the drug court judge should not be the judge conducting termination or probation revocation hearings, unless the participant and defense counsel specifically consent in writing to the judge hearing such matters.[95]

Due process and judicial impartiality concepts may require a different judge hear termination matters.

VII. [§8.7] DRUG COURT SANCTIONS AND DUE PROCESS

Closely related to the issue of termination/revocation is the use of jail as a sanction for program noncompliance. Does due process mandate all the procedural requirements contained in a revocation/termination hearing, even where the defendant has consented to the imposition of such sanctions as a condition to drug court participation? A person facing a probation revocation or drug court termination proceeding[96] is constitutionally entitled to an array of due process rights, including a hearing.[97] Similarly, a prison inmate

must be accorded certain due process rights, including a hearing, if the disciplinary proceeding could jeopardize good or earned time credits.[98] It seems incongruous indeed, for a drug court participant to not be entitled to a hearing where jail is a possible sanction[99] but a prisoner or parolee would be so entitled. At least one court has held that the drug court participant cannot, in advance, waive the right to be accorded the due process rights associated with a revocation hearing.[100] It is the position of the author that the best practice would dictate that, when the drug court participant contends that he or she did not engage in the conduct that is subject to a jail sanction, the court should give the participant a hearing with notice of the allegations, the right to be represented by counsel, the right to testify, the right to cross-examine witnesses, and the right to call his or her own witnesses.[101] The author believes that the hearing should be expedited (within two days), consistent with the participant's need to prepare for the hearing.[102]

Participants are entitled to a hearing where jail is a possible sanction.

Nondrug court participants have attacked, as a violation of due process, the assessment of drug court or mental health court fees, which are used to support these programs.[103] In denying the relief requested, the court characterized the assessments as fines not fees and found that the fines were not grossly excessive and were rationally related to the crime for which the defendant was sentenced—drug possession.[104]

VIII. [§8.8] EQUAL PROTECTION

"[N]or [shall any state] deny any person within its jurisdiction the equal protection of the laws."

~ U.S. Constitution[105]

Constitutional attacks on drug courts based upon equal protection grounds are usually based upon admittance or refusal to admit a defendant into the drug court program. The Fourteenth Amendment Equal Protection Clause guarantees that persons similarly situated with respect to a legitimate purpose of the law will receive like treatment. Three tests are used to determine whether a classification violates equal protection. When the legislation or governmental act involves a fundamental right or creates a suspect class, the strict scrutiny test is used.[106] An intermediate level of scrutiny is used when the classification impacts a liberty right and a semi-suspect class exists.[107] Under the third test, the classification must simply have a rational relationship to a legitimate governmental objective.[108]

The admission or exclusion of a defendant from a drug court program is analyzed under the rational basis equal protection test.[109] In *State v. Harner*,[110] the defendant complained that the absence of a drug court, where he was charged, violated his equal protection rights when such courts were available in adjacent counties. The Washington Supreme Court

held that because each county needed to tailor its programs to meet fiscal resources and community obligations, the decision not to fund a drug court was rationally related to a legitimate governmental purpose.[111] Other jurisdictions have followed the *Harner* rationale and have also held that the defendant is not entitled to a hearing before being rejected for drug court.[112]

Best practice requires a hearing where the facts upon which a sanction may be based are disputed.

In the recent case of *Evans v. State*,[113] a defendant, who was HIV positive, argued that his exclusion from drug court violated equal protection and the Americans with Disabilities' Act (ADA). The appellate court rejected his contention stating that it was not his HIV status that excluded him from drug court, but his complicated medical requirements, including the need for multiple medications which the program was ill equipped to handle. Such a justification presented a rational basis for rejection of Evans. Because Evans failed to demonstrate that his disabilities (HIV and mental illness) affected major life activities, he did not qualify for protection under the ADA.

Defendants have similarly argued that when a drug court is available in the local jurisdiction, it is a denial of equal protection to not make it available to all defendants. Appellate decisions have rejected such assertions because there is no right to enter drug court.[114] Similarly, constitutional attacks based upon a State's Privileges and Immunities Clause have been rejected.[115]

There is no constitutional right to enter the drug court.

Drug court participants have also averred that placing them in a drug court program constitutes a violation of equal protection. Applying the rational basis test, the New Mexico Court of Appeals held that juveniles could not reject the drug court term of probation because of strong rehabilitation goals in juvenile proceedings and the state's role of acting as *parens patriae* in the best interests of the child.[116]

As a related issue, courts have addressed whether illegal alien status is a proper consideration in determining eligibility for drug court status. Although not reaching the equal protection issue, the California Appellate Courts have held illegal status is a proper consideration in determining eligibility for drug court and probation.[117]

IX. [§8.9] RIGHT TO COUNSEL

"In all criminal prosecutions, the accused shall have the right… to have the Assistance of Counsel for his defense"

~ U.S. Constitution[118]

The right to counsel extends to all felony prosecutions and to misdemeanor prosecutions where incarceration is actually imposed.[119] The right to counsel attaches at every critical stage of the proceedings, after initiation of adversarial judicial proceedings.[120]

Probation and parole revocation proceedings are not considered a critical stage under the federal constitution,[121] but virtually every state requires counsel at probation revocation proceedings if the defendant so requests. Some jurisdictions have held that a modification of the terms of probation is a critical stage of the proceedings, where the right to counsel attaches, at least where the modification adds significant terms to probation.[122] If the sanctioning process is analogous to modification of probation (and the author believes it is), defense counsel should be present at the proceeding if this line of precedent applies. Of course, the defendant can waive his right to counsel.[123] Before permitting a waiver, the court should make a searching inquiry into the defendant's understanding of the right to counsel, including the disadvantages of self-representation.[124] The sentencing hearing is a critical stage of the proceeding and counsel should be present, absent a waiver. [125]

X. [§8.10] DOUBLE JEOPARDY

"[No person shall] be subject for the same offense to be twice put in jeopardy of life or limb" [126]

~ U.S. Constitution

The Double Jeopardy Clause protects against a second prosecution for the same offense after either an acquittal or a conviction and multiple criminal punishments for the same offense.[127] The double jeopardy prohibition against being punished multiple times for the same offense does not prevent consideration of misconduct, such as positive urine tests, upon imposition of the original sentence or upon resentencing.[128] Although the Double Jeopardy Clause prohibits multiple criminal penalties for the same conduct, vehicle forfeitures and driver's license revocations do not violate the Double Jeopardy Clause because they are administrative rather than penal in nature.[129]

Generally, double jeopardy does not apply to disciplinary, probation, parole, or bond revocation proceedings.[130] In a recent decision, the North Dakota Supreme Court held that the imposition of drug court sanctions did not bar a subsequent prosecution and conviction for the identical conduct upon which the sanctions were based.[131] However, adding additional conditions to a defendant's probation, such as drug court, without a violation of probation violates double jeopardy.[132] Although most jurisdictions consider juvenile delinquency proceedings to be civil in nature, the Double Jeopardy Clause applies to any juvenile proceeding that has the potential to deprive the juvenile of liberty.[133]

XI. [§8.11] RELATED ISSUES

A recent case from the California Supreme Court held that dependency drug courts do not have the authority through use of the court's contempt powers to impose jail sentences on parents who are not compliant with their treatment or testing regimens. [134] The *Nolan* court reasoned that because reunification services are voluntary, the statutory

scheme only permits loss of custody and termination of parental rights as the consequence for parental noncompliance with ordered reunification services.[135]

In *Brown v. State*, the Maryland Public Defender's Office filed an action attacking the fundamental jurisdiction of the courts to set up and run a drug court program.[136] The highest appellate court in Maryland rejected the Public Defender's argument, holding that the Appellant confused lack of jurisdiction with acting in excess of jurisdiction and also rejected the double jeopardy contention as not being timely raised.

XII. [§8.12] CONCLUSION

Drug court legal obligations are dictated by state statutory and constitutional requirements and the minimum mandates of the United States Constitution. In some circumstances, the author's proffered legal standards exceed those required by the U.S. Supreme Court and state law. In particular, the author believes the following practices constitute the best practices in the drug court field:

- Determine the availability of nondeity based 12-step alternatives to AA and NA in the community and encourage their development, if not available.
- Ensure that drug court participants are fully informed of the consequences of drug court enrollment, and that the surrender of any rights by the participant is done knowingly, voluntarily, and intelligently.
- Provide drug court participants due process rights at probation revocation hearings, drug court termination proceedings, and at sanction proceedings where jail is a potential sanction and where the defendant contests the underlying factual basis for the alleged violation.
- When contested, sanctioning hearings should be expedited. Expedition should, of course, be tempered by giving counsel and sufficient time to the drug court participant to prepare.
- Require retesting, by instrumented confirmation of any on-site, noninstrumented positive drug test unless the drug court participant acknowledges use.

Adherence to constitutional and statutory requirements, as may be supplemented by the author's recommended enhancements, when coupled with effective therapeutic drug court practices, will ensure the drug court participant has the best opportunity to obtain sobriety.

---

1 For example, working the 12-steps requires that the participant confess to God "the nature of our wrongs" (Step 5), appeal to God to "remove our short comings" (Step 7), and make "contact" with God to achieve the "knowledge of his will" by "prayer and meditation" (Step 11). See Alcoholics Anonymous 59-60 (3rd ed. 1976); Narcotics Anonymous, Hospitals and Institutions Handbook 2 (2006). In fact, the 12-steps basic text of Alcoholics Anonymous and Narcotics Anonymous mentions God in five of the twelve tenets. Alcoholics Anonymous 59-60 (3rd ed. 1976); Narcotics Anonymous, Hospitals and Institutions Handbook 2 (2006).

2 The 1st Amendment of the U.S. Constitution states that "Congress shall make no law respecting an establishment of religion or prohibiting the full exercise thereof. . ." U.S. CONST. amend. I. The 1st Amendment of the U.S. Constitution applies to the states via the 14th Amendment of the U.S. Constitution. *Id.;* U.S. CONST. amend. XIV. *See also* Lee v. Weisman, 505 U.S. 577, 587 (1992).

3 Kerr v. Farrey, 95 F.3d 472, 479-80 (7th Cir. 1996) (holding that the prison violated the Establishment Clause by requiring attendance at Narcotics Anonymous meetings which used "God" in its treatment approach); Griffin v.

Coughlin, 673 N.E.2d 98, 98 (N.Y. 1996), *cert. denied,* 519 U.S. 1054 (1997) (holding that conditioning desirable privilege—family visitation—on prisoner's participation in program that incorporated Alcoholics Anonymous doctrine was unconstitutional because it violated the Establishment Clause); Warner v. Orange County Dep't of Prob., 115 F.3d 1068, 1068 (2d Cir. 1997), *aff'd,* 173 F.3d 120 (2d Cir. 1999), *cert. denied,* 528 U.S. 1003 (1999) (holding that the county governmental agency violated the Establishment Clause by requiring DUI probationer to participate in A.A.). *See also* Bausch v. Sumiec, 139 F. Supp. 2d 1029, 1029 (E.D. Wis. 2001); Arnold v. Tenn. Bd. of Trs., 956 S.W. 2d 478, 484 (Tenn. 1997); *In re* Garcia, 24 P.3d 1091, 1091 (Wash. Ct. App. 2001); Rauser v. Horn, No. 98-1538, 1999 U.S. Dist. LEXIS 22580 (W.D. Pa. Dec. 3, 1999), *rev'd on other grounds,* 241 F.3d 330 (3rd Cir. 2001); Alexander v. Schenk, 118 F. Supp. 2d 298, 300 n.1 (N.D. NY 2000); Yates v. Cunningham, 70 F. Supp. 2d 47, 49 (D.N.H. 1999); Warburton v. Underwood, 2 F. Supp. 2d 306, 316-318 (W.D.N.Y 1998); Inouye v. Kemna, 504 F.3d 705, 705 (9th Cir. 2007) (concluding that parole officer had lost qualified immunity because he forced AA on Buddhist); Hanas v. Inner City Christian Outreach, 542 F. Supp. 2d 683, 683 (E.D. Mich. 2008) (holding that the drug court program manager and the drug court consultant were liable for actions related to referral to faith based program, when they knew of participant's objections while in the program, and when the program denied the participant the opportunity to practice his chosen faith—Catholicism); Thorne v. Hale, No. 1:08cv601 (JCC), 2009 WL 980136 (E.D. Va. 2009) (holding that a valid § 1983 civil rights claim was presented in the complaint, where the complaint stated that Hale and Killian were to some extent responsible for implementing the treatment regimen which included mandatory participation in AA/NA); Compl. at 15, Thorne v. Hale, No. 1:08cv601 (JCC), 2009 WL 980136 (E.D. Va. Mar. 26, 2009) (claiming that Killian "was responsible for all recommendations to Drug Court for treatment and clinical matters," including "substance abuse issues."); *id.* at 76 (claiming that Thorne was "subjected to the State religions of AA and NA by. . . [the] directors" of the Drug Court and the RACSB); id. at 89 (alleging due process deprivations by the "Directors" of the RACSB and the Drug Court). Members of the drug court ultimately prevailed in the *Thorne v. Hale* litigation, when the trial court granted summary judgment on the basis of absolute judicial immunity and dismissed the case. *Id.* The Fourth Circuit affirmed the granting of the summary judgment motion. *Thorne v. Hale,* No. 09-2305, WL1018048 (4th Cir. Mar. 19, 2010). *Thorne v. Hale* is noteworthy, even in light of the dismissal, because the initial dismissal motion was denied and because, when coupled with *Hanas v. Inner City Christian Outreach,* the authority makes it patently clear that First Amendment violations can have consequences for drug court staff. *Id. Hanas,* 542 F. Supp. 2d at 683.

4 Cox v. Miller, 296 F.3d 89, 89 (2d Cir. 2002) (holding that a confession to murder in an AA meeting was not protected by cleric-congregant privilege, despite 5th step requiring participant to admit to God, other human beings, and themselves the exact nature of their wrongs).

5 Kerr v. Farrey, 95 F.3d 472, 479 (7th Cir. 1996).

6 O'Connor v. California, 855 F. Supp. 303, 308 (C.D. Cal. 1994) (finding that the Establishment Clause was not violated because the DUI probationer had several choices of programs, including self-help programs that are not premised on monotheistic deity); *In re* Garcia, 24 P.3d 1091, 1093 (Wash. Ct. App. 2001); Americans United v. Prison Fellowship, 509 F.3d 406, 406 (8th Cir. 2007) (holding that a state supported non-coercive, non-rewarding faith based program violated the Establishment Clause of the U.S. Constitution because an alternative was not available).

7 Bausch v. Sumiec, 139 F. Supp. 2d 1029, 1036 (E.D. Wis. 2001) (stating that the choices needed to be made known to the participant). *See also* De Stephano v. Emergency Housing Group, 247 F.3d 397, 397 (2d Cir. 2001).

8 A variety of programs exist. *See, e.g.,* Smart Recovery, http://www.smartrecovery.org (last visited Aug. 1, 2010); Agnostic AAnyc.org, http://www.agnosticaanyc.org (last visited Aug. 1, 2010); Rational Recovery, http://www.rational.org (last visited Aug. 1, 2010).

9 The 1st Amendment of the U.S. Constitution states that "congress shall make no law. . . abridging the freedom of speech." U.S. CONST. amend. I. *See also* Roberts v. U.S. Jaycees, 468 U.S. 609, 622 (1984); Bd. of Directors v. Rotary Club, 481 U.S. 537, 544 (1987).

10 Oyoghok v. Municipality of Anchorage, 641 P.2d 1267, 1267 (Alaska Ct. App. 1982) (conditioning probation on not being within a two block radius); Johnson v. State, 547 So. 2d 1048, 1048 (Fla. Dist. Ct. App. 1989) (prohibiting defendant from being near high drug areas); State v. Morgan, 389 So. 2d 364, 364 (La. 1980) (prohibiting entrance into the French Quarter); State v. Stanford, 900 P.2d 157, 157 (Haw. 1995) (supporting a prohibition against entering Waikiki area); People v. Pickens, 542 N.E.2d 1253, 1253 (Ill. App. Ct. 1989). *But see* People v. Beach, 195 Cal. Rptr. 381, 385 (Cal. Ct. App. 1983) (holding unconstitutional defendant's banishment from the community where she has lived for the last 24 years); State v. Wright, 739 N.E.2d 1172, 1172 (Ohio Ct. App. 2000) (reversing prohibition of entering any place where alcohol is distributed, served, consumed, given away, or sold because it restricted the defendant from grocery stores and the vast majority of all residences).

11 *See* People v. Rizzo, 842 N.E.2d 727, 727 (Ill. App. Ct. 2005).

12 Andrews v. State, 623 S.E.2d 247, 247 (Ga. Ct. App. 2005) (restricting drug court participant from associating with drug users and dealers); People v. Jungers, 25 Cal. Rptr. 3d 873, 873 (Cal. Ct. App. 2005) (prohibiting contact with wife). *But see* Dawson v. State, 894 P.2d 672, 672 (Alaska Ct. App. 1995) (holding the restriction of unsupervised contact with drug using wife was too broad); People v. Forsythe, 43 P.3d 652, 652 (Colo. App. Ct. 2001) (prohibiting unsupervised contact with his own children); Jones v. State, 41 P.3d 1247, 1247 (Wyo. 2001) (prohibiting contact with persons of disreputable character); State v. Hearn, 128 P.3d 139, 139 (Wash. Ct. App. 2006) (prohibiting the association with drug users or dealers is constitutional); Birzon v. King, 469 F.2d 1241, 1242 (2d Cir. 1972); Commonwealth v. LaPointe, 759 N.E.2d 294, 294 (Mass. 2001).

13 Griffin v. Wisconsin, 483 U.S. 868, 868 (1987).

14 United States v. Knights, 534 U.S. 112, 112 (2001).

15 Samson v. California, 547 U.S. 847, 843 (2006).

16 State v. Kouba, 709 N.W. 2d 299, 299 (Minn. Ct. App. 2006) (recognizing that a waiver is sufficient in probation cases); State *ex rel.* A.C.C., 44 P.3d 708, 708 (Utah 2002) (recognizing waiver in juvenile case, but limited case to the facts); State v. McAuliffe, 125 P.3d 276, 276 (Wyo. 2005) (recognizing complete waiver, but search must be reasonable).

17 *Compare* State v. Ullring, 741 A.2d 1065, 1065 (Me. 1999) (holding that a search waiver as a condition of bond is constitutional), *and In re* York, 40 Cal. Rptr. 2d 308, 308 (Cal. 1995), *with* Terry v. Superior Court, 86 Cal. Rptr. 2d 653, 653 (Cal. Ct. App. 1999) (holding that a 4th Amendment waiver is an improper condition in diversion case, without statutory authority), *and* United States v. Scott, 450 F.3d 863, 863 (9th Cir. 2006) (concluding that a search waiver is probably improper when a person is on bond). *See also* Butler v. Kato, 154 P.3d 259, 259 (Wash. Ct. App. 2007).

18 *See* United States v. Jordan, 485 F.3d 982, 982 (7th Cir. 2007) (holding that alcohol use restrictions as part of supervised release should be based upon need).

19 United States v. Scott, 424 F.3d 888, 888 (9th Cir. 2005) (drawing distinction).

20 Steiner v. State, 763 N.E. 2d 1024, 1024 (Ind. Ct. App. 2002); Oliver v. U.S., 682 A.2d 186, 192 (D.C. Cir. 1996); State v. Ullring, 741 A.2d 1045, 1045 (Me. 1999).

21 Berry v. Dist. of Columbia, 833 F.2d 1031, 1035 (D.C. Cir. 1987).

22 *See, e.g.,* State v. Patton, 119 P.3d 250, 250 (Ore. Ct. App. 2005); Payne v. State, 615 S.E. 2d 564, 564 (Ga. Ct. App. 2005); Commonwealth v. Williams, 801 N.E. 2d 804, 804 (Mass. App. Ct. 2004); Martin v. State, 517 P.2d 1399, 1399 (Alaska 1974); Carswell v. State, 721 N.E.2d 1255, 1255 (Ind. Ct. App. 1999); People v. Balestra, 90 Cal. Rptr. 2d 77 (Cal. Ct. App. 1999).

23 People v. Beal, 70 Cal. Rptr. 2d 80, 80 (Cal. Ct. App. 1997).

24 Martell v. County Court, 854 P.2d 1327, 1327 (Colo. Ct. App. 1992) (holding that if a condition of bail is to refrain from the use of alcohol or drugs, supervision may include drug or alcohol testing); State v. Magnuson, 606 N.W. 2d 536, 536 (Wis. 2000).

25 U.S. CONST. amend. XIV.

26 *See* Richard C. Boldt, *Rehabilitative Punishment and the Drug Court Movement,* 76 WASH. U. L. Q. 1205, 1233-1234 (1998); *In re* Hill, 803 N.Y.S. 2d 365, 365 (N.Y. 2005).

27 NAT'L. ASS'N. OF DRUG COURT PROF'LS & BUREAU OF JUSTICE ASSISTANCE, U.S. DEP'T OF JUSTICE, DEFINING DRUG COURTS: THE KEY COMPONENTS (1997).

28 Fuentes v. Shevin, 407 U.S. 67, 67 (1972).

29 Morrissey v. Brewer, 408 U.S. 471, 471 (1972).

30 *Id.* at 481.

31 Both due process and equal protection concerns can arise in cases involving access to justice. Due process is generally concerned with the opportunity to obtain a fair adjudication on the merits while equal protection is designed to insure no differential treatment to two similarly situated classes of offenders. See Evitts v. Lucey, 469 U.S. 387, 387 (1985) (holding that an indigents right is the same as a wealthy person's right to receive effective assistance of counsel for first appeal of right).

32 State v. Melick, 129 P.3d 816, 816 (Wash. Ct. App. 2006); Adams v. Peterson, 968 F.2d 835, 835 (9th Cir. 1992) (holding that a showing of a knowing, voluntary and intelligent waiver must be present and that the full Boykin v. Alabama, 395 U.S. 238, 238 (1969) inquiry is not necessary to implement waivers to a stipulated fact trial); State *ex rel.* T.M., 765 A.2d 735, 735 (N.J. 2001); People v. Anderson, 833 N.E.2d 390, 394-95 (Ill. App. 2005).

33 State v. Drum, 225 P.3d 237, 237 (Wash. 2010) (holding that a drug court contract was not equivalent to a guilty plea, but more akin to a deferred prosecution, and that a court must still make a determination of the legal sufficiency of the evidence to convict, irrespective of stipulation by the parties); State v. Colquitt, 137 P. 3d 892, 892 (Wash. Ct. App. 2006).

34 People v. Byrnes, 813 N.Y.S. 2d 924, 924 (N.Y. App. Div. 2006); Wall v. State, No. 212, 2005 Del. LEXIS 17 (Del. 2005); State v. Bellville, 705 N.W.2d 506, 506 (Iowa Ct. App. 2005) (holding that the defendant must know he has the right and is surrendering the right to appeal before it can be said that he waived the right to appeal); People v. Conway, 845 N.Y.S.2d 545, 545 (N.Y. App. Div. 2007) (addressing the waiver of appeal).

35 State v. Jones, 131 Wash. App. 1021, 1021 (Wash. Ct. App. 2006) (addressing a search waiver); Wilkinson v. State, 641 S.E.2d 189, 189 (Ga. Ct. App. 2006). As part of her drug court contract the defendant waived her ability to contest a search and move for recusal of the drug court judge. *Id.*

36 Laxton v. State, 256 S.W. 3d 518, 518 (Ark. Ct. App. 2007) (holding that drug court participant was not entitled to "sanction" jail time as credit because such credit was not included in the contract); Commonwealth v. Fowler, 930 A.2d 586, 586 (Pa. 2007) (holding that because defendant voluntarily entered program, he was not entitled to presentence credit for time spent in inpatient program); People v. Black, 176 Cal. App. 4th 145, 97 Cal. Rptr. 3d 338, 338 (Cal. Ct. App. 2009) (holding that the defendant waived pre drug court incarceration credit to enter drug court program). *But see* Commonwealth v. Gaddie, 239 S.W.3d 59, 59 (Ky. 2007) (holding that the court did

not have jurisdiction to increase suspended sentence from 180 days to 1 year, even though the defendant agreed to modification in order to enter drug court). *See also* House v. State, No. 48A02-0806-CR-537 (Ind. Ct. App. Feb. 2, 2009).

37 Smith v. State, 840 So.2d 404, 404 (Fla. Dist. Ct. 2003); Louis v. State, 994 So.2d 1190, 1190 (Fla. Dist. Ct. App. 2007) (determining whether there was ineffective assistance of counsel for not advising client of drug court).

38 People v. Anderson, 833 N.E.2d 390, 390 (Ill. App. Ct. 2005) (holding that drug court termination requires hearing); State v. Perkins, 661 S.E. 2d 366, 366 (S.C. Ct. App. 2008) (holding that termination decision not reviewable but defendant entitled to notice and hearing on whether defendant violated conditions of his suspended sentence by being terminated from drug court). *See also infra* note 40.

39 State v. Varnell, 155 P.3d 971, 971 (Wash. Ct. App. 2007).

40 *See* People v. Anderson, 833 N.E.2d 390, 390 (Ill. App. Ct. 2005); State v. Cassill-Skilton, 94 P.3d 407, 410 (Wash. Ct. App. 2004); Hagar v. State, 990 P.2d 894, 899 (Okla. Crim. App. 1999); State v. Rogers, No. 31264, 2006 WL 2422648 (Ida. Ct. App. Aug. 22, 2006) (holding that contract waived such protections when knowingly and intelligently entered into), *rev'd,* State v. Rogers, 170 P. 3d 881, 881 (Idaho 2007) (holding that termination hearings required in drug courts, at least where defendant pled guilty and sentence deferred).

41 Gagnon v. Scarpelli, 411 U.S. 778, 781-782 (1973).

42 *Id.* at 786.

43 Black v. Romano, 471 U.S. 606, 612 (1983). *See also* Lawson v. State, 969 So.2d 222, 222 (Fla. 2007) (holding that the right to receive adequate notice of the conditions of probation is in part realized through the requirement that a violation be substantial and willful, however, the court need not define how many violations it will take to constitute a willful violation). *Id.*

44 Gagnon, 411 U.S. at 781-2.

45 *Compare* Staley v. State, 851 So.2d 805 (Fla. Dist. Ct. App. 2003), *with* State v. Rogers, No. 31264, 2006 WL 2422648 (Ida. Ct. App. Aug. 22, 2006).

46 *Staley,* 851 So.2d at 807.

47 State v. Rogers, No. 31264, 2006 WL 2422648, at 170 (Ida. Ct. App. Aug. 22, 2006) (holding that revocation hearing required not just recommended). *See also* Laxton v. State, 256 S.W. 3d 518, 518 (Ark. Ct. App. 2007) (holding that drug court participant was not entitled to "sanction" jail time as credit).

48 *Id.,* State v. Rogers, No. 31264, 2006 WL 2422648, at 170. In *State v. Rogers* the Appellate court noted that the drug court judge did provide the drug court participant sufficient constitutional protections at the hearing. *See id.* at 170 n.15.

49 State v. Rogers, 170 P.3d 881, 881 (Idaho 2007).

50 *Id.* at 882.

51 People v. Kimmel, 882 N.Y.S.2d 895, 895 (2009) (relying upon Torres v. Berbary, 340 F. 3d 63, 63 (2d Cir. 2003)). Although Kimmel is not appellate precedent, it is recommended reading because of its analysis if the issue. *See also* People v. Woods, 748 N.Y.S.2d 222, 222 (2002) (holding that the defendant was not entitled to a hearing, but noting every review was a hearing in which the defendant had an opportunity to participate.)

52 Gosha v. State, 927 N.E.2d 942, 942 (Ind. Ct. App. 2010). In *Gosha v. State,* the Court explained that termination from drug court requires the written notice of the claimed violations, the disclosure of the evidence against the defendant, the opportunity to be heard and present evidence, the right to confront and cross-examine witnesses, and a neutral and detached hearing body. *Id. See also* Harris v. Commonwealth, 689 S.E.2d 713, 713 (Va. 2010) ("Consequently, because Harris had no opportunity to participate in the termination decision, when deciding whether to revoke Harris' liberty and impose the terms of the plea agreement deprived Harris of the opportunity to be heard regarding the propriety of the revocation of his liberty interest.") Id.

53 *See* Gagnon v. Scarpelli, 411 U.S. 778, 790 (1973). However, where the probation revocation hearing is combined with an original sentencing, the defendant is entitled to counsel. Mempa v. Rhay, 389 U.S. 128, 128 (1967). *See also* Dunson v. Kentucky, 57 S.W.3d 847, 847 (Ky. Ct. App. 2001) (concluding that defendant's assertions that he was denied counsel were unfounded because he was never without counsel at any critical stage of the proceedings).

54 *See* Commonwealth v. Wilcox, 841 N.E.2d 1240, 1240 (2006); State v. Kouba, 709 N.W.2d 299, 299 (Minn. Ct. App. 2006); State v. Matey, 891 A.2d 592, 592 (N.H. 2006); State v. Yarborough, 612 S.E.2d 447, 447 (N.C. Ct. App. 2005); *Dunson,* 57 S.W.3d at 847.

55 *See* Argersinger v. Hamlin, 407 U.S. 654, 654 (1974) (holding that for any misdemeanor or petty offense trial that results in a jail sentence the defendant must be represented by counsel); Scott v. Illinois, 440 U.S. 367, 367 (1979) (holding that the defendant was not entitled to counsel at trial, where the offense the defendant was charged with authorized jail, but incarceration was never imposed); Alabama v. Shelton, 535 U.S. 654, 654 (2002) (explaining that where the defendant was not represented by counsel at trial, was convicted and received probation, and a suspended jail sentence, the jail sentence could never be imposed because defendant was not represented by counsel at trial).

56 Minnesota v. Murphy, 465 U.S. 420, 435 (1984).

57 Morgan v. Wainwright, 676 F.2d 476, 476 (11th Cir. 1982).

58 Pennsylvania v. Goldhammer, 474 U.S. 28, 28 (1985).

59 United States v. Steiner Warren, 335 F.3d 76, 76 (2d Cir. 2003).

60 *Compare* State v. Foster, 782 A.2d 98, 98 (Conn. 2001), *and* United States v. Gravina, 906 F. Supp. 50, 53-54 (D. Mass. 1995), *with* State v. Scarlett, 800 So.2d 220, 222 (Fla. 2001).

61 Minnesota v. Murphy, 465 U.S. 420, 426-436 (1985).

62 United States v. Mackinzie, 601 F.2d 221, 221 (5th Cir. 1979).

63 *See, e.g.,* State v. Sylvia, 871 A.2d 954, 954 (R.I. 2005); Wiede v. State, 157 S.W.3d 87, 87 (Tex. Crim. App. 2005). *Cf.* People v. Harrison, 771 P.2d 23, 23 (Colo. Ct. App. 1989). In *People v. Harrison,* the court explained that the standard of proof is preponderance of the evidence, unless there is an allegation of a new crime. *Id.* If there is an allegation of a new crime, and the defendant has not been convicted, the standard of proof is beyond a reasonable doubt. *Id.*

64 United States v. Pierre, 47 F.3d 241, 241 (7th Cir. 1995); State v. Johnson, 679 N.W.2d 169, 174 (Minn. Ct. App. 2004) (collecting cases).

65 Black v. Romano, 471 U.S. 606, 610-611 (1983); Bearden v. Georgia, 461 U.S. 660, 660 (1983) (holding that fundamental fairness prohibited revoking probation for failure to pay restitution when defendant could not pay).

66 People v. Joseph, 785 N.Y.S.2d 292, 291 (N.Y. Sup. Ct. 2004) (adopting Torres v. Berbary, 340 F.3d 63, 63 (2d Cir. 2003)).

67 Daubert v. Merrell Dow Pharmaceuticals, 509 U.S. 579, 593-4 (1993). In this case the multifactor analysis includes: whether the technique can and has been tested; whether the technique has been subject to peer review and testing; the techniques known or potential rate of error; whether there are standards controlling the technique's operation and whether the technique is generally accepted in the scientific field from which it arises. *Id.*

68 Frye v. United States, 293 F. 1013, 1013 (D.C. Cir. 1923).

69 People v. Shreck, 22 P.3d 68, 68 (Colo. 2001).

70 Mitchell v. Mt. Hood Meadows, 99 P.3d 748, 748 (Ore. Ct. App. 2004) (combining Fed. R. Evid. 702, Fed. R. Evid. 403, and the Daubert and other factors to determine the admissibility of urine testing results for marijuana and the degree of impairment).

71 Additional specimens collected for testing include blood and saliva. Eye scanning devices are occasionally used to determine impairment and recent use.

72 *See* Lahey v. Kelly, 518 N.E.2d 924, 924 (N.Y. 1987).

73 Spence v. Farrier, 807 F.2d 753, 756 (8th Cir. 1986); People v. Whalen, 766 N.Y.S.2d 458, 460 (N.Y. App. Div. 2003); Jones v. State 548 A.2d 35, 35 (D.C. 1998) (citing 6 jurisdictions that held EMIT to be reliable).

74 Louis v. Dep't of Corr., 437 F.3d 697, 697 (8th Cir. 2006); Lahey v. Kelly, 518 N.E.2d 135, 135 (N.Y. 1987); Peranzo v. Coughlin, 608 F. Supp. 1504, 1504 (S.D.N.Y. 1985); aff'd, 850 F.2d 125, 126 (2d Cir. 1988). But see State v. Kelly, 770 A.2d 908, 908 (Conn. 2001) (holding that the blood stain analysis by EMIT should have been confirmed by gas chromatography/mass spectroscopy).

75 Hernandez v. State, 116 S.W.3d 26, 44-46 (Tex. Crim. App. 2003) (citing 6 cases upholding FPIA); People v. Toran, 580 N.E.2d 595, 597 (Ill. App. Ct. 1991) (relying on thin layer chromatography).

76 *See, e.g.,* Grinstead v. State, 605 S.E.2d 417, 417 (Ga. Ct. App. 2004); Anderson v. McKune, 937 P.2d 16, 18 (Kan. Ct. App. 1997); Black v. State, 794 N.E.2d 561, 561 (Ind. Ct. App. 2003).

77 Willis v. Roche Biomedical Lab, 61 F.3d 313, 313 (5th Cir. 1995) (concluding that the on-site test was false positive for methamphetamine due to cold medicine consumption).

78 GC/MS is almost always reliable assuming proper storage, handling, measurement and collection techniques. Nat'l Treasury Employees Union v. Von Raub, 489 U.S. 656, 656 (1989); Wilcox v. State, 258 S.W.3d 785, 785 (Ark. Ct. App. 2007) (explaining that the test was not reliable because the pH level and temperature was not established).

79 *See, e.g.,* Louis v. Dep't. of Corr. Servs. of Neb., 437 F.3d 697, 697 (8th Cir. 2006).

80 *See, e.g.,* United States v. Gatewood, 370 F.3d 1055, 1055 (10th Cir. 2004) (holding that the use of drugs on pretrial release was relevant to defendant's acceptance of responsibility and that lying about use of drugs is grounds for denying downward departure from presumptive sentence).

81 *See* United States v. Bentham, 414 F. Supp. 2d 472, 471 (S.D.N.Y. 2006).

82 *See* United States v. Alfonso, 284 F.Supp.2d 193, 197-98 (D. Mass. 2003); United States v. Meyer, 485 F. Supp.2d 1001, 1001 (N.D. Iowa 2006); United States v. Snyder, 187 F. Supp. 2d 52, 59-60 (N.D.N.Y. 2002); United States v. Stumpf, 54 F. Supp. 2d 972, 972 (Nev. 1999); United States v. Gatewood, 370 F.3d 1055, 1055 (10th Cir. 2004).

83 *See* Woods v. Wills, No. 1:03-CV105, 2005 U.S. Dist. LEXIS 28851, at *29 (E.D. Mo. Oct. 27, 2005); *In re* S.W. 168 S.W. 3d 878 (Tex. App. 2005).

84 Berry v. Nat'l Med. Servs., *205 P.3d 745, 745* (Kan. App. Apr. 3, 2009).

85 Johnson v. State Med. Bd., 147 Ohio Misc.2d 121 (2008); Perez-Rocha v, Commonwealth, 933 A.2d 1102 (Pa. Commw. Ct. 2007).

86 Wykoff v. Resig, 613 F.Supp. 1504, 1513-1514 (N.D. Ind. 1985), *aff'd in unpub. opin.,* 819 F.2d 1143 (7th Cir. 1987); Thomas v. McBride, 3 F. Supp. 2d 989 (N.D. Ind. 1998).

87 Baxter v. Nebraska Dep't of Corr., 663 N.W.2d 136 (Neb. App. 2003); Noreault v. Coombe, 660 N.Y.S.2d 71, 71 (N.Y. App. Div. 1997). *See also id.* at n.65.

88 Judicial impartiality has not only due process ramifications but also potential disciplinary consequences for the judge.

89 *In re* Murchison, 349 U.S. 133, 136-139 (1955) (recusing a judge because he could not detach himself from personal knowledge of secret grand jury proceedings).

90 United States v. Ayala, 289 F.3d 16, 27 (1st Cir. 2002) (stating that the standard is whether the facts, as asserted, lead an objective reasonable observer to question the judge's impartiality).

91 Liteky v. United States, 510 U.S. 540, 555 (1994). *See, e.g.,* United States v. Microsoft, 253 F.3d 34, 117 (D.C. Cir. 2001) (holding that the judge's comments to the press while the case was pending demonstrated bias); Youn v. Track, 324 F.3d 409, 423 (6th Cir. 2003) (holding that the court's comments and rulings do not show bias when they were based upon evidence acquired during proceedings).

92 *Compare* United States v. Bailey, 175 F.3d 966, 969 (11th Cir. 1999) (holding that recusal was not required where judge received facts from judicial source), *with* Edgar v. K.L., 93 F.3d 256, 259 (7th Cir. 1996) (holding that judge who received off the record briefings had extra judicial personal knowledge of facts).

93 Alexander v. State, 48 P.3d 110, 115 (Okla. Crim. App. 2002). *But see* Wilkinson v. State, 641 S.E.2d 189, 191 (Ga. Ct. App. 2006). As part of her drug court contract the defendant waived her ability to move for recusal of the drug court judge. *Id.*

94 State v. Belyea, No. 2009-038, 2010 N.H. LEXIS 49 (N.H. May, 20, 2010) (holding that the defendant failed to show that a reasonable person would entertain significant concern about whether Judge Vaughan prejudged the facts or abandoned or compromised his impartiality in his judicial role on the drug court team). In this case, the court did not have extrajudicial facts. *Id.;* Ford v. Kentucky, and William E. Flener v. Kentucky, No. 2008-CA-001990-MR, No. 2009-CA-000889-MR, No. 2009-CA-000461-MR, 2010 Ky. App. Unpub. LEXIS 380 (Ky. Appellate Apr. 30, 2010) (holding that having same judge preside over drug court and revocation hearing is not a denial of right to impartial hearing/due process).

95 If continuing on the case would create an appearance of impropriety, such non-recusal would implicate Canon 2 of the Canons of Judicial Conduct. Model Code of Judicial Conduct R. 2.11 (2007). Similarly, if the judge has personal knowledge of the facts, the Canons of judicial Conduct may be implicated. See Inquiry of Baker, 74 P.3d 1077, 1077 (Or. 2003) (censuring judge for failing to disqualify herself from probation revocation hearing in which the events giving rise to the proceeding occurred at a restaurant in front of judge); Lozano v. State, 751 P.2d 1326, 1326 (Wyo. 1988) (holding that the mere fact that probation revocation judge witnessed defendant in bar drinking in violation of her probation was not error, where the defendant freely admitted she was drinking in violation of probation).

96 *See* discussion *supra* pp. 8-10.

97 *See supra* notes 33-34.

98 Wolff v. McDonnell, 418 U.S. 539, 557 (1974); Sandlin v. Conner, 515 U.S. 472, 472 (1995).

99 There is some debate, at least in one state, as to whether jail can be a sanction in a pre-plea "opt in" drug court program. *Compare* Diaz v. State, 884 So. 2d 299, 299 (Fla. Dist. Ct. App. 2004) (holding that jail cannot be used as a sanction in a pre-plea contractual drug court program), *and* Walker v. Lamberti, 29 So. 3d 1172, 1172 (Fla. Dist. Ct. App. 2010) (holding that a defendant who voluntarily agreed to participate in drug court cannot subsequently opt out to avoid jail–based drug treatment program), *with* Mullin v. Jenne, 890 So. 2d 543, 543 (Fla. Dist. Ct. App. 2005) (holding that jail can be used as a sanction for defendants who choose to remain in voluntary program).

100 *See* Staley v. State, 851 So. 2d 805, 805 (Fla. Dist. Ct. App. 2003) (concluding that waiver of hearing rights in a drug court contract impugns the integrity of the justice system and undermines public confidence in the judiciary); T.N. v. Portesy, 932 So. 2d 267, 267 (Fla. Dist. Ct. App 2005) (holding that a court cannot impose sanctions beyond those authorized by statute, even if agreed to by the juvenile drug court participant upon entry into program); State v. Rogers, 170 P.3d 881, 881 (Idaho 2007) (holding that termination hearings are required in drug courts, at least where defendant pled guilty and his was sentence deferred, but also noting in dicta that such requirements are not required when sanctions are imposed). Of particular concern to the author are cases such as Thorne v. Hale, No. 1:08cv601 (JCC), 2009 WL 980136 (E.D. Va. Mar. 26, 2009), *aff'd, Thorne v. Hale,* No. 09-2305, WL1018048 (4th Cir. Mar. 19, 2010), where the §1983 claimant was unsuccessful because of procedural requirements and absolute judicial immunity. *Id.* In this case, the federal court makes staffings and the sanctioning process sound like a Star Chamber: "Thorne claims that, during the 'sanctions' hearings that followed his failure to adhere to the drug court's rules, the allegations against him, the testimony of witnesses, and the presentation of evidence violated his Sixth Amendment rights. *Id.* at 57. Testimony, he asserts, was "made in secrete [sic] between the Drug Court and RACSB administrators, {Defendants Kelly Hale, Judith Alston and Sharon Gillian}," the RACSB, the Commonwealth's Attorney, and the state court judge, "to include whispered testimony to the presiding Judge at the bench, so as to exclude Plaintiff. . . from all measures of defense and redress commensurate with Due and Compulsory Process of Law." *Id.* Courts are requiring that substantive matters that affect a drug

court participant's due process rights be on the record so meaningful appellate review can occur. *See* Tyler T., 279 Neb. 806, 806 (2010) ("Given the therapeutic component of problem-solving-court programs, we are not prepared to say that each and every action taken in such a proceeding must be a matter of record. But we have no difficulty in concluding that when a judge of a problem-solving court conducts a hearing and enters an order affecting the terms of the juvenile's probation, the proceeding must be on the record. We agree with other courts which have held that where a liberty interest is implicated in problem-solving-court proceedings, an individual's due process rights must be respected.").

101 *In re* Miguel, 63 P.3d 1065, 1065 (Ariz. App. 2003). The Arizona Appellate Court appeared to endorse a similar procedure when the juvenile defendants raised the due process issue and the possibility of jail or detention sanctions at a review hearing. Id. See also Nicely v. Commonwealth, 2007-CA-002109-MR, 2009 Ky. App. LEXIS 54 (Ky. App. Apr. 24, 2009).

> Under these circumstances, if a sentencing court chooses to find a defendant in contempt for violating conditions of probation as opposed to revoking or modifying the conditions of probation, the defendant must be afforded certain due process rights, including a hearing. Pace, supra at 395. There is no evidence from the record presented to us that any hearings were held or that the trial court made a finding of contempt at any time during the course of Nicely's probation. To the contrary, each time Nicely was incarcerated, the court order clearly recited violations of the terms and conditions of the Drug Court Program. If the record were silent, we would remand this matter back to the trial court for an appropriate evidentiary hearing consistent with the holding in Cooke, supra. But, since the court previously found that Nicely violated the conditions of Drug Court, we believe the trial court abused its discretion when, nunc pro tunc, it found him in contempt as well.
>
> *Id.*

102 Resort to a revocation/termination petition with immediate remand may be appropriate, when the prosecutor feels that public safety may be jeopardized, if the drug court participant does not accept responsibility for the alleged non-compliant behavior.

103 State v. Paige, 880 N.E.2d 675, 675 (Ill. App. 2007).

104 *Id.* at 684.

105 U.S. CONST. amend. XIV.

106 *See* Adarand Constructors, Inc. v. Pena, 515 U.S. 200, 200 (1996); Johnson v. California, 543 U.S. 499, 514 (2005) (stating that the strict scrutiny test requires that the classification must serve a compelling state interest and be narrowly tailored to meet that interest).

107 Miss. Univ. for Women v. Hogan, 458 U.S. 718, 718 (1982).

108 McGowan v. Maryland, 366 U.S. 420, 425-426 (1961); Estelle v. Dorough, 420 U.S. 534, 534 (1975).

109 Participation in a drug court is not a fundamental right and drug offenders are not a part of any suspect or semi-suspect class. See Lomont v. State, 852 N.E. 2d 1002, 1002 (Ind. App. 2006).

110 State v. Harner, 103 P.3d 738, 738 (Wash. 2004); Lomont v. State, 852 N.E.2d 1002, 1005-09 (Ind. Ct. App. 2006).

111 *Id.* at 743. *See also* State v. Little, 66 P.3d 1099, 1099 (Wash. Ct. App. 2003).

112 People v. Forkey, 72 A.D.3d 1209, 1209 (N.Y. App. Div. 2010) (holding that the defendant is not entitled to hearing before being rejected for drug court); State v. Saxon, No. A-1964-08T4, 2010 N.J. Super. Unpub. LEXIS 613, (N.J. Mar. 23, 2010) (holding that the defendant is not entitled to enter the drug court program); Phillips v. State, 25 So. 3d 404, 404 (Miss. Ct. App. 2010).

113 Evans v. State, 667 S.E.2d 183, 183 (Ga. Ct. App. 2008).

114 Jim v. State, 911 So. 2d 658, 658 (Miss. Ct. App. 2005); C.D.C. v. State, 821 So. 2d 1021, 1025 (Ala. Crim. App. 2001) (analyzing the issue under due process clause, with same result).

115 Lomont v. State, 852 N.E.2d 1002, 1002 (Ind. Ct. App. 2006) (holding that the lack of a drug diversion program in the relevant county does not treat the defendant unfairly or unequally, as compared to other defendants, because all defendants in that county do not have access to a drug diversion program).

116 *In re* Miguel, 63 P.3d 1065, 1074 (Ariz. Ct. App. 2003).

117 People v. Cisneros, 100 Cal. Rptr. 2d 784, 784 (Cal. Ct. App. 2000) (holding that an illegal alien status is not automatic disqualification for drug court); People v. Espinoza, 132 Cal. Rptr. 2d 670 (Cal. Ct. App. 2003) (holding that an illegal alien status is proper consideration for denial of Prop. 36 referral to treatment). *See generally* Yemson v. United States, 764 A.2d 816, 819 (D.C. Cir. 2001) (affirming because appellant failed to show that his nationality and his immigration status served as the basis for the sentence he received, rather than his unlawful conduct).

118 U.S. CONST. amend. VI.

119 Argersinger v, Hamlin, 407 U.S. 25, 40 (1972).

120 Brewer v. Williams, 430 U.S. 387, 401 (1977).

121 Gagnon v. Scarpelli, 441 U.S. 778, 787 (1973).

122 State v. Kouba, 709 N.W.2d 299, 299 (Minn. Ct. App. 2006); State v. Sommer, 878 P.2d 1007, 1008 (N.M. Ct. App. 1994). *But see* DeMillard v. State, 190 P.3d 128, 128 (Wyo. 2008).

123 Faretta v. California, 422 U.S. 806, 822 (1975). *But see* Indiana v. Edwards, 128 S.Ct. 2379, 2379 (2008) (holding that a court may deny a person the right to self-representation due to mental illness, even when the court finds that the person is competent to stand trial).

124 Iowa v. Tovar, 541 U.S. 77, 92 (2004).

125 Mempa v. Rhay, 389 U.S. 128, 128 (1967); State v. Thomas, 659 N.W.2d 217, 217 (Iowa 2003). *See also* Dunson v. Kentucky, 57 S.W.3d 847, 847 (Ky. Ct. App. 2001) (concluding that defendant's assertions that he was denied counsel were unfounded because he was never without counsel at any critical stage of the proceedings).

126 U.S. CONST. amend. V.

127 United States v. DiFrancesco, 449 U.S. 117, 129 (1980).

128 Witte v. United States, 515 U.S. 398, 405 (1995); People v. Lopez, 97 P.3d 223, 223 (Colo. Ct. App. 2004), *aff'd on other grounds,* 113 P.3d 713 (Colo. 2005) (holding that sentencing for deferred judgment violations, including positive urine tests, does not violate double jeopardy). *See also* Doyle v. State, 302 S.W.3d 607, 607 (Ark. App. Feb.18, 2009).

129 One Car v. State, 122 S.W.3d 422, 422 (Tex. App. 2003); State v. Griffin, 109 P.3d 870, 870 (Wash. Ct. App. 2005).

130 United States. v. McInnis, 429 F.3d 1, 5 (1st Cir. 2005) (holding that double jeopardy does not apply to the revocation of supervised release because it is considered part of the original sentence); United States v. Carlton, 442 F.3d 802, 809 (2d Cir 2006).

131 *In re* O.F. *773 N.W.2d 206, 206* (N.D. 2009).

132 C.H. v. State, 850 So.2d 675, 675 (Fla. 2003).

133 Breed v. Jones, 421 U.S. 519, 529 (1975).

134 *In re* Nolan, 203 P.3d 454, 454 (Cal. 2009). In this case the NADCP filed an Amicus Brandeis Brief in support of using short jail sanctions to motivate behavior change. *Id.*

135 *Id.*

136 Brown v. State, 971 A.2d 932, 932 (Md. 2009).

Chapter 9

Confidentiality

Honorable William G. Meyer (Ret.)

I. [§9.1] INTRODUCTION 185
II. [§9.2] HIPAA. 185
A. [§9.3] HIPAA Order 186
B. [§9.4] HIPAA Consent Forms 186
C. [§9.5] 42 CFR PART 2. 186
D. [§9.6] What Is a Program Covered by Federal Confidentiality Laws? 187
E. [§9.7] What Information Is Protected? 187
F. [§9.8] How Can Protected Information Be Shared? 188
1. [§9.9] Consent 188
2. [§9.10] Mandatory Disclosures 190
a. [§9.11] Valid Court Order 190
b. [§9.12] Child Abuse and Neglect 191
c. [§9.13] Cause of Death 191
G. [§9.14] Permitted Disclosures 191
III. [§9.15] BEST PRACTICES IN THE CONFIDENTIALITY ARENA 191
IV. [§9.16] CONCLUSION 192

I. [§9.1] INTRODUCTION

The Ten Key Components (provided on page 217) are the seminal yardstick upon which drug courts operate, and Key Component 1 requires that "drug courts integrate alcohol and other drug treatment services with justice system case processing."[1]

One benchmark to the key component contemplates that the court and treatment providers maintain ongoing communication, including frequent exchanges of timely information on a participant's program performance, consistent with federal and state confidentiality law requirements.[2]

Two federal statutes presumptively regulate the disclosure of participant alcohol and other drug treatment information in the drug court context.[3] Congress enacted the Health Insurance Portability and Accountability Act (HIPAA) in 1996.[4] In 2002, the federal regulations relating to HIPAA were initially adopted.[5] The purpose of HIPAA was to improve the health care system through the establishment of standards and requirements for the electronic transmission of certain health information. As part of those standards, a privacy rule prohibited covered entities from disclosing health information without proper consent or authorization.

In the 1970s, the Drug Abuse Prevention, Treatment and Rehabilitation Act[6] was enacted to expand access and accessibility to substance abuse treatment programs.[7] The statute and regulatory scheme provide for the confidentiality of patients records "maintained in connection with the performance of any program or activity relating to substance abuse education, prevention, training, treatment, rehabilitation or research, which is conducted, regulated or directly or indirectly assisted by any department or agency of the United States."[8]

This chapter is not intended to be an exhaustive treatise on federal confidentiality laws. Rather, it is designed to give the judge an overview of the subject, enabling the court to ask the questions or do the research to determine federal compliance.[9] In some circumstances, the regulations are unclear and authoritative interpretations are divided. In such situations, the author always recommends opting for the interpretation that is the most restrictive, thus according the greatest confidentiality protection to the drug court participant.

II. [§9.2] HIPAA

Despite conventional wisdom and practice, the provisions of HIPAA do not apply to drug courts, law enforcement, or probation officers. As succinctly stated by the well-respected National GAINS Center:[10]

> Contrary to myth, HIPAA-covered entities do not include the courts, court personnel, accrediting agencies such as the JCAHO, and law enforcement.[11]

HIPAA also does not apply to correctional facilities or law enforcement having lawful custody of an inmate or detainee if the protected health information (PHI) is necessary to provide health care to the individual; to protect the individual, other inmates, security officers or employees; or for the administration, maintenance of safety and security of the facility including law enforcement.[12]

Although HIPAA does not apply to drug courts, the spirit of HIPAA should be respected.

Although HIPAA does not apply to courts, the author recommends that the court employ two procedures to comply with the spirit of HIPAA. The court should issue an administrative order requiring that treatment providers disclose relevant treatment information to the drug court team. The court should also require the execution of a consent form by the participant that meets HIPAA requirements. A sample administrative order and consent form are included as exhibits on pages 191 and 192 of this document.

A. [§9.3] HIPAA Order

Federal regulations permit a HIPAA-covered entity to disclose any protected health information in the course of a judicial proceeding in response to an order of court and only to the extent that the PHI is expressly authorized by such an order.[13] Although not required by the rule, the order should acknowledge that disclosure of the information will be used by members of the drug court team for drug court purposes, that no redisclosure will occur, and that the order expires upon the participant's termination or graduation from the drug court program. Finally any order should provide that the disclosure should be the "minimum necessary to accomplish the intended use, disclosure, or request."[14] Thus, the court should limit the disclosure to whether the individual attended treatment, participated in treatment, prognosis, and any information the treatment provider believes is necessary to put the drug court participant's compliance with treatment in context. A sample order is depicted in Exhibit 1 on page 191 of this document.

B. [§9.4] HIPAA Consent Forms

HIPAA consent can be integrated into the participant's 42 CFR (Code of Federal Regulation) Part 2 consent form which is discussed herein. Proper advisements, acknowledgements, and written consents should follow the Part 2 process. For HIPAA purposes, consent can be revoked at any time, and treatment cannot be conditioned upon consent.[15] However, drug courts can properly condition participation in the drug court program upon execution of a HIPAA consent form.[16]

C. [§9.5] 42 CFR PART 2

Part 2, as it is commonly known by practitioners, prohibits the release of identification and alcohol or other drug-use information from any program that is assisted or regulated by the federal government, with certain exceptions.

D. [§9.6] What Is a Program Covered by Federal Confidentiality Laws?

The federal confidentiality law applies to any "program or activity relating to substance abuse education, prevention, training, treatment, rehabilitation or research, which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States."[17] The definition has two components: (1) that the program involves substance abuse education, treatment, or prevention, and (2) that it is regulated or assisted by the federal government. Involving substance abuse education, treatment, or prevention is quite broad because it includes not only diagnosis and treatment, but also referral for treatment. Thus, a court employee who administers an alcohol or other drug screening and assessment or a judge who orders substance abuse treatment as a condition of probation or drug court participation arguably brings the court within the ambit of the federal definition of program.[18] The second part of the definition is equally as broad because it covers both direct and indirect funding and assistance. The regulations include, *inter alia*, (1) any entity being a recipient of any federal funds, including funds not used for alcohol or other drug diagnosis, treatment, or referral; (2) activities conducted by a state or local governmental unit, which through revenue sharing or otherwise receives federal funds that could be (but are not necessarily) spent on a substance abuse program; or (3) a program that receives tax exempt status or the program has donors who receive income tax deductions for contributions to the program. Thus, any state or local court system would almost certainly qualify as being a recipient of federal assistance.[19]

Irrespective of whether the drug court meets the two tier qualification for being a federally assisted program, the drug court judge is undoubtedly going to be the recipient of treatment information protected by federal confidentiality laws.[20] When a court receives information protected by the federal confidentiality laws, the court is prohibited from redisclosing such information, absent a proper consent or those limited authorized disclosures permitted without consent.[21] Hence, it is prudent to assume that the federal confidentiality laws apply when operating a drug court.[22]

E. [§9.7] What Information Is Protected?

The federal confidentiality laws apply to all records relating to the identity, diagnosis, prognosis, or treatment of any patient in a substance abuse program. Thus, 42 U.S.C. § 290 dd applies to information that either reveals the identity of a person receiving treatment or discloses that a person is receiving, has received, or has applied to receive substance abuse treatment services.[23] Drug-testing results alone are not protected information, unless used for the diagnosis, treatment, or referral for treatment.[24] Because of the therapeutic use of drug-testing results, the drug court should generally consider them as covered by the federal confidentiality laws.

F. [§9.8] How Can Protected Information Be Shared?

The general rule is that for participants in alcohol and drug treatment programs, patient identifying information cannot be shared. However, the federal regulations carve out exceptions. Information can be shared where there is proper written consent. Under limited circumstances, where there is no consent there exist permissive and mandatory disclosures. The alternatives will be discussed in turn.

1. [§9.9] Consent

There are two requirements for procuring a valid consent, the advisement and the actual consent. The advisement must contain the following notices:[25]

1. A header with the following statement: "This notice describes how medical and drug and alcohol related information about you may be used and disclosed and how you can get access to this information. Please review it carefully."
2. A citation to both HIPAA and the confidentiality law and regulations.
3. A description, including at least one example, of the types of uses and disclosures that the program is permitted to make for treatment, payment, and health care operations (include only those permitted under 42 CFR Part 2).
4. A description, including at least one example, of each of the other purposes for which the program is permitted or required to disclose PHI without the individual's consent (this should include only those permitted under 42 CFR Part 2, including a warning that information can be released if the patient commits or threatens to commit a crime on program premises or against program personnel) and that the program must report suspected child abuse or neglect.
5. A statement that other uses and disclosures will be made only with the individual's written consent and that the individual may revoke this consent.
6. A statement of the individual's rights and a description of how the individual may exercise his or her rights.
7. A statement that the program is required by law to maintain the privacy of and to provide individuals with notice of its legal duties and privacy practices.
8. A statement that the program is required to abide by the terms of the notice.
9. A statement that the program reserves the right to change the terms of the notice, and a description of how the program will provide individuals with a revised notice.
10. A statement that (1) a violation of 42 CFR Part 2 is a reportable crime and that (2) under HIPAA, individuals may complain to the program and to the Department of Health and Human Services (HHS) if they believe their privacy rights have been violated, together with (3) a description of how the complaint may be filed.
11. The name, title, and telephone number of a contact for further information.
12. The date on which the notice became effective.

In the criminal justice context, consent cannot be revoked.[26] Conversely, HIPAA requires that consent can be revoked. However, if the drug court has issued an appropriate order, it can still obtain the needed treatment participation information.[27]

The elements of the written consent are as definite as the notice. The consent form requires ten elements:[28]

1. The name or general designation of the program(s) making the disclosure.
2. The name of the individual or organization that will receive the disclosure.
3. The name of the patient who is the subject of the disclosure.
4. The purpose or need for the disclosure.
5. A description of how much and what kind of information will be disclosed.
6. The patient's right to revoke the consent in writing and the exceptions to the right to revoke or, if the exceptions are included in the program's notice, a reference to the notice.
7. The program's ability to condition treatment, payment, enrollment, or eligibility of benefits on the patient agreeing to sign the consent, by stating either (1) that the program may not condition these services on the patient signing the consent, or (2) the consequences for the patient refusing to sign the consent.
8. The date, event, or condition upon which the consent expires if not previously revoked.
9. The signature of the patient (and/or other authorized person).
10. The date on which the consent is signed.

In the criminal justice context, expiration of the consent may be conditioned on an event instead of a date. Thus, expiration may be conditioned upon the drug court participant's successful completion of or termination from the program.[29] Once the consent form has been completed, the participant must be informed that the information disclosed is protected by federal law and that any further disclosures (redisclosure) must be made in accordance with 42 CFR, Part 2.[30] Disclosures that are permitted pursuant to a valid consent form include information that can be used for a probation revocation, including alcohol or other drug-use admissions.[31] A sample consent form is included in Exhibit 2 on page 192 of this chapter.

Although not explicitly required, the drug court should employ practices that will ensure the participant's consent is knowingly obtained and entered into voluntarily.[32] The participant should have the opportunity to consult a lawyer before executing the consent.

Because of potential literacy concerns, the notification and consent and redisclosure prohibition should be read to the participant before execution. When appropriate, the consent should be translated for the participant. The participant should be asked to reexecute the consent during program participation when there is a change in drug court team membership and to rectify any situation where the participant was still using drugs when the original consent was obtained. Finally, the various team members should enter into a memorandum of understanding (MOU) that details the information which will be shared, by whom, and for what limited purpose. The MOU should also contain the acknowledgment of team members as to the applicability of and adherence to federal and state confidentiality laws including those related to redisclosure. Of particular significance, are the limitations upon prosecutorial use of information gained from treatment programs and in staffing. The MOU should also include file access limitations and storage standards.

In addition to the practices surrounding the execution of the consent and the team execution of the MOU, the court should consider certain additions to the consent. First, the participant should admit he or she was advised and had the opportunity to have counsel present. The consent could also contain language acknowledging sobriety and understanding. Finally, in the consent form, the participant should recognize that the courtroom is public and the potential exists for disclosure of confidential information during open court proceedings.[33]

2. [§9.10] Mandatory Disclosures

There are three situations where disclosure is mandatory:

- The existence of a valid court order
- Child abuse or neglect
- Cause of death

a. [§9.11] Valid Court Order

The prerequisites for a valid court order are determined by the nature of the proceeding and the type of information sought to be disclosed. A subpoena or search warrant or other court order not meeting these requirements is not valid.[34]

In a civil context,[35] before a court may issue an order, the program and the patient must be given notice and the opportunity to participate in the hearing.[36] If the information is being sought to investigate or prosecute the patient, notice need only be given to the program.[37] If the program is the target of the investigation, no notice need be given.[38]

At the hearing, the person seeking the information must establish and the court must find "good cause."[39] The good-cause finding requires the court to determine that the information is not available elsewhere, and the need for disclosure outweighs any adverse effect on the patient, the doctor-patient relationship, and the program's effectiveness.[40]

Where the request for the information is for the investigation or prosecution of a patient, a higher standard must be met.[41] Not only must the good-cause standard be established but the court must find:

- The crime involved is extremely serious (caused or threatening to cause death or serious bodily injury);
- The records sought to be obtained are likely to contain significant information for the investigation or prosecution;
- There is no other practical way to obtain the information;
- The program had an opportunity to be represented by counsel.[42]

Disclosure is limited to those parts of the records which are essential to the purpose of the order and disclosure is restricted to those persons responsible for investigating or prosecuting the case. No "confidential communications"—statements by the patient to program personnel—may be disclosed unless the requirements of 42 CFR § 2.63 are met.

Successful applications for a court order, whether civil or criminal, are limited to "objective data" such as treatment program dates of enrollment, discharge, or medications.[43] Requests for confidential communications must meet one of the three expressed requirements in 42 CFR § 2.63(a).[44]

In addition to a valid court order, mandatory disclosures include situations of child abuse and neglect and identifying the cause of death.

b. [§9.12] Child Abuse and Neglect

Most states have mandatory child abuse and neglect reporting laws. Both 42 C.F.R Part 2 and HIPAA have provisions that exempt confidentiality protection in situations where the state mandates child-abuse and neglect reporting.[45]

c. [§9.13] Cause of Death

Because states have reporting requirements concerning the cause of death, 42 CFR Part 2 exempts the confidentiality of patient identifying information for such mandatory reports.[46]

G. [§9.14] Permitted Disclosures

Programs are permitted—but not required to—disclose patient identifying information in cases of medical emergency;[47] in reporting crimes on program premises or against staff;[48] to entities having administrative control;[49] to qualified service organizations;[50] and to outside auditors, evaluators, central registries, and researchers.[51]

Disclosures to entities having administrative control and to qualified service organizations require written agreements. Auditors, central registries, and researchers need to have in place written plans to assure confidentiality before disclosures can be made.

III. [§9.15] BEST PRACTICES IN THE CONFIDENTIALITY ARENA

As the foregoing well illustrates, federal confidentiality laws are complex, often confusing, and with occasional conflicting interpretations. At least theoretically, failure to properly follow federal confidentiality laws can lead to withdrawal of funding, program license revocation, and potential criminal penalties.[52] Neither HIPAA nor 42 CFR Part 2 provides a private right of action.[53]

By following best practices,[54] drug courts can greatly reduce the potential of a sanction:

- Designate a privacy official who is responsible for the drug court program's compliance with federal and state confidentiality law requirements.
- Provide the privacy official with the necessary resources to do the job.[55]
- Ensure that appropriate administrative, technical, and physical safeguards are in place to protect the privacy of patient information. This includes locked storage cabinets;

agreed-upon procedures to redact and segregate drug court files into what is available to the public and what is confidential; and the installation of electronic firewalls to prevent access to participant information.

- Ensure that written policies and procedures are in place which limit the disclosed information to the minimum necessary to accomplish the intended use.
- Require that all team members and staff be trained and periodically retrained on federal and state confidentiality requirements.
- Review the current notification, consent, and redisclosure forms to ensure they meet federal and state standards.
- Employ the best practices outlined previously on the reobtaining of consent and contents of the consent form.
- Document all privacy policies and procedures.
- Assume that the confidentiality laws are going to apply to disclosures and, therefore, take all precautions to protect participant's confidentiality rights.

IV. [§9.16] CONCLUSION

Drug courts contemplate the integration of criminal case processing and treatment participation. Sharing of limited treatment information is a necessary function of drug court operations. Compliance with federal confidentiality laws can be readily accomplished with proper procedures, notification, and consent forms and limitations on disclosure to the minimum necessary to accomplish the intended purpose of the disclosure.

Exhibit 1. HIPAA Order

HIPAA ORDER

IN THE _____ COURT

_____, STATE OF _____
(County, District)

Case No. _____

People of the State of _____	)	
Plaintiff,	)	ORDER RE:
v.	)	Limited Release of Specific Substance Abuse Treatment Records
_____	)	
Defendant.	)	

This matter is before the court for consideration of the limited release of specific substance abuse treatment records. The court makes the following findings:

1. On _____, the defendant was accepted into/referred to the
(Date)
_____ Drug Court.

2. As a condition of participation in the drug court program, the defendant must attend substance abuse treatment and the drug court team must monitor the defendant's progress in substance abuse treatment.

3. The defendant has voluntarily and knowingly signed a HIPAA and 42 C.F.R. Part 2 compliant release.

4. The information necessary to monitor the defendant's progress in substance abuse treatment includes:

> defendant's diagnosis, defendant's urinalysis results, defendant's treatment attendance or nonattendance, defendant's cooperation with treatment, defendant's progress in treatment, and defendant's prognosis. This treatment information is the minimum necessary to carry out the purpose of the disclosure. *See* 45 C.F.R. §165.502(b)(11) and 42 C.F.R § 2.13(a).

It is therefore ordered that:

1. (_____) shall provide to the members of the
Name of treatment provider
drug court team (as reflected in the HIPAA/42 C.F.R. Part 2 Consent to Release Form or team member replacements) the following information:

> defendant's diagnosis, defendant's urinalysis results, defendant's treatment attendance or nonattendance, defendant's cooperation with treatment, defendant's progress in treatment, and defendant's prognosis.

2. The named treatment provider shall continue to provide the treatment information until defendant's successful completion of or termination from the drug court program or further court order, whichever shall first occur.

3. The drug court team shall not redisclose the information received pursuant to this Order, except as may be provided by law.

SO ORDERED this ____ day of _____, 20___.

_____
Judge

Exhibit 2. Consent for the Release of Confidential Information

CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION:

CRIMINAL JUSTICE SYSTEM REFERRAL

I, _____, authorize (initial whichever parties apply):
(Name of defendant)

□ *[The ABC Alcohol and Drug Treatment Program]*_____,
(Name or general designation of program making disclosure)

□ *[The Probation Department] employees supervising my case,*

□ *[The Case Managers] employees supervising my case]*_____.

□ _____ □ _____
(Name of the appropriate drug court) (Name of prosecuting attorney)

□ _____ □ _____
(Name of criminal defense attorney) (Other)

to communicate with and disclose to one another the following information (nature and amount of the information as limited as possible):

_____ my diagnosis, urinalysis results, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program, prognosis, and

_____ _____

The purpose of the disclosure is to inform the person(s) listed above of my attendance and progress in treatment.

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. Parts. 160 & 164. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically as follows:

[Specify the date, event, or condition upon which this consent expires. This could be one of the following:]

_____ There has been a formal and effective termination or revocation of my release from confinement, probation, or parole, or other proceeding under which I was mandated into treatment, or

_____ _____
(Specify other time when consent can be revoked and/or expires)

I understand that I might be denied services if I refuse to consent to a disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I recognize that my review hearings are held in an open and public courtroom and it is possible that an observer could connect my identity with the fact that I am in treatment as a condition of participation in drug court. I specifically consent to this potential disclosure to third persons.

I understand that if I refuse to consent to disclosure or attempt to revoke my consent prior to the expiration of this consent, that such action is grounds for immediate termination from drug court.

I have been provided a copy of this form.

I acknowledge that I have been advised of my rights, have received a copy of the advisement, and have had the benefit of legal counsel or have voluntarily waived the right to an attorney. I am not under the influence of drugs or alcohol. I fully understand my rights and I am signing this Consent voluntarily.

Dated: _____ _____
Signature of Drug Court Participant

Witness: _____ _____
(position)

PROHIBITION ON REDISCLOSURE
OF CONFIDENTIAL INFORMATION

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

1 Nat'l. Ass'n. of Drug Court Prof'ls & Bureau of Justice Assistance, U.S. Dep't of Justice, Defining Drug Courts: The Key Components 9-10 (1997), *available at* http://www.ojp.usdoj.gov/BJA/grant/DrugCourts/DefiningDC.pdf.

2 *Id.* at 4. This chapter does not cover juvenile drug court operations or family dependency court operations. Because these are civil proceedings, many of the applicable provisions such as the duration of or the permissibility of a revocation of consent are different than those employed in criminal cases.

3 In addition, individual states have statutes that protect AOD treatment disclosures. Furthermore, evidentiary privileges, such as the physician-patient privilege and ethical obligations may constrain the free exchange of drug court participant-treatment provider information. This chapter does not address state law confidentiality provisions, ethical limitations, or evidentiary privileges.

4 Health Insurance Portability and Accountability Act of 1996, Pub. L. No. 104-191, 110 Stat. 1936.

5 *See* 45 C.F.R. Parts 160-164. These regulations have been consistently amended.

6 Public Health Services Act of 1944, 42 U.S.C. § 290 dd.

7 United States *ex. rel.* Chandler v. Cook County, 277 F.3d 969, 982-8 (7th Cir. 2002), *aff'd on other grounds,* 538 U.S. 119 (2003).

8 42 U.S.C. § 290dd-2.

9 No attempt has been made to address state mandated confidentiality requirements.

10 The National GAINS Center is funded by the United States Department of Health and Human Services through the Substance Abuse and Mental Health Services Administration (SAMHSA).

11 John Petrila, CMHS Nat'l GAINS Ctr. for Systemic Change for Justice, Dispelling the Myths About Information Sharing Between the Mental Health and Criminal Justice Systems (2007).

12 45 C.F.R. § 165.512(k)(5).

13 45 C.F.R. § 165.512(e)(1).

14 *See* 45 C.F.R. § 164.502(b), 164.514(d). Technically, the "minimum necessary" requirement does not apply when the participant has consented to disclosure, but the better practice in drug courts is that the standard applies regardless of the existence of consent.

15 45 C.F.R. § 164.508(b)(4).

16 *See* Legal Action Ctr., Confidentiality and Communication, A Guide to the Federal Drug & Alcohol Confidentiality Law and HIPAA 129 (2006).

17 42 U.S.C. § 290dd-2; 42 C.F.R. § 2.11-2.12.

18 *See* Jeffrey Tauber et al., Nat'l Drug Court Inst., Federal Confidentiality Laws and How They Affect Drug Court Practitioners 6 (1999).

19 Not all courts have read the regulations in such an expansive manner. *See, e.g.,* Ex parte Execution, 773 So.2d 431, 431 (Ala. 2000) (holding that the treatment program must receive the federal funds, and not just the University of Alabama at Birmingham). *See also* United States v. Zamora, 408 F. Supp. 2d 295, 295 (S.D. Tex. 2006) (relying on the 42 C.F.R. § 2.12(e)(2) exception and stating that the treatment program itself not the hospital must receive direct federal assistance and noting emergency room exception); Ctr. for Legal Advocacy v. Earnest, 320 F.3d 1107, 1111-1112 (10th Cir. 2003) (holding, consistent with amendment to federal regulations, that referrals to substance abuse treatment providers by emergency rooms does not make emergency rooms a program unless the ER's primary function is AOD treatment or the ER holds itself out to the public as providing such services).

20 Tauber et al., *supra* note 18, at 8.

21 42 C.F.R. § 2.32, 2.35; *see* Legal Action Ctr., *supra* note 16, at 35-36, 135-136.

22 This interpretation is not without its detractors. In United States v. White, 902 F. Supp. 1347, 1352 (D. Kansas 1995) The court stated:
The information concerning White's history of substance abuse will be disclosed in connection with the magistrate judge's performance of his official duties in pronouncing sentence. Moreover, if *White's* analysis and interpretation of the regulations were correct, any mention by the magistrate judge of the information gleaned from the evaluation performed by the Pawnee Mental Health Center during sentencing in open court would potentially constitute a violation of those regulations, subjecting the magistrate judge to criminal penalties. Clearly this is not and cannot be the law.

23 *See* State v. Johnson, 836 N.E.2d 1243, 1243 (2005) (holding that the statements to AOD assessor were about homicide, and not about the identity, diagnosis, treatment or prognosis of any patient and, thus, were not protected); United States v. Smith, 511 F. 3d 77, 77 (1st Cir. 2007) (holding that a casual reference to a drug abuse treatment would not bar admission of Order of Commitment to mental health institution, where reference could be excised).

24 Legal Action Ctr., *supra* note 16, at 129.

25 Excerpted from Legal Action Ctr., *supra* note 16, at 94-96; 45 C.F.R. § 164.520(b); 42 C.F.R. § 2.22(b).

26 42 C.F.R. § 2.35, Edwards v. Stephens, ___ F. Supp.2d ___ (W.D. La. 2006).

27 Legal Action Ctr., *supra* note 16, at 41.

28 42 C.F.R. § 2.31(a); 45 C.F.R. § 164.508(c); Legal Action Ctr., *supra* note 16, at 27.

29 Tauber et al., *supra* note 18, at 10; Legal Action Ctr., *supra* note 16, at 40. *See also* State v. Wheat, 76 P.3d 280, 280 (Wash. Ct. App.) (holding that although the defendant had executed a consent to disclosure of his records before entry into the treatment program, there was no release signed to obtain the treatment records when the investigation disclosed the failed drug tests); State v. Johnson, 836 N.E.2d 1243, 1243 (2005 (addressing the issue of strict construction and need for consent).

30 *See* Legal Action Ctr., *supra* note 16, at 36, sample forms at pp. 242 and 284.

31 State v. Rudy, 974 So. 2d 1164, 1164 (Fla. App. 4th Dist. 2008).

32 These suggestions for best practices are partially obtained from Tauber et al., *supra* note 18, at 9.

33 *See* State v. Noelle Bush, Case #48-02 CF 6371-0, (October 15, 2002) (holding that open and public courtroom trumps federal confidentiality requirements). Even though court proceedings are open, the best practice would dictate that for graduations that new consents be executed or that the participant be given the option of a more private ceremony.

34 Legal Action Ctr., *supra* note 16, at 59-69.

35 At least one court has ruled that a criminal probation revocation proceeding is a civil proceeding. People v. Silkworth, 538 N.Y.S.2d 692, 692 (1989).

36 42 C.F.R. § 2.64.

37 42 C.F.R. § 2.65.

38 42 C.F.R. § 2.66.

39 42 C.F.R. § 2.64(d); Carter v. Knox County, 761 NE2d 431, 431 (Ind. App. 2002) (specifying procedure); Hicks v. Talbott Recovery Systems, 196 F.3d 1226, footnote 32 (11th Cir. 1999).

40 42 C.F.R. § 2.64(d); Nelson v. Labor Finders, 897 So.2d 501, 501 (Fla. App. 2005).

41 42 C.F.R. § 2.65(d). United States v. Shinderman, 515 F. 3d 5, 5 (1st Cir. 2008) (holding that ex parte orders are permitted in limited circumstances and notice to non-patient aggrieved party does not have to be contemporaneous with the issuance of the order).

42 *See* United States v. Hughes, 95 F. Supp. 2d 49, 49 (Mass. 2000); State v. Center for A Drug Free Living, 842 So.2d 177, 177 (Fla. App. 2003).

43 *In re* Marvin, 711 A.2d 756, 756 (Conn. 1998); *In re* 1993 Regular Grand Jury (Hosp. Subpoena), 854 F. Supp. 1380, 1384 (S.D. Ind. 1993).

44 The requirements are met when the disclosure is necessary (1) to protect against a threat to life or of serious bodily injury or (2) is necessary to investigate or prosecute an extremely serious crime; or (3) is in connection with a proceeding where the patient has already presented testimony concerning confidential communications. 42 C.F.R. 2.63(a); Granger v. McBride, No. 2:04 CV 8, 2006 U.S. Dist. LEXIS 34689 (N.D. Ind. 2006).

45 42 C.F.R. § 2.12(c)(6); 45 C.F.R. §164.512(b)(1)(ii); In Re B.S. 659 A.2d 1137 (Ut. 1995).

46 42 C.F.R. § 2.15(b).

47 45 C.F.R. § 164.506(c); 42 C.F.R. § 2.51.

48 45 C.F.R. § 164.502(j)(2), 164.512(f)(2); 42 C.F.R. § 2.12 (c)(5).

49 45 C.F.R. § 164.502(a)(1), 164.506(a), (c); 42 C.F.R. § 2.12(c)(3).

50 45 C.F.R. § 160.103, 164.504(e); 42 C.F.R. § 2.12 (c)(4).

51 45 C.F.R. § 164.501, 164.506, 164.512; 42 C.F.R. § 2.53(c)-(d); 42 C.F.R. § 2.52; 45 C.F.R. § 164.512(i)(1)(ii).

52 *See* 42 C.F.R. § 2.4; 45 C.F.R. § 160.408; Legal Action Ctr., *supra* note 16, at 97-99.

53 Werdehausen v. Benicorp Ins. Co., 487 F.3d 660, 660 (8th Cir. 2007); Acara v. Banks, 470 F.3d 569, 569 (5th Cir. 2006); Ellison v. Cocke County, 63 F.3d 467, 467 (6th Cir. 1995); 42 U.S.C. § 290dd; 42 C.F.R. Part 2.

54 Many of these recommended practices are distilled from Legal Action Ctr., *supra* note 16, at 20-24.

55 At a minimum the privacy official should have a copy of: (1) Legal Action Ctr., Confidentiality & Communication 2006; (2) Jeffrey Tauber, Nat'l Drug Court Inst., Federal Confidentiality Laws and How They Affect Drug Court Practioners (1999); and (3) U.S. Dep't of Justice, Practical Guide for Applying Federal Confidentiality Laws to Drug Court Operations (1999), *available at* http://www1.spa.american.edu/justice/documents/1936.pdf. In addition, the individual should be aware of the U.S. Department of Health & Human Services' web site for HIPAA at http://www.hhs.gov/ocr/privacy/ (last visited Aug. 4, 2010).

Chapter 10

Ethical Obligations of Judges in Drug Courts

Honorable William G. Meyer (Ret.)

I. [§10.1] INTRODUCTION 199
A. [§10.2] Integrity and Independence 199
B. [§10.3] Relations with Participants 201
C. [§10.4] Reporting Crimes and Other Misconduct 202
II. [§10.5] PRIVATE CONDUCT OF THE JUDGE 202
A. [§10.6] Providing Information and References 203
B. [§10.7] Impartiality and Decorum: Courtroom Conduct 204
C. [§10.8] Impartiality and Decorum: Conduct Outside the Courtroom 205
D. [§10.9] Ex Parte Contacts 205
E. [§10.10] Use of Nonpublic Information 206
III. [§10.11] DISQUALIFICATION AND RECUSAL OF THE JUDGE 207
A. [§10.12] Personal Knowledge of Facts 207
B. [§10.13] Extra Judicial Activities 208
IV. [§10.14] OTHER JUDICIAL ACTIVITIES 208
A. [§10.15] Publicity and Educational Activities 208
B. [§10.16] Civic Activities—Board Member of Treatment Provider 210
C. [§10.17] Board Member—Other Civic Organizations 210
D. [§10.18] Fund-Raising 210
E. [§10.19] Political Activity and the Drug Court 211
V. [§10.20] CONCLUSION 211

"Four things belong to a judge: to hear courteously, to answer wisely, to consider soberly, and to decide impartially."

~ Socrates [1]

I. [§10.1] INTRODUCTION [2]

In all judicial proceedings, the judge bears the ultimate responsibility for ensuring the parties receive a fair hearing in a dignified forum. Although certain aspects of the drug court judge's role may change, the ultimate responsibility is no different. The unique nature of drug court practice—and the political visibility of many drug courts—requires that the drug court judge be ever vigilant in complying with ethical requirements. Focusing on selected provisions of the 2007 American Bar Association's (ABA) Model Code of Judicial Conduct, (hereinafter referred to as The Canons of Judicial Conduct or simply the Canons or Model Code), this chapter highlights potential ethical problems for drug court judges and offers suggested resolutions. Because some jurisdictions have not adopted the Model Code, or have deviated in some respects from the ABA's formulation, judges should also refer to their own jurisdiction's ethical rules and opinions for guidance.

Four aspects of drug court practice raise special concerns for a judge who would live up to the expectations of the Socratic charge and the Canons of Judicial Conduct. First, the collaborative nature of drug court decision making (seen most clearly in staffings) may undermine perceptions of judicial independence and impartiality. Second, the intimacy that develops between participants and members of the drug court team—especially judges—can blur the boundaries between judicial action and personal involvement. Third, the direct contact between judges and participants makes participants vulnerable. While defense counsel remains responsible for protecting participants' rights, the judge shares responsibility. Finally, the drug court judge cultivates local support and develops community partnerships through education and leadership. Proper ethical boundaries must be observed, so the judge is not perceived as trading on the judicial office.

Dealing ethically with these and other issues will not prevent the judge from acting effectively in drug court. Rather, the success of drug courts depends on the trustworthiness and integrity of judges who serve in them.

A. [§10.2] Integrity and Independence

Canon 1 requires a judge to uphold the integrity and independence of the judiciary.[3] Not only must the judge harmonize personal conduct to the legal and ethical demands of the role, but the judge must ensure that those with whom he or she works (and the institution in which he or she works) conform to these ethical and legal obligations.[4] In fulfilling these two sets of obligations, the judge serves as an example for others.

Canon 1 has twofold significance for drug courts. First, as this Canon's official commentary recognizes, "Conduct that compromises or appears to compromise the independence,

integrity, and impartiality of a judge undermines the public confidence in the judiciary."[5] As nontraditional legal institutions, drug courts may not enjoy the same presumption of legitimacy accorded to other legal institutions and so need to be especially concerned with maintaining public confidence in their integrity. Second, the Canon focuses on independence as an essential characteristic of the judge's professional responsibility, but at least two of the Ten Key Components[6] (included on page 217 of this benchbook) of drug courts seem to undermine judicial independence.

Key Component 6 dictates that "a coordinated strategy governs drug court responses to participants' compliance."[7] The coordinated strategy is typically effected through staffings, in which members of the drug court team meet in advance of a participant's hearing to discuss the participant's progress in treatment and to reach consensus about rewards and sanctions. This collaborative decision-making process does not violate the judge's duty of independent judgment so long as the final decision remains with the judge. The judge may not delegate this responsibility for a final decision to other members of the drug court team.[8] In any event, the judgment made at staffing can only be tentative, subject to modification by the court based upon what the participant says during the court proceeding. Staffings must be considered in light of restrictions on ex parte contacts, found in Section 2.9 of the Canons.

Common ethical issues arise from:

- *The collaborative nature of drug courts*
- *The enhanced relationship between judge and drug court participant*
- *The community advocacy role of the drug court judge*

Like the coordinated strategy of Key Component 6, the mandate to "forge partnerships" in Key Component 10 reflects the drug court model's commitment to collaborative work among all stakeholders toward a set of common goals.[9] A growing body of research underscores the benefits of this collaboration, but the emphasis on partnerships is not without its ethical pitfalls.

The call for "partnerships between drug courts and law enforcement"[10] raises the most obvious ethical concerns. To the extent that the partnership educates law enforcement officers about drug court practices, the collaboration raises no serious ethical difficulties.[11] However, any such partnership must ensure that the court is neither perceived nor acting as an instrument of law enforcement, but maintains its constitutionally mandated role as independent arbiter and guardian of legal rights. In particular, special care should be taken to guard against inappropriate ex parte contacts between the court and law enforcement. Any direct communication between the court and law enforcement about a particular case should be disclosed to all members of the drug court team. For further discussion of ex parte communications, see the discussion following later in this chapter.

Less obvious, but no less serious ethical concerns arise from the call for linkages between drug courts and community-based organizations.[12] Coalition building has been a vital part of the drug court movement's success. Drug courts have succeeded in marshaling a

wide range of resources in their communities, providing their participants with treatment and social services and at the same time responding to community concerns. These coalitions have provided crucial political support for drug courts. As with the drug court/law enforcement partnership, ethical assessment of these coalitions depends upon the exact nature of the linkages. Where the court/community coalition functions primarily as an exchange of general information, with the court educating the community about its practices and procedures and the community organization educating the court about available resources, ethical concerns are minimized.[13]

However, where community organizations and other institutions take a more active role in providing "guidance and direction to the drug court program," as Key Component 10 advises, heightened ethical sensitivity is required. At a minimum, and whether this guidance and direction is provided through a formal or informal mechanism, court/community partnerships should never include discussion of particular cases that are pending before the court.[14] Even if particular cases are not discussed, a judge must ensure that the court's participation in formal or informal coalitions with community organizations does not appear to a reasonable person to undermine the judge's independence, integrity, or impartiality.[15] Thus, the judge or court personnel should not participate in discussions of how to allocate law enforcement resources (e.g., to target certain offenses or geographical areas); participation in such conversations would imply the court's endorsement of arrests resulting from such reallocations.

Judges may not give up independent judgment in a collaborative court.

Where the court/community partnership is effectuated through a formal structure, like the steering committee suggested under Key Component 10 (organized as a nonprofit corporation), special ethical issues arise for the drug court judge and court personnel. Ethical aspects of participation in such an organization are covered under Canon 3 of the Model Code and discussed later in this chapter.

B. [§10.3] Relations with Participants

The judge's personal engagement with each participant is the keystone of the drug court model. "This active, supervising relationship, maintained throughout treatment, increases the likelihood that a participant will remain in treatment and improves the chances for sobriety and law-abiding behavior."[16] This personal engagement stands in tension with a common vision of the judge as a detached arbiter, figuratively blind to the parties before the court. However common this understanding of the judge, the Canon requires not disengagement, but impartiality. The judge may show concern about a participant's progress in recovery—even to the point of celebrating a participant's success—but the judge must extend the same quality of engagement and concern to each participant. Such engagement must be in the context of judicial proceedings. In one case, a judge was sanctioned for meeting privately and individually (sometimes at their homes) with probationers.[17] The judge justified a portion of his conduct on his sincere concern for the welfare of addicts and their progress. The Nebraska Supreme Court was

unpersuaded and found that the judge's conduct constituted a violation of Canon 1 (uphold integrity and independence of judiciary) and Canon 2, in that the judge failed to act in a manner that promotes public confidence in the impartiality of the judiciary.[18] The drug court judge does not function as a therapist and should not seek to develop a therapeutic relationship with individual drug court participants. Nevertheless, effective performance as a drug court judge requires continuing interdisciplinary education: the judge and the drug court staff need to understand both the range of available treatment options and the theories and practices supporting specific treatment approaches.

C. [§10.4] Reporting Crimes and Other Misconduct

One question that frequently arises is whether a judge's obligation to uphold the integrity of the judiciary requires drug court judges to report illegal drug use by participants under their supervision. Some states have statutes requiring judges (and other specified officials) to report crimes; drug court judges should be familiar with any such statutes in their own states. In the absence of such a statute, however, all states that have addressed this issue have held that a judge has no ethical obligation to report criminal activity disclosed during court proceedings.[19] While Rule 2.15 of the Canons requires the court to report misconduct by an attorney or a judge in certain circumstances, no duty exists to report criminal activity by others. Moreover, where the prosecutor has the same information as the judge (which will ordinarily be the case in drug court), there is no need to report the offense because law enforcement officials are already aware of it. A custom of not prosecuting certain offenses disclosed during drug court proceedings is often reflected in memoranda of understanding and in participants' agreements with the court. In any event, to the extent that judges have any duty to report crimes, commentators have distinguished between serious crimes, such as murder, and the less serious offenses, such as possession, that are ordinarily disclosed in drug court.[20]

II. [§10.5] PRIVATE CONDUCT OF THE JUDGE

Drug court judges should be aware that their conduct, both on and off the bench, may be scrutinized more closely than that of other judges. To comply with Canon 2, judges need to be sensitive to this reality. This requires particular caution with respect to substance abuse.[21] For example, being stopped for driving while impaired would be embarrassing for any judge, but particularly for a drug court judge. Judges who themselves need substance abuse treatment (including ongoing participation in community support groups such as Alcoholics Anonymous) are not disqualified from presiding in drug courts, so long as their own problems do not interfere with their role in the drug court.

Judges should be wary of participation in outside drug court activities such as picnics or other social contacts.

The drug court judge must be circumspect in attending gatherings of drug court participants outside the confines of the courthouse. As noted by one court[22] in censuring a judge who attended a picnic hosted by a convicted felon:

> Improper conduct includes creating or acquiescing in any appearance of impropriety. When a judge chooses to attend a party hosted by a convicted criminal, there may be wholly innocuous reasons explaining such a decision. However, the judge must realize that members of the public cannot know the judge's subjective motives and may put a very different cast on his or her behavior. Such conduct could be perceived as evidencing sympathy for the convicted individual or disagreement with the criminal justice system that brought about the conviction. At worst, such conduct may raise questions concerning the judge's allegiance to the judicial system. Those impressions could generate legitimate concern about the judge's attitude toward judicial responsibilities, weakening confidence in the judge and the judiciary.

Thus, attendance at and participation in picnics, bowling events, baseball, and amusement park, or similar activities with probationers is potentially problematic. Additionally, attendance at a law enforcement function, such as a ball game with community police officers, adds another dimension as an appearance of partiality towards law enforcement.

The Canons don't prohibit all non-court contact with participants. For instance, if there was a picnic and the district attorney, defense counsel, law enforcement, other members of the drug court team, and drug court participants were present and the judge made a cameo appearance and said a few words of encouragement, such conduct would not violate the Canons. The question the judge must ask is whether the extrajudicial activities the judge engages in would cast reasonable doubt upon the judge's capacity to act impartially as a judge or whether the activity would threaten public confidence in the integrity of the judiciary.[23]

A. [§10.6] Providing Information and References

A judge may not voluntarily testify as a character witness.[24] A court ordinarily should not act as a conduit for information about participants to those outside the drug court team, particularly where, as in drug courts, strict confidentiality laws may apply. Drug courts should develop forms, agreed upon by all members of the drug court team, for the release of information about participants (where such releases are appropriate). Each participant must sign the release.[25] The entire drug court team should review all other inquiries submitted to the judge or court personnel. The court should not convey or permit others to convey that they are in a special position to influence the judge.[26]

A judge must be impartial but not indifferent.

References raise even more serious concerns because they place the court's stature behind an individual who has been (and may still be) subject to the court's jurisdiction. It is

particularly inappropriate for a judge to aid a participant in other litigation. Thus, one drug court judge was disciplined for sending an unsolicited character reference to another judge who was about to sentence a participant in an unrelated case.[27] While less egregious, it would still be troubling for a judge to serve as advocate for a participant by, for example, asking the participant's employer to be patient while the participant undergoes treatment.[28] The best way to avoid ethical problems is to have the prosecutor perform these services in lieu of the judge. A prosecutor's word in this context will carry nearly as much weight as a judge's because the prosecutor is also a public official and is in some respects the participant's adversary.

B. [§10.7] Impartiality and Decorum: Courtroom Conduct

Rule 2.3 of the Canons prohibits the judge from manifesting bias or prejudice, either by words or conduct, including, but not limited to, bias or prejudice based upon race, sex, gender, religion, national origin, ethnicity, disability, age, sexual orientation, marital status, socioeconomic status, or political affiliation.[29] Additionally, the judge shall not permit staff, court officials, and others subject to the judge's direction and control to manifest such bias or prejudice.[30] Because of the continuing personal engagement between participants and the drug court judge, the judge runs the risk of being influenced by factors other than the merits of each participant's case. Participants with friendly dispositions or particularly compelling experiences may attract the judge's compassion and leniency, while those with less friendly personalities may provoke the opposite response. Psychological concepts of *transference* and *countertransference* further complicate the judge's engagement with participants—a judge's identification with a participant (which may be unconscious) may lead to disparate treatment, including excessively harsh treatment, through countertransference. The same concerns with favoritism or prejudice apply to other court personnel, such as the drug court coordinator, who will also have ongoing personal engagement with participants. Drug court judges and personnel should be trained to recognize such bias in themselves and others.

Conduct within the courtroom that can raise concern ranges from simple praise to clapping for participants to coming down from the bench to shake hands with, or hug, participants.[31] These practices, which seem inconsistent with normal courtroom restraint and impersonality, reflect the underlying nature of drug court. A drug court judge's primary role is not to mediate a dispute between two litigants; rather, drug court judges actively promote the successful treatment of participants. The law does not prohibit a judge from assuming this orientation; a judge must be impartial but not indifferent. Applause, handshakes, and hugs do not suggest partiality when they promote the objectives of the drug court and are distributed without favoritism. Applause and physical contact may, however, negatively impact the court's dignity. There are no clear guidelines for protecting courtroom decorum. Judges must listen to their own instincts and respect community standards.

C. [§10.8] Impartiality and Decorum: Conduct Outside the Courtroom

Concerns about impartiality and dignity may arise from a judge's contacts with participants outside of the courtroom, in activities such as picnics (which are customary in some drug courts). Here, it is possible to enunciate guidelines. First, judges should not transact business with participants outside the courtroom, nor should they, in any manner, imply that a participant will receive special treatment during judicial proceedings. Second, extrajudicial contact between judges and participants should not be conducted in a secretive manner, lest outsiders suspect that the judge is concealing inappropriate conduct. Third, gatherings outside the courtroom should be open to all participants, or else invitations should be extended based on clearly identified criteria (even if the judge plays no role in preparing the invitation list), in order to avoid the perception that the judge is favoring some participants over others. Moreover, notwithstanding any selection criteria, a judge should never be alone with a single participant outside the courtroom or the judge's chambers.

There is a "therapeutic court exception" to ex parte communications in the ABA model code, but few states have adopted it.

D. [§10.9] Ex Parte Contacts

Regulation of ex parte contacts in the drug court context is evolving. Under the 1990 version of the ABA Model Code of Judicial Conduct, ex parte communications were prohibited, except in limited situations involving administrative purposes, scheduling, or emergencies.[32] The 2007 ABA Model Code of Judicial Conduct[33] dramatically changes the ethical landscape by permitting ex parte communications in drug and other problem solving courts. Rule 2.9(A)(5) of the 2007 Model Code provides that a judge may "initiate, permit, or consider any ex parte communication when expressly authorized by law to do so." The comment to this provision states: "A judge may initiate, permit, or consider ex parte communications when authorized by law, such as when serving on therapeutic or problem-solving courts, mental health courts, or drug courts. In this capacity, judges may assume a more interactive role with parties, treatment providers, probation officers, social workers, and others." At this point in time, only a handful of states have adopted the 2007 changes to their judicial conduct canons.[34] Because so few states have adopted the 2007 "therapeutic court exception" to the prohibition against ex parte communications, the remainder of this section shall address the subject under the 1990 ABA Model Code.

The informal nature of drug court proceedings should not be construed to relax the limitations on ex parte contacts. In particular, the judge should not initiate any extrajudicial factual inquiries; should not initiate legal inquiries without the consent of all parties; and should immediately report all unsolicited ex parte contacts to all parties. Because staffings include more than simply court personnel, the rules on ex parte

contacts apply and all parties or their representatives should be entitled to attend. In fact, empirical research notes both improved outcomes and cost savings when both defense counsel and prosecutors attend staffings.[35]

Case law concerning prohibited and unethical ex parte communication focuses on the most egregious conduct. For example, in *Briesno v. Superior Court*,[36] in a case involving allegations that police officers beat a motorist, the trial judge sent his law clerk to the prosecutor with the message, "don't stay up all night, that the judge says trust him, he knows what he is doing." In another case, a judge kept a telephone on the bench and called people whom he described as "friends of the court" during the trial to get information on how he should rule. The Arizona Supreme Court had no difficulty in determining that this conduct violated Canon 1 (proceedings lacking in order and decorum) and Canon 3 (prohibited ex parte communications).[37]

Contacts between judges and probation officers require additional comment. Generally, the probation department acts as an arm of the court, so it is not improper for a judge to communicate with probation officers outside of regular court proceedings. Not all ex parte communications with probation officers are protected, however.[38] Cautious judges will observe the limitations listed above—that judges should not initiate contact and should insure that all parties are made aware of the substance of ex parte contacts—even in communications with probation officers.

E. [§10.10] Use of Nonpublic Information

All members of the drug court team, including judges and court personnel, should recognize the highly sensitive nature of participants' disclosures in treatment and, occasionally, in court.[39] The judge should ensure compliance with federal and state regulations concerning the confidentiality of information disclosed in treatment, including waivers of confidentiality that strictly limit disclosures to information necessary to carry out the court's mission.

Whether or not court proceedings are in open court or are open to the public depends on the type of case (juvenile or adult) as well as state law. In general, most adult court proceedings are open to the public and drug courts are no exception.[40] The value here is freedom of information and a desire not to have the perception of "star chamber" proceedings.

Be cautious about discussing personal information in open court.

In actuality, this requirement places special considerations on the shoulders of the drug court team to handle participant information in open court with utmost care. For example, the team should be careful not to discuss personal issues in open court, limiting review hearings to program compliance facts. Participants can be called to the podium by their first names. It is crucial that each participant sign a consent wherein the public nature of the open court proceedings is made clear.

Calendars could be labeled, *Department 2 Review Hearings* as opposed to *Drug Court Cases.* What the team needs to do is take a close look at its own proceedings and determine how best to protect the confidential nature of the treatment issues and operate in a public courtroom if their state law requires. The approximately 2500 operational drug courts in the United States have shown that these issues can be successfully resolved.[41]

III. [§10.11] DISQUALIFICATION AND RECUSAL OF THE JUDGE

A judge is disqualified whenever the judge's impartiality might reasonably be questioned, regardless whether any of the specific provisions of Rule 2.11 of the Canons apply.[42] A judge should disclose on the record information that he or she believes the parties or their lawyers might consider relevant to the question of disqualification, even if he or she believes there is no real basis for disqualification.

Judges sitting in drug court often have substantial information about drug court participants—some of which was gained through on-the-record colloquies and pleadings and other information from informal staffings with defense counsel, the prosecutor, treatment provider, and probation. The Oklahoma Supreme Court[43] recognized the potential for accusations of bias against a drug court judge for information obtained in the court's supervisory role and recommended an alternate judge handle termination proceedings:

> However, we recognize the potential for bias to exist in a situation where a judge, assigned as part of the Drug Court team, is then presented with an application to revoke a participant from Drug Court. Requiring the District Court to act as Drug Court team member, evaluator, monitor and final adjudicator in a termination proceeding could compromise the impartiality of a district court judge assigned the responsibility of administering a Drug Court participant's program.
>
> Therefore, in the future, if an application to terminate a Drug Court participant is filed, and the defendant objects to the Drug Court team judge hearing the matter by filing a Motion to Recuse, the defendant's application for recusal should be granted and the motion to remove the defendant from the Drug Court program should be assigned to another judge for resolution.

A. [§10.12] Personal Knowledge of Facts

Related to the issue of ex parte contacts is the question of a judge having independent knowledge of disputed facts in a case. When a drug court judge receives information from a treatment provider or other source, this would be subject to the rules on ex parte contacts, not Rule 2.11's disqualification based upon a judge's "personal knowledge."[44] The reason this does not qualify as "personal knowledge" is that the judge has not personally observed the events in question; therefore, the judge can conduct an evidentiary hearing without having

to testify or otherwise place his or her own credibility in issue.[45] Judges should, however, recuse themselves from any adjudications arising out of events that they did witness, such as a participant appearing in court intoxicated or a participant attempting to escape.

B. [§10.13] Extra Judicial Activities

The personal engagement between the drug court judge and participants must be limited to the judicial role and context: a judge may not enter into a relationship with participants apart from that established by (and confined to) the drug court context. *In re Jones* provides an egregious example of improper relationships: a judge who professed concern for the alcohol problems of defendants that he had sentenced to probation, met privately with several of the probationers and even visited and shared meals with them at their homes.[46]

IV. [§10.14] OTHER JUDICIAL ACTIVITIES

A. [§10.15] Publicity and Educational Activities

Rules 3.1 and 3.7 of the Canons authorize judges to act as educators.[47] It is especially important for drug court judges to assume this role, both because drug courts should be part of larger community efforts and because the public is entitled to understand why drug courts deviate from certain legal traditions. At the same time, the judge's public comments must be circumscribed by concerns about the appearance of partiality.[48] There are two primary constraints on judicial utterances: (1) a judge should not indicate an unwillingness to obey the law; and (2) a judge should not manifest a predisposition toward a particular outcome in a pending case. Ultimately, judges must maintain a delicate balance. They should not isolate themselves from their communities. They must, however, heed the line between nonjudicial activities that interfere with the business of judging and those that enrich judicial institutions or at least do no harm to them.

In the drug court context, it is common for judges to attempt to build public support for treatment-oriented programs. The clear import of these presentations is that this method of case processing is preferable to that which otherwise exists in the criminal justice system. Often, these comments include success stories about past or current drug court participants. Such comments do not violate the Canons, so long as the judge is not foretelling a future result or disclosing confidential information that could be used to identify a drug court participant. Indeed, Rule 3.7 specifically allows judges to speak, teach, write, and participate in extrajudicial activities concerning the law, the legal system, and the administration of justice.[49] Rules 3.2 and 3.7 also authorize judges to attend governmental hearings on behalf of drug court programs, drug courts in general, or affiliated treatment agencies. Moreover, Rule 2.11 permits general informative explanations on court procedures.[50]

A judge's speech is most often questioned when it approaches activist support for a particular cause. The opinion by Circuit Judge J. Posner of the U.S. Court of Appeals for the 7th Circuit, in *Buckley v. Illinois Judicial Inquiry Board,*[51] makes clear that those who

become judges or candidates for judicial office do not forfeit their free speech rights under the First Amendment of the United States Constitution. A blanket prohibition on judicial statements about controversial issues in law or politics would not survive constitutional scrutiny. Any limitation on judicial speech must be closely linked to the specific harms identified in Rule 3.1 speech that would appear to "undermine the judge's independence, integrity, or impartiality"; "lead to frequent disqualification"; or "interfere with the proper performance of judicial duties."[52]

Cases interpreting the limits of permissible judicial speech vary by jurisdiction. For example, the Washington Supreme Court held that it was permissible for a judge to attend and speak at an antiabortion rally. The remarks of the judge at the rally included "Nothing is, nor should be, more fundamental in our legal system than the preservation and protection of innocent human life." The court found that the comments did not call into question the judge's ability to be impartial in an abortion case.[53] A judge was not censured for attending a telethon on domestic violence prevention because it was deemed to be similar to those dedicated to improvement of the law.[54] *In re Bonin*[55] is a close case: the Massachusetts Supreme Judicial Court disciplined the chief judge of the Massachusetts Superior Court for attending a lecture by Gore Vidal on sex and politics that was sponsored by a gay activist group. The court explained that discipline was warranted not because of the content of the lecture but the fact that the lecture was being held as a fund-raiser for defendants currently awaiting trial in superior court, even though Judge Bonin was not assigned to hear the case.[56] Because the case was not before Judge Bonin, the concern about lack of impartiality must be diminished, but as chief judge of the court in which the case was pending, public perception of the entire court's bias seems a reasonable concern.[57]

It seems clear that judges may advocate changes in the law so long as they make clear their own intention to adhere to the existing law. In *In re Gridley*,[58] the Florida Supreme Court declined to sanction a judge who wrote about his moral opposition to the death penalty in his church newsletter; the court noted that, in the same writing, the judge had reaffirmed his duty to follow the state's law. Thus, a judge may criticize mandatory minimum sentences, so long as the judge acknowledges that he or she is bound to impose them while they remain in effect.

Because drug courts may attract opposition (particularly, though not exclusively, in the context of political campaigns), understanding the boundaries of appropriate judicial commentary is important. A drug court may avoid concerns about inappropriate judicial participation in political conflicts by establishing a media relations office outside the judge's supervision. Nevertheless, judges may find themselves called on to respond to critics, and Rule 2.10 offers basic guidance. The judge is permitted to explain the law and the court's procedures and respond directly or through a representative to allegations in the media or elsewhere concerning the judge's conduct in a matter.[59] However, in responding to criticisms, the judge must be truthful[60] and the explanation "[m]ust be limited to a moderate and dignified response to the attack made upon the judge and may not be of a nature in quantity or substance that creates more harm than benefit to the judicial system."[61] *Ad hominem* replies, such as questioning critics' competence, should be avoided as they call into question the judge's impartiality and demean the court's character.

B. [§10.16] Civic Activities—Board Member of Treatment Provider

Because of their involvement in drug treatment, drug court judges may be asked to serve on the board of directors for a treatment provider.[62] They should abstain. If the provider is a governmental agency, service is precluded by Rule 3.4 of the Canons. [63] If the provider is private, the judge should not be on its board because the treatment provider may seek a contract with the drug court, placing the judge in violation of Rule 3.7.[64] In a recent case, a drug court judge required defendants to contribute to I Care, an organization that provided substance abuse education to young children. The drug court judge sat on the advisory council for the organization. While finding this a violation of the Canons, the Louisiana Supreme Court refused to impose any sanction, given the altruistic motives of the judge and his unblemished record. [65]

C. [§10.17] Board Member—Other Civic Organizations

Key Component #10 recommends the formation of a drug court steering committee, which "provides policy guidance and acts as a conduit for fund-raising and resource acquisition." Subject to restrictions on fund-raising described below under Rule 3.7, a drug court judge may serve on the steering committee or on the board of other organizations operating drug education programs. However, the judge's participation becomes more complicated if the steering committee or other organization "engages in advocacy toward the adoption, repeal, or modification of particular substantive laws or towards the courts' use and application of existing laws in a particular manner."[66] The line between permitted advocacy of improvements in the legal system and forbidden political engagement is notoriously hard to draw. Resolution of difficult cases, however, should return to the principles articulated under Canon 1: does the advocacy for or against a particular change in the law reasonably call into question the judge's independence and impartiality?[67]

D. [§10.18] Fund-Raising

Operating a drug court often requires fund-raising. The role that judges may play in that fund-raising is limited by Rule 3.7 and its underlying rationale, which is that judges should not use their office to pressure potential donors into making contributions.[68] If the organization is a nonprofit, the judge may assist the organization in planning related to fund-raising.[69] To avoid any appearance of coercion, judges should not personally solicit funds.[70] Nor should the judge impose sentences on defendants that require them to contribute to an organization connected with the judge or the drug court over which the judge presides.[71] A judge may serve on the board of the organization that conducts the fund-raising, but neither the judge nor any other person acting on behalf of the organization should rely on the judge's office to encourage donations. It is appropriate for a judge's name to appear on organizational letterhead used in a fund-raising solicitation, if comparable designations are used by other persons.[72]

Judges should not personally solicit funds to support the drug court.

E. [§10.19] Political Activity and the Drug Court

Canon 4 merits attention from drug court judges because the drug court concept remains a fairly political one, and some candidates for public office have criticized drug courts. Canon 4 prohibits a judge or candidate for judicial office from engaging any political or campaign activity that is inconsistent with the independence, integrity, or impartiality of the judiciary.[73] Because of the political context, any response to these criticisms will itself appear to be political activity, implicating the restrictions in the Canon and associated rules. If the criticisms arise from a political campaign in which the drug court judge is not a candidate (*e.g.,* an election for district attorney or a different judicial position), the judge may respond to the criticisms, but must ensure that the response does not constitute public opposition to the candidate. It may seem less like a particular judge's involvement in political action if the drug court establishes a media relations operation outside of the judge's supervision. However, as long as the media relations operation remains within a part of the drug court sphere, the judge has a duty to ensure that the operation does not undertake political activity (as defined by Canon 4) that the judge himself or herself would be forbidden to undertake.

If the drug court judge is a candidate for judicial election and the judge's opponent in the election has made criticisms, the judge may respond to the criticisms.[74] The most difficult question in this respect is balancing the judge's appropriate defense of his or her past record with the prohibition under Rule 4.1 on statements that commit, or appear to commit, the judge to future decisions.[75] At minimum, the judge may both explain and defend the drug court model in general terms. The judge may not state an intention to decide future cases in a particular manner (e.g., "I will enroll all drug offenders in treatment") unless the statement simply reflects an intention to follow established law. In 2002, the U.S. Supreme Court[76] struck down Minnesota's Canon of Judicial Conduct, on First Amendment grounds, that prohibited judicial candidates from expressing opinions on views on disputed legal and political issues. Since that decision, the lower federal courts have been divided on how far the First Amendment reaches in this area.[77]

In states where the judge is permitted to discuss past cases, the drug court judge should take particular care to ensure that confidential information about drug court participants is not disclosed. Under no circumstance should a judge comment on a case pending before him or her.

V. [§10.20] CONCLUSION

Because of their nontraditional functioning and process, drug court operations provide the judge with the opportunity to unwittingly cross the bounds into ethical violations. Drug court judges must zealously ensure that their conduct meets the highest standards of ethical compliance. Drug court judges are frequently in the public limelight because of many human interest stories generated by the successes (and failures) in the drug court. Judges must be ever vigilant to situations and behaviors that might be perceived as not being impartial, independent, or judicious. Strict adherence to the Canons of Judicial Conduct can avoid any such claims.

1 Eugene A. Wright, *Courtroom Decorum and the Trial Process,* 51 JUDICATURE 378, 382 (1968).

2 This chapter is an update, distillation, and adaptation of the excellent publication by KAREN FREEMAN-WILSON, NAT'L DRUG COURT INST., ETHICAL CONSIDERATIONS FOR JUDGES AND ATTORNEYS IN DRUG COURT (2001).

3 Canon 1 states: "A Judge Shall Uphold and Promote the Independence, Integrity and Impartiality of the Judiciary and Shall Avoid Impropriety and the Appearance of Impropriety." MODEL CODE OF JUDICIAL CONDUCT Canon 1 (2007).

4 *See* MODEL CODE OF JUDICIAL CONDUCT R. 2.12 (2007).

5 MODEL CODE OF JUDICIAL CONDUCT R. 1.2 cmt. 3 (2007).

6 NAT'L. ASS'N. OF DRUG COURT PROF'LS & BUREAU OF JUSTICE ASSISTANCE, U.S. DEP'T OF JUSTICE, DEFINING DRUG COURTS: THE KEY COMPONENTS (1997) (delineating the 10 key components that are the basic elements that characterize effective drug court programs). These are the seminal standards by which drug court practitioners plan, implement, and enhance their drug courts. *Id.*

7 *Id.* at 2.

8 *See, e.g., In re* Briggs, 595 S.W.2d 270, 270 (Mo. 1980); In re Bristol et. al. (N.Y. Commission on Judicial Conduct, Nov. 4, 1992); In re Hughes, 874 So. 2d 746, 746 (La. 2004) (removing judge from office because he allowed convicted felons to frequent her courtroom, giving them access to confidential juvenile files, hired friends to work in the drug court, allowed staff to run her docket in her absence); JAMES J. ALFINI ET AL, JUDICIAL CONDUCT AND ETHICS § 6.03 (4th ed. 2007).

9 Key Component #10: "Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court program effectiveness." NAT'L. ASS'N. OF DRUG COURT PROF'LS & BUREAU OF JUSTICE ASSISTANCE, *supra* note 6, at 23.

10 *Id.*

11 On relationship between police and drug courts in education and training see NAT'L ASS'N OF DRUG COURT PROF'LS, U.S. DEP'T OF JUSTICE, COMMUNITY POLICING AND DRUG COURTS/COMMUNITY COURTS PROJECT: A THREE YEAR PROGRESS REPORT (2000).

12 NAT'L. ASS'N. OF DRUG COURT PROF'LS & BUREAU OF JUSTICE ASSISTANCE, *supra* note 6, at 23.

13 *See* MODEL CODE OF JUDICIAL CONDUCT R. 3.1, 3.7 (2007).

14 *See* MODEL CODE OF JUDICIAL CONDUCT R. 2.10 (2007); United States v. Microsoft Corp. 253 F.3d 34, 34 (D.C. Cir. 2001) (deciding that judge must be removed from case due to his comments about case).

15 MODEL CODE OF JUDICIAL CONDUCT R. 3.1(C).

16 NAT'L. ASS'N. OF DRUG COURT PROF'LS & BUREAU OF JUSTICE ASSISTANCE, *supra* note 6, at 15.

17 *In re* Jones, 581 N.W.2d 876, 876 (Neb. 1998).

18 MODEL CODE OF JUDICIAL CONDUCT (1990).

19 Cynthia Gray, A Judge's Obligation to Report Criminal Activity 18 JUDICIAL CONDUCT REPORTER 3 (1996).

20 *Id.*

21 *See, e.g., In re* Esquiroz, 654 So. 2d 558, 558 (Fla. 1995) (driving while impaired).

22 Matter of Blackman, 591 A.2d 1339, 1339 (N.J. 1991). Judge Blackman argued that his attendance was an innocent mistake; he had no improper motive and had been friends with the defendant for many years. *Id.* The court was unpersuaded and stated: "The lesson is that a judge who attends a public or social event will be perceived as endorsing or supporting not only the event itself but also persons associated with the event." *Id.*

23 *See* MODEL CODE OF JUDICIAL CONDUCT R. 1.2 (2007).

24 MODEL CODE OF JUDICIAL CONDUCT R. 3.3 (2007).

25 For more information about releases from participants, see JEFFREY TAUBER ET AL., NAT'L DRUG COURT INST., FEDERAL CONFIDENTIALITY LAWS AND HOW THEY AFFECT DRUG COURT PRACTITIONERS (1999). *See also* CHAPTER 8 OF THIS JUDICIAL MANUAL.

26 *In re* Hughes, 874 So.2d 746, 746 (La. 2004).

27 *In re* Fogan, 646 So.2d 19, 19 (Fla. 1994).; In re Marullo, 692 So.2d 1019, 1019 (La. 1997).

28 However, four jurisdictions have permitted judges to provide employment or other recommendations as long as the reference is based upon the personal knowledge of the judge. Alfini et al., *supra* note 8, at § 10.05A n. 147, § 2.07C (discussing the need for personal knowledge and the clarity of the 2007 rule changes).

29 MODEL CODE OF JUDICIAL CONDUCT R. 2.3 (2007).

30 *Id.*

31 Decorum is addressed in MODEL CODE OF JUDICIAL CONDUCT R. 2.8 (2007).

32 MODEL CODE OF JUDICIAL CONDUCT Canon 3B (1990).

33 MODEL CODE OF JUDICIAL CONDUCT R. 2.9(A)(5) cmt. (2007).

34 The states include Minnesota, Montana, Indiana, Idaho, and Arkansas. New York permits ex parte communications in drug courts by an administrative order.

35 Shannon M. Carey et al., NPC Research, Exploring the Key Components of Drug Courts: A Comparative Study of 18 Adult Drug Courts on Practices, Outcomes and Costs (2008), *available at* http://www.ncjrs.gov/pdffiles1/nij/grants/223853.pdf.

36 Briseno v. Superior Court, 284 Cal. Rptr. 640, 640 (Cal. Ct. App. 1991).

37 *In re* Anderson, 814 P.2d 773, 773 (Ariz. 1991).

38 United States v. Gonzales, 765 F.2d 1393, 1393 (9th Cir. 1985); People v. Smith, 378 N.W.2d 384, 384 (Mich. 1985).

39 Model Code of Judicial Conduct R. 3.5 (2007) prohibits the judge from using nonpublic information that is acquired in a judicial capacity for any purpose except those related to judicial duties.

40 See State v. Noelle Bush, Case #48-02 CF 6371-0, (October 15, 2002) (holding that open and public courtroom trumps federal confidentiality requirements). *See generally* Argersinger v. Hamlin, 407 U.S. 25, 25 (1972); Gannett Co. Inc. v. DePasquale, 43 NY2d 370, 370, *aff'd,* 443 US 368, 368 (1979).

41 For further information about confidentiality in drug court, *see infra* Ch. 9.

42 Model Code of Judicial Conduct R. 2.11 (2007). Also, due process requires that a judge possess neither actual nor apparent bias in favor of or against a party. United States v. Ayala, 289 F.3d 16, 27 (1st Cir. 2002) (holding that the standard is whether the facts, as asserted, would lead an objective reasonable observer to question the judge's impartiality); Liteky v. United States, 510 U.S. 540, 555 (1994). *See, e.g.,* United States v. Microsoft, 253 F.3d 34, 117 (D.C. Cir. 2001) (finding that judge demonstrated bias by his comments to press while case was pending); Young v. Track, 324 F.3d 409, 423 (6th Cir. 2003) (finding that the court's comments and rulings did not show bias when they were based upon evidence acquired during proceedings).

43 Alexander v. State, 48 P.3d 110, 110 (Okla. 2002). *But see* Wilkinson v. State, 641 S.E.2d 189, 189 (Ga. App. 2006) (allowing the defendant to waive her ability to move for recusal of the drug court judge as part of her drug court contract).

44 Model Code of Judicial Conduct R. 2.11(A)(1) (2007) provides that a judge who has "personal knowledge of disputed evidentiary facts concerning the proceeding" shall disqualify himself or herself in that proceeding.

45 Alfini et al., *supra* note 8, at § 4.05F.

46 *In re* Jones, 581 N.W. 2d 876, 876 (1998). For this and other misconduct, the judge was removed from office. *Id.*

47 Model Code of Judicial Conduct (2007).

48 Alfini et al., *supra* note 8, at § 9.02A, §10.06B.

49 Model Code of Judicial Conduct (2007).

50 Model Code of Judicial Conduct (2007).

51 Buckley v. Illinois Judicial Inquiry Bd., 997 F.2d 224, 224 (7th Cir. 1993).

52 Model Code of Judicial Conduct (2007).

53 *In re* Sanders, 955 P.2d 369, 369 (Wash. 1998).

54 Allen v. State, 737 N.E. 741, 741 (Ind. 2000).

55 *In re* Bonin, 378 N.E.2d 669, 669 (Mass. 1978).

56 *Id.* at 685; Alfini et al., *supra* note 8, at §10.05D.

57 This concern was magnified by the significant publicity surrounding the judge's attendance at the lecture. Alfini et al., *supra* note 8, at §10.05D notes that "a photograph of the judge [with the lecturer] did, in fact, appear the next day in a Boston newspaper under the headline 'Bonin at benefit for sex defendants.'"

58 417 So.2d 950 (Fla. 1982).

59 *See* Model Code of Judicial Conduct R. 2.10(D)-(E) (2007); Alfini et al., *supra* note 8, at §10.06E; Office of Disciplinary Counsel v. Souers, 611 N.E.2d 305, 305 (Ohio 1993) (imposing no sanction on judge who made public statements explaining a sentencing order).

60 *See* Office of Disciplinary Counsel v. Ferreri, 710 N.E.2d 1107, 1107 (Ohio 1999).

61 *In re* Conrad, 944 S.W.2d 191, 191 (Mo. 1997).

62 *See In re* Rainaldi, 722 P.2d 70, 70 (N.M. 1986) (disciplining a judge for referring clients to a DWI school he partially owned).

63 Model Code of Judicial Conduct R. 3.4 (2007).

64 Model Code of Judicial Conduct R. 3.7 (2007).

65 *In re* Morvant, 15 So. 3d 74, 74 (La. 2009). *See also In re* Johnson, 1 So. 3d 438, 438 (La. 2009).

66 COMMITTEE ON JUDICIAL ETHICS, CALIFORNIA JUDGES ASSOCIATION, OPINION NO. 46, JUDICIAL PARTICIPATION IN ORGANIZATIONS AND GOVERNMENTAL BOARDS WHICH ADDRESS ISSUES INVOLVING THE ADMINISTRATION OF JUSTICE AND SOCIAL PROBLEMS IN THE COMMUNITY (1997).

67 MODEL CODE OF JUDICIAL CONDUCT Canon 1 (2007).

68 MODEL CODE OF JUDICIAL CONDUCT (2007).

69 MODEL CODE OF JUDICIAL CONDUCT R. 3.7(A)(1) (2007).

70 Rule 3.7(A)(2) of the Model Code of Judicial Conduct permits the judge to solicit contributions for non-profit entities from family members and other judges over whom the judge does not exercise supervisory authority. MODEL CODE OF JUDICIAL CONDUCT R. 3.7(A)(2) (2007).

71 *In re* Morvant, 15 So. 3d 74, 74 (La. 2009).

72 MODEL CODE OF JUDICIAL CONDUCT R. 3.7 cmt. 4 (2007).

73 MODEL CODE OF JUDICIAL CONDUCT Canon 4 (2007).

74 MODEL CODE OF JUDICIAL CONDUCT Canon 4 cmt. 8-9 (2007).

75 MODEL CODE OF JUDICIAL CONDUCT R. 4.1(A)(13) (2007). Pledges, promises and commitments should be distinguished from statements of personal views or beliefs on legal and social issues, which are not prohibited.

76 Republican Party v. White, 536 U.S. 765, 765 (2002).

77 ALFINI ET AL., *supra* note 8, at § 11.08.

Epilogue

Leaving A Legacy

Honorable William G. Meyer (Ret.)
Honorable Karen Freeman-Wilson (Ret.)

"We cannot change the cards we are dealt, just how we play the hand."

~ Randy Pausch [1]

As a judge, you have ascended to the pinnacle of the legal profession. But your career choice has dealt you a hand in the criminal justice system where almost sixty percent of all individuals arrested for virtually any crime tests positive for one or more illegal drugs at the time of arrest;[2] eighty percent of incarcerated offenders abused alcohol or other drugs before they were incarcerated;[3] and fifty percent of jail and prison inmates are clinically addicted.[4]

Strategies to reduce crime and addiction through incarceration have resulted in one of every one hundred U.S. citizens being confined in jail or prison,[5] a per capita incarceration rate greater than twenty-six of the largest European countries combined[6] and greater than any country in the world.[7] More than sixty percent of the people in prison are now racial and ethnic minorities.[8] For black males in their twenties, one in every eight is in prison or jail on any given day.[9]

The deterrent effect of incarceration has little impact on either recidivism or drug abuse. Sixty to eighty percent of drug abusers commit a new crime (typically a drug-driven crime) after release from prison.[10] Almost ninety-five percent return to drug abuse after release from prison.[11] Even offenders who seek treatment have a sixty to eighty percent probability of dropping out of treatment prematurely without regular judicial supervision.[12]

Such statistics are discouraging when considering the probability of successfully rehabilitating a drug addict in the criminal justice system. But as Winston Churchill observed: "the pessimist sees difficulty in every opportunity and the optimist sees the opportunity in every difficulty." Establishing and operating a drug court presents an opportunity. Drug courts reduce crime and substance abuse at a rate greater than three times that realized through traditional probation,[13] with resulting cost savings of $4,000–$12,000 per offender.[14] Research establishes that drug courts' impact on crime reduction is between three and fourteen years.[15] In family drug courts, parents are more

likely to attend and complete treatment and their children spend significantly less time in out-of-home placements, such as foster care, because family reunification rates are fifty percent higher than traditional dependency court resolutions.[16] The 2008 report card on drug courts reflects that 844 drug-free babies had been born to mothers active in drug court in the preceding twelve months—a potential savings of hundreds of thousands of dollars per child when compared to the costs of attending to drug-affected newborn.[17] Bluntly, drug courts have been found to appreciably reduce crime, while being more cost effective than any alternative.[18]

More than any other judicial assignment, running a drug court docket will give the judge the opportunity to serve the community by restoring offenders to being productive members of society; to rebuild the family units by returning a healthy mother, father, or spouse to the familial milieu; and to transform the addict from a drain on the system to an employed, law abiding contributor to the community and his or her family. Moreover, the drug court judge improves the judicial system by breaking the cycle of addiction and crime, through a cost-effective process that reduces recidivism, thus permitting scarce judicial resources to focus on violent offenders. Few callings compare with the opportunity to leave a legacy that enhances the community, strengthens the criminal justice system, mends families, and restores individuals. That is not to say that the drug court judge's job is not demanding. Challenges will vary from resource acquisition, to bureaucratic intransience, to participant noncompliance. By accepting the challenge, recognize that mistakes will be made. As then-Senator Obama aptly observed:[19]

Being a drug court judge could be the most rewarding assignment you will ever have.

> Making your mark on the world is hard. If it were easy, everybody would do it. But it's not. It takes patience, it takes commitment, and it comes with plenty of failure along the way. The real test is not whether you avoid this failure, because you won't—it's whether you let it harden or shame you into inaction, or whether you learn from it; whether you choose to persevere.

The challenges faced by a drug court judge will promote both personal and professional growth resulting in job satisfaction which far exceeds that obtained by running a traditional court docket.[20] In the final analysis, the worth of what you leave behind is not what is engraved in stone monuments, but what is woven into the lives of others.[21]

---

1 Randy Pausch, The Last Lecture (2008).

2 Nat'l Inst. of Justice, U.S. Dep't of Justice, Annual Report on Drug Use Among Adult and Juvenile Arrestees (2000).

3 Steven Belenko et al., Nat'l Ctr. on Addiction & Substance Abuse, Behind Bars: Substance Abuse and America's Prison Population (1998).

4 Jennifer C. Karberg & Doris J. James, U.S. Dep't of Justice, Substance Dependence, Abuse, and Treatment of Jail Inmates, 2002 (2005); S. Fazel et al.; *Substance Abuse and Dependence in Prisoners: A Systematic Review,* 101 Addiction *101*, 181-191 (2006).

5 The Pew Center on the States, One in 100: Behind Bars in America 2008 (2008).

6 *Id.*

7 Roy Walmsley, Int'l Ctr. for Prison Studies, World Prison Population (seventh edition) (2007), *available at* http://www.kcl.ac.uk/depsta/law/research/icps/downloads/world-prison-pop-seventh.pdf.

8 Marc Mauer, The Sentencing Project, Racial Disparities in the Criminal Justice System (2009), *available at* http://www.sentencingproject.org/doc/publications/rd_mmhousetestimonyonRD.pdf.

9 *Id.*

10 Patrick A. Langan & David J. Levin, U.S. Dep't of Justice, Recidivism of Prisoners Released in 1994 (2002); Cassia Spohn & David Holleran, *The Effect of Imprisonment on Recidivism Rates of Felony Offenders: A Focus on Drug Offenders,* 40 Criminology 329, 329-357 (2006).

11 Thomas E. Hanlon et al., *The Response of Drug Abuser Parolees to a Combination of Treatment and Intensive Supervision,* 78 Prison J. 31, 31-44 (1998); Steven S. Martin et al., *Three-year Outcomes of Therapeutic Community Treatment for Drug-Involved Offenders in Delaware: From Prison to Work Release to Aftercare,* 79 Prison J. 294, 294-320 (1999); David N. Nurco et al., *Recent Research on the Relationship Between Illicit Drug Use and Crime, 9* Behav. Sci. L. 221, 221-249 (2006).

12 Douglas Longshore et al., Integrated Substance Abuse Program, Evaluation of the Substance Abuse and Crime Prevention Act (2005); Douglas B. Marlowe, *Effective Strategies for Intervening with Drug Abusing Offenders,* 47 Vill. L. Rev. 989, 989-1025 (2001).

13 Shannon M. Carey et al., *California Drug Courts: Outcomes, Costs and Promising Practices: An Overview of Phase II in a Statewide Study,* 3 *J. Psychoactive Drugs* 345, 345-356 (2006).

14 *Steve Aos et al., Wash. State Inst. for Pub. Policy, Evidence-Based Public Policy Options to Reduce Future Prison Construction, Criminal Justice Costs, and Crime Rates* (2006); Christopher T. Lowenkamp et al., *Are Drug Courts Effective: A Meta-Analytic Review,* J. Community Corrections, Fall 2008, at 5-28; Deborah Koetzle Shaffer, Dep't of Criminal Justice, Reconsidering Drug Court Effectiveness: A Meta-Analytic Review 3 (2006); David B. Wilson et al., *A Systematic Review of Drug Court Effects on Recidivism,* 2 J. Experimental Criminology 459, 459-487 (2006).

15 Denise C. Gottfredson et al., *The Baltimore City Drug Treatment Court: 3-Year Self-Report Outcome Study,* 29 Evaluation Rev. 42, 42-64 (2005); Michael W. Finigan et al.; NPC Research, The Impact of a Mature Drug Court Over 10 Years of Operation: Recidivism and Costs (2007).

16 Sharon M. Boles et al., *The Sacramento Dependency Drug Court: Development and Outcomes;* 12 Child Maltreatment 161, 161-171 (2007); Sonia D. Worcel et al., NPC Research, National Family Treatment Drug Court Evaluation (2007); James R. Milliken & Gina Rippel, *Effective Management of Parental Substance Abuse in Dependency Cases,* 5 J. Center Families, Children & Cts. 95, 95-107 (2004).

17 C. West Huddleston, III et al., Nat'l Drug Court Inst., Painting the Current Picture: A National Report Card on Drug Courts and Other Problem-Solving Court Programs in the United States 15 (2008).

18 *Id.* at 6.

19 Barack Obama, United States Senator, Speech at the Campus Progress Annual Conference: Our Past, Our Future and Vision for America (July 12, 2006).

20 Deborah Chase & Peggy Fulton Hora, *The Best Seat in the House: The Court Assignment and Judicial Satisfaction,* 47 Family Ct. Rev. 209, 209-238 (2009); Peggy Fulton Hora & Deborah J. Chase, *Judicial Satisfaction When Judging in a Therapeutic Key,* 7 Contemp. Issues L. (2003/2004).

21 Pericles.

The Ten Key Components

Key Component 1 Drug courts integrate alcohol and other drug treatment services with justice system case processing.

Key Component 2 Using a nonadversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights.

Key Component 3 Eligible participants are identified early and promptly placed in the drug court program.

Key Component 4 Drug courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services.

Key Component 5 Abstinence is monitored by frequent alcohol and other drug testing.

Key Component 6 A coordinated strategy governs drug court responses to participants' compliance.

Key Component 7 Ongoing judicial interaction with each drug court participant is essential.

Key Component 8 Monitoring and evaluation measure the achievement of program goals and gauge effectiveness.

Key Component 9 Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations.

Key Component 10 Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court program effectiveness.[1]

---

1 National Association. of Drug Court Professionals & Bureau of Justice Assistance, U.S. Dep't of Justice, Defining Drug Courts: The Key Components (1997), *available at* http://www.ojp.usdoj.gov/BJA/grant/DrugCourts/DefiningDC.pdf.

Performance Benchmarks

Benchmark 1 Initial and ongoing planning is carried out by a broad-based group, including persons representing all aspects of the criminal justice system, the local treatment delivery system, funding agencies, the local community other key policymakers.

Benchmark 2 Documents defining the drug court's mission, goals, eligibility criteria, operatin gprocedures, and performance measures are collaboratively developed, reviewed, and agreed upon.

Benchmark 3 Abstinence and law-abiding behavior are the goals, with specific and measurable criteria marking progress. Criteria may include compliance with program requirements, reductions in criminal behavior and AOD use, participation in treatment, restitution to the victim or to the community, and declining incidence of AOD use.

Benchmark 4 The court and treatment providers maintain ongoing communication, including frequent exchanges of timely and accurate information about the individual participant's overall program performance.[1]

Benchmark 5 The judge plays an active role in the treatment process, including frequently reviewing of treatment progress. The judge responds to each participant's positive efforts as well as to noncompliant behavior.

Benchmark 6 Interdisciplinary education is provided for every person involved in drug court operations to develop a shared understanding of the values, goals, and operating procedures of both the treatment and justice system components.

Benchmark 7 Mechanisms for sharing decision making and resolving conflicts among drug court team members, such as multidisciplinary committees, are established to ensure professional integrity.[2]

---

1 All communication about an individual's participation in treatment must be in compliance with the provisions of 42 CFR, Part 2 (the federal regulations governing confidentiality of alcohol and drug abuse patient records), and with similar State and local regulations

2 National Association. of Drug Court Professionals & Bureau of Justice Assistance, U.S. Dep't of Justice, Defining Drug Courts: The Key Components (1997), *available at* http://www.ojp.usdoj.gov/BJA/grant/DrugCourts/DefiningDC.pdf.

Abbreviations

AA: Alcoholics Anonymous

ABA: American Bar Association

ADA: Americans with Disabilities Act

ADP: antisocial personality disorder

AIDS: acquired immunodeficiency syndrome

AOD: alcohol or other drugs

APA: American Psychiatric Association

ASAM: American Society of Addiction Medicine

BAC: blood alcohol content

BJA: Bureau of Justice Assistance

BPs: best practices

CASE: copy and steal everything

CBT: cognitive behavioral therapy

CCJ: Conference of Chief Justices

CEO: chief executive officer

CFR: Code of Federal Regulation

CM: contingency management

CNS: central nervous system

COSCA: Conference of State Court Administrators

CRA: community reinforcement approach

CSAT: Center for Substance Abuse Treatment

DOJ: Department of Justice

detox: detoxification

DSM-IV: Diagnostic and Statistical Manual of Mental Disorders

DTs: delirium tremens

DWI: driving while impaired

DWI-D: driving while impaired by drugs

ECT: electroconvulsive therapy

EMIT: enzyme multiple immunoassay technique

EBP: evidence-based practice

EtG: ethyl glucuronide

EtS: ethyl sulfate

FDA: Food and Drug Administration

FPIA: fluorescein polarization immunoassay test

FRE: Federal Rules of Evidence

GAD: general anxiety disorder

GC-MS: gas chromatography-mass spectrometry

GED: General Educational Development

GPS: Global Positioning System

HHS: (U.S. Department of) Health and Human Services

HIPAA: Health Insurance Portability and Accountability Act

HIV: human immunodeficiency virus

MET: motivational enhancement therapy

mg/dL: milligrams per deciliter

MOA: memorandum of agreement

MOU: memorandum of understanding

NA: Narcotics Anonymous

NADCP: National Association of Drug Court Professionals

NDCRC: National Drug Court Resource Center

NDCI: National Drug Control Institute

ng/mL: nanograms per milliliter

NIDA: National Institute on Drug Abuse

NIJ: National Institute of Justice

NREPP: National Registry of Evidence-Based Practices and Programs

GAINS: **G**athering Information
Accessing what works
Interpreting/integrating the facts
Networking
Stimulating change

OJP: Office of Justice Programs

ONDCP: Office of National Drug Control Policy

OTC: over the counter

PET: positron emission tomography

PHI: protected health information

PTSD: posttraumatic stress disorder

PPC: Patient Placement Criteria

Ret.: retired

rehab: rehabilitation

RPT: relapse prevention therapy

RFP: request for proposal

SAMHSA: Substance Abuse and Mental Health Services Administration

SSA: single state agency

SSRI: selective serotonin reuptake inhibitors

SVT: specimen validity testing

SCRAM: Secure Continuous Remote Alcohol Monitor

TASC: Treatment Alternative to Street Crimes (later) Treatment Accountability for Safer Communities

U.S.: United States