Recommended Practices

ACKNOWLEDGMENTS

In September 2004, Deputy Chief Administrative Judge for Court Operations and Planning, Judy Harris Kluger, created a multi-disciplinary advisory committee, chaired by Judge Stephen Herrick of Albany County, to produce a comprehensive guide for New York's drug treatment courts. She envisioned a resource document that would promote quality and consistency in drug treatment court operations by cataloguing the best of what the field knows about the drug court model and the substance-abusing offender population. The Recommended Practices for New York State Criminal Drug Treatment Courts is that resource.

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Advisory Committee for Recommended Practices for New York State
Criminal Drug Treatment Courts

Chairperson, Honorable Stephen W. Herrick, County Court Judge, Albany County

Gerianne Abriano, Bureau Chief, Red Hook, Kings County District Attorney's Office

Linda Baldwin, Project Manager, Office of the Deputy Chief Administrative Judge for Court Operations and Planning

Justin Barry, Citywide Drug Treatment Court Coordinator, New York City Criminal Court

Steve Hanson, Director, Bureau of Addiction Treatment Centers, New York State Office of Alcoholism and Substance Abuse Services

Cindy Heady-Marsh, (ret.) formerly Project Manager, Office of the Deputy Chief Administrative Judge for Court Operations and Planning

Honorable Deborah Kaplan, Acting Supreme Court Justice, New York State Supreme Court, Civil Term, New York County

Honorable Leslie G. Leach, (ret.), Deputy Attorney General of State Counsel, New York Attorney General's Office; formerly Administrative Judge, 11th Judicial District, Supreme Court, Queens County

Robert Lonski, Director, Erie County Assigned Counsel Program

Honorable James W. McCarthy, Acting Supreme Court Justice, New York State Supreme Court, Oswego County

Michael Magnani, Director, Division of Grants and Program Development,
New York Unified Court System

Edward Nowak, Public Defender, Monroe County Public Defender Office (ret.)

Kenneth Perez, Unit Head, Criminal Justice, Division of Treatment and Practice Innovation, New York State Office of Alcoholism and Substance Abuse Services

Valerie Raine, Director, Drug Court Programs, Center for Court Innovation

Honorable Laura A. Ward, Acting Supreme Court Justice, New York State Supreme Court, Criminal Term, New York County

RECOMMENDED PRACTICES FOR NEW YORK STATE ADULT DRUG TREATMENT COURTS

I. INTRODUCTION

The Office of Court Drug Treatment Programs (OCDTP) is pleased to present Recommended Practices for New York Adult Drug Treatment Courts. This document is designed to serve as a resource for drug court practitioners in New York's adult drug treatment courts. To identify these practices, the OCDTP utilized a multi-disciplinary team approach that included the following components:

- a national drug court literature review of research findings that are associated with drug court policies, procedures and operations;
- structured site visits to eleven drug courts in New York that represent diverse geographical and political characteristics;
- consultant services from a clinician with extensive experience in drug court operations;
- an advisory committee comprised of all professional disciplines represented in the drug court model;
- a review of outcome data derived from the Universal Treatment Application and the New York Statewide Evaluation;
- results from a statewide survey of all drug treatment courts in New York;
- research and drug court program expertise from the Center for Court Innovation; and
- ongoing coordination and review by OCDTP staff.

The recommendations in this document are intended to guide New York's drug court professionals as they seek to improve program outcomes for the participants and the communities they serve. The growing body of rigorous drug court research, along with findings drawn from the field of behavior modification, support many of these recommendations. In areas where the research is wanting, the drafters of the document looked to New York drug court data, promising practices observed at the site visits, and the experience of the dedicated drug court professionals who served on the advisory committee. Finally, these recommendations generally follow the model outlined in the seminal document in the drug treatment court field, Defining Drug Courts: The Key Components(1997). Drug court practitioners should note two important aspects of these recommendations. First, they are recommendations, not mandated practices. Second, the authors understand that local resources may impact the ability of individual programs to implement particular recommendations.

In addition to the recommended practices, this document includes the following resources:

- a catalogue of forms and judicial Orders which are typically used in drug court operations;
- administrative Orders and Advisory Opinions related to drug court practices; and
- selected case law that addresses constitutional requirements in the drug court setting.

Finally, this document is intended to be a dynamic resource that will continue to incorporate new research and developments in drug court practice.

II. ADMINISTRATION

Court Structure and Operations

A. Office of Court Drug Treatment Programs

Under the direction of the Deputy Chief Administrative Judge for Court Operations and Planning, this office is responsible for the statewide implementation, expansion, and support of drug treatment courts. The Deputy Chief Administrative Judge and her staff work closely with the Administrative Judges in each of New York's twelve judicial districts.

1. Office of Court Administration - Coordination and Leadership

    a. Implement goals of the Chief Judge
    b. Establish and maintain relationships with national agencies and associations involved with drug treatment court programs
    c. Participate in projects with other state agencies that advance the goals of the Office of Court Drug Treatment Programs (OCDTP)
    d. Provide technical assistance on drug treatment court related issues as required by the Divisions of the Office of Court Administration
    e. Coordinate and participate in drug treatment court research projects

2. Court Operations

    a. Develop and implement statewide drug treatment court policies and procedures
    b. Work with the administrative office in each judicial district to implement and support the operation of their drug treatment court programs
    c. Provide guidance to the judicial districts on issues concerning the operation of their drug treatment courts
    d. Work with the drug treatment courts in each district to identify and implement best practices and innovative procedures
    e. Respond to requests for technical assistance from the judicial districts

3. Human Resources

    a. Participate on interview panels for positions in the drug treatment courts
    b. Make recommendations on Requests for Reclassification
    c. Participate in the development of Title Standards
    d. Make recommendations on appropriate work volume by title

4. Fiscal

    a. Submit budget proposals to the Unified Court System (UCS) Budget Office to support statewide drug treatment court initiatives
    b. Submit New Court Budget Requests to the UCS Budget Office on behalf of new drug treatment courts implemented outside of the UCS Budget cycle

c. Make recommendations to the UCS Budget Office on requests for resources
d. Make recommendations to the UCS Budget Office on requests for new positions

5. Technology

a. Maintain the statewide management information system, the Universal Treatment Application (UTA), for the drug treatment programs and develop enhancements and modifications to meet state and local needs; respond to user feedback regarding modifications and functionality
b. Provide training for users of the Universal Treatment Application
c. Establish and maintain the OCDTP Intranet site
d. Provide support to the Problem-Solving Section of the UCS Internet site
e. Participate in the development of new computer programs and applications to support the drug treatment courts

6. Training

a. Develop and conduct statewide training sessions for new employees in the drug treatment courts and new members of drug treatment court teams
b. Develop and conduct training sessions for full drug treatment court teams
c. Develop and conduct training on special drug treatment court topics, as needed
d. Work with drug treatment courts to plan and implement training to meet the needs of the local community

B. Judicial District Administrative Office

Under the direction of the District Administrative Judge, each District Office is responsible for the operation and management of all trial courts and court agencies within its judicial district.

1. Drug Treatment Court District Liaison

a. Coordinate the receipt and distribution of drug treatment court-related information for the judicial district
b. Respond to requests for drug treatment court information from the District Administrative Judge and the OCDTP
c. Provide information to the OCDTP on changes in their drug treatment courts that should be reflected on the monthly Status Report
d. Promote participation in training opportunities for drug treatment court staff and related agencies

2. Court Operations

a. Review and assist with operational procedures for the trial courts district-wide
b. Review and assist with operational procedures for the drug treatment courts district-wide

c. Make requests for obtaining any necessary Hub Court designations as a local Criminal Court Hub Court
d. Make requests for obtaining any necessary Superior Court for Drug Treatment designations

3. Human Resources

a. Review staffing levels throughout the judicial district
b. Review titles and work with the court to determine need for additional staff
c. Review and process reclassification requests
d. Post new positions and participate in the hiring process for new drug treatment court staff

4. Fiscal

a. Purchasing

i. Process requests for instant read drug tests and other drug testing supplies in accordance with the purchasing guidelines
ii. Implement and process procedures for laboratory confirmation tests
iii. Process requests for office supplies

b. Contracts for goods and services

i. Review and assist courts with bid process
ii. Establish district-wide acquisition protocols

c. Grants

i. Adhere to fiscal reporting requirements
ii. Assist and participate in the grant application process as needed

d. Annual budget process

i. Review and process requests for additional resources from all courts in the district
ii. Review and process, as appropriate, requests for funds to expand programs

e. Budgets for new drug treatment courts

i. Work with OCDTP when preparing budgets for new drug treatment courts

5. Technology

a. Provide general automation support for all court applications
b. Provide and support hardware/software for all court applications

C. Trial Courts

Under the direction of the District Administrative Judge, the trial court is responsible for the day-to-day operations of the drug treatment court in collaboration with the local community. The trial court utilizes the District Administrative Office and ODTCP as needed for support.

1. Judge

   a. Preside over court sessions for the drug treatment court
   b. May participate in and preside over the drug treatment court team staffing
   c. Work collaboratively with the local community and treatment court team to enhance the progress of the participants and the drug treatment court program
   d. Participate in statewide trainings as they relate to alcohol and substance abuse
   e. May participate in the interview process for new drug court staff
   f. Review and participate in policy and procedure recommendations for the drug treatment court

2. Court Manager

   a. Monitor and review all operations of the drug treatment court, including data entry into the UTA
   b. Supervise drug treatment court staff, providing guidance and feedback
   c. Monitor and approve all requests for time and leave, including work related activity in the community
   d. Review and process all requests for travel and training in accordance with travel guidelines
   e. Review and submits all budget requests from the drug treatment court
   f. Participate in the interview process for new drug court staff
   g. Review and submit all requests for supplies from the drug treatment court
   h. Review and submit all grant-related reports
   i. Participate in statewide training programs as appropriate
   j. Act as court liaison with treatment community and social service agencies

3. Coordinator

   a. Handle the day-to-day operations of the drug treatment court
   b. Supervise case managers, if applicable
   c. Work within the community and collaboratively with the team to promote the drug court concept
   d. Work directly with participants, performing case management as required
   e. Keep community partners informed of participants' progress
   f. Maintain the UTA with complete information about each participant
   g. Prepare calendars for court, schedule meetings and trainings for team members and stakeholders
   h. Comply with time and leave requirements
   i. Establish and implement procedures for random/monitored drug testing
   j. Assist Court Managers with budget, purchasing, and grant-related reports
   k. Participate in statewide trainings

Division of Grants and Program Development

A. Mission

The mission of the Division of Grants & Program Development is to support courts across the state in the design, development, funding and evaluation of innovative problem-solving initiatives. Those initiatives include the development of training programs and courts dedicated to serving communities, protecting victims and addressing the underlying causes of crime and family problems.

B. Role

1. Coordinates with administrative judges, judicial districts, and local courts in the submission of all grant proposals and the implementation of all grant-funded programs.

2. Works with the Division of Financial Management, the Division of Administrative Services, local courts, and district offices to integrate grant-funded projects into the Unified Court System's (UCS) budgeting process.

3. Serves as the day-to-day link to the Center for Court Innovation, the UCS' research and development arm (http://www.courtinnovation.org), to help develop prototypes, conduct research, and obtain funding.

4. Assists in the development of training programs associated with problem-solving courts to be conducted in partnership with the Unified Court System's Judicial Institute.

Center for Court Innovation

A. Role

1. Founded as a public/private partnership between the New York Unified Court System and the Fund for the City of New York, the Center for Court Innovation is a non-profit think tank that helps courts and criminal justice agencies aid victims, reduce crime, and improve public trust in justice.

2. In New York, the Center functions as the court system's independent research and development arm. In that capacity, the Center works with the Unified Court System to develop and implement problem-solving courts, provide training and technical assistance, and produce documents that serve as resources for problem-solving professionals throughout the state.

B. Drug Treatment Courts

1. Center staff works closely with the Office of Court Drug Treatment Programs to develop and conduct trainings for new and experienced drug court practitioners. These trainings include programs for new drug treatment court teams and new drug treatment court team members. Trainings are developed on an ongoing basis in the areas of adult and family treatment court practices, confidentiality laws, small group facilitation skills, and other topics of relevance to the drug treatment court programs.

2. The Center uses a multi-disciplinary approach to document effective and promising practices for New York's drug treatment courts.

3. The Center's research department evaluates both the process and impact of adult, family, and juvenile drug treatment courts in New York. It also writes monographs and white papers on various aspects of drug treatment court practice.

III. ADMISSION PROCESS

A. Eligibility Criteria

Recommended Practice: A drug court program should be as inclusive as resources and political support will allow, while remaining mindful that the program should not be available to those who would seek the program solely to avoid legal consequences. When setting eligibility criteria, the drug court team should ask the following questions:

- What charges should the drug court include?
- What criminal histories should the drug court target? exclude?
- What type of drug use is the court targeting?
- What diagnosis will the court require for admission?
- What is the community's treatment capacity?
- What is the court's time and staff capacity?
- What is the probation department's supervision capacity?
- What legal and ethical considerations may affect the eligibility of certain populations (e.g., non-legal residents, informants)?

Rationale: In order to measure program performance, a drug court should be very clear about the population it intends to admit to its program. Clarity in admission criteria will assist the Court in assessing whether it is reaching all appropriate offenders.

1. Targeted Charges

Recommended Practice: When deciding which charges to target, the drug court team should consider four factors:

- which offenses are typically committed by the substance-abusing population (e.g., drug offenses, non-drug offenses, specific charges);
- which offenses the prosecutor's office deems admissible from a public safety perspective;
- which offenses the defense bar deems serious enough to consider drug court as an alternative to traditional case processing; and
- which offenses carry longer alternative periods of incarceration.

Rationale: In order to capture the greatest number of eligible participants, the drug court team should identify the types of crimes being committed by the substance-abusing population. The team should consider reaching beyond drug possession charges (which will usually signal use or abuse) and examine charges that may be drug-driven, (e.g., petit larceny, criminal trespass, grand larceny, commercial burglary). At the same time, the prosecutor should be mindful of the types of charges that the community will tolerate in the drug court. For example, some drug courts will not admit any sale charges, while others will admit sale charges if the sale involves a relatively small amount of money and is committed to support personal use. Similarly, communities with a high incidence of

charges under Section 1192 of the Vehicle and Traffic Laws may want to include these offenses in their program. In these jurisdictions, the drug court team will want to formulate policies that are strict enough to address concerns about the risk factors associated with VTL Section 1192 offenders.

2. Targeted Criminal History

Recommended Practice: When deciding which criminal histories to target or exclude, the drug court team should consider the following three factors:

- which offenders are likely to face incarceration if processed in the traditional setting;
- of those offenders, which will the prosecutor deem eligible from a public safety perspective; and
- the effect of convictions for violent offenses on eligibility for the drug court program.

Rationale: As with targeted charges, the drug court team should seek to be as inclusive as possible within the constraints of public safety factors when identifying the types of criminal histories that will be accepted into the drug court program. The drug court should consider whether the offender would ordinarily face incarceration. Generally, offenders will be more inclined to participate in drug court if their alternative in traditional case processing would likely involve jail or prison time. In addition, research shows that longer alternative periods of incarceration (e.g., predicate felon facing 3-6 years versus a misdemeanant facing one year) produce higher drug court graduation rates.[1] While offenders with a history of violence are strictly prohibited in drug courts that receive federal funding, this population should be carefully examined where courts do not receive such funding. Offenders who have a history of violence but are otherwise eligible for drug court should be assessed on a case-by-case basis. Factors to consider will include the nature of the offense (isolated minor assault versus arson, robbery, etc.); severity of the offense; years at liberty since the offense occurred; number of previous violent offenses, etc. Note that treatment providers typically have their own admission criteria regarding clients with histories of violence.

3. Drug Use

Recommended Practice: The drug court should use available resources, such as Police and Probation, to keep current with drugs of choice in the offending population and changes in their patterns of use.

Rationale: When setting eligibility criteria, the drug court must determine whether sufficient resources are available to treat and monitor a participant. Different drugs may require different types of treatment. For example, if young adults in the drug court generally use marijuana only, then the drug court will require treatment providers who are skilled and experienced with testing and monitoring individuals who use that drug. If the jurisdiction is not equipped to address the needs of a particular type of drug user, then the drug court should probably not admit that type of drug user to the program.

4. Diagnosis

Recommended Practice: The drug court should decide whether eligible offenders should include individuals with substance abuse and substance dependence diagnoses, or only those with a substance dependence diagnosis.

Rationale: As with drugs of choice, the drug court team needs to know that participants will receive treatment appropriate for their clinical level of use. In addition, the number of treatment slots available to the drug court may dictate whether the program can include the larger population of those who abuse and those who are dependent.

5. Co-Occurring Population

Recommended Practice: *Treatment providers* - The drug court should ascertain whether the local provider community can offer appropriate treatment and other supportive services for individuals diagnosed with a co-occurring disorder. When assessing treatment capacity, the drug court should consider the "reasonable accommodation" standard set by the Americans with Disabilities Act.

Rationale: Research has shown that individuals diagnosed with co-occurring disorders are best served in treatment programs that can simultaneously provide mental health and addiction treatment using practitioners trained in both domains.[2] "Integrated services" include medication management, cognitive-behavioral, and motivational enhancement therapies. Contingency management improves adherence to medication and links to community services.[3] In considering whether individuals with co-occurring disorders have adequate access to services, practitioners should keep in mind that the Americans with Disabilities Act prohibits discrimination against persons with disabilities, including drug and alcohol abuse.[4]

Recommended Practice: *Refining admission criteria* - The drug court should assess which types of mental illness it can accommodate. The drug court may wish to distinguish between those with Axis I Disorders (Clinical Disorders) and those with Axis II Disorders (Personality Disorders). Another approach is to formulate guidelines for admission according to functionality, rather than by diagnosis. In order to formulate an appropriate policy, the drug court should consult closely with clinical professionals who understand the challenges presented by the co-occurring population and are aware of available treatment resources in the community.

Rationale: Individuals with co-occurring disorders are frequently associated with a poor prognosis for involvement in treatment[5] and compliance with medication[6]; greater rates of hospitalization[7]; more frequent suicidal behavior[8]; and difficulties in social functioning[9]. These challenges, along with the difficulty in accurately assessing co-occurring disorders, require careful planning and implementation.

Recommended Practice: *Modifications to drug court policies and procedures* - The drug court should expect that individuals with co-occurring disorders may not be able to adhere to all of the specific drug court requirements and may benefit from more individualized sanctions. The team should consider modifying both the requirements and sanctions scheme for this population.

Rationale: Many factors can affect the ability of individuals with co-occurring disorders to meet all program requirements. Medication can cause serious physiological side effects; the severity of the mental illness may impair one's ability to maintain employment; and the level of functionality can vary widely among the mentally ill population. With respect to sanctions, treatment experts recommend that incarceration be used sparingly for individuals with co-occurring disorders.[10]

Recommended Practice: Once these decisions have been reached, all drug court programs should develop an effective screening tool to identify offenders with mental illness and make a proper diagnosis.

Rationale: An accurate screening tool will help the Court admit only those with eligible diagnoses. However, the assessment process is complicated by the fact that frequently, drug use masks mental illness. As a result, mental illness may surface some period after admission to the drug court. In these cases, the drug court may wish to allow a participant to opt out of the program if the drug court is unable or unwilling to address the mental health issues.*

*For detailed information on this topic, consult ROGER H. PETERS & FRED C. OSHER, CO-OCCURRING DISORDERS AND SPECIALTY COURTS,(2d ed., 2004), *available at* http://gainscenter.samhsa.gov/pdfs/courts/CoOccurringSpecialty04.pdf

6. Age

Recommended Practice: The drug court should determine whether community providers offer age-appropriate services, particularly for the young adult population (approximately 16-22 years old).

Rationale: This population typically requires very different treatment plans than the adult population, including educational, recreational, and family services. Frequently, young adults have not used drugs for long enough to be diagnosed with substance abuse dependence (or even abuse). Their drug of choice is typically marijuana, which presents testing challenges that are not insurmountable but require special attention to the issue of interpretation of positive results. Without services specifically targeted for this group, the drug court will likely retain them in treatment for shorter periods of time than the older participants. In addition, the drug court will need to structure a sanctions and incentives scheme that is specifically designed to motivate young adults. Finally, the drug court and treatment providers will need to address gang membership in communities where gangs are a factor. Gang membership will impact both the individual's readiness for engagement in treatment, as well as the treatment provider's capacity for effectively delivering services.

Recommended Practice: If the Court decides to admit this population, it may want to establish a separate track where young adults are grouped together, and apart from older drug court participants.

Rationale: Given the significantly different issues and needs of the "young adult" population, participants will be more likely to remain engaged if they can identify with others similarly situated.*

*For a detailed discussion of the young adult population, see the following monograph: BUREAU OF JUSTICE ASSISTANCE, JUVENILE DRUG COURTS: STRATEGIES IN PRACTICE (2003), *available at* http://www.ncjrs.gov/pdffiles1/bja/197866.pdf

7. Pharmacological Interventions

Discussion

Methadone maintenance therapy can be a controversial topic when utilized in the criminal justice context. Most drug courts in New York City will only admit individuals on methadone if they are prepared to withdraw completely from methadone use and it is medically advisable to do so (i.e., they are at low enough dosages to withdraw in a reasonable period of time, they do not have compromised immune systems, etc.). Many other drug courts around the State will consider methadone maintenance as an appropriate treatment plan.

Treatment professionals and researchers who have studied the effects of methadone maintenance consistently urge methadone maintenance as an effective and proven medication for eliminating the craving for heroin. They also are equally emphatic that methadone maintenance must be accompanied by appropriate treatment. Finally, in 2006, the National Institute on Drug Abuse published its *Principles of Drug Abuse Treatment for Criminal Justice Populations*.[11] Principal #12 states, "Medications are an important part of treatment for many drug abusing offenders," and notes that both methadone and buprenorphine are helpful in normalizing brain function in those addicted to heroin. Criminal justice professionals tend to view methadone as another drug that is addictive and subject to misuse. In addition, many methadone clinics do not offer sufficient treatment services in conjunction with methadone administration which can result in continued use of illegal substances in addition to methadone maintenance. Finally, methadone clinics have become associated with illegal sale of methadone near the clinics, loitering, and other behavior that draws complaints from neighborhood residents.

Note: There are Methadone programs in the New York City area that provide comprehensive treatment services found in OASAS licensed 822 (non-Methadone) outpatient clinics. In addition, OASAS licensure now ensures that all 822 clinics must accept clients on Methadone for treatment. In these situations, the two programs must carefully coordinate services to the individual.[12]

Naltrexone, Vivitrol, Buprenorphine, Subutex, and Suboxone

In recent years, the Food and Drug Administration has approved several medications for the treatment of opioid and alcohol dependence. Designed to treat opioid addiction, Naltrexone and Vivitrol have also been shown to be effective treatments for alcoholism. Buprenorphine, Subutex and Suboxone are used to treat opioid dependence.

Recommended Practice: Drug court programs should become thoroughly educated about the benefits, side effects, and philosophical issues associated with pharmacological interventions. Since drug courts uniformly adopt the disease model of addiction, effective and scientifically proven medications should be seriously considered where indicated. Drug court programs should make their decisions about medications in

the same manner that they make other treatment-related decisions, in close consultation with the treatment professionals on their team.

8. Non-English speaking participants

Recommended Practice: First, drug court programs should consider the availability of programs that can provide treatment services in the participant's first language. Second, drug court staff should be particularly sensitive to the cultural proficiency of treatment providers who are serving individuals from diverse ethnic backgrounds.

9. Lesbian, Gay, Bisexual, and Transgender Populations

Recommended Practice: Drug court programs should explore the availability of treatment providers that understand the challenges faced by individuals whose sexual orientation is different from that of the majority of the population.*

*For a thorough discussion of this topic, see CENTER FOR SUBSTANCE ABUSE TREATMENT, A PROVIDER'S INTRODUCTION TO SUBSTANCE ABUSE TREATMENT FOR LESBIAN, GAY, BISEXUAL AND TRANSGENDER INDIVIDUALS (2001),*available at* http://kap.samhsa.gov/products/manuals/pdfs/lgbt.pdf

10. Non-Citizens

Recommended Practice: *Legal Permanent Residents* - If the drug court wants to include legal non-residents, it should consider adjusting its plea policy. The Court could either defer prosecution but require a written agreement that the participants will not object to the admission of any and all evidence by the prosecution, should the offender be terminated from drug court; or require a plea to a charge that does not serve as grounds for deportation.

Rationale: Legal non-citizens face very serious deportation consequences for admitting to drug use and/or sale. Even if the plea is later vacated, admission on the record of drug use and/or sale has been held sufficient grounds for deportation.[13] If the participant admits to certain non-drug offenses, there may also be serious deportation consequences.

Recommended Practice: *Illegal non-citizens* – The drug court should almost always exclude illegal non-citizens from participation.

Rationale: Admitting undocumented aliens raises obvious legal and ethical issues for the Court. For the illegal non-citizen, the risk of detection by the Immigration and Customs Enforcement (ICE) agency is heightened because of jail sanctions. In addition, illegal aliens are generally ineligible for benefits that pay for substance abuse treatment and typically unable to pay for them without government sponsored assistance.*

*For a detailed discussion of the collateral consequences of criminal convictions for non-citizens, visit: Immigrant Defense Project at http://www.immigrantdefenseproject.org or Collateral Consequences of Criminal Charges at http://www2.law.columbia.edu/fourcs/

Recommended Practice: All drug courts should designate one member of the team to serve as an expert advisor on immigration issues.

Rationale: Over the past several years, both statutory and case law have become increasingly strict with respect to legal non-residents who are convicted of a crime or even admit facts sufficient to support a finding of guilt. In order to avoid unintended consequences (including mandatory deportation), the drug court should ensure that at least one team member is thoroughly educated on collateral consequences for legal non-residents.

Recommended Practice: If there is any question regarding an individual's legal status, the drug court staff should require proof of citizenship.

Rationale: Given the potential of extremely serious consequences for the legal non-resident, program staff should be absolutely certain that each drug court participant is either a citizen or has been appropriately advised of the collateral consequences of participation.

11. Confidential Informants

Recommended Practice: Drug courts should avoid admission of confidential informants into their program.

Rationale: Admission of confidential informants into the drug court program poses many challenges for the informant, the court, and the treatment program. If the prosecutor intends to continue using the informant in the investigation of criminal activity, the informant will have to frequent locations that will be counter-therapeutic. Other drug court participants will inevitably discover his/her status and tend to perceive that the person is receiving favorable treatment from the prosecutor and/or the court. Additionally, informants are generally held in extremely low regard and profoundly mistrusted by those who are likely to participate in the drug court. This status places them in potential danger within the court and treatment provider settings. Even if the prosecutor ceases to use the informant, many of the above concerns will still impact the drug court program.

B. Screening Process

1. Legal Screening

The first step in screening cases for drug court typically involves a paper review of the case to determine if preliminary criteria for eligibility are evident. Factors may include charge, criminal history, place of occurrence, self-reported addiction, and other factors. Ideally, all cases that meet the established criteria will then proceed to the drug court for review by the entire team.

a. Timeliness

Recommended Practice: Most drug courts should seek to develop a formal screening process designed to capture all eligible offenders as quickly as possible. Written eligibility criteria and review of cases close in time to the arrest or violation of probation

will produce more expeditious entry into the drug court. Notwithstanding the desirability of early placement into treatment, judges, prosecutors and defense counsel must be afforded the time necessary to review each case, protect constitutional rights, and inform each defendant of all consequences of drug court participation.

Rationale: Research has found that the sooner an individual enters treatment after a crisis (in drug courts, the arrest represents the crisis), the longer the person will remain in treatment. In turn, length of time in treatment is directly related to long-term sobriety.[14] A formal screening process builds capacity and ensures that drug courts can assess all potentially eligible defendants in a timely manner. A formal process does not preclude a supplemental, informal "back-door" process to allow case-by-case decisions on offenders who do not fall squarely within the eligibility criteria.*

> *For more information on recommended duration of treatment for the criminal justice population, see NATIONAL INSTITUTE OF DRUG ABUSE, PRINCIPLES OF DRUG ABUSE FOR CRIMINAL JUSTICE POPULATIONS (2006), *available at* http://www.drugabuse.gov/PDF/PODAT_CJ/PODAT_CJ.pdf

b. Drug Court Team Review

Recommended Practice: Once a case has satisfied "paper eligibility" criteria, the drug court team should review the case to decide whether the individual should be clinically assessed for eligibility.

Rationale: Although the prosecutor typically will render the final decision on admission to the drug court, a team review of "paper eligible" cases will support a more in- depth consideration of eligibility.

Recommended Practice: The prosecutor assigned to the drug court should be empowered to make the final admission decision for his or her office in the majority of cases.

Rationale: Waiting for a supervisor's decision on every case will further delay entry into drug court, thereby affecting placement into treatment as close as possible to time of crisis.

c. Linkage to Defense Counsel

Recommended Practice: Defense counsel should be involved as early as possible in the admission process to discuss the drug court program and its appropriateness with the client. Once "paper eligibility" criteria have been satisfied, defense counsel should have the opportunity to consult with the defendant before drug court personnel approach the defendant regarding participation in the drug court and/or drug or alcohol use.

Rationale: Early involvement by defense counsel serves three important purposes. First, it promotes consideration of constitutional and other legal issues affecting the case (e.g., 4th Amendment issues, consequences of a guilty plea, etc.). Second, providing the client with complete information about the program, including its requirements, intensified supervision, and potentially longer period in the system, will promote more informed decision-making about entering the program. Third, a thorough explanation of the drug

court process will encourage honest and candid responses by the defendant to inquiries by the drug court staff.*

*For a thorough analysis of a defense attorney's obligations in the drug court setting, see NATIONAL DRUG COURT INSTITUTE, CRITICAL ISSUES FOR DEFENSE ATTORNEYS IN DRUG COURT (Monograph Series 4 2003), *available at http://www.ndci.org/CriticalIssues.pdf*

2. Clinical Assessment

a. Clinical Screening

Recommended Practice: The drug court team should look at the offender's clinical appropriateness for participation. Aspects of appropriateness include:

- DSM diagnosis (abuse, dependence);
- current use (type, frequency, intensity);
- substance abuse history and its relation to criminal justice history;
- psychological/behavioral functioning (including cognitive factors);
- current mental status;
- medical status (including intoxication or withdrawal potential);
- presence of Traumatic Brain Injury (TBI);
- participant motivation; and
- cultural/ethnic/religious orientation and the impact on participation.

Screening tools, such as the Addiction Severity Index (ASI), the Michigan Alcohol Screening Test (MAST), the Global Assessment of Individual Needs (GAIN), are useful in determining the client's appropriateness for admission. OASAS also recommends use of the HELPS (a brief screening for Traumatic Brain Injury) as well as a screen for Fetal Alcohol Spectrum Disorders, as both of these conditions will impact treatment and the individual's ability to comply with program requirements. Also, instruments such as the MAST, for example, can be given to the client in paper form to fill out prior to the interview.

Recommended Practice: In cases where a potential participant appears to be suffering from a co-occurring mental disorder, the drug court program should have provisions for psychiatric referral and evaluation prior to recommending admission to the drug court program. OASAS recommends use of the Modified Mini Screen (MMS) to identify potential participants with coexisting disorders. The MMS can be accessed at http://www.oasas.state.ny.us/hps/research/documents/ MINIScreenUsersGuide.pdf

Recommended Practice: Assess clinical eligibility before executing a participant contract.

Rationale: Legal and ethical questions can arise if an offender admits guilt and is subsequently deemed clinically ineligible.

Recommended Practice: If court-based treatment providers are responsible for conducting the initial assessment and placement, the drug court should establish protocols to avoid any appearance of conflict.

Rationale: Conflicts of interest (real or perceived) can occur when a treatment provider assesses the offender and then refers the individual to his or her own program.

b. Clinical Assessment

Recommended Practice: The clinical assessment should match participants to appropriate levels of care and modalities of available substance abuse services. Basic components of the assessment include:

- diagnosis (dependence, abuse, other);
- engagement of the participant in determining motivation and goals;
- meaningful, strength-oriented treatment planning; and
- level of care determinations with reference to the Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition Text Revision (DSM-IV-R) of the American Psychiatric Association (2000).

Recommended Practice: An effective clinical assessment should reflect the following components:

- an objective, strength-based clinical evaluation which clarifies the nature and extent of a substance abuse disorder in relation to a range of bio-psychosocial areas (e.g., substance abuse history, treatment history, medical, psychological, familial, vocational, and other domains of functioning);
- identification of the client's needs, strengths, resources and problem areas along this continuum (Note that initial contact with the participant may not result in a full and accurate reporting of all aspects of the person's current and past functioning); and
- regular review and updating to ensure that a comprehensive picture of each client is reflected in the Universal Treatment Application(UTA) or client file (Note that the UTA is the customized computer application utilized by all drug courts in New York State).

Recommended Practice: Wherever feasible, the drug court professional who conducts the assessment should be a Certified Alcoholism and Substance Abuse Counselor (CASAC), who considers the following guidelines when interviewing the offender:

- potential client is drug and alcohol free during the interview;
- language of the interview is clearly worded and in the primary language of the client;
- environment for the interview is conducive to establishment of trust and rapport with 1-1.5 hours allocated for the Assessment;[15]
- participation of family members or significant others is encouraged to gather additional information (with client's permission); and
- the interviewer is trained in interviewing techniques and the use of evidence-based assessment tools.*

*Recent studies indicate the efficacy of a Stages of Change/Motivational Interviewing approach that assists the client in recognizing his/her problem (in this case, the role and relationship of substance abuse to and with the criminal justice system) and elicits client

motivation to make the changes necessary to successfully complete the drug court program.[16] The use of these techniques requires training and consultation with a clinical practitioner.

NOTE: In New York State, **Level of Care for Alcohol and Drug Treatment Referral (LOCADTR)** is a patient placement criteria system designed for use in making level of care decisions in New York State. Level of care determination is a clinical procedure provided by OASAS-certified alcoholism and substance abuse treatment services or by qualified health professionals as defined in OASAS chemical dependence regulation.*

* For a complete listing of New York State regulations governing chemical dependence outpatient services, see 14 N.Y. COMP CODES R. & REGS. tit. 14 § 822.1 – 822.13 (2008), *available at http://www.oasas.state.ny.us/regs/822.cfm*

The purpose of the level of care determination procedure is to assure that a client in need of chemical dependence services is placed in the least restrictive, but most clinically appropriate level of care available. It is the responsibility of the treatment provider to make an appropriate placement. Note that Certified Alcoholism and Substance Abuse Counselors are authorized to conduct assessments and make referrals to treatment, as is common practice in drug court programs. They can not, however, make the final decision on admission to a particular treatment program.

In addition, the **ASAM Placement Criteria** (American Society of Addiction Medicine) provides a similar mechanism for organizing an appropriate referral process. These manuals are available to professionals and can be adapted to the Screening and Assessment instruments used by drug court staff.

*An excellent resource for many clinical screening, assessment and treatment issues is The Treatment Improvement Protocols (TIPs) Series, which presents best practice guidelines for the treatment of substance abuse. This series is produced by the Center for Substance Abuse Treatment, Office of Evaluation, Scientific Analysis, and Synthesis. For more information, visit: http://www.csat.samhsa.gov/publications.aspx

To request a print copy of a TIP publication, visit: http://www.kap.samhsa.gov/products/manuals/tips/index.htm

C. Becoming a Participant – Plea Structure and Contract/Participant Agreement

1. Courtroom Observation

Recommended Practice: Drug courts should require eligible offenders to observe drug court for at least one session before reaching a final decision regarding admission to drug court. After observation, the drug court judge should discuss questions and concerns that the observer may have.

Rationale: Observation of drug court helps an offender make an informed decision about entering drug court. The experience can also provide motivation for those who believe they cannot abstain from drugs or are not ready to stop using.

2. Pre-Plea or Post-Plea Model

Recommended Practice: The drug court team should carefully consider whether to utilize a pre-plea diversion model or a post-plea structure. Both models offer advantages and disadvantages, depending on the severity of the charge and the legal and clinical profile of the participant. In cases that would not typically result in incarceration (e.g., misdemeanors with little or no criminal history), a pre-plea structure may be the only arrangement in which defense counsel will advise the client to participate in drug court.

Rationale: A post-plea structure promotes many important goals of the drug court. They include the following:

- simplifying options for the participant (stay in treatment or go to jail/prison);
- incorporating research findings that increased leverage (i.e., certainty of incarceration upon failure) promotes retention in the program;[17]
- relieving prosecutors of the burden of proving a case many months after an arrest; and
- achieving finality of a disposition for the court.

In courts where the probation department provides community-based supervision, participants may be sentenced to probation with drug court as a condition of their sentence. A pre-plea diversion model may be appropriate in certain misdemeanor cases where incarceration is unlikely in traditional case processing. The pre-plea model allows an individual to benefit from drug court without exposing him or her to permanent liability from a criminal conviction.

Recommended Practice: In a post-plea structure, the prosecutor should be encouraged to provide open file discovery, laboratory results, and information regarding the constitutional legality of any search and seizure.

Rationale: Drug courts generally utilize a modified adversarial approach that works most effectively when all parties have access to the same information. Withholding information undermines this approach and encourages gamesmanship which will ultimately discourage participation in the drug court.

3. Drug Court Contracts and Participant Handbooks

Recommended Practice: Drug courts should execute a written contract that includes all of the Court's expectations of the participant and specifically, what legal action the court promises to take if the participant complies with the drug court mandate or fails to meet the drug court's expectations. The contractual agreement should explain to participants:

- the "contingency" nature of the drug court structure, including the use of incentives and sanctions; and
- the drug court phases, including their relationship to treatment, recovery and graduation.

Rationale: Clear expectations of required behavior and consequences for non-compliance will help the participant to set goals and learn consequential thinking when the court sanctions negative behavior.

Recommended Practice: The court should carefully consider which legally established rights the participant is required to forfeit. For example, forfeiture of the right to appeal, 4th Amendment protections, and reasonable restrictions on association have been found acceptable by nearly all appellate courts. On the other hand, forfeiture of the right to scientifically valid drug testing or an evidentiary hearing of any kind at termination and sentencing may run afoul of due process requirements.

Rationale: Although appellate review of the drug court process is still minimal, the legal rights and protection afforded parolees and probationers can and will most likely be applied in the drug court setting. In the more established arena of parole and probation, courts have been given considerable latitude in imposing conditions on individuals being supervised. Courts have upheld geographical restrictions, so long as they are narrowly drawn. They generally uphold searches based on an executed waiver. Forfeiture of the right to appeal, with some limited exceptions, is permissible as a condition of a plea agreement. Conversely, due process probably requires scientifically accepted and reliable evidence of drug use if the participant is to be deprived of his/her liberty.[18] And in New York, a trial court must hold some kind of evidentiary hearing, formal or informal, where the factual basis for finding a breach of conditions of release and sentence to incarceration is established.[19]

Recommended Practice: In cases where participants are under 18 years old, the drug court should have a parent or guardian present at the time of plea and/or admission to the drug court. Where appropriate, the court should encourage the parent or guardian to participate in the drug court process and, where appropriate, co-sign the drug court contract.

Rationale: Both legal and practical considerations support the inclusion of parents and guardians. Frequently, the participant will be living at home and will depend on the parent or guardian for treatment insurance as well as coordination of school and treatment attendance.

Recommended Practice: The drug court should develop and distribute to each participant a Participant Handbook that outlines the requirements of the drug court program. The Handbook should be available in the client's preferred language. The Handbook should be made available to the offender prior to admission into the Drug Court.

Rationale: Clarity around expectations promotes informed decision-making about whether to enter the drug court program and enhances the perception of the Court's fairness by the participant.

Recommended Practice: The drug court should provide the participant with the greatest legal incentive possible, consistent with local sensibilities and the prosecutor's judgment, to encourage participants to complete the program. Outcomes can range from vacatur of the plea and dismissal of all charges to early discharge from probation to reduction of a felony to a misdemeanor.

Rationale: The "value" of the benefit of graduation will affect the motivation of the participant.[20]

Recommended Practice: The participant should know the penalty upon termination from the drug court program before admission to drug court. The Court's discretion in sentencing can be maintained by framing the jail/incarceration period in the language, "up to a maximum of" a particular number of days or years.

Rationale 1: "Up to a maximum of" allows the court to consider the participant's behavior and length of time in drug court. The court may want to impose a greater sentence on a participant who absconds and never attends treatment than a participant who ultimately fails, but remained in treatment for an extended period of time and always appeared in court.

Rationale 2: In certain misdemeanor cases, the actual sentence may ultimately fall far short of one year, but "up to" language may carry more weight with the participant during drug court participation.

NOTE: Research suggests that the Court should set a specific incarceration alternative regardless of the nature of a participant's involvement with drug court. Vague jail/prison alternatives may undermine the drug court message that specified behaviors have certain consequences.[21]

IV. ACTIVE DRUG COURT PARTICIPANT PROTOCOLS

A. Supervision Model

In all drug treatment courts, judicial monitoring constitutes the ultimate supervision of the participant. In order to provide the most effective monitoring, judges rely on information provided by drug court team members who supervise the participant at treatment, in court, and in the community. The prosecutor and defense counsel may also convey information otherwise unknown by those who provide community-based supervision of the participant.

Recommended Practice: Supervision of the drug court participant should include:

- community-based supervision that allows for monitoring the participant outside of treatment and the court (where legally and clinically appropriate, practices may include announced and unannounced home visits, curfew checks, enforcement of location restrictions, and family engagement);
- case management services that seek to address the individual needs of each participant, including education, employment, health, dental, housing, parenting, and civil legal needs;
- scheduled and random drug testing; and
- ongoing assessment of progress in treatment as reported by the provider, timely recommendations by treatment regarding changes in level of care, and early intervention when participant is not compliant.

NOTE: In drug courts where probation is not utilized, community-based supervision may not be practical.

Models of Supervision

1. *Probation* (generally, upstate model)

Under the probation supervision, model, the participant is placed on probation and supervised by a probation officer who is a member of the drug court team. The probation officer frequently provides both community supervision and case management services.

Strengths of this model: a) capacity to provide community- based supervision, including home visits with drug testing; enforcement of curfews and location restrictions; b) ability to visit sites to confirm education and/or employment involvement; and c) law enforcement component which reassures prosecutors and may result in a greater number of individuals being admitted to the drug court.

Weaknesses of this model: a) the probation officer may be viewed by participants as "law enforcement," which can inhibit candor about struggles with treatment compliance

and other personal issues (e.g., dysfunctional family environment where drugs or other criminality may be present, spousal or partner abuse, etc.); b) the probation officer may not be sufficiently trained in substance abuse treatment, which can affect his or her ability to recognize behavior that signals a need for changes in level of care and/or clinical intervention; and c) conflict between a more traditional probation model that focuses on enforcement and the drug court model which should include a strength-based approach.

NOTE: Most of these issues can be addressed by training probation officers in substance abuse treatment and the disease model of addiction.

2. *Court-based case managers* (generally, New York City model)

Under this model, the participant enters a guilty plea, but sentencing is deferred pending participation in treatment. A court-based case manager with clinical training is assigned to monitor compliance and provide case management services.

Strengths of this model: a) the case manager may be viewed by participants as a "counselor," which may encourage greater disclosure about problem areas in their lives; b) a clinical background makes it more likely that the case manager will recognize behavior that suggests a need for adjustment to the treatment plan; and c) the case manager is more likely to be familiar with a strength-based approach.

Weaknesses of this model: a) court-based case managers do not provide community-based supervision that allows home visits, randomized drug testing, enforcement of curfews and location restrictions, and visits to educational and/or employment sites to confirm participation; and b) court-based case managers may experience conflict between a "clinical" and "law enforcement" role.

3. *Treatment provider case management*

In a small number of drug courts, treatment providers are charged with performing the case management function as well as monitoring participant compliance. In these courts, the participant is not on probation, and there is no court-based case manager.

Strengths of this model: a) treatment providers are more likely to recognize clinical barriers and the need for change in level of care; and b) treatment professionals are more familiar with participant's progress in treatment.

Weaknesses of this model: a) treatment providers do not provide community-based supervision that allows for home visits, enforcement of curfews and location restrictions, and visits to educational and/or employment sites to confirm participation; and b) treatment providers can experience conflict between their treatment role and their duty to report non-compliance to the drug court.

Recommended Practice: Regardless of which supervision model is utilized, the drug court team members, especially the judge, should routinely inform clients about the contingencies of treatment participation and about how participation will be monitored by legal agents.

Rationale: Research has found that higher retention rates are "associated with proactively [informing offenders of] the contingencies of program participation, consistent messages among multiple criminal justice agents and treatment staff, the use of behavioral contracts and judicial orders, and swift returns to custody upon failure."[22]

B. Court Operations

1. Drug Court Team

Recommended Practice: The drug court team should include at a minimum:

- Judge
- Prosecutor
- Defense attorney
- Coordinator
- Treatment representative
- Probation (outside of New York City) or Case Manager (New York City)

Where appropriate and feasible, the team will benefit from the inclusion of:

- Department of Social Services representative
- Housing liaisons
- Law enforcement liaison (Police, Sheriff)
- Mental health professional
- Vocational/education counselors
- Chief Clerk or Deputy Chief Clerk

Recommended Practice: To the extent possible, drug court team members should include dedicated prosecutors, defense attorneys, and treatment representatives. When new members join the team, they should be trained in the fundamental components of the drug court model (e.g., the team approach, pharmacology of addiction, sanctions and incentives, and the recovery process).

Rationale: Staff consistency and training promote teamwork, trust, and a stable environment for participants. Constantly changing faces encourage participants, particularly in the early stages of recovery, to split/manipulate team members.

Recommended Practice: Where practical, the drug court should ask the local public defender's office to assign an attorney(s) to represent drug court participants. In jurisdictions where there is no public defender, the court should make an effort to ensure that drug court participants are represented by attorneys who are thoroughly familiar with the court's policies, procedures, and protocols. Similarly, the District Attorney's office should assign one prosecutor to the drug court.

Rationale: Consistency of attorneys promotes smooth operations, facilitates swift referral to treatment, solidifies the team dynamic, and ensures that the lawyers are familiar with the drug court process.

Recommended Practice: The prosecutor's office should develop a written statement of intent regarding use of information obtained in drug court in the prosecution of the instant, past, and future cases.

Rationale: Effective drug courts depend on honest disclosure by participants regarding their drug use. Fear of prosecution for admission of criminal behavior will undermine the atmosphere of trust required for disclosure.

Recommended Practice: The drug court team should set aside one day per year to review the court's policies and procedures, explore areas of concern, and set goals and objectives. If possible, this meeting should occur away from the court. In most jurisdictions, the team can identify a facility in the community that can be used at little or no cost.

Rationale: Drug courts are dynamic in nature. Drugs of choice change; participant characteristics, such as age, ethnicity, and gender may shift over time; new treatment approaches emerge; and new staff members join the team. The day-to-day demands on time and resources frequently leave no room for the review or reflection necessary to improve the program. Part of this annual review should include an examination of the program's compliance with federal confidentiality laws and laws affecting the confidentiality of HIV/AIDS information.[23]

Recommended Practice: Drug court coordinators should attempt to convene regionally, on a quarterly basis, to examine trends in drug use, identify obstacles in drug court operations, and brainstorm solutions.

2. Staffings

Recommended Practice: Time permitting, the entire drug court team should meet prior to each drug court session to review each individual's progress in treatment since the last appearance. Topics may include treatment attendance; who should be drug tested; phase advancements; sanctions, incentives; terminations; and graduation candidates. Each team member should have an opportunity to be heard regarding the court's action at the upcoming court appearance. The team should strive to reach consensus, but final decision-making must be left to the judge. The judge's decision should not be litigated in open court except where failure to do so would impinge on the team member's ethical obligations (e.g., defense attorney is obligated to present his or her client's wishes regardless of whether they are consonant with the drug court's policies and procedures).

NOTE: Where treatment providers participate in staffings, their presence should be limited to discussion of participants in their program.

Rationale: The focus of the drug court session is the participant's progress in treatment, not the legal aspects of the case. From a treatment perspective, a united front achieves two important objectives. First, it diminishes the participant's ability to fragment the team when he or she perceives conflict or disagreement among its members. Second, a unified message clarifies expectations for the participant.

V. DRUG COURT OPERATIONS

A. Court Appearances

1. Judicial Style

Every judge possesses his or her own unique style. The drug court model accommodates a wide range of approaches which span from lenient to stern and informal to formal. Many styles will work, so long as the judge creates a safe space in the courtroom that is conducive to building self-esteem and teaching participant accountability.

Recommended Practice: Although there is no single recommended judicial style, the judge should be aware of his or her style and maintain consistency in the messages that are sent to the participants. Judicial responses may be individualized but the overall approach to participants should be constant. When judges customize their sanctions and incentives to the individual, care should be taken to explain the rationale for different responses to other participants in the courtroom.

Rationale: Behavioral research informs us that perceived certainty of response has a deterrent effect. Individuals who perceive the judicial response as predictable will have greater success at controlling their behavior. Conversely, unpredictable responses lead to "learned helplessness" on the part of the participant.[24]*

*For additional information about effective judge-defendant interaction, see C. Petrucci, *The Judge-Defendant Interaction: Toward a Shared Respect Process, in* JUDGING IN THE THERAPEUTIC KEY: THERAPEUTIC JURISPRUDENCE AND THE COURTS (B.J. Winnick & D.B. Wexler, eds., 2002)

Recommended Practice: The judge should maintain a balance between his or her role as caring authority figure and role as judge. The judge needs to gain participant's trust through effective communication and understanding the challenge of recovery. At the same time, the judge must resist being perceived as the participant's friend. Accordingly, the court should generally discourage ongoing group activities that include the judge, drug court staff, and participants (e.g., softball teams, bowling nights, etc).

Rationale: For many participants, motivation towards compliance stems from the fact that an individual with great authority cares about their well-being. If the relationship moves too close to perceived friendship, that motivation is diminished. Also, judges must remain mindful that they may one day have to sentence a participant to a lengthy period of incarceration.

2. Courtroom Atmosphere

Drug court professionals frequently speak of drug court as "theater," with participants in the "audience" watching the drug court in action. The behavior and attitudes that the participants observe affect their overall perception of the drug court's fairness.

Recommended Practice: Ensure that participants and other members of the drug court audience can clearly hear the proceedings, either by using a smaller courtroom or utilizing microphones. Avoid bench conferences and talking in legal jargon or shorthand whenever possible.

Rationale: Communication between the judge and participants should be designed to affect the audience as well as the participant before the court. Poor acoustics undermine this goal.

Recommended Practice: All drug court team members and court staff (e.g., clerks, stenographers, court officers, bailiffs) should recognize the importance of non-verbal communication. They should remain attentive and engaged during the drug court proceeding, avoiding side conversations and activities unrelated to the drug court process.

Rationale: Participants and their family and friends in the audience take their cues from the drug court team and court staff. If any of the team or court staff are reading the paper, not applauding, walking in and out of the courtroom, the audience is likely to become uninterested and non-supportive.

Recommended Practice: Drug court staff should follow the same rules they require of participants (e.g., show up on time, dress appropriately, pay attention during session, be mindful that drug court occurs in a formal courtroom setting, etc.).

Rationale: Again, participants will naturally follow drug court staff's lead or feel resentful if the same rules do not apply to drug court staff.

Recommended Practice: Know the population. If most participants are required to be in school or employed, try to schedule court sessions accordingly.

Recommended Practice: Require most drug court participants to remain in the courtroom for the entire calendar. In larger drug courts where the calendar takes an entire day, require participants to remain for at least half of the day. The drug court may want to reward participants who are doing well by calling their cases early and permitting them to leave. This practice should probably be limited to those individuals who have maintained long periods of compliance. If participants are permitted to leave early, make all general announcements at the beginning of the session.

Rationale: Drug court participants benefit from observing other cases for at least three reasons:

- when participants observe others doing well, they are reminded that other similarly situated individuals have achieved success. This reassurance can provide motivation for their own recovery;

- when they observe the court imposes sanctions on non-compliant participants, they learn consequential thinking; and

- in a good drug court, observation of numerous cases should enhance participants' perception that the court is fair and treats all participants equally. Positive perceptions of fairness promote buy-in to the drug court process.

Recommended Practice: The drug court should attempt to use a strength-based approach when communicating with participants. Even when a participant is non-compliant, the court should include mention of what they have done well. Examples include:

- A participant tests positive after several months of abstinence – remind the participant that he remained clean for several months and ask what helped him do so well – what changes did he experience that led to use?

- A participant is testing negative, working a steady job but is starting to miss treatment appointments, claiming that work prevents regular attendance at treatment – commend the participant for her work record and abstinence – ask the counselor or case manager to sit with the participant and draft a schedule on paper that will facilitate attendance at treatment.

Conversely, drug court judges should avoid communication that can be construed as public shaming or revealing intensely personal facts about the participant's life.

Rationale: Research indicates that a strength-oriented approach promotes successful program completion. Using a strength-oriented approach, the drug court judge will point out examples of client's capabilities (skills, educational achievements), responsible behaviors (work or attempts at work, positive family interactions), and talents. The judge will then relate these strengths to the participant's potential for achieving success in recovery. In addition, counselor optimism regarding the participant's ability to change is associated with positive treatment engagement.[25]

Recommended Practice: Judges and other drug court staff (probation, counselors, case managers) should routinely and repeatedly inform participants about the contingencies of treatment participation (i.e., the consequences of non-compliance).

Rationale: Research reveals that, among offenders who are mandated to participate in substance-abuse treatment, higher retention rates are associated with proactively engaging offenders in understanding the contingencies of program participation, consistent messages among multiple criminal justice agents and treatment staff, and swift returns to custody upon failure.[26]

Recommended Practice: At each court appearance, the court should ask the participant to set one new goal that he or she intends to accomplish before the next court appearance or by a certain date in the near future.

Rationale: Behavioral research suggests that small, manageable objectives are more easily achieved than grandiose goals. The satisfaction of completing a small task provides motivation for the next step.[27]

3. Frequency of Court Appearances

Recommended Practice: Frequency of court appearances should usually be linked to phase status (see B3 below) and generally decrease in frequency as the participant moves through the phases of the drug court program. The court should require appearances at least once per week at the outset and gradually reduce frequency to once per month in the final phase. Regardless of frequency of judicial hearings, the court

should ensure that the treatment provider informs the court immediately of significant non-compliance by the participant.

Rationale: Judicial status hearings, especially with a high risk population, tend to enhance compliance among drug court participants.[28] More frequent appearances early in the program hold participants accountable and tend to promote a positive relationship with the judge. Decreasing frequency with phase advancement provides an incentive for the participant.

NOTE: Under certain circumstances and where feasible, drug courts may consider using videoconferencing technology in place of in court appearances. In cases where travel from the provider to court is onerous and/or court appearances might disrupt treatment (particularly early on in the process), the court may wish to explore this option. It should also be noted that treatment providers generally cannot be reimbursed for their time escorting participants to and from court.

B. Treatment Court Mandate

The drug court should distinguish between the "court" mandate and the "treatment" mandate. The court may want to set requirements for time in the drug court, frequency of appearances, drug testing protocols, and other court related components. In reaching these requirements, the court may consider the severity of the instant criminal offense or the extent of the participant's criminal history. However, regulations promulgated by the New York State Office of Alcoholism and Substance Abuse Services (OASAS) require licensed treatment professionals to make treatment decisions based on approved clinical assessment criteria. These criteria will include history of substance use, previous treatment episodes, modalities previously utilized, job status, housing situation, health history, etc.

1. Treatment

Recommended Practice: The drug court program should follow the recommendations of the treatment professionals regarding Level of Care Determination (LOCADTR).

Rationale: According to OASAS, "[t]he purpose of the level of care determination procedure is to assure that a client in need of chemical dependence services is placed in the least restrictive, but most clinically appropriate level of care available. It is the responsibility of the provider to make an appropriate placement."[29]

Levels of Care refer to the following treatment services:

Crisis Services – Medically managed detoxification; in-patient/residential medically-supervised withdrawal; and out-patient medically-supervised withdrawal

Outpatient Services – Non-intensive outpatient; intensive outpatient; outpatient rehabilitation; and methadone maintenance

Inpatient Rehabilitation Services – Short-term residential treatment (14-30 days)

Residential Services – Intensive residential rehabilitation; community residential; and supportive living

*For a review of LOCADTR guidelines, see NEW YORK STATE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES, GUIDELINES FOR LEVEL OF CARE DETERMINATION (LOCADTR 2.0 2001) *available at:*
http://www.oasas.state.ny.us/treatment/health/locadtr/LOCADTR2-3&cover.pdf

2. Special Considerations

a. Heroin Users

Recommended Practice: Notwithstanding the recommendations above, long-term heroin users will frequently require medically-supervised detoxification and some period of residential treatment to achieve abstinence.[30]

b. Homeless individuals

Recommended Practice: Homeless individuals or those with unstable housing should be considered for inpatient referrals.[31]

c. Self-help Groups

Recommended Practice: Participants should be encouraged to utilize self-help groups in conjunction with substance abuse treatment. Drug court staff should develop a directory of self-help groups, including, but not limited to, Alcoholics Anonymous and Narcotics Anonymous.

Rationale: The purpose of self-help groups is to re-establish social relationships with sober peers and gain abstinence time. A recent study that tracked individuals for 16 years concluded that people who become involved in both Alcoholics Anonymous and treatment fare better that those who obtain only treatment.[32]

NOTE: While self-help groups can provide support for those in recovery, they are not treatment.[33] They should be promoted only as an adjunct to formal substance abuse treatment. Additionally, the law prohibits ordering an individual to participate specifically in Alcoholics or Narcotics Anonymous groups. Courts have held that these groups are inherently religious and therefore violate the Establishment Clause of the Constitution.[34]

d. Site Visits to Treatment Providers

Recommended Practice: Drug court coordinators or other appropriate staff should periodically conduct site visits to their treatment providers.

Rationale: Site visits accomplish several objectives. First, they serve to educate the drug court team about the services offered by a particular provider. Second, they communicate to the provider that the drug court considers treatment a key stakeholder in the drug court process. Finally, site visits can help drug court staff to address complaints from participants about program actions or activities.

NOTE: In most cases, the drug court should give the provider notice that its staff wants to visit the facility and, when practical, request that all drug court participants assigned to

that provider be convened to meet the court staff. Unannounced visits can create unintended defensiveness and impair effective communication between the Court and treatment.

3. Phases

Recommended Practice: Drug courts should organize their programs into a series of phases with specific and quantifiable goals and objectives for each phase. The length of phases and the number of "clean" days required may vary, but the objectives must be clearly announced to the participant.

Rationale: Phases give participants more manageable and achievable goals. Short-term goals that participants can accomplish and measure will motivate them to advanced to the next stage of goals and objectives.[35]

Example

Phase One: The focus of this phase is to encourage the participant to choose a drug-free life and establish a foundation of abstinence by beginning to develop appropriate life skills. Specific objectives might include:

- Attend a drug court orientation session
- Begin treatment and attend all required sessions
- Report to probation officer or other community-based supervisor
- Complete detoxification and remain abstinent
- Submit to random drug screenings
- Attend all required drug court sessions
- Permit unannounced home visits by community-based supervision agency
- Comply with curfews
- Complete an educational/employment plan and literacy assessment
- Arrange for complete physical and dental examination
- Explore life skills, health, education, and employment programs

Phase Two: The focus of this phase is to stabilize the participant in treatment, offer strategies for living without alcohol and other drugs, and develop the individual's educational/employment goals. Specific objectives might include:

- Attend all required treatment sessions
- Report to probation officer or other community-based supervisor
- Remain abstinent
- Submit to random drug screenings
- Attend all required drug court sessions
- Permit unannounced home visits by community-based supervision agency
- Start educational program or job skills training
- Attend required life skills, parenting skills, health, employment, or education programs

Phase Three: The focus of this phase is to move the individual towards self-sufficiency while re-connecting with the community at large. Specific objectives might include:

- Attend all required treatment sessions
- Focus on relapse prevention
- Report to probation officer or other community-based supervisor
- Remain abstinent
- Submit to random drug screenings
- Attend all required drug court sessions
- Permit unannounced home visits by community-based supervision agency
- Actively participate in educational program or job skills training
- Develop continuing care plan and community re-integration strategy
- Attend graduate group and graduate review panel
- Plan and complete required community service projects
- Participate in victim/offender mediation, as appropriate

Recommended Practice: When a participant falters significantly (e.g., positive drug screens, multiple absences from treatment sessions), return the participant to the beginning of their current phase rather than to the beginning of Phase One (unless they are currently in Phase One).

Rationale: Relapse and other forms of non-compliance are a normal part of the recovery process. Sanctions should be designed to motivate, not discourage, participants. For example, sanctioning someone in Phase Three to start all over in Phase One erases the positive sense of accomplishment that motivated the participant to complete Phase One earlier in the process.

4. Troubleshooting with Treatment Providers

Recommended Practice: If the Court is unable to resolve a concern with a treatment provider directly, it should contact the appropriate OASAS Field Office via a letter that defines the issue, with copies to Ken Perez at OASAS, 1450 Western Avenue, Albany, NY 12203 and Frank Jordan at the Unified Court System, 25 Beaver Street, 11th Floor, New York, NY 10003. OASAS and UCS staff will track the issue until it is resolved. For a directory of Field Offices, visit http://www.oasas.state.ny.us/pio/regdir.cfm

C. Drug Testing

The following recommended practices for drug testing are derived in large measure from formal training presentations by Paul Cary, Director of the Toxicology and Drug Monitoring Laboratory, University of Missouri Health Care System.

1. Quality Assurance

Recommended Practice: Drug testing should be:

- Scientifically valid – employs proven methods and techniques and is accepted by the scientific community

- Therapeutically beneficial – provides an accurate profile of participant's drug use and offers rapid results for appropriate response

- Legally defensible – able to withstand challenge and has been scrutinized by legal/judicial review

Recommended Practice: Drug testing protocols should be in writing and staff should be trained to strictly follow each step of the process.

Rationale: The integrity of the drug testing regimen is critical to the fair and effective operation of the court. The judge must be able to rely on the accuracy of drug testing results. If participants observe an erratic or casual approach to the process, they may tend to either lose confidence in the drug court or become inclined to challenge unfavorable results.

2. Drug Testing Specimens

The following specimens can be utilized for detection of substance use:

- Urine
- Breath
- Hair
- Sweat-patch test
- Saliva – oral fluids
- Eye scanning devices

Urine remains the specimen of choice because it is readily available in large quantities, contains high concentrations of drugs, provides both recent and past usage, and is a good analytical specimen. Hair analysis is effective for detection of usage in the past 90 days but will not detect very recent use as the hair must have time to grow. The sweat patch is generally reliable but is subject to false positives due to environmental factors.

3. Drug Testing Protocols

Recommended Practice: Urine collections should be directly observed by a staff member of the same sex.

Rationale: Reliability and accuracy of urinalysis testing (no substitution or adulteration) can only be achieved by "witnessed" collection.

Recommended Practice: Both the collector and the participant should wash hands prior to collection. The sample should be reviewed for temperature (90-100 degrees Fahrenheit), color, odor, and the presence of solids or other particles.

Rationale: Clean hands will avoid contaminating the sample and analysis of temperature, color, odor and particles will help ensure a reliable sample.

Recommended Practice: Drug testing should follow a two-step approach. First, each sample should be screened to separate negative samples from "presumptively" positive samples. Second, if a screening reveals a positive result and the participant contests the

screen, a confirmation test should be conducted to validate the result. Immunoassay testing is a common method for confirming the presence of a prohibited substance in drug courts. Gas chromatography-mass spectrometry (GC-MS) testing is the forensic method of testing for a specific drug. In contested cases, a GC-MS confirmation test should always be ordered. A confirmation test can be eliminated in cases where the participant admits to use. The drug court, probation department, or treatment provider should assume responsibility for payment of the confirmation test.

Rationale: A participant is entitled to a scientifically reliable testing process, which can only be achieved with a confirmation test. In the few New York drug courts where immunoassay analyzers (EMIT) are utilized, a confirmation with a second EMIT test has been found sufficient by reviewing courts. However, in most New York drug courts, the initial screen is performed with non-instrumented test cups or dip sticks. Since the reliability of these tests continues to be debated, the court should order a GC-MS confirmation test when the participant contests a positive result. If the court is clear regarding the consequences for lying about drug use (e.g., increased sanctions), then the program should experience relatively few challenges to drug screen results. In cases where a confirmation test is ordered, equal access to justice principles place responsibility for payment of the test on parties other than the participant. The court may consider increasing the severity of the sanction where a contested result is confirmed as positive.

Recommended Practice: Drug courts should establish written protocols for participants who challenge the results of a drug test.

Rationale: A clearly articulated protocol for challenging a test result (e.g., who pays for it, severity of sanctions, laboratory used for testing, scientific reliability of GC-MS testing, etc.) will likely reduce specious challenges.

Recommended Practice: Where feasible, participants should always be tested for alcohol, regardless of whether it is their drug of choice.

Rationale: Substance abusers will frequently substitute with easily accessible alcohol, which cannot always be detected on breath or observed in a participant's behavior.

Recommended Practice: Drug courts should not use certain biomarkers, such as EtG, as stand-alone confirmation of relapse.

Rationale: Research has not yet established an acceptable standard to distinguish possible exposure to alcohol in various commercial products from consumption of alcoholic beverages.[36]

4. Drug Test Interpretation

Recommended Practice: Utilize drug testing results as only one of many indicators of the participant's overall program compliance.

Rationale: Relying too heavily on drug test results to measure compliance can distort the court's assessment of the participant's progress. For example, if a participant is testing clean but missing sessions, appearing late for court, and has recently lost a job, the program staff should examine the possibility that the samples are unreliable or that

other aspects of her recovery are in jeopardy. Conversely, if a participant is doing well in all other areas but tests positive once, the program may want to consider that the dirty urine is a minor lapse, meriting a response but not one that will disrupt otherwise positive progress.

Recommended Practice: Drug courts should interpret urinalysis test results qualitatively, not quantitatively. The program should interpret test results only as "Positive" or "Negative."

Rationale: Urine drug concentrations are of little or no interpretative value. Utilizing urine drug test levels produces interpretations that are inappropriate, factually unsupportable, and without a scientific foundation. Many factors can affect drug levels (e.g., water loading, urine volume or output, age, exercise, and salt and protein intake). Moreover, drug tests are not linear and are not designed to accurately quantify drug concentrations.

Recommended Practice: Drug court programs should routinely measure creatinine levels of their collected samples. If abnormal creatinine levels are detected, the court should first explore any physiological reasons that the individual may have abnormal levels without intentionally diluting the sample. Second, the court may wish to increase the frequency of the individual's drug testing for a period of time. Third, the Court should examine whether there are other indicators of drug use (e.g., missed appointments, lateness, etc.). After eliminating valid reasons for abnormal creatinine levels, the court should follow its policy for "substituted" samples.

Rationale: Normal human creatinine levels will vary during the day but healthy individuals will rarely produce creatinine levels of less than 20mg/dL. Levels lower than 20mg/dL suggest diluted urine (usually, from water loading) and may not accurately reflect an accurate picture of recent drug use. Levels less than 5mg/dL are considered "substituted" samples. Notwithstanding established "normal" levels of creatinine, the court should proceed cautiously if considering a sanction based solely on "abnormal" creatinine levels since there is a very small percentage of individuals who will test at low levels without water loading.

Recommended Practice: Establish a policy that participants are responsible for what they put in their bodies. The policy should also address the fact that certain prescribed and over-the-counter medicines may produce false urine test results. If a physician prescribes medication, the participant should be required to immediately notify the appropriate drug court team member (probation officer, case manager, or coordinator) and produce the written prescription. Before taking over-the-counter medicines, the participant should discuss with the appropriate drug court team member to learn if the medicine can affect drug test results.

Answers to Frequently Asked Questions

Passive inhalation of marijuana smoke will not cause a "positive" result if standard cutoffs are used, (i.e., 20, 50,100 mg/mL).

Advil will not cause "false-positive" results for marijuana.

Poppy seeds, in very small amounts, will cause a positive result for opiates.

Drinking vinegar or cranberry juice will not produce a "negative" urine drug test.

5. Drug Testing Frequency

Recommended Practice: To the greatest extent possible, drug testing should be random and progressive. In Phase One, testing should be aggressive (2x/week minimum); in Phase Two, testing frequency should be reduced as an abstinence reward (1x/week); and in Phases Three (and Four), testing frequency should be reduces further (1x/2 weeks). Testing schedules should always be subject to increased frequency when a positive test occurs or other relapse factors are observed.

Rationale: Unexpected, unannounced, and unanticipated testing will limit a participant's ability to "plan ahead." Random testing is also an effective tool for participants (especially younger individuals) when confronted with peer pressure to use. "I can't – I could be tested at any time!"

*For detailed discussion of common drug testing issues in the drug court setting, see:

JEROME J. ROBINSON & JAMES W. JONES, DRUG TESTING IN A DRUG COURT ENVIRONMENT: COMMON ISSUES TO ADDRESS (Office of Justice Programs Drug Courts Program Office, Drug Court Clearinghouse and Technical Assistance Project, 2000), *available at http://www.ncjrs.gov/pdffiles1/ojp/181103.pdf*

Paul L. Cary, *The Use of Creatinine-Normalized Cannabinoid Results to Determine Continued Abstinence or to Differentiate Between New Marijuana Use and Continuing Drug Excretion From Previous Exposure*, DRUG COURT REVIEW, Summer 2002, at 83-103 (publication of the National Drug Court Institute)

Paul L. Cary, *Urine Drug Concentrations: The Scientific Rationale for Eliminating the Use of Drug Test Levels in Drug Court Proceedings*, DRUG COURT PRACTITIONER FACT SHEET, January 2004 (publication of the National Drug Court Institute)

Paul L. Cary, *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 REVIEW, Spring 2006, at 23-58 (publication of the National Drug Court Institute)

D. Motivating the Participant

Drug courts utilize a scheme of graduated sanctions and rewards to change the behavior of participants. In recent years, drug court practitioners have looked to the world of behavioral research to identify the most promising approaches to achieve this goal. Based on a review of behavioral research literature, particularly in the criminal justice setting, William G. Meyer, Sr., Judicial Fellow at the National Drug Court Institute, catalogued "Ten Science-Based Principles of Changing Behavior Through the Use of Reinforcement and Punishment". These soon-to-be-published principles, printed in their entirety, are included in the Appendix at the end of this document. They should be of great assistance as the court seeks to respond to participant behavior in creative and effective ways. (Note that reproduction of these principles is subject to the approval of the National Drug Court Institute).

1. Clinical Perspective

As Judge Meyer notes in his review, sanctions and incentives will have disparate impacts on different drug court participants. Accordingly, the underlying approach to using sanctions and incentives requires a philosophical shift from a simple learning model to a combination of ongoing clinical assessment, motivational strategies, cognitive-behavioral interventions, and the development of continuing care strategies.

Recommended Practice: Encourage "intentional behavior change" through motivational strategies so that participants' goals reflect their understanding of life-change "benefits" to ceasing drug use and other antisocial behaviors, as opposed to perceiving "costs" in relation to attending treatment and becoming abstinent.[37]

Recommended Practice: The range and specific types of sanctions should be set forth in writing and given to all participants.

Rationale: The drug court wants to be able to customize its sanctions and incentives to the individual while, at the same time, notifying the participant of potential consequences to his or her behavior.

Recommended Practice: Resist a "blanket" policy that directs every client to a higher and more intensive level of care as the result of a relapse.

Rationale: Without proper re-assessment, this clinical decision may put a client at risk, if not for active use, then for treatment and drug court failure. Re-assessment after a relapse is particularly important with dual-diagnosis clients, adolescents, and elderly participants, who are more likely to be experiencing other psychiatric or physical disturbances that may be impacting their recovery.

Recommended Practice: Re-assess, at least every three months, each participant's progress and problems to avoid potential lapses and treatment failures. Re-assessment should include not only the client's urinalysis and attendance reports, but the existence of any life stress problems, such as difficulties in educational/vocational programs, family and/or domestic violence problems, emerging psychological or emotional problems, housing problems, lack of appropriate social support, etc.

Rationale: This approach helps a participant to assess the "intrinsic benefits of recovery."

2. Jail Sanctions

Recommended Practice: Consider sanctions of incarceration in the following circumstances:

- the commission of a criminal act (non drug-related) as determined by the court and law enforcement personnel;
- consistent failure to attend the program, maintain appointments, and abide by contractual agreements with the Court; and
- "chronic" relapsing behavior after the first 3–6 months of treatment and after clinical re-assessment.

Recommended Practice: Refrain from using incarceration as an exclusive or predominant sanction. Instead, employ a range of sanctions that take into account the participant's incarceration history, employment status, age, health, mental health issues, and other individual characteristics of the participant.

Rationale: Research has shown that incarceration is not necessarily the harshest punishment for many criminal offenders. Graduated sanctions allow the court to individualize its response to each participant and minimize the risk that the offender will become habituated to jail sanctions.[38]

3. Essays

Recommended Practice: Essays can be an appropriate sanction for non-compliance, but the court should consider whether reading them in open court will shame or embarrass the participant.

Rationale: Essays may reveal low literacy levels or highly personal issues. Reading in open court in front of peers may produce a perception, albeit unintended, that the judge seeks to humiliate the participant. This perception will offset the benefit of having written the essay.

NOTE: For ethical and financial reasons, the Office of Court Drug Treatment Programs has advised drug court staff to refrain from soliciting or distributing incentives with a monetary value. However, research has found that a "contingency management protocol," in which vouchers or points are rewarded for abstinence and compliance in increasing amounts, has produced favorable outcomes. A contingency management protocol permits participants to exchange vouchers or points for items consistent with a drug-free lifestyle (movie tickets, sports tickets, gift certificates). Clients are able to choose which rewards they receive, based on their points-earned value. For those lapsing into drug use, the point values are lost and reset to the original level as a form of "sanction." The drug court may wish to explore ways to utilize contingency management without involving the court directly in the solicitation of goods or services.[39]

E. Leaving the Drug Court - Graduation

1. Graduation Requirements

Recommended Practice: Establish specific and concrete requirements for graduation and communicate them clearly to participant upon entry into drug court. Include these requirements in the Participant Handbook and in the written drug court contract. If restitution is a factor, include the specific amount and payment schedule in the individual's contract. The court should refrain from changing requirements during the course of participation. If the drug court alters its requirements as a policy matter, apply them only to new participants.

Rationale: Individuals in recovery, particularly the early stages, experience short-term memory loss, difficulty with abstract thinking, and other cognitive deficits associated with damage to the brain from substance abuse. Formulating goals in the most explicit manner will enhance the participant's comprehension of the program's requirements.

Recommended Practice: Graduation requirements should usually include, at a minimum:

- completion of the drug court's program phases (typically, three-four);
- a specified period of clean time;
- treatment provider approval for graduation;
- progress toward vocational, educational, and employment goals; and
- a written graduation application.

Additional requirements may include:

- community service;
- suitable residence; and
- a sponsor.

Rationale: Including requirements that are not directly related to abstinence sends a message that recovery is a holistic process, not simply abstinence. Stable employment, in particular, has been related to decreased relapse among substance users following treatment.[40]

2. Graduation Decision

Recommended Practice: Inform participants that the drug court team and the appropriate treatment provider will be involved in the decision to approve graduation applications. If a participant has met all obligations of the initial contract with the drug court, the graduation application should be approved.

Rationale: Failure to approve a graduation application without advising the client of any remaining, unfulfilled expectations at least three months in advance is clinically unsound and may engender non-compliance, a return to use, and other negative outcomes. Note that three months in advance of expected graduation coincides with the final re-assessment of client progress and provides an opportunity for the team to advise the client that he or she may not be leaving the drug court as anticipated.

Recommended Practice: The drug court should avoid linking completion of the drug court's requirements with completion of treatment.

Rationale: Although the treatment provider should be part of graduation decision-making, there may be cases where a participant should continue in treatment after he or she has fulfilled all drug court requirements. Individuals with co-occurring disorders will need ongoing treatment. In misdemeanor cases, the drug court might not have sufficient leverage to hold the participant in treatment for the clinically indicated period of time.

Recommended Practice: The drug court team should review continuing care plans with participants prior to graduation. Any suggestions or questions regarding the basis for the plan should be discussed and approved as part of the graduation process.

Recommended Practice: The drug court team should notify the treatment provider that it is considering graduation for a particular participant and invite their input on the decision.

Rationale: Notice allows the provider to address the individual needs of the participant. In appropriate cases, the treatment provider can offer a detailed continuing care plan or recommend that the individual remain in treatment notwithstanding the lifting of the court mandate.

Recommended Practice: Drug court staff should conduct an exit interview with all graduating participants to determine which components of the drug court worked best (and least well) from their perspective. Ideally, similar interviews should be conducted with those who are terminated, although such interviews may be difficult to obtain if the terminated participant is resistant.

Rationale: Too often, drug court programs overlook input from the actual participants in assessing the effectiveness of their programs. Drug court participants can provide valuable insight into what actually motivates them to succeed and what factors undermine progress.*

> *For a discussion of participant perspectives, see DONALD J. FAROLE & AMANDA B. CISSNER, SEEING EYE TO EYE? PARTICIPANT AND STAFF PERSPECTIVES ON DRUG COURTS (Center for Court Innovation 2005), *available at:* http://www.communityjustice.org/_uploads/documents/eye_to_eye.pdf

3. Timing of Graduation

Recommended Practice: When participants succeed in fulfilling their drug court requirements, the court should deliver any promised legal incentives as close in time to completion as possible.

Rationale: Regardless of the drug court's legal incentive (e.g., dismissal or charges, reduction of charges, termination from probation), the participant's perception of fairness is adversely affected if he or she must continue under the court's supervision after fulfilling all requirements. In addition, the court, the participant, and the defense attorney face the possibility that a participant could commit an infraction after technically completing the program. Some courts resolve this issue by executing the legal incentive either at the precise time that requirements are met or within one to two months of fulfillment of the contract. Participants are then invited back for a more formal graduation event conducted once every year.

F. Leaving the Drug Court - Termination

1. Clinical vs. Law Enforcement Non-Compliance

Recommended Practice: Termination criteria should be individualized both to the jurisdiction and the participant. However, in all cases, distinctions should be made between termination for clinical reasons (e.g., repeated drug use) and termination for law enforcement violations (e.g., re-arrest, absconding).

Rationale: Perception of fairness is a critical component of the drug court program's credibility and effectiveness. A drug court that responds in the same fashion to drug use as it does to willful commission of a crime or absconding runs the risk of being perceived

as unfair. Since most drug courts adhere to the disease model of addiction, the drug court should rigorously examine the treatment plan of those struggling to achieve abstinence. More intensive psychological examinations coupled with increased levels of care may help promote compliant behavior. Conversely, the drug court should consider jail sanctions, and ultimately termination, for law enforcement violations.

2. Clinical Non-Compliance

Recommended Practice: Failure to comply with program standards should be assessed in terms of the client's intellectual, cognitive, and affective capacities. Clients who are developmentally or organically impaired, who are dealing with a chronic and/or fatal illness, or who are diagnosed with severe mental illness require referrals to appropriate services and an alternative legal mandate that does not punish them for their disabilities.

Recommended Practice: In cases of dual-diagnosis, incarceration has been demonstrated to further impair the condition of mental illness; additionally, residential programs have not been shown to retain such individuals in treatment. The best case scenario for termination of these participants is an alternative-to-incarceration sentence, with a referral to an integrated out-patient program that addresses both the individual's mental illness and substance abuse.[41] These programs will often assist clients in finding housing and, if possible, vocational training.

Recommended Practice: In cases of chronic relapse, the drug court should consider termination when:

- the treatment resources in the jurisdiction have been exhausted;
- all appropriate levels of care have been utilized;
- the participant does not wish to continue in treatment; or
- the court concludes that further participation would undermine the effectiveness of the program.

Rationale: Recognizing that recovery is a process that can include multiple relapse episodes, the drug court will want to offer as many opportunities for success as local treatment resources permit. However, while recovery is a lifelong process, the court is not a lifelong monitoring body. At some point, the court must provide other offenders with the opportunity to participate in drug court and communicate to all participants that the tolerance of the court is not unlimited.

3. Law Enforcement Non-Compliance

Recommended Practice: Re-arrest during program participation should be assessed on a case-by-case basis. The following factors can be considered:

- Does the new arrest render the participant ineligible for the drug court (e.g. violent charge, felony charge in a misdemeanor court)? If so, termination is probably appropriate.

- Is the new arrest associated with relapse (e.g., petit larceny, trespass)? If so, the drug court may consider retaining the participant and upwardly adjusting the jail alternative.

Rationale: A case-by-case approach gives the court flexibility to weigh public safety considerations against the possibility that the new arrest is, in fact, a manifestation of relapse that merits a sanction rather than termination from the program.

Recommended Practice: In cases where the participant absconds, the drug court should consider the following factors:

- the participant's length of time in the program before absconding;
- the participant's length of time between absconding and returning to court;
- whether participant returned to court voluntarily or involuntarily; and
- any previous incidents of absconding.

Rationale: Voluntary returns suggest a desire to return to treatment and an expectation of being held accountable. Drug court teams may look more favorably on retaining participants under these circumstances. On the other hand, the drug court should consider terminating a participant who is returned to court involuntarily after a several months of absence.

4. Termination Process

Recommended Practice: Drug courts should not only notify the treatment provider of intent to terminate but should allow the provider an opportunity to participate in the decision-making process.

Rationale: Effective communication between the court and the treatment provider is critical to the drug court process. The treatment provider frequently possesses the most reliable information regarding the participant's prognosis for successful recovery.

Recommended Practice: The drug court must consider legal due process requirements when terminating a participant.*

> * It is recommended that drug courts review *Torres v. Berbary*, 340 F.3d 63 (2d Cir. 2003), for guidance in satisfying due process concerns at termination.

Rationale: In *Torres*, the court found that the "preponderance of the evidence" standard was not satisfied by a single report from the treatment provider that contained "multiple levels of hearsay and speculation." The court concluded that due process requires "some kind of hearing" in cases where the participant contests the factual basis for termination. *Torres* does not necessarily mandate a formal, full-blown hearing, but it does require that, in contested cases, the court establish an evidentiary basis for finding a breach of conditions of release and sentencing the individual to a prison term.[42] *Torres* suggests that courts look to procedural standards used in probation and parole revocation proceedings.

Recommended Practice: In cases where the judge terminates a participant from the program, the participant and defense attorney should consent in writing to the drug court judge conducting the revocation proceeding and sentence. If no consent is provided, the drug court judge should consider referring the case to another judge for hearing and sentence.

Rationale: Due process requires that judges possess neither actual nor apparent bias in favor of or against a party.[43] In the course of a drug court case, the judge tends to learn a great deal about participants, their families, their drug use, and other undesirable behaviors. Further, the frequent appearances in the drug court and the interaction between the judge and participant can potentially interfere with the judge's ability to be impartial and neutral. While New York's appellate courts have not addressed this issue, one reviewing court has suggested that in contested cases, recusal from the revocation hearing and sentence is recommended.[44] At the very least, the court should consider this option when the circumstances of a case raise the issue.

5. Post-Termination

Recommended Practice: When a participant is terminated, the drug court team should conduct a thorough examination of the reasons for failure and explore ways in which the drug court staff might have addressed the participant's failure to comply with program requirements.

Rationale: Individual case reviews may reveal areas of needed improvement in drug court practices. Case reviews can help the team identify common factors that lead to termination and facilitate the implementation of modifications in the program's policies and procedures.

G. Continuing Care Plan

Recommended Practice: The drug court team should develop a Continuing Care Plan (CCP) for participants who are favorably discharged from the drug court.

Rationale: A CCP promotes the maintenance of changes achieved in drug court after the participant has successfully completed the program. Research indicates that long-term support and continuing care "contribute significantly" to the ongoing effects of substance abuse treatment, whatever the treatment approach.[45] Such a plan should be formulated in steps, beginning upon the participant's entry into the drug court and continuing to his or her completion. The CCP targets ongoing treatment, community resources, family, housing, employment, and social networks designed to help the client re-integrate into the social environment without resorting to former illegal and self-defeating patterns of behavior.

Recommended Practice: The drug court program should utilize tools designed to increase the participant's acceptance of the Continuing Care Plan. Strategies include:

- Plan a "transition" group for clients who will be graduating from the drug court at the same time. At these group meetings, conduct an orientation to the concept and process of Continuing Care, and encourage participants to share concerns and ask questions.

- Prior to release from drug court, require participants to meet with one or two of the outside agencies that will form the Continuing Care network.

- Engage a spouse, significant other, or other family member in the Plan. Encourage the participant to enter into a "contract" to attend a certain number of sessions or meetings at the referral site. The family member can assist in supporting such attendance by ensuring that appointments are kept. Family therapy or collateral counseling may also be arranged.

- Plan an alumni group meeting as a follow-up to the continuing care process. This group can share its experiences with other upcoming drug court graduates as an introduction to the benefits of the CCP.

Rationale: Participants' expectations concerning their Continuing Care Plans play a major role in successful reintegration. If participants believe that they will benefit from engaging in such long-term care, they may be more likely to participate fully.*

*For further discussion of this approach, see Dennis M. Donovan, *Continuing Care: Promoting the Maintenance of Change*, *in* TREATING ADDICTIVE BEHAVIORS (W. Miller & N. Heather eds., 1998)

[1] *See* MICHAEL REMPEL ET AL., THE NEW YORK STATE ADULT DRUG COURT EVALUATION: POLICIES, PARTICIPANTS, AND IMPACTS (2003), *available at* *www.courts.state.ny.us/whatsnew/pdf/NYSAdultDrugCourtEvaluation.pdf*

[2] *See* K.T. MUESER ET AL., INTEGRATED TREATMENT FOR DUAL DISORDERS: A GUIDE TO EFFECTIVE PRACTICE (2003)

[3] *See* NATIONAL INSTITUTE OF DRUG ABUSE, PRINCIPLES OF DRUG ABUSE FOR CRIMINAL JUSTICE POPULATIONS (2006), *available at* *www.drugabuse.gov/PDF/PODAT_CJ/PODAT_CJ.pdf*

[4] *See* Americans with Disabilities Act, 42 U.S.C. § 12111-12134 (2008); *see also* Ellen M. Weber, *Bridging the Barriers: Public Health Strategies for Expanding Drug Treatment in Communities*, 57 RUTGERS L. REV. 631 (2005).

[5] A.T. McLellan, *"Psychiatric Severity" as a Predictor of Outcome from Substance Abuse Treatment, in* PSYCHOPATHOLOGY AND ADDICTIVE DISORDERS (R.E. Meyer, ed., 1986); R.D. Weiss, *The Role of Psychopathology in the Transition from Drug Use to Abuse and Dependence, in* VULNERABILITY TO DRUG USE (M. Glantz & R. Pickens, eds., 1986).

[6] R.E. Drake et. al, *Alcohol Use and Abuse in Schizophrenia: A Prospective Community Study*, JOURNAL OF NERVOUS AND MENTAL DISEASE, July 1989, at 408-414.

[7] D. Safer, *Substance Abuse by Young Adult Chronic Patients*, HOSPITAL AND COMMUNITY PSYCHIATRY, May 1987, at 511-514.

[8] C. Caton, *The New Chronic Patient and the System of Community Care*, HOSPITAL AND COMMUNITY PSYCHIATRY, July 1981, at 475-478.

[9] K. EVANS & J.M. SULLIVAN, DUAL DIAGNOSIS: COUNSELING THE MENTALLY ILL SUBSTANCE ABUSER (1990).

[10] *See* ROGER H. PETERS & FRED C. OSHER, CO-OCCURRING DISORDERS AND SPECIALTY COURTS, (2d ed., 2004), *available at* *http://gainscenter.samhsa.gov/pdfs/courts/CoOccurringSpecialty04.pdf*

[11] *See* NATIONAL INSTITUTE OF DRUG ABUSE, PRINCIPLES OF DRUG ABUSE FOR CRIMINAL JUSTICE POPULATIONS (2006), *available at* *www.drugabuse.gov/PDF/PODAT_CJ/PODAT_CJ.pdf*

[12] *See* 14 N.Y. Comp Codes R. & Regs. tit. 14 § 822.1 - 822.13 (2008) (OASAS regulations for 822 medically-supervised programs), *available at* *www.oasas.state.ny.us/regs/822.cfm*

[13] *See* Matter of Roldan-Santoyo, 22 I. & N. Dec. 512 (BIA 1999).

[14] REMPEL, *supra* note 1.

[15] (NIAAA/HHS, 2003)

[16] *See, e.g.*, R. MILLER & S. ROLLNICK, MOTIVATIONAL INTERVIEWING: PREPARING PEOPLE FOR CHANGE (2002); J.O. Prochaska & C.C. DiClemente, *Common Processes of*

Self-Change in Smoking, Weight Control, and Psychological Distress, in COPING AND SUBSTANCE ABUSE: A CONCEPTUAL FRAMEWORK (S. Shiffman & T. Wills eds., 1985); CENTER FOR SUBSTANCE ABUSE TREATMENT, TIP 35: ENHANCING MOTIVATION FOR CHANGE IN SUBSTANCE ABUSE TREATMENT (Treatment Improvement Protocol (TIP) Series 2001).

[17] REMPEL, *supra* note 1; Hung-En Sung, *Drug Treatment Alternative-to-Prison Ninth Annual Report* (Kings County District Attorney's Office, Brooklyn, NY) 1999.

[18] *See* People v. Whalen, 766 N.Y.S.2d 458, 460 (App. Div. 2003) (discussing requirement of scientific acceptance and reliability of evidence in probation violation context).

[19] *See* Torres v. Berbary, 340 F.3d 63 (2d Cir. 2003).

[20] *See* D. Young & S. Belenko, *Program Retention and Perceived Coercion in Three Models of Mandatory Drug Treatment*. JOURNAL OF DRUG ISSUES, Winter 2002, at 297-328; D. Gottfredson, et al., *Effectiveness of Drug Treatment Courts: Evidence from a Randomized Trial*, 2 CRIMINOLOGY AND PUBLIC POLICY 171, 196 (2003).

[21] *See* D. Young & S. Belenko, *Program Retention and Perceived Coercion in Three Models of Mandatory Drug Treatment*. JOURNAL OF DRUG ISSUES, Winter 2002, at 297-328.

[22] *See Id.*

[23] *See* Health Insurance Portability and Accountability Act, 42 C.F.R., Part 2.

[24] *See* A. Harrell & J. Roman, *Reducing Drug Use and Crime Among Offenders: The Impact of Graduated Sanctions*, JOURNAL OF DRUG ISSUES, Winter 2001, at 207-232; W.M. Burdon. et al., *Drug Courts and Contingency Management*, JOURNAL OF DRUG ISSUES, Winter 2001, at 73-90; MOTIVATING BEHAVIOR CHANGE AMONG ILLICIT-DRUG ABUSERS: RESEARCH ON CONTINGENCY MANAGEMENT INTERVENTIONS (S.T. Higgins & K. Silverman eds., 1999).

[25] *See* W.R. MILLER & S. ROLLNICK, MOTIVATIONAL INTERVIEWING: PREPARING PEOPLE FOR CHANGE (1991).

[26] *See* Young & Belenko, *supra* note 16.

[27] ROBERT S. HELGOE, A COMMUNITY REINFORCEMENT APPROACH: TREATING COCAINE ADDICTION AND HIERARCHY OF RECOVERY, National Institute on Drug Abuse (Hazelden Bookstore).

[28] *See* D.B. Marlowe et al., *The Judge is a Key Component of Drug Court*, DRUG COURT REVIEW, 2004, at 1-34.

[29] NEW YORK STATE OFFICE OF ALCOHOLISM AND SUBSTANCE ABUSE SERVICES, GUIDELINES FOR LEVEL OF CARE DETERMINATION (LOCADTR 2.0 2001), *available at http://www.oasas.state.ny.us/treatment/health/locadtr/LOCADTR2-3&cover.pdf*

[30] *See* REMPEL, *supra* note 1.

[31] *See* REMPEL, *supra* note 1.

[32] *See* Bernice S. Moos & Rudolf H. Moos, *Paths of Entry into Alcoholics Anonymous: Consequences for Participation and Remission*, ALCOHOLISM: CLINICAL & EXPERIMENTAL RESEARCH, October 2005.

[33] *See* W.R. Miller, et al., *What works? A Methodological Analysis of the Alcohol Treatment Outcome Literature, in* HANDBOOK OF ALCOHOLISM TREATMENT APPROACHES: EFFECTIVE ALTERNATIVES (2d. ed., R. K. Hester & W. R. Miller eds., 1995).

[34] *See* DeStefano v. Emergency Hous. Group, Inc., 247 F.3d 397 (2d Cir. 2001); *In re* Griffin v. Coughlin, 673 N.E.2d 98 (N.Y. 1996).

[35] *See* HELGOE, *supra* note 27.

[36] SUBSTANCE ABUSE TREATMENT ADVISORY (Center for Substance Abuse Treatment, Substance Abuse and Mental Health Services Administration, Rockville, MD), Sept. 2006.

[37] R. Demmel et al., *Readiness to Change in a Clinical Sample of Problem Drinkers: Relation to Alcohol Use, Self-Efficacy, and Treatment Outcome*, EUROPEAN ADDICTION RESEARCH, 2004, at 133-138.

[38] A. Harrell & J, Roman, *Reducing Drug Use and Crime Among Offenders: The Impact of Graduated Sanctions*, JOURNAL OF DRUG ISSUES, Winter 2001, at 207-232; J. Roll et al., *An Experimental Comparison of Three Different Schedules of Reinforcement of Drug Abstinence Using Cigarette Smoking as an Exemplar*, JOURNAL OF APPLIED BEHAVIORAL ANALYSIS, Winter 1996, at 495-504.

[39] Stephen T. Higgins et al., *Voucher-Based Incentives: A Substance Abuse Treatment Innovation*, ADDICTIVE BEHAVIORS, Nov.-Dec. 2002, at 887-910.

[40] J.S. Atkinson, et al., *The Relationship Among Psychological Distress, Employment, and Drug Use Over Time in a Sample of Female Welfare Recipients*, JOURNAL OF COMMUNITY PSYCHOLOGY, May 2003, at 223-234.

[41] K.T. Mueser et al., INTEGRATED TREATMENT FOR DUAL DISORDERS: A GUIDE TO EFFECTIVE PRACTICE (2003).

[42] *But see* People v. Valencia, 819 N.E.2d 990 (N.Y. 2004) (holding that no evidentiary hearing is required where defendant admitted the facts constituting violation of the drug treatment agreement).

[43] *See In re* Murchison, 349 U.S. 133, 136-139 (1955).

[44] *See* Alexander v. State, 48 P.3d 110 (Okla. Crim. App. 2002).

[45] *See* Dennis M. Donovan, *Continuing Care: Promoting the Maintenance of Change, in* TREATING ADDICTIVE BEHAVIORS (W. Miller & N. Heather eds., 1998).

Ten Science-Based Principles of Changing Behavior Through the Use of Reinforcement and Punishment

William Meyer
Sr. Judicial Fellow
National Drug Court Institute
1/14/06

1. **SANCTIONS SHOULD NOT BE PAINFUL, HUMILIATING OR INJURIOUS**.

a. Research on offender perceptions and specific deterrence effects on offenders subject to sanctions report that:

1. Certainty of sanctions does exert a specific deterrent effect on future behavior.

2. Perceived severity, if certainty is present, does not exert a deterrent effect on future behavior. Harrell, A., & Roman, J. (2001). "Reducing Drug Use and Crime Among Offenders: The Impact of Graduated Sanctions." *Journal of Drug Issues*, 31 (1), 207-232.

3. Exploratory studies report that drug court participants who perceived a more certain and meaningful connection between their own conduct and the imposition of sanctions and rewards tended to have better outcomes than individuals who did not perceive such a connection. Douglas B. Marlowe, David S. Festinger, Carol Foltz, Patricia A. Lee, Nicholas S. Patapis, "Perceived deterrence and outcomes in drug court", *Behavioral Sciences and the Law,* v.23: 181-198 (2005)

b. While research on animals indicate that severity of punishment is directly related to behavior extinguishment, the same is not necessarily true for criminal offenders.

Research reports that controlling for age, socioeconomic status, and time of incarceration the risk that the offender would re-offend was not related to the prior sanctions imposed irrespective of whether the sanction was probation, a fine or prison. The one exception to this finding is when first and second time offenders received prison instead of a fine or probation, they were more likely to re-offend. Brennan, P and Mednick, S., "Learning Theory Approach to Deterrence of Criminal Behavior," Vol. 103 *Journal of Abnormal Psychology,* pp. 430-440 (1994).

c. In controlled studies, participants tend to choose heavy future punishment over smaller immediate punishers. As it relates to substance abusers, they tend to discount the future consequences. The immediacy of the effect is the best predictor of whether there will be a change in the status quo.

Murphy, J. G., Vuchinich, R. E., & Simpson, C. A. (2001). "Delayed Reward and Cost Discounting." *The Psychological Record*, 51, 571-588.

d. Multi-disciplinary research posits that defiant behavior results when sanctions are perceived as unfair punish the individual not the act, imposed on individuals poorly bonded to the community and on individuals who fail to feel shame or contrition for their acts. Sherman, L. W. (1993). "Defiance, Deterrence, and Irrelevance: A Theory of the Criminal Justice Sanction." *Journal of Research in Crime and Delinquency*, 30 (4), 445-473.

2. **RESPONSES ARE IN THE EYES OF THE BEHAVER.**

a. Contrary to expectations, incarceration is not necessarily viewed by the criminal offender as the harshest punishment. In a comparison of alternative sanctions to prison time, 6-24% of inmates surveyed preferred 12 months incarceration compared to sanctions ranging from a halfway house (6.7%), probation (12.4%) or day fines (24%). Those inmates desiring alternative sanctions seemed to have better connections with the community, for example children, job, etc. Wood, P. B., & Grasmick, H. G. (1995). "Inmates Rank the Severity of Ten Alternative Sanctions Compared to Prison." Oklahoma Department of Corrections; www.doc.state.ok.us/DOCS/OCJRC/OCJRC95/950725j.htm See also Petersilla, J. and Deschanes, E., "What Punishes? Inmates Rank the Security of Prison v. Intermediate Sanctions?" *Federal Probation*, Vol. 58, No. 1 (March 1994).

b. Research also indicates that punishment or the possibility of punishment as a sanction tends to be a greater motivator of behavior for those addicts who have a lot to loose. For those addicts who have nothing to lose, the threat or actual imposition of punishment causes them to withdraw from treatment or drop out. The use of positive reinforcement has been shown to be particularly effective in motivating abstinence in this population. See Higgins, S. T., & Silverman, K. (1999). *Motivating Behavior Change Among Illicit-Drug Abusers.* Washington, D.C.: American Psychological Association; particularly Chapter 17, Crowley, T., "Clinical Implications and Future Directions," pp. 345-351.

c. An extensive study focusing on whether criminal sanctions reduce, increase or have no effect on future crimes found the following:

1. Similar sanctions have completely different effects depending upon the social situation and offender type.

2. Treatment can increase or decrease criminality depending on offenders' personality type.

3. Criminal sanctions decrease criminality in employed offenders but increase criminality in unemployed offenders.

4. Threat of criminal sanctions deters future criminality in people who are older.

5. People obey laws more when they believe laws are enforced fairly. See Sherman, L. W. (1993). "Defiance, Deterrence, and Irrelevance: A Theory of the Criminal Justice Sanction." *Journal of Research in Crime and Delinquency*, 30 (4), 445-473.

d. The concept of the perception of fairness and its effect on the behaver may have greater importance than previously believed. Behavioral economic research suggests that people will react to perceived unfairness by engaging in activity that will "punish" the person perceived as being unfair even to the extent of punishing themselves to get back at that person. Andreoni, J., Harbaugh, W., & Vesterlund, L. (2001). "The Carrot or the Stick? Rewards, Punishments and Cooperation." Unpublished paper, National Science Foundation Grant.

e. Just as a sanction may be misperceived, so can a system of rewards. Providing such things as appointment books, pencils or even increasing monetary rewards as a bonus may even jeopardize continued abstinence. Higgins, S. T., & Silverman, K. (1999). *Motivating Behavior Change Among Illicit-Drug Abusers.* Washington, D.C.: American Psychological Association., pp. 334-335.

f. As drug court professionals we must be particularly cognizant of the participant perception that a response of increased drug treatment imposed upon therapeutic recommendation will be perceived by the participant as a punishment. To the extent we can persuade the participant that treatment is in their best interest, we should do so. See Center for Substance Abuse Treatment, "Combining Substance Abuse Treatment with Intermediate Sanctions for Adults in the Criminal Justice System." Rockville, Maryland: Center for Substance Abuse Treatment, U.S. Department of Health and Human Services publication SMA 94-3004; 1994 d. *Treatment Improvement Protocol (TIP) Series 12.*

3. **RESPONSES MUST BE OF SUFFICIENT INTENSITY**.

a. Animal Research has demonstrated that punishment must be of sufficient intensity to motivate the change in behavior. If the punishment is of not sufficient consequence, the behaver is not motivated to change or becomes habituated to the punishment Azrin, N. and Holz, W. "Punishment" in Honig W. (ed). *Operant Behavior: Areas of Recidivism and Application.*

(Meredith Publishing 1966) pp. 381-447. Particularly p. 426 and 433. Using animal testing, authors answer whether punishment is effective in eliminating undesirable behavior and what has to be present to heighten efficacy.

b. Research also indicates that graduated sanctions work in the drug court context. Using the DC drug court, a positive drug test sanction group was compared with a group not sanctioned for positive urine testing. The graduated sanction group had significantly fewer arrests than the non-sanctioned group. Harrell, A., & Roman, J. (2001). "Reducing Drug Use and Crime Among Offenders: The impact of Graduated Sanctions." *Journal of Drug Issues*, 31 (1), 207-232.

c. Research on graduated rewards demonstrates that participants receiving graduated reinforcement achieved greater mean levels of abstinence than participants receiving fixed reinforcement. Roll, J., Higgins, S. and Badger, G. "An Experimental Comparison of Three Different Schedules of Reinforcement of Drug Abstinence Using Cigarette Smoking as an Exemplar." *Journal of Applied Behavioral Analysis*, Vol. 29, p. 495-504 No. 4 (Winter 1996).

d. A word of caution to practitioners: Some rewards may actually interfere with a person's intrinsic motivation. (See unintended consequences below). Deci, E. L., Koestner, R., & Ryan, R. M. (1999). "A Meta-analytic Review of Experiments Examining the Effects of Extrinsic Rewards on Intrinsic Motivation." *Psychological Bulletin*, 125 (6), 627-668.

4. **RESPONSES SHOULD BE DELIVERED FOR EVERY TARGET BEHAVIOR**.

a. Early animal research pointed out that punishment is only effective if it is delivered for every targeted behavior. Azrin, N. and Holz, W. "Punishment" in Honig W. (ed). *Operant Behavior: Areas of Recidivism and Application*. (Meredith Publishing 1966) pp. 381-447. Particularly p. 426 and 433.

b. Outcomes in the criminal justice context is in line with animal-based research. In work by Brennan & Mednick, those offenders who received sanctions on a continuous schedule evidenced a significantly lower arrest rate than those offenders who received intermittent sanctions. Brennan, P. and Mednick, S. "Learning Theory Approach to the Deterrence of Criminal Recidivism." Vol. 103, *Journal of Abnormal Psychology*, pp. 430-440 (1994).

c. Experts in contingency management suggest that reinforcers be used for every target behavior. Higgins, S. T., & Silverman, K. (1999). *Motivating Behavior Change Among Illicit-Drug Abusers.* Washington, D.C.: American Psychological Association. (Particularly see Kirby and Crowley pp. 334 and 349). Recent research indicates the mere opportunity to participate in getting an immediate reward can be effective in changing behavior. Participants who had clean urine tests were given an opportunity to draw paper slips from a fishbowl. Prizes indicated on the slips ranged from nothing to a dollar to a TV set. Results showed group drawing for reward was more likely to complete treatment (84% vs. 22%) and significantly more likely to be abstinent. Petry, N. M., Martin, B., Cooney, J. L., & Kranzler, H. R. (2000). "Give Them Prizes and They Will Come: Contingency Management for Treatment of Alcohol Dependence." *Journal of Consulting and Clinical Psychology*, 68 (2), 250-257. Petry, N. M. (2001). "Contingent Reinforcement for Compliance with Goal-related Activities in HIV-positive Substance Abusers." *The Behavior Analyst Today*, 2 (2), 78-85.

d. Rewards need not be something tangible to be effective in motivating behavior, praise when delivered both immediately and continuously for achieving target behavior is very effective. Deci, E. L., Koestner, R., & Ryan, R. M. (1999). "A Meta-analytic Review of Experiments Examining the Effects of Extrinsic Rewards on Intrinsic Motivation." *Psychological Bulletin*, 125 (6), 627-668.

5. **RESPONSES SHOULD BE DELIVERED IMMEDIATELY.**

a. In laboratory settings, a one hour delay in imposition of punishment has been demonstrated to decrease the sanctions' ability to change behavior. Delay in imposition of sanctions can allow other behaviors to interfere with the message of the sanction. Marlowe, D. B., & Kirby, K. C. (1999). "Effective Use of Sanctions in Drug Courts: Lessons from Behavioral Research." *National Drug Court Institute Review*, II (1), 11-xxix.

b. Similarly, experts in contingency management recommend that the uses of positive and negative reinforcements are more efficacious when imposed immediately. Griffith, J. D., Rowan-Szal, G. A., Roark, R. R., & Simpson, D. D. (2000). "Contingency Management in Outpatient Methadone Treatment: A Meta-analysis." *Drug and Alcohol Dependence,* 58, 55-66. Higgins, S. T., & Silverman, K. (1999). *Motivating Behavior Change Among Illicit-drug Abusers*, Washington, D.C.: American Psychological Association, pp. 334. Burdon, W., *et al.* "Drug Courts and Contingency Management." *Journal of Drug Issues*, 31(i), pp. 73-90 (2001).

c. What we have learned about the schedule of reinforcement from behavioral research is now being confirmed by the biomedical brain research. The effects of reinforcement appear to be exerted in the brain areas that are part of the dopamine reward system. From brain research, scientists conclude, "rewards and punishments received soon after an action are more important than rewards and punishments received later." Dayan, P., & Abbott, L. F. (2001). *Theoretical Neuroscience: Computational and Mathematical Modeling of Neural Systems.* Cambridge, MA: MIT Press.

6. **UNDESIRABLE BEHAVIOR MUST BE RELIABLY DETECTED.**

a. Early studies by Crowley and others demonstrated in a contingency management situation, abstinence must be reliably detected. Higgins, S. T., & Silverman, K. (1999). *Motivating Behavior Change Among Illicit-Drug Abusers.* Washington, D.C.: American Psychological Association. (Particularly see Kirby's chapter, pp. 330-332 and Crowley's chapter, p. 339).

b. Failure to reliably detect drug use in effect puts a person on an intermittent schedule of rewards and sanctions which is ineffectual in changing behavior. Marlowe, D. B., & Kirby, K. C. (1999). "Effective Use of Sanctions in Drug Courts: Lessons From Behavioral Research." *National Drug Court Institute Review*, II (1), 11-xxix.

c. Random and frequent scheduling of urine testing that is both quantitative and qualitative can make detection relatively foolproof. See Higgins, S. T., & Silverman, K. (1999). *Motivating Behavior Change Among Illicit-Drug Abusers.* Washington, D.C.: American Psychological Association, pp. 283-308.

d. The credibility of an intermediate sanction program is dependent upon reliable drug use detection. Torres, S. (1998). "A Continuum of Sanctions for Substance-abusing Offenders." *Federal Probation*, 62 (2), 36-45.

7. **RESPONSES MUST BE PREDICTABLE AND CONTROLLABLE.**

a. Early research in contingency management provided patients with clear, usually written agreements or contracts. Higgins, S. T., & Silverman, K. (1999).,*Motivating Behavior Change Among Illicit-Drug Abusers.* Washington, D.C.: American Psychological Association, p. 348-349.

b. Abstinence based research indicates that perceived certainty of consequence does have a deterrent effect. Obviously, this perception is based not only on what does occur but what the participant expects will

occur. See Harrell, A., & Roman, J. (2001). "Reducing Drug Use and Crime Among Offenders: The Impact of Graduated Sanctions." *Journal of Drug Issues*, 31 (1), 207-232.

c. Using a contingency management protocol "requires clear articulation of behaviors that further treatment plan goals," Burdon, W., *et al.* "Drug Courts and Contingency Management.", *Journal of Drug Issues*, 31(i), pp. 73-90 (2001).

d. Failure to specify particular behaviors that are targeted and the consequences for non-compliance can result in a behavior syndrome known as "learned helplessness where a drug court participant can become aggressive, withdrawn and/or despondent." Marlowe, D. B., & Kirby, K. C. (1999). "Effective Use of Sanctions in Drug Courts: Lessons from Behavioral Research.", *National Drug Court Institute Review*, II (1), 11-xxix.

8. **RESPONSES MAY HAVE UNINTENTIONAL SIDE EFFECTS.**

a. Punishments that are too excessive or used inappropriately may cause unanticipated side effects like learned helplessness. Marlowe, D. B., & Kirby, K. C. (1999). "Effective Use of Sanctions in Drug Courts: Lessons from Behavioral Research.", *National Drug Court Institute Review*, II (1), 11-xxix.

b. Applied research in behavior analysis suggests that negative side effects from punishment contingencies include behavioral supervision, fear, anger, escape and avoidance. Higgins, S. T., & Silverman, K. (1999). *Motivating Behavior Change Among Illicit-Drug Abusers.* Washington, D.C.: American Psychological Association p. 330.

c. Even the application of positive reinforcements can have negative unexpected consequences – the addition of bonus payments to an escalating pay schedule actually reduced weeks of cocaine abstinence. Higgins, S. T., & Silverman, K. (1999). *Motivating Behavior Change Among Illicit-Drug Abusers.* Washington, D.C.: American Psychological Association p. 335.

d. Frequency of contacts between the judge and drug court participant can actually have a negative impact on successful program completion. However, this does not apply to ASPD participants and those participants with substantial substance abuse problems. Marlowe. D. B., Festinger, D.S., & Lee, P.A. (2003), "The Role of Judicial Status Hearings in Drug Court", *Offender Substance Abuse Report*, 3, 33-46. Marlowe. D. B., Festinger, D.S., & Lee, P.A. (2004), "The Judge is a Key Component of Drug Court, *Drug Court Review*, 4, 1-34. Marlowe, D. B., Festinger, D. S.,

Lee, P. A., Dugosh, K. L., Beansutti, K. M., (2006) "Matching Judicial Supervision Hearing to Client's Risk Status in Drug Court", *Crime & Delinquency*, 52-1, 52-76,

e. Behavioral research strongly suggests that extrinsic rewards for behavior that is intrinsically motivated can actually reduce the motivation to continue that behavior. Thus, additional economic rewards for a person who intrinsically likes their work can actually reduce desire to work. Motivation by praise is the most effective way of heightening participants intrinsic motivator. Deci, E. L., Koestner, R., & Ryan, R. M. (1999).,"A Meta-analytic Review of Experiments Examining the Effects of Extrinsic Rewards on Intrinsic Motivation." *Psychological Bulletin*, 125 (6), 627-668.

9. **BEHAVIOR DOES NOT CHANGE BY PUNISHMENT ALONE.**

a. Punishment has the drawbacks pointed out under other principles (See 8(a) and (b) above.)

b. Controlled comparisons of reinforcement and punishment report that clients in the reinforcement contingency stayed in treatment while those in the punishment contingency did not. Higgins, S. T., & Silverman, K. (1999). *Motivating Behavior Change Among Illicit-Drug Abusers.* Washington, D.C.: American Psychological Association, p. 330.

c. Effects of punishment are temporary and the punished behavior returns when the punishment contingency terminates. Higgins, S. T., & Silverman, K. (1999). *Motivating Behavior Change Among Illicit-Drug Abusers.* Washington, D.C.: American Psychological Association, p. 330.

d. Punishment is most effective when used in combination with other behavior notification techniques such as positive reinforcement. Marlowe, D. B., & Kirby, K. C. (1999). "Effective Use of Sanctions in Drug Courts: Lessons from Behavioral Research." *National Drug Court Institute Review*, II (1), 11-xxix. Higgins, S. T., & Petry, N. M. (1999). "Contingency Management: Incentives for Sobriety." *Alcohol Health & Research*, 23 (2), 122-127.

f. Recent contingency management research involving stimulant abusers found that the use of prize based incentive reinforcers resulted in improved treatment retention and abstinence. Petry, N., Pierce, J. and Stitzer, M. *et. al.* "Effect of Prize-Based Incentives on Outcomes in Stimulant Abusers in Outpatient Psychosocial Treatment Programs", *Archives of General Psychiatry,* v. 82: 1148-1155 (Oct. 2005)

10. **THE METHOD OF DELIVERY OF THE RESPONSE IS AS IMPORTANT AS THE RESPONSE ITSELF.**

a. If the participant feels that the process is unfair either to him or to others, the participant will be defiant. Andreoni, J., Harbaugh, W., & Vesterlund, L. (2001)., "The Carrot or the Stick?: Rewards, Punishments and Cooperation.",Unpublished paper, National Science Foundation Grant. Sherman, L. W. (1993). "Defiance, Deterrence, and Irrelevance: A Theory of the Criminal Justice Sanction." *Journal of Research in Crime and Delinquency*, 30 (4), 445-473. Thus, the drug court judge must articulate the differences in two apparently similar situations where there is a different judicial response. Otherwise a perception of unfairness will be projected.

b. Research based upon patient physician communication has demonstrated that interpersonal skills and empathic communication can improve patient satisfaction. Hubble, M. A.,Duncan, B. L., & Miller, S. D. (Editors) (1999). *The Heart & Soul of Change: What Works In Therapy.* Washington, DC: American Psychological Association, p. 274-275.

c. Psychiatrists who are enthusiastic about the effectiveness of a prescribed course of treatment and communicate same to the client obtain a significantly higher success rate (77% to 10%). Hubble, M. A.,Duncan, B. L., & Miller, S. D. (Editors) (1999). *The Heart & Soul of Change: What Works In Therapy.* Washington, DC: American Psychological Association, p. 277.

d. Research has consistently demonstrated that the psychoactive effects of a drug can vary based upon how the physician described the expected effect. Hubble, M. A.,Duncan, B. L., & Miller, S. D. (Editors) (1999). *The Heart & Soul of Change: What Works In Therapy.* Washington, DC: American Psychological Association, p. 300-309.

e. Certain styles of participant – therapist interaction result in more compliant behaviors. For instance, in parent training, confrontational and teaching oriented approaches tended to result in non-compliant responses whereas when support and facilitation were used compliant behaviors resulted. Patterson, G. A., & Forgatch, M. S. (1985). "Therapist Behavior as a Determinant for Client Noncompliance: a Paradox for the Behavior Modifier." *Journal of Consulting and Clinical Psychology*, 53, 846-851.

f. Research involving substance abuse (alcohol) using the two styles above confrontative vs. client centered (motivational interviewing - MI) approach resulted in reduced alcohol use in MI group and less resistance to change. Lawendowski, A. L. (1998).,"Motivational Interviewing with Adolescents Presenting for Outpatient Substance Abuse Treatment.", Unpublished doctoral dissertation, University of New Mexico;. "Dissertation Abstracts International," 59-03B, 1357;. Miller, W. R., Benefield, R. G., & Tonigan, S. (1993).,"Enhancing

Motivation in Problem Drinking: A Controlled Comparison of Two Therapist Styles." *Journal of Consulting and Clinical Psychology*, 61, 455-461.

g. Motivational interviewing techniques shown to be successful include (1) let client do talking; (2) open-ended questions; (3) no more than two playbacks of what client said per main question; (4) complex reflections (playbacks) should be used at least 50% of the time when summarizing totality of clients statements; and (5) do not move beyond clients level of readiness. Do not warn confront or give unwelcome advice. Miller, B. (1999). Kaiser. "Motivational Interviewing Newsletter for Trainees," 6 (1), 1-2; Rollnick, S., & Miller, W. R. (1995). "What is Motivational Interviewing?" *Behavioral and Cognitive Psychotherapy*, 23, 325-334.

h. Even brief motivational interventions can be efficacious. Six months after enrolling in a comparison study, 22% oof those who received a brief motivational intervention tested negative for cocaine use and 40% of the opiate abusers tested negative for opiates, compared with 16% and 30% ,respectively who did not receive the intervention. Bernstein J., Bernstein E., *et. al.*, "Brief Motivational Visit at Clinic reduces Cocaine and Heroin Use", *Drug and Alcohol Dependence* v.77(1):49-59 (2005)

i. Recent research confirms that motivational interviewing techniques are effective in the drug court context. When a judge uses positive reinforcement with a participant, the number of positive urine tests is lower than when neutral or critical comments are employed. Scott Senjo & Leslie Leip, *Testing Therapeutic Jurisprudence Theory: An Empirical Assessment of the Drug Court Process*, 3 WESTERN CRIMINOLOGY REVIEW 1-21 (2001) also available at http://wcr.sonoma.edu/v3n1/senjo.html

NEW YORK STATE DRUG TREATMENT COURT EXPERIENCE

In 2007, the Office for Court Drug Treatment Programs and the Center for Court Innovation conducted a survey of New York's ninety-one criminal drug treatment court programs. The survey sought to gather basic data from the courts regarding their eligibility criteria, referral processes, and operational policies and procedures. Responses from 89 courts reflect both significant differences, (e.g. requirements and legal consequences for graduation, or methadone policies) and many common characteristics (e.g. frequent court appearances and drug testing). The results, which follow here, support the widely accepted premise that the drug court model does indeed include key components, but can be adapted to meet local preferences and resources. Reviewing how other programs approach their policies and procedures can serve two purposes. First, the data can provide a perspective or barometer for one's own program. Second, examination of other drug court operations can generate ideas about new directions or program adjustments for one's own court, such as eligibility criteria or graduation requirements.

THE DRUG COURT TEAM

Roles on Team

Drug court judge	100%
Coordinator	88%
Case managers	49%
Probation	69%
Parole	0%
Treatment agency	73%
Law enforcement	49%
Mental health agency	42%
Public defender	90%
Prosecutor	90%

45% of courts include other professional members – county drug and alcohol representative, clerk, Division of Social Services, education, faith-based organization, vocational/educational/employment representatives

Dedicated Prosecutor

Yes	88%
No	9%

Dedicated Defense Attorney

Yes	81%
No	16%

Staffings

Regular Staffings

Yes	91%
No	7%

Prosecutor at Staffings

Yes	87%
No	6%

Defense Attorney at Staffings

Yes	88%
No	7%

Case Management

Case Management

Drug court case manager/coordinator	90%
Probation	40%
Treatment provider	34%
TASC	9%

9% of courts utilize other case managers – Catholic Charities, COURTS program, mental health agency

ADMISSION PROCESS

Eligibility Criteria

Charge Severity

Violent felonies	2%
Non-violent felonies	75%
Non-violent misdemeanors	74%
Violent misdemeanors	7%
Violations	34%

Charge Type

Drug possession	99%
Drug sale	37%
DWI	73%
Non-drug	82%
Probation violator	84%
Parole violator (new criminal charge)	35%
Parole violator (technical violation)	19%

Criminal History

Prior violent felony conviction	9%
Prior non-violent felony conviction	82%
Prior violent misdemeanor conviction	31%
Prior non-violent misdemeanor conviction	93%

16% of courts cited other criteria (prior violence only if it occurred more than 10 years prior; no prior DWI; no prior weapons; no prior sex offenses)

Ineligible Characteristics

Severe mental illness	84%
Age limits	35%
Illegal immigrants	51%
No discernible drug addiction	90%
Denial of drug use	67%
Refusal to go to program	88%
Insufficient criminal history	15%
Medical reasons	57%
Prior drug court participant	40%

19% of courts considered other criteria (history of domestic violence; weapons; out-of-county resident; sex offenders)

Methadone

Yes, no restrictions	27%
Yes, but must move towards abstinence	28%
No	13%
No policy	25%
Other	7%

Screening Process

Referral to Drug Treatment Court

Automatic referral for designated charges	20%
Prosecutor	87%
Defense attorney	92%
Coordinator/case manager	53%
Non-drug court judges	64%
Multiple referral sources	56%

29% of courts receive referrals from other sources (clerks; Probation; drug court judge; law enforcement; treatment providers; pre-trial services; self-referral)

Becoming a Participant

Required to Plead Guilty before Admission

Yes	87%
No	6%
Depends on charge	4%
No policy	3%

Required to Sign Contract before Admission

Yes	91%
No	6%
Depends on case	2%

Participant Informed of Precise Incarceration Alternative

Yes, exact amount of incarceration	37%
Yes, approximate amount of incarceration	49%
Yes, promise of incarceration without a specific time	4%
No	4%
Sometimes	4%

DRUG COURT OPERATIONS

Court Appearances

Frequency of Court Appearances

Linked to Phases – 66%

Phase I	1x/week (80%)	1x/2weeks (19%)	
Phase II	1x/2weeks (80%)	1x/month (15%)	
Phase III	1x/2weeks (20%)	1x/3weeks (30%)	1x/month (47%)
Phase IV where applicable	1x/month		

Not linked to Phases – 27%

1x/week	42%
1x/2weeks	33%
Case by case determination	13%

Treatment Court Mandate

Treatment Modalities Utilized

Out-patient	49%
Intensive out-patient	71%
Rehab (28-30 days)	36%
Long-term residential	27%

Phase Structure

Courts with Phase structure	93%
Courts with no Phase structure	7%

Number of Phases

Three Phases	60%
Four Phases	28%
Five Phases	6%

Case Manager Meetings

Regular Case Manager Meetings Required

Yes	58%
No	3%
As needed	37%

Drug Testing

Frequency

Drug testing of participants is performed by multiple parties and at widely varying degrees of frequency. *Drug treatment court staff* usually test at every court appearance, which ranges from once a week to once a month. IN addition to testing at court appearances, many programs utilize a random call-in system whereby participants are called on the telephone and told to report immediately for testing. *Treatment providers* test on suspicion and/or randomly for in-patient clients, and once a week or randomly for out-patient clients. *Probation staff* test at their discretion, but at least once a week for those in early phases of the program and at least once a month for those in the later phases.

Observed

Yes	97%
No	2%

Random

Yes	70%
No	1%
Sometimes	28%

Sanctions and Incentives

Sanctions

Judicial Admonishment	88%
Essays	85%
Community Service	82%
Upward adjustment in treatment modality	69%
Increased frequency of judicial status hearings	65%
Return to previous phase	64%
Jury/penalty box	35%
Jail, 1-3 days	92%
Jail, 4-7 days	75%
Jail, 8-14 days	47%
Jail, more than 14 days	26%

24% of courts use other sanctions – curfew, daily reporting, electronic monitoring, increased drug testing

Incentives

Judicial praise	99%
Phase promotion	91%
Certificates	79%
Decreased frequency of judicial status hearings	70%
Downward adjustment of treatment modality	51%
Sober coins	36%
Tickets to events	22%

22% of courts use other sanctions – leave court early, gift cards, praise from staff, applause

Graduation Requirements

Minimum Months in the Drug Treatment Court (83%)

6 months	1%
8 months	3%
9 months	4%
11 months	1%
12 months	78%
14 months	3%
18 months	3%

Minimum Months Clean (87%)

Fewer than 6 months	10%
6-9 months	31%
9-12 months	8%
More than 12 months	43%

Community Service (19%)

Fewer than 20 hours	24%
20-40 hours	29%
More than 40 hours	12%
Case-by-case	12%

Fees

Yes	30%
No	70%

Employed or in School

Yew	72%
No	28%

High School Degree or GED

Yes	37%
No	63%

Completion of Treatment Program

Yes	72%
No	28%

Graduation Application

Yes	48%
No	52%

29% of courts included other requirements – sober support groups, alumni group involvement, victim impact panels, stable housing

Participant Can Graduate while on Methadone Maintenance

Yes	38%
No	16%
Some	6%
No policy exists	37%

Legal consequences of graduation

Vacatur of plea, all charges dismissed	21%
Vacatur of plea, plea to lesser charge	26%
Conviction stands, sentenced to conditional discharge or Probation	24%
Conviction stands, discharged from Probation	1%
Conviction stands, remain on Probation	28%

Termination Criteria

Grounds for Termination

Case-by-case decision	91%
Continued non-compliance	83%
Voluntary by participant	73%
New arrest	66%
Warrant issued	36%
Medical reason	31%
Specified number of positive drug tests	18%

Legal Consequences of Termination

Incarceration, fewer than 6 months	8%
Incarceration, 6-12 months	17%
Incarceration, 1 year	22%
Incarceration, Greater than 1 year	16%

30% of the courts responded "Other" which generally included indeterminate prison sentences or a policy of case-by-case determinations regarding period of incarceration.

Additional Resources

- Alcohol/Drug Webliography

- Commonly Abused Drugs
http://www.ncsconline.org/wc/publications/Res_JudEdu_SubstanceAbuseMaterial8Pub.pdf

- Mental Health/Alcohol and Other Drugs Glossary
http://www.ncsconline.org/wc/publications/Res_JudEdu_SubstanceAbuseMaterial3Pub.pdf

- Additional publications are available at the National Center for State Courts:
http://www.ncsconline.org/

ALCOHOL/DRUG WEBLIOGRAPHY

Prepared by Hon. Peggy Fulton Hora
Edited by Valerie Raine

AA World Services
www.alcoholics-anonymous.org
Home page of Alcoholics Anonymous General Services Office.

Addiction Treatment Forum
www.atforum.com
Home page of Addiction Treatment Forum, which contains information, research, and news for the addiction treatment field.

Al-Anon and Alateen
www.al-anon.alateen.org
Alcoholics recovery program. Fellowship of relatives and friends of alcoholics.

Alcohol and Drug Services
www.adsyes.com
Home page of Alcohol and Drug Services. Substance abuse education, prevention, and treatment services.

Alcohol Policies Project, Center for Science in the Public Interest
www.cspinet.org
Home page of Center for Science in Public Interest, which promotes health by educating the public about nutrition and alcohol.

American Academy of Addiction Psychiatry
www.aaap.org
Information on the field of Addiction Psychiatry.

American Council on Alcoholism
www.aca-usa.org
A public education group dedicated to educating the public about the effects of alcohol, alcoholism, alcohol abuse and the need for prompt, effective, readily available and affordable treatment.

American Council for Drug Education
www.acde.org
The American Council for Drug Education is a substance abuse prevention and education agency that develops programs and materials based on the most current scientific research on drug use and its impact on society.

American Foundation for Addiction Research (AFAR)
www.addictionresearch.com
AFAR is dedicated to fostering scientific research, understanding the causes and nature of addictive disorders, and disseminating this information to the public.

American Medical Association
www.ama-assn.org
Home page for the American Medical Association.

American University Justice Programs, Drug Court Clearinghouse
http://spa.american.edu/justice/drugcourts.php
The Clearinghouse and Technical Assistance Project (DCCTAP) assists justice system officials and professionals in addressing issues relating to drug court programs in their jurisdictions.

Anonymous One
www.anonymousone.com/main.htm
"A recovery resource like no other." 12 step meetings, sober living, club treatment, and more.

Anonymously Yours Bookstore
http://ay12steps.com
Recovery bookstore and gift shop, with other recovery resources.

Bureau of Justice Assistance (BJA)
www.ojp.usdoj.gov/BJA
Acting as an arm of the US Department of Justice, BJA provides leadership and services in grant administration and criminal justice policy development to support local, state, and tribal justice strategies to achieve safer communities.

Bureau of Justice Statistics (BJS)
www.ojp.usdoj.gov/BJS
Acting as an arm of the US Department of Justice, BJS collects, analyzes, publishes, and disseminates information on crime, criminal offenders, victims of crime, and the operation of justice systems at all levels of government.

Center for Disease Control and Prevention (CDC)
www.cdc.gov
The mission of the CDC is to promote health and quality of life by preventing and controlling disease, injury, and disability.

Center for Substance Abuse Prevention (CSAP)
www.samhsa.gov/centers/csap/csap.html
A division of the Substance Abuse and Mental Health Services Administration (SAMHSA), CSAP works with States and communities to develop comprehensive prevention systems that create healthy communities in which people enjoy a quality life.

Center for Substance Abuse Research, University of Maryland
www.cesar.umd.edu
Home page of Center for Substance Abuse at the University of Maryland.

Center for Substance Abuse Treatment (CSAT)
www.csat.samhsa.gov
Home page for CSAT, a division of SAMHSA. Promotes the quality and availability of community-based substance abuse treatment services.

CSAT Technical Assistance Publications (TAPs)
http://tie.samhsa.gov/TAPS/index.html
Home page for Technical Assistance Publications from the Substance Abuse and Mental Health Services Administration.

CSAT Treatment Improvement Protocols (TIPs)
http://tie.samhsa.gov/external/tips.html
Home page for Treatment Improvement Exchange TIP information.

Children of Alcoholics Foundation
www.coaf.org
National, non-profit organization that provides a range of educational materials and services on parental substance abuse.

Community Anti-Drug Coalitions of America (CADCA)
www.cadca.org
CADCA is a membership organization of over 5,000 anti-drug coalitions.

Cornell University Medical College
www.med.cornell.edu/neuro
Neuroscience web page of Cornell Medical College.

Dana Alliance for Brain Initiatives
www.dana.org/brainweb
The Dana Foundation is a private philanthropic organization with principal interests in brain science, immunology, and arts education.

Drug Court Technology
www.drugcourttech.org
Home page for Drug Court Technology, which provides technical staff and planners with an overview of how technology can improve courts.

Drug Strategies
www.drugstrategies.org
Non-profit research institution that promotes alternative approaches to drug problems throughout the United States.

DSM IV
www.behavenet.com/capsules/disorders/d4class.htm
Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition.

Dual Diagnosis Anonymous
www.ddaworldwide.org
A 12-step program for people with co-occurring mental health and addiction disorders.

Dual Recovery Anonymous
http://draonline.org
An independent, twelve step self-help organization for people with a dual diagnosis.

Hazelden
www.hazelden.org
Publisher of books on recovery, addiction, treatment, education & research.

Healthy Nations Initiative
www.uchsc.edu
University of Colorado Health Science Center.

Higher Education Center for Alcohol and Other Drug Prevention
www.edc.org/hec
United States Department of Education website for drug and alcohol prevention.

Institute on Behavioral Research
www.ibr.tcu.edu
The IBR is dedicated to evaluating and improving the effectiveness of programs dedicated to reducing drug abuse and related problems.

Johnson Institute Foundation
www.johnsoninstitute.com
The Johnson Institute Foundation is committed to improving the public's understanding of addiction as a treatable illness.

Join Together Online
www.jointogether.org
Join Together Online is a leading provider of information, strategic planning assistance, and leadership development for community-based efforts to advance effective alcohol and drug policy, prevention, and treatment.

Legal Action Center
www.lac.org

The Legal Action Center is the only non-profit law and policy organization in the United States whose sole mission is to fight discrimination against people with histories of addiction, HIV/AIDS, or criminal records, and to advocate for sound public policies in these areas.

LifeRing Recovery
www.unhooked.com/
A secular 12-Step recovery program.

MedWeb
www.medweb.emory.edu/MedWeb
Emory University MedWeb is a catalog of biomedical and health related web sites maintained by Emory University.

Methamphetamine Campaign
www.stopdrugs.org/methcrisis.html
Background information and fact sheets dedicated to methamphetamine.

Methamphetamine Treatment Project (MTP)
www.methamphetamine.org
MTP is a multi-site initiative to study the treatment of methamphetamine dependence.

Monitoring the Future Study, University of Michigan
www.isr.umich.edu/src/mtf
Monitoring the Future is an ongoing study of the behaviors, attitudes, and values of American secondary school students, college students, and young adults on a wide range of issues, including alcohol and substance use.

Mothers Against Drunk Driving
www.madd.org
A non-profit organization that focuses on the effects of drunk driving and underage drinking, and how they relate to victims of those crimes.

Narcotics Anonymous
www.na.org
Home page for Narcotics Anonymous, an international, community-based association of recovering drug addicts.

National Addiction Technology Transfer Centers
www.nattc.org
A nationwide, multi-disciplinary resource that draws upon the knowledge, experience, and latest work of recognized experts in the field of addiction.

National Association of Addiction Treatment Providers
www.naatp.org
Professional organization that represents almost 200 not-for-profit and for-profit treatment providers.

National Association of Alcoholism and Drug Abuse Counselors (NAADAC)
www.naadac.org
NAADAC's mission is to lead, unify and empower addiction focused professionals to achieve excellence through education, advocacy, knowledge, and standards of practice, ethics, professional development and research.

National Association of Drug Court Professionals (NADCP)
www.nadcp.org
NADCP is a voluntary membership organization that promotes and advocates for drug treatment courts and provides for collection and dissemination of information, technical assistance, and mutual support to association members.

National Association for Children of Alcoholics
www.nacoa.net
NACA's mission is to advocate for all children and families affected by alcoholism and other drug dependencies.

National Association of State Alcohol and Drug Abuse Directors (NASADAD)
www.nasadad.org
NASADAD's purpose is to foster and support the development of effective alcohol and other drug abuse prevention and treatment programs throughout the country.

National Center for State Courts (NCSC)
www.ncsconline.org
The National Center is an independent, nonprofit organization dedicated to the improvement of justice.

National Center on Addiction and Substance Abuse at Columbia University (CASA)
www.casacolumbia.org
CASA's mission is to inform Americans on the economic and social costs of substance abuse and its impact on their lives.

National Clearinghouse for Alcohol and Drug Information (NCADI)
http://ncadi.samhsa.gov
NCADI is the world's largest resource for current information and materials concerning substance abuse.

National Council for Community Behavioral Healthcare
www.nccbh.org
NCCBH is the trade association of mental health and substance abuse providers.

National Council on Alcoholism and Drug Dependence (NCADD)
www.ncadd.org
NCADD advocates prevention, intervention and treatment through offices in New York and Washington, and a nationwide network of affiliates.

National Criminal Justice Reference Service (NCJRS)
www.ncjrs.org
NCJRS is a federally sponsored information clearinghouse for people around the country and the world involved with research, policy, and practice related to criminal and juvenile justice and drug control.

National Families in Action
www.nationalfamilies.org
The mission of NFIA is to help families and communities prevent drug use among children by promoting policies based on science.

National Health Information Center
www.health.gov/nhic
NHIC puts health professionals and consumers who have health questions in touch with those organizations that are best able to provide answers.

National Institute on Drug Abuse (NIDA)
www.nida.nih.gov
NIDA's mission is to lead the nation in bringing the power of science to bear on drug abuse and addiction.

NIDA Club Drugs
www.clubdrugs.org
Comprehensive information on club drugs used by young adults.

NIDA Marijuana
www.marijuana-info.org
Resources regarding marijuana use, its effects and treatment.

NIDA Steroids
www.steroidabuse.org
Information on steroids and their effects.

National Institutes of Health
www.nih.gov
NIH sponsors research to help prevent, detect, diagnose, and treat disease and disability, from the rarest genetic disorder to the common cold.

National Institute of Justice
www.ojp.usdoj.gov/nij
NIJ is the research and development agency of the U.S. Department of Justice and is the only federal agency solely dedicated to researching crime control and justice issues.

National Inhalants Prevention Coalition
www.inhalants.org
NIPC is a public-private effort to promote awareness and recognition of the under-publicized problem of inhalant use.

National Judicial College (NJC)
www.judges.org
NJC provides educational opportunities for judges on a variety of topics, including substance abuse.

National Library of Medicine (Medline)
www.ncbi.nlm.nih.gov
National Center for Biotechnology Information (NCBI) creates public databases, conducts research in computational biology, develops software tools for analyzing genome data, and disseminates biomedical information.

National Mental Health Association (NMHA)
www.nmha.org
NMHA is the country's oldest and largest non-profit organization that addresses all aspects of mental health and mental illness.

National Organization on Fetal Alcohol Syndrome
www.nofas.org
Information on Fetal Alcohol Syndrome.

National Youth Anti-Drug Media Campaign
www.theantidrug.com/index.html
A multi-lingual prevention website dedicated to preventative techniques for youth.

Neuroscience for Kids
http://faculty.washington.edu/chudler/neurok.html
Neuroscience for Kids is for all students and teachers who would like to learn more about the nervous system.

Neurosciences on the Internet
www.neuroguide.com
A searchable index of neuroscience resources available on the Internet.

New York Office of Alcoholism and Substance Abuse Services
www.oasas.state.ny.us
OASAS plans, develops and regulates the state's system of chemical dependence and gambling treatment agencies. Its mission is to improve the lives of New Yorkers by leading a premiere system of addiction services through prevention, treatment, and recovery.

Partners for Substance Abuse Prevention
http://prevention.samhsa.gov
A virtual meeting place for those involved in substance abuse prevention.

Partnership for a Drug-Free America
www.drugfreeamerica.org
The Partnership for a Drug-Free America is a non-profit coalition of professionals from the communications industry, whose mission is to help teens reject substance abuse.

Physicians' Leadership on National Drug Policy
www.plndp.org
Physicians' organization, responsible for producing the films "Addiction and Addiction Treatment," and "Health, Addiction Treatment, and the Criminal Justice System."

Quitnet (Stop Smoking)
www.quitnet.org and www.quitnet.com
Information on how to quit smoking, as well as facts and statistics on tobacco use.

Robert Woods Johnson Foundation
www.rwjf.org/main.html
RWJF was established as a national philanthropy in 1972. Today, it is the largest US foundation devoted to improving the health and health care of all Americans.

Safe and Drug Free Schools Program
www.ed.gov/about/offices/list/osdfs
Federal government's primary vehicle for reducing drug, alcohol and tobacco use, and violence, through education and prevention activities in our nation's schools.

Smoke-Free Families
www.smokefreefamilies.org
A national program working to identify and disseminate evidence-based approaches to improving smoking cessation rates during pregnancy.

Society for Neuroscience
www.sfn.org
World's largest organization of scientists and physicians dedicated to understanding the brain, spinal cord and peripheral nervous system.

Society for Neuroscience Brain Briefings
www.sfn.org/briefings
Information on neuroscience for the lay audience.

Students Against Destructive Decisions (SADD)
www.saddonline.com
To provide students with the best prevention and intervention tools possible to deal with the issues of underage drinking, drunk driving, drug abuse and other destructive decisions.

Substance Abuse and Mental Health Services Administration (SAMHSA)
www.samhsa.gov
SAMHSA is the federal agency charged with improving the quality and availability of prevention, treatment, and rehabilitative services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illnesses.

SAMHSA FAS Prevention
http://fascenter.samhsa.gov
Fetal Alcohol Syndrome information and prevention materials.

SAMHSA Prevention Pathway
http://preventionpathways.samhsa.gov
Information on prevention programs, program implementation, evaluation, technical assistance, online courses, and a wealth of other prevention resources.

SAMHSA Substance Abuse and Mental Health Statistics
www.drugabusestatistics.samhsa.gov
Provides the latest national data on alcohol, tobacco, and drug abuse.

SAMHSA Substance Abuse Treatment Locater
http://findtreatment.samhsa.gov
Find the right drug abuse treatment program or alcohol abuse treatment program.

Sober Housing
www.sober.com/Directory
A national directory of sober housing.

Web of Addictions
www.well.com/user/woa
The Web of Addictions is dedicated to providing accurate information about alcohol and other drug addictions.

Wheeler Center on Neurobiology and Addiction
www.ucsf.edu/cnba/index.html
The Wheeler Center for the Neurobiology of Addiction has brought together core faculty in cellular, molecular and systems neurosciences to explore and identify the neural circuits, molecular targets and biochemical actions that help drugs of abuse take command of the brain.

White House Office of National Drug Control Policy (ONDCP)
www.whitehousedrugpolicy.gov
The principal purpose of ONDCP is to establish policies, priorities, and objectives for the Nation's drug control program.

Women for Sobriety, Inc.
www.womenforsobriety.org
A non-profit organization dedicated to helping women overcome alcoholism and other addictions.

Commonly Abused Drugs

Substance: Category and Name	Examples of *Commercial* and Street Names	DEA Schedule*/ How Administered**	*Intoxication Effects*/Potential Health Consequences
Cannabinoids			*euphoria, slowed thinking and reaction time, confusion, impaired balance and coordination*/cough, frequent respiratory infections; impaired memory and learning; increased heart rate, anxiety; panic attacks; tolerance, addiction
hashish	boom, chronic, gangster, hash, hash oil, hemp	I/swallowed, smoked	
marijuana	blunt, dope, ganja, grass, herb, joints, Mary Jane, pot, reefer, sinsemilla, skunk, weed	I/swallowed, smoked	
Depressants			*reduced pain and anxiety; feeling of well-being; lowered inhibitions; slowed pulse and breathing; lowered blood pressure; poor concentration*/confusion, fatigue; impaired coordination, memory, judgment; respiratory depression and arrest, addiction *Also, for barbiturates—sedation, drowsiness*/depression, unusual excitement, fever, irritability, poor judgment, slurred speech, dizziness *for benzodiazepines—sedation, drowsiness*/dizziness *for flunitrazepam*—visual and gastrointestinal disturbances, urinary retention, memory loss for the time under the drug's effects *for GHB*—drowsiness, nausea/vomiting, headache, loss of consciousness, loss of reflexes, seizures, coma, death *for methaqualone—euphoria*/depression, poor reflexes, slurred speech, coma
barbiturates	*Amytal, Nembutal, Seconal, Phenobarbital;* barbs, reds, red birds, phennies, tooies, yellows, yellow jackets	II, III, V/injected, swallowed	
benzodiazepines (other than flunitrazepam)	*Ativan, Halcion, Librium, Valium, Xanax;* candy, downers, sleeping pills, tranks	IV/swallowed	
flunitrazepam***	*Rohypnol;* forget-me pill, Mexican Valium, R2, Roche, roofies, roofinol, rope, rophies	IV/swallowed, snorted	
GHB***	*gamma-hydroxybutyrate;* G, Georgia home boy, grievous bodily harm, liquid ecstasy	under consideration/swallowed	
methaqualone	*Quaalude, Sopor, Parest;* ludes, mandrex, quad, quay	I/injected, swallowed	

Dissociative Anesthetics			*increased heart rate and blood pressure, impaired motor function*/memory loss; numbness; nausea/vomiting *Also, for ketamine—at high doses, delirium, depression, respiratory depression and arrest* *for PCP and analogs—possible decrease in blood pressure and heart rate, panic, aggression, violence/loss of appetite, depression*
ketamine	*Ketalar SV;* cat Valiums, K, Special K, vitamin K	III/injected, snorted, smoked	
PCP and analogs	*phencyclidine;* angel dust, boat, hog, love boat, peace pill	I, II/injected, swallowed, smoked	
Hallucinogens			*altered states of perception and feeling; nausea*/chronic mental disorders, persisting perception disorder (flashbacks) *Also, for LSD and mescaline—increased body temperature, heart rate, blood pressure; loss of appetite, sleeplessness, numbness, weakness, tremors* *for psilocybin—nervousness, paranoia*
LSD	*lysergic acid diethylamide;* acid, blotter, boomers, cubes, microdot, yellow sunshines	I/swallowed, absorbed through mouth tissues	
mescaline	buttons, cactus, mesc, peyote	I/swallowed, smoked	
psilocybin	magic mushroom, purple passion, shrooms	I/swallowed	
Opioids and Morphine Derivatives			*pain relief, euphoria, drowsiness*/respiratory depression and arrest, nausea, confusion, constipation, sedation, unconsciousness, coma, tolerance, addiction *Also, for codeine—less analgesia, sedation, and respiratory depression than morphine* *for heroin—staggering gait*
codeine	*Empirin with Codeine, Fiorinal with Codeine, Robitussin A-C, Tylenol with Codeine;* Captain Cody, Cody, schoolboy; (with glutethimide) doors & fours, loads, pancakes and syrup	II, III, IV/injected, swallowed	
fentanyl	*Actiq, Duragesic, Sublimaze;* Apache, China girl, China white, dance fever, friend, goodfella, jackpot, murder 8, TNT, Tango and Cash	II/injected, smoked, snorted	
heroin	*diacetylmorphine;* brown sugar, dope, H, horse, junk, skag, skunk, smack, white horse	I/injected, smoked, snorted	
morphine	*Roxanol, Duramorph;* M, Miss Emma, monkey, white stuff	II, III/injected, swallowed, smoked	
opium	*laudanum, paregoric;* big O, black stuff, block, gum, hop	II, III, V/swallowed, smoked	

Stimulants			
amphetamine	*Adderall, Biphetamine, Dexedrine;* bennies, black beauties, crosses, hearts, LA turnaround, speed, truck drivers, uppers	II/injected, swallowed, smoked, snorted	*increased heart rate, blood pressure, metabolism; feelings of exhilaration, energy, increased mental alertness*/rapid or irregular heart beat; reduced appetite, weight loss, heart failure *Also, for amphetamine—rapid breathing; hallucinations/* tremor, loss of coordination; irritability, anxiousness, restlessness, delirium, panic, paranoia, impulsive behavior, aggressiveness, tolerance, addiction *for cocaine—increased temperature*/chest pain, respiratory failure, nausea, abdominal pain, strokes, seizures, headaches, malnutrition *for MDMA—mild hallucinogenic effects, increased tactile sensitivity, empathic feelings, hyperthermia*/impaired memory and learning *for methamphetamine—aggression, violence, psychotic behavior*/memory loss, cardiac and neurological damage; impaired memory and learning, tolerance, addiction *for methylphenidate—increase or decrease in blood pressure, psychotic episodes*/digestive problems, loss of appetite, weight loss *for nicotine—tolerance, addiction;*additional effects attributable to tobacco exposure - adverse pregnancy outcomes, chronic lung disease, cardiovascular disease, stroke, cancer
cocaine	*Cocaine hydrochloride;* blow, bump, C, candy, Charlie, coke, crack, flake, rock, snow, toot	II/injected, smoked, snorted	
MDMA (methylenedioxy-methamphetamine)	*DOB, DOM, MDA;* Adam, clarity, ecstasy, Eve, lover's speed, peace, STP, X, XTC	I/swallowed	
methamphetamine	*Desoxyn;* chalk, crank, crystal, fire, glass, go fast, ice, meth, speed	II/injected, swallowed, smoked, snorted	
methylphenidate	*Ritalin;* JIF, MPH, R-ball, Skippy, the smart drug, vitamin R	II/injected, swallowed, snorted	
nicotine	bidis, chew, cigars, cigarettes, smokeless tobacco, snuff, spit tobacco	not scheduled/smoked, snorted, taken in snuff and spit tobacco	

Other Compounds			
anabolic steroids	*Anadrol, Oxandrin, Durabolin, Depo-Testosterone, Equipoise;* roids, juice	III/injected, swallowed, applied to skin	*no intoxication effects*/hypertension, blood clotting and cholesterol changes, liver cysts and cancer, kidney cancer, hostility and aggression, acne; adolescents, premature stoppage of growth; in males, prostate cancer, reduced sperm production, shrunken testicles, breast enlargement; in females, menstrual irregularities, development of beard and other masculine characteristics
inhalants	*Solvents (paint thinners, gasoline, glues), gases (butane, propane, aerosol propellants, nitrous oxide), nitrites (isoamyl, isobutyl, cyclohexyl);* laughing gas, poppers, snappers, whippets	not scheduled/inhaled through nose or mouth	*stimulation, loss of inhibition; headache; nausea or vomiting; slurred speech, loss of motor coordination; wheezing*/unconsciousness, cramps, weight loss, muscle weakness, depression, memory impairment, damage to cardiovascular and nervous systems, sudden death

*Schedule I and II drugs have a high potential for abuse. They require greater storage security and have a quota on manufacturing, among other restrictions. Schedule I drugs are available for research only and have no approved medical use; Schedule II drugs are available only by prescription (unrefillable) and require a form for ordering. Schedule III and IV drugs are available by prescription, may have five refills in 6 months, and may be ordered orally. Most Schedule V drugs are available over the counter.
**Taking drugs by injection can increase the risk of infection through needle contamination with staphylococci, HIV, hepatitis, and other organisms.
***Associated with sexual assaults.

SOURCE: National Institute on Drug Abuse at http://165.112.78.61/DrugsofAbuse.html

MENTAL HEALTH/ALCOHOL AND OTHER DRUGS GLOSSARY[1]

Addiction A chronic, relapsing disease characterized by compulsive drug-seeking and use and by neurochemical and molecular changes in the brain.

Adrenal glands Glands located above each kidney that secrete hormones, e.g., adrenaline.

Affect A fluctuating change in emotional "weather," as compared to **mood** which is more pervasive and sustained emotional "climate."

Agonist An agent that mimics the action of a natural neurotransmitter.

Amino acids The building blocks of proteins some of which function as neurotransmitters.

Analog A chemical compound that is similar to another drug in its effects but differs slightly in its chemical structure.

Anhedonia The inability to experience pleasure.

Antagonist An agent that blocks or reverses the actions or effects of another agent.

Antidepressants A group of drugs used in treating depressive disorders.

Anxiety A strong emotional response of fear and dread accompanied by physical signs such as rapid heartbeat and perspiration.

Anxiety Disorders

Panic Disorder (unprovoked panic attacks)
Agoraphobia (generalized irrational fear)
Social Phobia (irrational fear of embarrassment)
Specific Phobia (other specific irrational fears)
Obsessive-Compulsive Disorder (obsessive thoughts and compulsive rituals)
Generalized Anxiety Disorder (nonspecific anxiety)
Post-traumatic Stress Disorder (non-acute psychological consequences of previous trauma) and Acute Stress Disorder (acute psychological consequences of previous trauma)

Attention Deficit Disorder (ADD) A syndrome usually characterized by serious and persistent difficulties resulting in poor attention span, weak impulse control and hyperactivity in some cases. It is also linked to abnormal dopamine transmission.

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[1] This glossary was developed by Judge Peggy Hora, Alameda County Superior Court, Hayward, CA.

Buprenorphine A mixed opiate agonist-antagonist medication for the treatment of heroin addiction.

Crack Slang for a smokable form of cocaine.

Craving An emotional experience or mental state caused by a neuroadaptive change in the brain after long-term alcohol or other drug use.

Delusion A false belief based on incorrect inference about external reality that is firmly sustained despite what almost everyone else believes and despite what constitutes incontrovertible and obvious proof or evidence to the contrary.

Dependence An adaptive physiological state that occurs with regular drug use and results in a withdrawal syndrome when drug use is stopped; usually occurs with tolerance.

Depression A sustained feeling of sadness.

Detoxification A process of allowing the body to rid itself of a drug while managing the symptoms of withdrawal; often the first step in a drug treatment program.

Disorientation Confusion about the time of day, date, or season (time); where one is (place); or who one is (person).

Dissociation A disruption in the usually integrated functions of consciousness, memory, identity or perception of the environment.

Dopamine A neurotransmitter present in regions of the brain that regulate movement, emotion, motivation, and the feeling of pleasure. Alcohol, heroin and tobacco elevate levels of dopamine. A new view says it is an aid to learning and may explain why addictive drugs can drive continued use without producing pleasure.

Elevated An exaggerated feeling of well-being, or euphoria or elation. A person with elevated mood may describe feeling "high," "ecstatic," "on top of the world," or "up in the clouds."

Euthymic Mood in the "normal" range, which implies the absence of depressed or elevated mood.

Expansive Lack of restraint in expressing one's feelings, frequently with an overvaluation of one's significance or importance.

Fentanyl A medically useful opioid analog that is 50 times more potent than heroin.

Grandiosity An inflated appraisal of one's worth, power, knowledge, importance or identity.

Hallucination A sensory perception that has the compelling sense of reality of a true perception but that occurs without external stimulation of the relevant sensory organ. Hallucinations may be auditory, gustatory (involving taste, usually unpleasant), mood-congruent or -incongruent, olfactory, somatic, tactile or visual.

Hallucinogens A class of drugs such as LSD, PCP, and MDMA ("Ecstasy") which effect serotonin receptors and can cause hallucinations, distort time and space and confuse reality and illusion.

Levo-alpha-acetyl-methadol (LAAM) An FDA-approved medication for heroin addiction that patients need to take only three to four times a week.

Limbic System Parts of the cerebral cortex, hippocampus, hypothalamus and other brain structures that together function in the expression of emotional behavior.

Marijuana The dried leaves from the hemp plant *(cannabis sativa)* whose psychoactive chemical, *tetrahydrocannabinol* (THC), can produces a variety of effects such as uncontrollable laughter, paranoia and memory loss. Marijuana use causes a sharp rise in dopamine levels.

Methadone A long-acting synthetic medication shown to be effective in treating heroin addiction.

Mood A pervasive and sustained emotion that colors the perception of the world including depression, elation, anger and anxiety.

Mood Disorders

Major Depressive Disorder (major depression without mania)

Bipolar I Disorder (mania with/without major depression)

Bipolar II Disorder (hypomania with major depression)

Cyclothymic Disorder (numerous brief episodes of hypomania and minor depression)

Dysthymic Disorder (prolonged minor depression without mania/hypomania)

Neuron A nerve cell.

Neurotransmitters Chemicals in the brain allowing neurons to communicate and signal one another. They may be small molecules such as dopamine, serotonin or norepinephrine or larger protein chains called peptides. There are over 100 different neurotransmitters in the brain.

Opiates Natural brain chemicals such as endogenous opioids like endorphins or artificial drugs such as heroin or morphine which reduce pain and increase pleasure, relaxation and contentment.

Panic attacks Discrete periods of sudden onset of intense apprehension, fearfulness, or terror, often associated with feelings of impending doom.

Personality Disorders

Paranoid Personality Disorder (suspicious, distrustful)

Schizoid Personality Disorder (socially distant, detached)

Schizotypal Personality Disorder (odd, eccentric)

Antisocial Personality Disorder (impulsive, aggressive, manipulative)

Borderline Personality Disorder (impulsive, self-destructive, unstable)

Histrionic Personality Disorder (emotional, dramatic, theatrical)

Narcissistic Personality Disorder (boastful, egotistical, "superiority complex")

Avoidant Personality Disorder (shy, timid, "inferiority complex")

Dependent Personality Disorder (dependent, submissive, clinging)

Obsessive-Compulsive Personality Disorder (perfectionistic, rigid, controlling)

Pharmacokinetics The pattern of absorption, distribution, and excretion of a drug over time.

Phobia A persistent, irrational fear of a specific object, activity or situation that results in a compelling desire to avoid it. This often leads either to avoidance of the phobic stimulus or to enduring it with dread.

Physical dependence An adaptive physiological state that occurs with regular drug use and results in a withdrawal syndrome when drug use is stopped; usually occurs with tolerance.

Poly-drug user An individual who uses more than one drug including alcohol.

Post Traumatic Stress Disorder (PTSD) A condition that is caused by repeated traumas and is experienced by combat veterans, prostitutes and battered women.

Psychosis Disturbances of perception and thought processes which include schizophrenia and severe mood disorders.

Receptor A protein usually found on the surface of a neuron or other cell that recognizes and binds to neurotransmitters or other chemical messengers.

Rush A surge of pleasure that rapidly follows administration of some drugs.

Schizophrenia & Psychotic Disorders

Schizophrenia

Serotonin A neurotransmitter which excites the motor neurons governing muscle activity, quiets the sensory neurons that mediate hunger and pain, and pacifies neurons in the limbic system. Drugs such as Prozac are "selective serotonin reuptake inhibitors" (SSRIs) and can help with compulsive behaviors, depression and other mood state disorders. "Low serotonin syndrome" includes behavioral characteristics for impulsivity, aggression, violence and antisocial personality disorder. Boys have a lower level of serotonin which may explain why they are more likely than girls to carry through with suicide, become alcoholics/addicts and have ADD.

Stimulant Illicit drugs such as cocaine or methamphetamine or a licit drug such as caffeine which cause a buildup of dopamine in the synapse between neurons and intensify feelings of pleasure.

Substance-Related Disorders

Alcohol Dependence (alcoholism)

Amphetamine Dependence (stimulants, speed, uppers, diet pills)

Cannabis Dependence (marijuana, grass, pot, weed, reefer, hashish, bhang, ganja)

Cocaine Dependence (coke, crack, coca leaves)

Hallucinogen Dependence (psychedelics, LSD, mescaline, peyote, psilocybin, DMT)

Inhalant Dependence (sniffing: glue, gasoline, toluene, solvents)

Nicotine Dependence (tobacco)

Opioid Dependence (heroin, methadone, morphine, demerol, percodan, opium, codeine,darvon)

Phencyclidine Dependence (PCP, angel dust)

Sedative Dependence (sleeping pills, barbiturates, seconal, valium, librium, ativan, xanax, quaaludes)

Synapse A microscopic gap separating adjacent neurons where neurotransmitter and receptors cluster.

Syndrome A grouping of signs and symptoms, based on their frequent co-occurrence, that may suggest a common underlying pathogenesis, course, familial pattern, or treatment selection.

Tolerance A condition in which higher doses of a drug are required to produce the same effect as during initial use; often is associated with physical dependence.

Withdrawal A variety of symptoms that occur after use of an addictive drug is reduced or stopped.