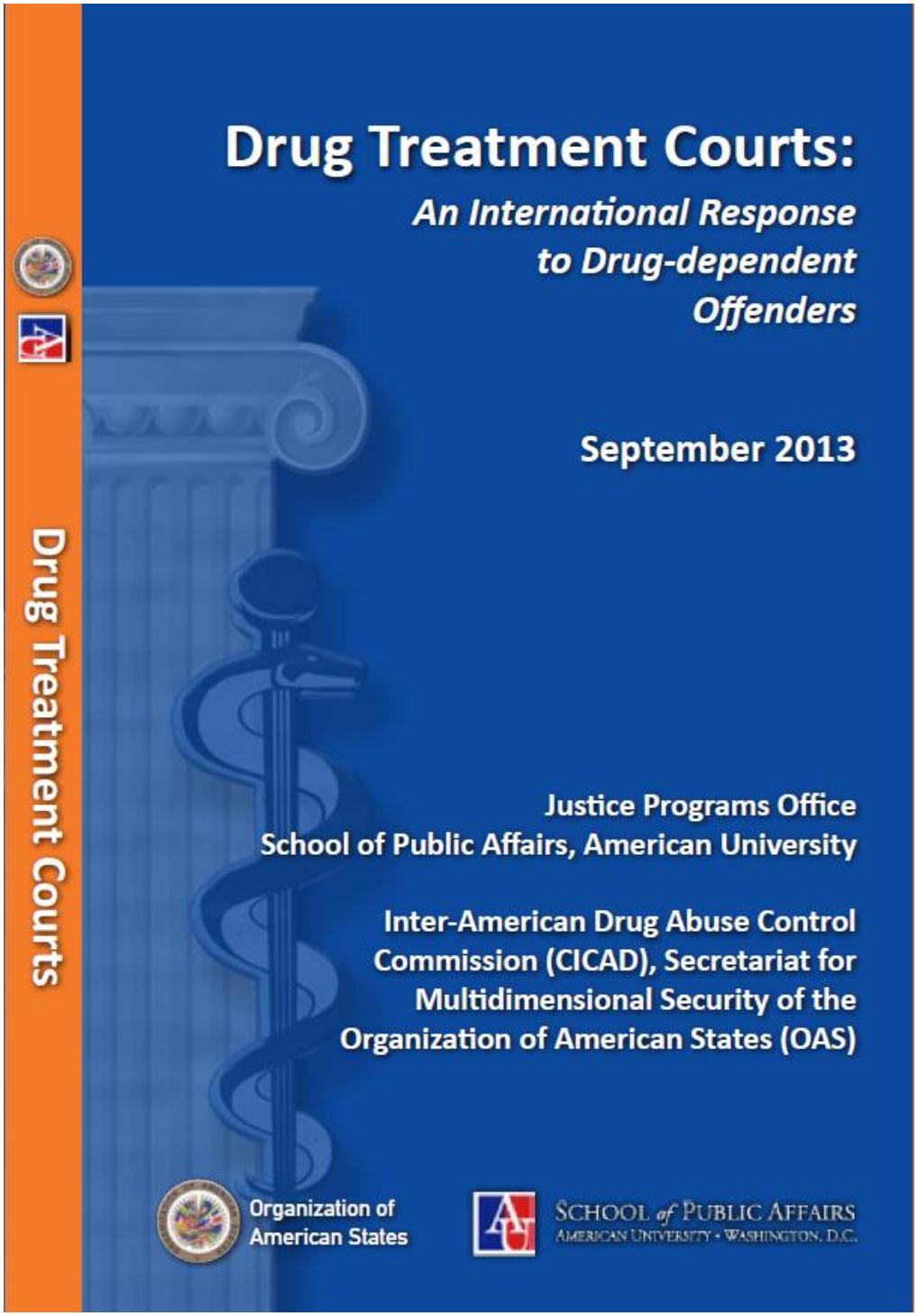
Drug Treatment Courts:
An International Response to Drug-dependent Offenders
September 2013
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In Memory of

The Honorable Justice Paul Bentley
(1940- 2011)

A Close Friend and Drug Treatment Court Pioneer

Justice Bentley was one of the architects and a contributing author to this publication. He contributed to the drug treatment court concept and practice in a very tangible way. He was a leader in convincing policy makers and professionals from all over the world, and in particular in the Americas, that investing in drug treatment courts was worthwhile for both justice and public health systems and the communities they serve. He trained and worked with judges, prosecutors, defense attorneys, treatment providers, police officers, and many more, and gave of himself freely, while doing so. In his day-to-day life as a drug treatment court judge in Toronto, he saw that his approach gave drug-dependent offenders a second chance. We miss him immensely.

DRUG TREATMENT COURTS: AN INTERNATIONAL RESPONSE FOR DRUG-DEPENDENT OFFENDERS

A practical approach to Drug Treatment Courts for Policy Makers

September 2013

This publication has been prepared as a follow-up to "Establishing Drug Treatment Courts: Strategies, Experiences and Preliminary Outcomes," prepared by the Organization of the American States (OAS) and American University in 2010 to provide an overview of Drug Treatment Court (TDC) activity in countries where these programs were being planned and/or implemented. The 2010 publication provided a snapshot of the planning issues, operational characteristics, and implementation experience of 20+ programs (in addition to those in the U.S.) that had been implemented in 14 countries along with various programmatic and policy issues that were being addressed in varying degrees. The present publication is designed to address in greater depth these major policy and implementation issues that these 20+ Drug Treatment Courts were addressing and programs will need to continue to address as DTCs mature and evolve. These relate to:

- determining who DTCs should serve;
- bringing together the justice system, public health and other sectors to work collaboratively to provide the infrastructure and support these programs require;
- developing sound treatment practices and services that reflect ongoing research findings and are adapted to the various cultures and environments in which DTCs need to operate;
- identifying meaningful performance measures that can track the impact – and benefit – of DTCs for both individual participants and the communities in which they live; and, most important,
- sharing the "lessons learned" by justice system, public health and other leaders involved with DTCs in the course of shifting policy and practice from a primarily punitive to a more therapeutic/treatment oriented response to drug use which is consistent with the findings resulting from both scientific research and practical experience.

The authors contributing to this publication are drawn from multiple disciplines and a range of countries in which the Drug Treatment Court model has been implemented and who share their perspectives and experiences regarding issues relevant to the design and implementation of drug treatment courts. The editors have made every effort to include each chapter as presented by the authors. The views expressed in each chapter do not necessarily represent the views of all contributors, nor of the sponsoring institutions.

ACKNOWLEDGEMENTS

We are deeply grateful to the authors of the chapters included in this publication. While they represent different countries, disciplines and experiences, all, are in remarkable agreement regarding the devastating impact of addiction, the barriers that must be overcome to meaningfully address it, and the promise which Drug Treatment Courts hold in developing sustained multi-agency systemic responses to addicted offenders.

Special appreciation is extended to the leaders of the Organization of American States for their vision in promoting drug treatment courts in the Americas and the support that has been provided to this initiative, including: Ambassador **James F. Mack**, former Executive Secretary of the Inter-American Drug Abuse Control Commission, Secretariat for Multidimensional Security of the Organization of American States, and Mr. **Rafael Franzini**, former Assistant Executive Secretary of CICAD for their contributions during the launch of this initiative in November 2010 and for supporting the first negotiations with OAS member states; and Ambassador **Adam Blackwell**, Secretary for Multidimensional Security of the OAS, for ensuring that the Drug Treatment Court Program for the Americas was always present in the Secretariat's agenda, and last but not least, Ambassador **Paul E. Simons**, Executive Secretary of CICAD/OAS, for his leadership in promoting the Drug Treatment Program for the Americas, allowing the program to be able to take off and expand throughout the Americas. Under the leadership of Ambassador Simons and under the Drug Treatment Court Program for the Americas, countries such as Argentina, the Bahamas, Barbados, Colombia, Costa Rica, the Dominican Republic, Jamaica, Mexico, Panama, Peru, El Salvador, and Trinidad and Tobago are currently either exploring, implementing or expanding the Drug Treatment Court model. As a result, a growing number of countries are joining others in this Hemisphere to make this model of treatment under judicial supervision is a solid reality, such as in the United States, Canada, and Chile.

We are also deeply grateful for the additional institutional support that has made this publication possible, including: the School of Public Affairs at American University which, under the leadership of current Dean **Barbara S. Romzek** and former Dean **William LeoGrande**, has provided the academic support and student assistance that made the information gathering, analytic processes and editorial tasks necessary to produce these publications possible; the National Association of Drug Court Professionals (NADCP) and, particularly Mr. **West Huddleston**, CEO, for recommendations regarding potential authors for the chapters of this publication and highlighting critical issues to address, and Judge **Jamey H. Hueston**, District Court of Baltimore City, Maryland, and Vice-Chair of NADCP, for her contributions to the workshop organized at OAS Headquarters in Washington D.C. in November 2010 for the contributing authors; the International Association of Drug Treatment Courts (IADTC), and its then Chairman, Justice **Paul Bentley**, who made it possible for us to reach out to other international contributors from the UK, Australia, and Canada; and Paz Ciudadana in Chile, and to the European Commission for the contributions made to CICAD in 2007, which resulted in the participation of our colleagues from Belgium. We would also like to thank Justice **Kofi Barnes**, current Chairman of IADTC for continuing the work of Justice Bentley in keeping the flame of the international movement alive.

Special thanks and appreciation to **Maria Agustina Cocha** and **Joseph Spadafore** for the invaluable support in the final edition efforts to have this publication ready.

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FOREWORD

The Hemispheric Drug Strategy (approved by the OAS General Assembly in June 2010) acknowledges that drug dependency is a chronic, relapsing disease that must be dealt with as a core element of public health policy. The strategy calls on member states to "explore the means of offering treatment, rehabilitation and recovery support services to drug-dependent offenders as an alternative to criminal prosecution or imprisonment."

In 2013, the OAS concluded its historic Report on the Drug Problem of the Americas as was mandated by the VI Summit of the Americas. The report analyzed a myriad of potential and actual alternatives to strengthen drug policy, including how judicial systems address drug-involved offenders. Some of the alternatives examined vary in their scope and applicability, including the use of drug treatment courts (DTCs) as one possible alternative that warrants further research and investment.

Time after time, courts in most countries are frequented by a high percentage of drug dependent individuals with similar profiles, problems and trauma history. They commit a variety of offenses, are sent to prison and/or to a treatment facility without meaningful follow-up. It is not long before these individuals return to court, crossing the same threshold; they may face the same judge, who again imposes a sentence, often ordering the offender to pursue a similar course of treatment in addition to whatever incarceration has been imposed. Follow-up rarely occurs and, even if the offender begins some treatment, it is generally not adequate to address his/her years of addiction and all of the public health, socio-economic and other impacts the addiction has caused. The individual is lost in a cycle of relapse, recidivism, and prison, with the revolving door continuing to spin, with the public bearing the social brunt of this problematic approach.

Most of our countries are facing similar repercussions from drug use: (1) high rates of crime committed by both persons under the influence of drugs and others involved with the drug trade; (2) heavy reliance upon incarcerating drug dependent offenders with no available treatment services and a resulting prison population with a high percentage of non-violent drug offenders who, without treatment, invariably commit new crime once released; and (3) Lack of meaningful follow-up with drug dependent offenders who go through the current court system except when they reappear in the police and court caseloads. The high financial – and other – costs of the current system make it imperative that the decision to pursue the development of DTCs as a less costly – and more effective -- alternative be seriously undertaken. We firmly believe that promoting DTCs should be a strategic priority for our member states, not only as a means to more effectively treat offenders with a drug abuse problem, but also to promote public safety, reduce crime and violence, encourage productive endeavors, and ultimately promote the wellbeing of our citizens and communities.

During the time this publication was being drafted, a growing number of countries approached CICAD to request help in exploring, expanding, and/or consolidating DTCs as an alternative to incarceration for drug-dependent offenders. These requests shaped our hemispheric approach when designing this publication. We wanted to provide policy makers and those responsible for the implementation of DTCs with a guidebook to assist them in addressing the key policy, interagency, and operational issues that surround DTCs implementation efforts. This report therefore compiles the experiences and insights of professionals who have been involved with the design and operations of DTCs as well as perspectives from academic and research experts working closely with them.

The OAS and American University are honored to join with the authors of the chapters in this publication to make this guidebook a reality. I believe this publication will serve as an excellent resource

for those working in various disciplines and roles within this model. We still have a long way to go in finding solutions to the problem of drug addiction and criminality. Development of DTCs, I believe, is not the only solution, but it is definitely an important step forward in the good direction.

Ambassador Paul E. Simons
Executive Secretary
Inter-American Drug Abuse Control Commission
Secretariat for Multidimensional Security
Organization of American States

INTRODUCTION

Much stress has been given to the impact of drugs and crime which is clearly enormous. The high social and monetary cost of drug trafficking and abuse in other sectors, however, has also become clear over the last forty years. The health costs of leaving drug dependence untreated are significant, and particularly for countries with fragile economies, large youth populations, and hard-pressed health care systems, untreated drug abuse is a major current and future health burden.

The cost to a country's economy and governance is also high: drug and alcohol use contribute to a significant loss of worker productivity, and the "collateral cost" of imprisonment –loss of family income while the wage-earner is in prison, stigmatization of the prisoner and his family, loss of civil rights, and stigmatization –are tangible negative impacts.[1]

Drug and alcohol impaired people pose a risk to themselves and to others when they drive a vehicle of any kind. In a survey in Canada, approximately seven per cent of drivers tested positive for illicit drugs, and one third of fatal traffic accidents were related to drug use.[2] Social costs are less able to be quantified, but we know that drug abuse is related to job loss, higher welfare costs, family disintegration, and social isolation. Preliminary studies conducted in Canada, Chile, Barbados and Costa Rica showed that by far the largest cost of drug abuse – whether by offenders or by the general population -- lies in the loss of worker productivity, that is, days absent from work.[3]

The cost to individual drug-dependent offenders is significant. Their health is often poor, and they may face a host of problems beyond their drug use and criminal behavior: they may lack stable housing, education, a job, or a family support system.

In many countries, prisons and local jails may have no drug treatment programs, which means that drug-dependent prisoners or arrestees may either go through an unsupervised and dangerous withdrawal from drugs on their own or, may find a source of supply within the prison or from visitors. Unsurprisingly, drug use does not necessarily stop at the jailhouse door.

The alternative to incarceration that we discuss in this publication is court-supervised treatment for drug dependent offenders known as drug treatment courts (DTCs).[4] A DTC is a specialized docket within a court composed of cases involving offenders who have committed nonviolent drug and drug-related offenses directly related to their substance use/addiction and who are participating in a court-supervised program of treatment and related services. A judge, trained in the special issues presented by addicted offenders, oversees the progress of participants in the Drug Treatment Court , their progress (or lack thereof) in the court-supervised treatment program through random and frequent drug testing

[1] Collateral Costs: Incarceration's Effect on Economic Mobility. The Pew Charitable Trusts: Washington, D.C., 2010. Accessed Feb. 10, 2010 at http://www.economicmobility.org/assets/pdfs/EMP_Incarceration.pdf.

[2] Canadian Center on Substance Abuse (CCSA), 2010 Roadside Surveys showed that 7.2% of drivers in a randomly selected sample tested positive for drugs, and that 33% of fatally injured drivers tested positive for drugs. http://www.ccsa.ca/2011%20CCSA%20Documents/2011_ccsa_news_release_march_28_en.pdf

[3] CICAD studies on the economic and social cost of drugs. See www.oas.cicad.org for the original studies in these countries (original languages only).

[4] Other alternatives to incarceration for drug offenders that do not entail the active and ongoing judicial leadership/oversight and supervision characteristic of TCSs have been introduced in some countries, such as through Drug Treatment and Testing Orders, or community service orders. Some jurisdictions such as Uruguay use a "diversion" scheme, whereby the court orders the offender into drug treatment, but does not supervise the treatment process. Little information is available on the outcomes of these diversion schemes~~, but see Hawken, Angela and Mark Kleiman, "Managing Drug Involved Probationers with Swift and Certain Sanctions: Evaluating Hawaii's HOPE," 2009. https://www.ncjrs.gov/pdffiles1/nij/grants/229023.pdf~~

and other supervision. DTC services generally consist of intensive outpatient treatment services, case management and additional ancillary services. A DTC thus brings together the courts, the health care system and other community services in a coordinated program that focuses upon providing intensive substance abuse and other treatment (particularly mental health) and support services (housing, educational, vocational, etc.) the offender may need, close supervision, and prompt treatment-focused responses to relapse if/when it occurs.

The authors of this publication come from different professions and from countries with different legal traditions. What brings them together is the conviction that drug treatment courts offer an effective health and public safety response for drug-dependent offenders.

Three of the ideas that run throughout this publication are central to the premises of drug treatment courts. First the research findings that drug addiction is a chronic relapsing disease, similar to asthma, diabetes, and hypertension, which can be effectively managed through professional treatment.[5] Second: the conviction that the leverage and authority of the justice system can be used to promote therapeutic objectives, including the health of individuals and the community, in addition to the rule of law – a belief imbedded in the concept of therapeutic jurisprudence. Third: a practical consideration that DTC outcomes have been shown to be better than those of imprisonment in reducing crime and drug use and the related health and social costs associated with drug dependent offenders. These ideas are discussed in this publication, with many references for further study.

The first drug treatment court was established in Miami in 1989, as a judicial response to the cycling in and out of court of the same drug-dependent offenders for the same sort of crime. The U.S. now has approximately 2,600 DTCs. Canada (13 courts), Chile (18 courts), Australia, Scotland (Glasgow and Fife), Eire (Dublin and Cork), Bermuda, Jamaica (Kingston and Montego Bay), the Cayman Islands, Belgium (Ghent and Liège), Norway (Oslo), Mexico (Nuevo Leon) followed this path by implementing the DTC model or through DTC pilot projects. Since the OAS launched the Drug Treatment Court Program for the Americas in 2010, the Dominican Republic (Santo Domingo), Costa Rica (San Jose/Pavas), Trinidad and Tobago (San Fernando), and Argentina (Salta) have also set up similar court-supervised drug treatment programs. Other countries such as Panama, Peru, Colombia, and Barbados are currently exploring the model. We could expect them to launch their first pilot projects in 2013/2014. These countries encounter similar challenges, and find common solutions as they implement the model. As described in the 2010 publication, ***Establishing Drug Treatment Courts: Strategies, Experiences and Preliminary Outcomes***, drug treatment courts have proven adaptable to varying legal and public health environments in different countries.

Drug use among offenders

Offenders as a whole are heavy users of drugs and alcohol, compared to the general population. A U.S. study in 2002 found that 68 per cent of jail inmates were dependent on or abusing drugs and alcohol and that 55 percent had used illicit drugs during the month before their offense.[6] These rates of drug and alcohol use are about eight times the rate of drug and alcohol use among the general population.[7] Arrestees are much more liable to be drug users than the general population: the U.S. Arrestee Drug

[5] U.S. National Institute on Drug Abuse (NIDA), *The Science of Addiction*, accessed at http://www.nida.nih.gov/scienceofaddiction/. For the view that addiction is not a disease, see Schaler, Jeffrey A. Addiction is a Choice. Open Court Publishing: Chicago and La Salle, 2000.

[6] Bureau of Justice Statistics. Substance Dependence, Abuse and Treatment of Jail Inmates, 2002. http://bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail&iid=1128.

[7] Males 18 and older surveyed in the 2008 National Survey on Drug Use and Health (NSDUH), the primary U.S. population survey on drug use, 8 per cent reported using marijuana in the prior 30 days.

Comment [CC1]: Re the footnote reference to Project Hope and why I deleted it. This study touts the benefits of the continued punitive response to drug addiction represented in the Project HOPE approach – e.g., "swift and certain sanctions – e.g., incarceration—for continued drug use rather than the therapeutic approach DTCs are advancing, with no focus on the clinical assessments needed to determine the needs of the individual offender, including mental health needs that can be substantial, or the recognition of addiction as a chronic disease which requires treatment and not simply punishment/sanctioning. There is also no long term positive evaluation findings from Project Hope and none that would be relevant since those offenders who are subject to Project Hope sanctions are not assessed in terms of the nature of their Substance abuse needs, mental health problems and other criminogenic factors that are so important to address in a drug court setting. Legislators like Project HOPE because it is cheap (no services) and enhances public safety (temporarily) because offenders are promptly incarcerated for continued use but it is not an appropriate response for those who are addicted and, as the research has clearly shown, will not only not stop using drugs because they go to jail, but will often have their conditions exascerbated –relected in not only continued drug use and its ramifications but, for example, the increased rate of suicides in jail and overdoses upon release.

Abuse Monitoring Program (ADAM II) found in 2009 that sixty per cent or more of arrestees interviewed tested positive for drugs, which means that they had been using drugs shortly or very shortly before their arrest.[8] Data from other parts of the world (Grenada[9] and the United Kingdom,[10]) show similar orders of magnitude.

Drug-using arrestees, many of whom are repeat offenders, are often not treated for their addiction: only a very small minority in the U.S. 2009 ADAM II survey said they had ever received any kind of treatment for their drug use. Drug treatment courts help remedy this missed opportunity for treating both drug dependence and antisocial, criminal behavior.

Some drug-dependent offenders have committed crimes in order to finance their drug habit,[11] or else have offended while under the influence of drugs and/or alcohol. Drug treatment court is an alternative to prison for these offenders, and offers the opportunity of a long-term solution to drug abuse and criminal behavior, as we shall discuss in this publication.

In Chapter 1, two of the major proponents of therapeutic jurisprudence (TJ) and solution-focused courts, David Wexler and Magistrate Michael King, look at how our understanding of addiction as a chronic, relapsing disease meshes with the idea of therapeutic jurisprudence – the full engagement of the judge and the court system in finding solutions to the health and other problems of individual offenders. This chapter provides the theoretical underpinnings for DTCs, which began over twenty years ago as a pragmatic effort led by the Miami-Dade County Circuit Court to suspend the criminal process for certain drug offenders at the front end while they were referred to intensive court coordinated treatment programs. In the chapter, Wexler and King also suggest a potential adaptation of the Drug Treatment Court Judge concept to the "back end" of the justice system process in the form of a "Correctional and Reentry Judge", already familiar in Latin America. If such a position could be infused with true TJ principles that would include respectful interactions, patient voice, behavioral contracting, and family involvement, and others that would be motivators for offender rehabilitation, the full potential benefits of Re-Entry programs could become reality. Chapter 2 details the experiences and insights of two judges who set up and ran DTCs in Canada: the late Justice Paul Bentley and Justice Kofi Barnes. The chapter provides an outstanding synthesis, from very practical experience, of the key elements that make a DTC successful as well as describe some of the modifications that were made in the Canadian DTCs as operational experience during the early years in particular warranted. The judges also stress the importance of judicial leadership and commitment of individual judges in creating drug treatment courts -- common to all DTC experience to date, in both common law and civil law countries. The Canadian DTC judges also focus on the importance of ancillary, or "wrap around" services such as those providing housing, education, and vocational services, to "reintegrate" the offender back into his community.

[8] 2009 ADAM II Annual Report, http://www.whitehousedrugpolicy.gov/publications/pdf/adam2009.pdf. ADAM consists of face-to-face interviews of adult male arrestees in police booking facilities within forty-eight hours of their arrest, combined with a voluntary urine sample. In 2009, in nine of the ten reporting sites, sixty per cent or more of these arrestees tested positive for any drugs (because many drugs disappear from the urine in a few days, this statistic means that sixty per cent of arrestees had been using drugs shortly or very shortly before they committed the crime for which they were arrested). Note that most drugs remain in the urine only for two or three days, and therefore a positive urine sample means that drug use was recent.

[9] Grendin Fact Sheet. Drug Control Secretariat, Ministry of Education and Human Resource Development, Grenada, Vol. 3, No. 1, March 2011. www.gov.gd/ncodc.html.

[10] U.K. House of Commons, Hansard Written Answers, March 7, Columns 2842W, http://www.publications.parliament.uk/pa/cm200708/cmhansrd/cm080307/text/80307w0003.htm

[11] In 2004, a U.S. Bureau of Justice Statistics (BJS) self-report survey identified the drug-crime link more precisely: 17 per cent of state prisoners and 18 per cent of federal prisoners surveyed said that they had committed their most recent offense to acquire money to buy drugs. http://bjs.ojp.usdoj.gov/index.cfm?ty=pbdetail&iid=778.

This chapter is also notable for its meshing of the two figures of "offender" and drug treatment "client" in an explicit recognition of the two faces of the DTC participant (similarly, in Ghent, Belgium, the DTC refers to its program participants as "the accused/client", see Chapter 4).

In Chapter 3, Dr. Grace Campbell of the DTC in Glasgow, Scotland, and Dr. Myo Oo of Kingston, Jamaica discuss the treatment of drug dependent offenders in a DTC setting from both a public health and a clinical perspective, providing a practitioner-oriented discussion of the critical elements of substance abuse treatment from both perspectives. Each of these physicians bring extensive experience providing drug treatment and rehabilitation for drug-dependent individuals, including drug treatment court participants. Their approaches are very similar, although they work in different social and economic circumstances: Dr. Campbell in Scotland, a country with many resources and universal health care coverage, and Dr. Oo in Jamaica, a still developing country where resources are relatively scarce. Dr. Campbell discusses the critical importance – and challenges – of the public health and justice systems working together. Dr. Oo discusses the multiple dimensions and levels of treatment and related services that are critical to an effective clinical response to drug addiction and the myriad of mental health, socio-economic, and other ramifications of the disease. Each author discusses in practical terms the multiple dimensions that effective substance abuse treatment programs must embody, whether it be multi-agency/multi-disciplinary (Dr. Campbell) or multi-dimensional (Dr. Oo). The premise of both physicians is that substance abuse is a chronic disease, with relapse frequent among patients in drug treatment, which must be addressed, whether they are or are not in a drug court program. In Chapter 4, we hear from two jurisdictions that have recently established drug treatment courts: Belgium and Mexico. Judge Jorn Dangreau and Prosecutor Annemieke Serlippens write about their experiences in Ghent, Belgium, as well as Judge Jesus Demetrio Cadena Montoya, Berenice Santamaría González and Luz María García Rivas about the DTC in the State of Nuevo León, Mexico. Belgium and Mexico are civil law countries that have found a way to introduce the DTC model without changing their laws. As Judge Dangreau and Prosecutor Serlippens note, legal systems are conservative and not given to change. It was therefore important to both jurisdictions that their new DTCs fit into the established legal context, (e.g., use of the power to conditionally suspend proceedings), and not require a major overhaul of the legal framework for implementation. This is why their DTCs when established were considered as "pilot" projects subject to evaluation. Mexico is moving its entire court system away from a paper-based case system to oral proceedings; this has meant, in the case of the DTC in Nuevo León, which the offender, judge, prosecutor, defense counsel, treatment provider and social worker can engage with each other in non-adversarial proceedings. (By contrast, Jamaica, a common law country, changed its laws to allow for introduction of DTCs). What is evident in both Belgium and Nuevo León is that their new drug treatment courts benefitted greatly from contacts with established DTCs in other countries, but then made adjustments to the model to fit local conditions.

Who is eligible to enter drug treatment court, and why? Doug Marlowe deals with this topic in Chapter 5, stressing that DTCs – with the intensity of treatment services and supervision provided – should be reserved for those offenders who are "high risk/high need" in terms of the likelihood of their completing less intensive, non-DTC programs substance abuse treatment programs. This message is reiterated by Justice Barnes in Chapter 2, who urges those involved with planning DTCs to resist the urge to widen their net to admit low-need offenders who may be equally well served by other types of rehabilitation programs. This is not to say that offenders whose drug use appears to be clinically less severe cannot benefit from participating in a DTC but, rather, that the *intensive substance treatment* services should be reserved for those deemed "high risk/high need" while other services provided by the DTC -- drug testing, less intensive counseling, housing, educational, vocational, etc., -- may still be beneficial for other drug using offenders. For this reason, some DTCs are developing multiple "tracks" for program participation and services that can accommodate the broad range of needs substance using offenders generally present.

Some DTC jurisdictions, like Chile, began by admitting only first offenders, and most programs limited their focus to people charged with a non-violent crime. Other jurisdictions, such as Jamaica, throw their net wider, and admit offenders charged with more serious offenses, provided they have been clinically assessed as being dependent on drugs. Recent research is demonstrating, as Dr. Marlowe notes, that violent offenders and individuals with a long criminal record in fact benefit quite well from drug treatment courts.[12]

The need to reach drug using youth – including the young adult population -- was a critical priority identified by almost all respondents to the 2010 Adult DTC survey. While the early successes of the adult drug court programs in the U.S. quickly prompted efforts to adapt the adult drug court model to juvenile offenders, effectively implementing and sustaining these programs has presented unforeseen challenges on a number of levels. From a clinical perspective, treating adolescents and young adults involved with drugs requires a very different approach from that used effectively with the adult drug courts – one that takes into strong account the developmental issues adolescents are dealing with that directly relate to the nature of their drug use and the treatment and related strategies that can be effective.

In Chapter 6, Michael Nerney provides insights into how various factors associated with the development of the adolescent brain affect adolescents' approach to drug use and the nature and configuration of substance abuse and mental health treatment approaches that are more or less likely to have impact.

In Chapter 7, Caroline Cooper addresses various considerations that go into developing an effective management information and evaluation capability for DTCs that looks at both (a) the quality and effectiveness of the DTC program and services as well as (b) the progress (or lack thereof) of the program participants. Orienting policy makers and others in the community to what DTCs are doing, the populations they are serving, the services they are providing and the accomplishments they are achieving as well as identifying gaps and/or other program deficiencies (e.g., employment services, housing, etc.) which may require community resources to fill necessitates the ongoing compilation of sound, accurate, and comprehensive data. The chapter also suggests a methodology for developing comparative assessments of multiple drug courts that can provide a critical foundation for then comparing the progress of the participants served by these various programs that takes into account the potentially varying quality of the programs in which these participants are enrolled.

In Chapter 8, Anna McG. Chisman draws on her experience as Head of Drug Demand Reduction in CICAD/OAS to discuss how international cooperation on drug policy has been key to the development of drug treatment courts around the world.

Chile, uniquely among civil law countries, has adopted the drug court model as a national policy, and since 2004, has created eighteen DTCs. In Chapter 9, the final chapter, Ana María Morales Peillard and Javiera Cárcamo Cáceres describe the national policy-making process, and discuss how the government and civil society organizations are organizing themselves to provide a long-term sustainable base for DTCs.

[12] Multi-Site Adult Drug Court Evaluation (MADCE). Urban Institute, RTI and the Center for Court Innovation, Washington, D.C., July 2011 http://www.urban.org/url.cfm?ID=901438

DTCs do not normally accept offenders accused of drug production or drug trafficking crimes. These types of serious crimes are governed by international conventions to which almost every country in the world has subscribed. Nor do they accept those accused of committing violent acts such as vengeance killings, which may be classified as "drug crimes".

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CHAPTER 1 PROMOTING SOCIETAL AND JURIDICAL RECEPTIVITY TO REHABILITATION: THE ROLE OF THERAPEUTIC JURISPRUDENCE

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Introduction

Drug treatment courts (DTCs) are more likely to be embraced by—and to thrive in-- jurisdictions that value rehabilitation, rather than those that are focused almost exclusively on punishing past wrongdoing. In turn, rehabilitation can be fostered by a legal system's willingness to promote the perspective and principles of therapeutic jurisprudence (TJ). This chapter will introduce TJ, touch on its relationship to DTCs, and propose a roadmap for its application in practice.

DTCs and TJ are close cousins, but they are not identical twins. DTCs began atheoretically and 'in the trenches' by practical, creative, intuitive, and frustrated judges desperate to break the revolving door cycle –arrest, conviction, sentence, release, arrest—of drug addicted offenders in the criminal justice system. In contrast, TJ began, at about the same time, as an academic approach looking at the therapeutic and anti-therapeutic impact of the law (legal rules, legal procedures, and the roles of legal actors).[1] About ten years later, in a classic article by American drug court judges Peggy Hora and William Schma, the close connection between DTCs and TJ was underscored, and a symbiotic relationship was solidly established.[2]

In fact, Judges Hora and Schma proposed TJ and its principles as a guiding theory for DTCs, and, since then, the two perspectives have been virtually inseparable. Many practices of DTCs, such as graduation ceremonies and follow-up hearings) have captured the interest of TJ scholars, and TJ writing (e.g., how judges might enhance compliance with judicial orders and conditions of release) has in turn affected the daily operation of DTCs and other so-called 'problem-solving' courts.

Nonetheless, although the conventional wisdom is that DTCs routinely 'apply' TJ principles, there are several instances where, in our judgment, drug court judges do not use what we regard as the better TJ practices—where the judges have become somewhat heavy-handed or paternalistic, for example.[3]

[1] David B. Wexler, The Development of Therapeutic Jurisprudence: From Theory to Practice, 68 Revista Jurídica Universidad de Puerto Rico 691(1999) (discussing the origin). The original paper, written and presented in 1987, was later published as "An Introduction to Therapeutic Jurisprudence", in David B. Wexler, Therapeutic Jurisprudence: The Law as a Therapeutic Agent 3 (1990) and also in David B. Wexler & Bruce J. Winick, Essays in Therapeutic Jurisprudence 17 (1991). For a short overview of therapeutic jurisprudence, see the updated essay, David B. Wexler, Therapeutic Jurisprudence and its Application to Criminal Justice Research and Development, in 7 Irish Probation Journal 94 (2010), and available online at http://ssrn.com/abstract=1628804 .

[2] Peggy Fulton Hora, William G. Schma, & John T.A. Rosenthal, Therapeutic Jurisprudence and the Drug Treatment Court Movement: Revolutionizing the Criminal Justice System's Response to Drug Abuse and Crime in America, 74 Notre Dame L. Rev. 439 (1999).

[3] One major area where TJ and DTCs differ is in the latter's sometimes compromised role of defense counsel as a 'team member.' See the discussion in David B. Wexler, Rehabilitating Lawyers: Principles of Therapeutic Jurisprudence for Criminal Law Practice 132-133 (2008) hereafter cited as "Rehabilitating Lawyers". At present, there is fortunately a clear trend towards criticizing the "compromised" role and of embracing the more robust approach advocated by therapeutic jurisprudence.

It is also the case that DTCs and TJ have been somewhat modified in their cultural transplantation from one legal system to another. See James L. Nolan, Legal Accents, Legal Borrowing: The International Problem-Solving Court Movement (2009).

Accordingly, in a later section of this chapter, we speak of how conceptualizing DTCs more as "solution-focused" courts than as "problem-solving" courts might bring DTCs even closer to TJ and its aspirations. Indeed, in our view, by adhering to the true fundamentals of TJ, societal receptivity to DTCs may increase.

Comment [CC2]: I am concerned by the reference in FN 3 to the "compromised role of defense counsel" I will follow up with David on this to see if there is other language we can use – we need to ensure the active role of defense counsel in DTCs even though David's observation may unfortunately be true.

Brief Overview of TJ

Let us, then, turn our attention squarely to therapeutic jurisprudence. TJ concentrates on the traditionally underappreciated aspect of the law's impact on emotional life and psychological well-being. It does not seek to elevate therapeutic goals above other goals—such as due process[4]—but it does urge us to be aware of the impact of the law on people's lives and, so far as possible, to promote processes that will yield therapeutic and rehabilitative results.

TJ thinking has profited from the use of several simple conceptual frameworks. In the criminal law arena, it has made use of a 'tripartite' framework for looking at how the law and legal actors may operate therapeutically (or anti-therapeutically).[5] Under the tripartite framework, we should pay particular attention to (1) the pertinent *Legal Landscape* (the rules and procedures operative in a jurisdiction), (2) the available *Treatment and Services*, and (3) the *Practices and Techniques* (the roles and behaviors) that are or can be used by legal actors, such as judges, lawyers, therapists.

The area of *Treatments and Services* is covered elsewhere in this publication by others more suited to dealing with those topics. From our legal perspective, suffice it to say here that there is ample evidence that, even in instances where services and treatments are in place (a situation that we, of course, would like to see far more often than at present), connecting persons in need with available services is often precipitated by a legal crisis, such as an arrest. In other words, like it or not, our criminal justice and legal system often functions as a type of emergency room, and thus lawyers and judges will often find themselves involved in a type of triage, even if that is not what they bargained for when they applied to law school.[6]

More within our bailiwick are the areas of *Legal Landscapes* and *Practices and Techniques*. The *Legal Landscape* is simply the applicable laws and procedures operative in a jurisdiction. The *landscape*, or some of its components, may be what we might call TJ-friendly or TJ-unfriendly. For example, harsh mandatory sentences are TJ-unfriendly, whereas a legal scheme with some flexibility in sentencing, especially as regarding the possible imposition of non-incarcerative dispositions, would be reasonably friendly. So too would be the ability to postpone for a time the imposition of sentence, thereby allowing, in some instances, a defendant to engage in a treatment program and to demonstrate his or her newly-acquired ability to live appropriately in the community.

In contrast to the established laws and legal procedures recognized by a jurisdiction, the area of *Practices and Techniques* deals with the simply-grasped notion of how judges and lawyers behave, how they interact with clients, and the like. In essence, this component of the framework relates to the highly important concept of the roles of legal actors. Does the judge introduce him or herself? Does he or she seek to pronounce correctly the defendant's name? Does the judge make eye-contact or, instead,

[4] Indeed, other justice system goals may well have therapeutic implications. A litigant denied due process, for example, is likely to feel resentment and distrust for the justice system.
[5] David B. Wexler, A Tripartite Framework for Incorporating Therapeutic Jurisprudence in Criminal Law Education, Research, and Practice, 7 Fla. Coastal L. Rev. 95(2005).
[6] Rehabilitating Lawyers, supra note 4, at 13-14.

look down at notes or at a computer screen? Does the judge ask the defendant about his or her goals? Does the judge make an effort to explain the imposed sentence? The conditions of release?

In the United States, the area of *Practices and Techniques* has received an important boost from the publication by Judges Burke and Leben of a White Paper on *Procedural Justice,* a short, readable document, available online,[7] that, in simple language and without resort to heavy scientific jargon, summarizes the psychological area of procedural justice. Judges Burke and Leben explain the importance of treating litigants with respect, of according them 'voice', and of assuring them—through 'validation'—that, regardless of the ultimate result, they are being taken seriously. Burke and Leben note that litigants often are more concerned with the fairness accorded them than they are with the actual outcome of the litigation. Therapeutic jurisprudence, which is always on the lookout for promising developments in psychology and criminology and of how insights from those developments can be imported into the law, has long looked to the area of procedural justice, for it seems litigants will accept and comply even with adverse judicial decisions if the litigants feel the process was fair.

The Burke and Leben White Paper, a product of the American Judges' Association, has been very widely distributed, and promises to 'mainstream' the procedural justice concept to the American judiciary. Through the efforts of the Puerto Rico judiciary, the paper has been translated to Spanish, and that version is also available online.

Respectful treatment of litigants should not be regarded as a controversial or unduly time-consuming matter. Importantly, studies also show public trust and confidence in the courts is higher when courts are perceived as procedurally fair and as embracing an ethic of care.[8]

It is time, then, for the procedural fairness document—or a document much like it tailored to local law and culture—to find its way to other jurisdictions. There is no good reason why its essence should not be required reading for judges and court personnel internationally. Surely, it is one very important way to increase public trust and confidence in the judicial system, to pave the way towards greater use of therapeutic jurisprudence, and to increase receptivity to drug treatment courts and the like.

When we turn our attention to matters regarding enhancing compliance with judicial orders—such as conditions of probation—and with the reduction of recidivism, the judicial application of procedural justice will take us some distance. But to make a real dent in recidivism, knowledge of procedural justice needs to be combined with knowledge of some of the principles and techniques of therapeutic jurisprudence. For instance, procedural justice does not itself deal with the important issue of the role of the family in helping an offender find his or her way. Nor does it urge judges, when pronouncing sentence (even a serious one), to emphasize an offender's strengths and to condemn the act but not the actor. These matters and many more are, however, *central* to TJ and to its recommended practices and techniques.[9] Accordingly, in a commentary[10] on the excellent White Paper, Wexler urged that the

[7] Kevin Burke & Steve Leben, Procedural Fairness: A Key Ingredient in Public Satisfaction, 44 Court Rev. 4 (2008). Court Review is available online, and the article is also linked to at the TJ website bibliography at www.therapeuticjurisprudence.org A Spanish translation is available on the TJ website bibliography and is entitled Equidad Procesal: Elemento Principal con la Satisfacción de la Cuidadanía.

[8] Roger K. Warren, Public Trust and Procedural Justice, in Bruce J. Winick & David B. Wexler (eds.), Judging in a Therapeutic Key: Therapeutic Jurisprudence and the Courts 132 (2003).

[9] David B. Wexler, Adding Color to the White Paper: Time for a Robust Reciprocal Relationship between Procedural Justice and Therapeutic Jurisprudence, 44 Court Rev. 38(2008). Court Review is available online and the article is linked to as well in the TJ website bibliography at www.therapeuticjurisprudence.org A Spanish translation is also

procedural justice white paper be distributed to American judges together with a compact, readable manual on TJ—a manual published by Canada's National Judicial Institute.[11]

> *It is our recommendation, therefore, that an appropriate procedural justice document be widely distributed to the judicial branch, ideally coupled with some judicial training sessions where feasible. Beyond the procedural justice basics, we recommend TJ resources[12] and training be offered, especially to those judges operating in a juridical context governed by a reasonably TJ-friendly legal landscape.*

TJ-friendly Legal Landscape

Jurisdictions will need to canvass their laws and procedures to assess the "TJ-friendly" features[13] but, as an important illustration, we will here focus on one important genre: the judicial role, recognized in a number of Latin American and European jurisdictions, that monitors the treatment and progress of incarcerated persons, including the granting of conditional release, the setting of specific conditions of that release, and, if necessary, the revocation of the release. This role is unknown to American law and, in fact, Wexler has proposed the key provisions of the Spanish law for consideration as a model for a US re-entry court.[14]

We will soon describe the model, which, for present purposes, we will call a *Correctional and Reentry Judge (CRJ).* First, though, it is important to note the clear cut relevance of a CRJ to our interest in drug treatment courts. True, the CRJ works at the 'back end' of the criminal process—including the

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available on the TJ site, under the title Complemento al Informe Oficial: ya es la hora de establecer una relación sólida entre la Equidad Procesal y la Justicia Terapéutica.

[10] Ibid.

[11] See Susan Goldberg, Judging for the 21st Century: A Problem-Solving Approach (2005). See www.nji.ca/Public/documents/JudgingfoR21scenturyDe.pdf. The Canadian manual was published in both English and French, and the bulk of it has also been translated to Spanish. All versions may be retrieved by searching under "Goldberg" in the bibliography of the TJ website at www.therapeuticjurisprudence.org

Note that since the publication of the Canadian manual, the recent and authoritative *Solution-Focused Judging Bench Book* was prepared by Magistrate Michael King. It is available online through several websites, including the bibliography of the TJ website at www.therapeuticjurisprudence.org , and reference to it should surely be distributed to all recipients of the White Paper and the Canadian manual.

[12] Crucial resources include the website of the International Network on Therapeutic Jurisprudence at www.therapeuticjurisprudence.org (with an important listserv one may join by sending a BLANK email to tjsp-subscribe@topica.com), an important new Facebook page at www.facebook.com/TherapeuticJurisprudence , and the website of the Australasian Therapeutic Jurisprudence Clearinghouse, available through the parent Australasian Institute of Judicial Administration at www.aija.org.au. Essential manuals are Michael S. King, *Solution-Focused Judging Bench Book* (2009) (linked to on the TJ website bibliography), and the Canadian National Judicial Institute's monograph, by Susan Goldberg, *Judging for the 21st Century: A Problem-Solving Approach* (2005)..Seewww.nji.ca/Public/documents/JudgingfoR21scenturyDe.pdf . The English and French versions, as well as a Spanish translation, are available under "Goldberg" in the bibliography at www.therapeuticjurisprudence.org

[13] For some assistance, see Arie Freiberg, Post-Adversarial and Post-Inquisitorial Justice: Transcending Traditional Penological Paradigms, online at http://ssrn.com/abstract=1609468. A somewhat shortened version is in the 8 European Journal of Criminology 82 (2011).

[14] David B. Wexler, Spain's JVP (Juez de Vigilancia Penitenciaria) Legal Structure as a Model for a Re-Entry Court, 7(1) Contemporary Issues in Law 1(2004); David B. Wexler & Jeanine Calderon, El Juez de Vigilancia Penitenciaria: Un Modelo para la Creación de Juzgados de reinserción en las Jurisdicciones Angloamericanas en Aplicación de los Principios del 'Derecho Terapéutico', 2 Rev. Española de Investigación Criminológica (2004). The Spanish journal is available online, and the article is also linked to in the TJ website bibliography at www.therapeuticjurisprudence.org

conditional release (equivalent to 'parole') of offenders—while the drug treatment court judge works at the 'front end' of the process, in a process roughly equivalent to diversion.[15]

But note that, for reasons of political acceptability, drug courts typically have rather strict eligibility requirements and routinely exclude offenders charged with more serious offenses and offenders with prior records[16]. Such exclusions are especially the case when a jurisdiction is first toying with the creation of drug (or other special) courts.[17] Where drug courts do not exist, of course, offenders are processed through the traditional criminal justice system, as they are in jurisdictions where drug court exists and but where offenders with prior records or charged with serious crimes or crimes of violence are excluded from the program. Such offenders, if sentenced to incarceration, will, in jurisdictions with a CRJ structure, fall within the jurisdiction of the CRJ. Accordingly, if CRJs are equipped to apply TJ principles in the context in which they work, they can in essence establish a 'back-end' drug treatment court. If such a court proves successful, the road seems to be paved for the later launching of a 'front-end' DTC. (Whenever created, a "front-end" DTC may, depending on the jurisdiction's legal landscape, often be instituted under an already existing provision relating to diversion, bail, or post-conviction probation. Even if not technically "necessary", however, specific authorizing legislation can be helpful in adding credibility and political durability to the newly established DTC.)

Although CRJs are common in Latin America, Panama has just enacted such a law. In a recent article parsing the law and urging that it be implemented energetically, the distinguished author, a magistrate and professor of law, noted the new law offers the opportunity for real treatment of problems such as drugs, domestic violence, and mental health[18]--areas where current lack of coordination, supervision, and treatment routinely lead to recidivism. It is noteworthy, too, that those areas—drugs, domestic violence, and mental health—are the principal areas where, in the United States at least, 'front-end' problem-solving courts have developed.

Before looking in more detail at CRJs and how they might be infused with TJ to maximize their rehabilitative functioning, let us contrast the model with the current US "back end" legal landscape. In the United States, with 'truth in sentencing' measures and other legal provisions designed to promote uniformity, discretionary parole release was abolished in the federal criminal system and in many state systems. Instead, in the federal system, a specified incarcerative term is usually followed by a period of

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[15] David B. Wexler, *Therapeutic Jurisprudence, Legal Landscapes, and Form Reform: The Case of Diversion*, 10 Fla. Coastal L. Rev. 361(2009). An online version appears at http://ssrn.com/abstract=1340705 .Of course, jurisdictions may also wish to explore front-end diversion possibilities with certain kinds of offenders. The cited article offers some TJ tips on how diversion might appropriately be implemented.

[16] Though strict eligibility standards are 'typically" the rule, especially in the United States (where federal funding is restricted to those not deemed to be "violent offenders"~~without a charge or history of violent behavior)~~, violent offenders are not universally ineligible. Thus, in the Perth, Western Australia Drug Court, where Michael King once presided, referrals are accepted from the higher courts. Occasionally, participants included young persons charged with robbery with violence.

[17] For example, "When mental health courts first emerged, most only accepted participants charged with nonviolent misdemeanor crimes. An increasing number of courts, however, are now accepting participants charged with felonies…". Hope Glassberg & Elizabeth Dodd, A Guide to the Role of Victims in Mental Health Courts viii (2008). Some mental health courts have even begun to accept participants charged with violent crimes, including domestic violence. Id. In some courts, such as the Brooklyn Mental Health court, the consent of the victim is required in order for more serious cases to be handled in there. Id at 13. The Guide is available online at http://consensusproject.org/downloads/guidetocvinmhc.pdf See also Allison D. Redlich et al, The Second Generation of Mental Health Courts, 11 Psychology, Public Policy & Law, 527-538.

[18] Juan Francisco Castillo, La Propuesta de Modificación de la Ejecución de las Penas: El Juez de Cumplimiento, Cuadernos Panameños de Criminología, Segunda Época No. 7, pp. 92,114(2008).

supervised release, and the length and conditions of that release are set at the time of sentencing. In TJ terms, this scheme is about as 'unfriendly 'as one can get.

Comment [CC3]: There have been changes in the "violent offender" restrictions per the 2007 Second Chance Act which, in essence, focuses the application to prior felonies, with misdemeanors excluded. So, rather than get into the definitions, which aren't that clear, I think we should just reference "violent offenders" I believe the 'charge" aspect is also not applicable if the "charge" was subsequently dropped or didn't result in a conviction.

The federal supervised release system constitutes a legal landscape entirely sapped of motivational strength—in no way does it reward or encourage inmate reform efforts. The length of an offender's incarceration and the period of supervised release are both set at the time of sentence imposition, as are the specific conditions of supervised release. Thus, there is no legal incentive to do well in prison in hopes of advancing one's release date. Nor is there any legal encouragement for an offender, during incarceration, to think through his or her needs and his risk factors, and to propose a relapse prevention plan with meaningful individually tailored conditions that will help in a transition to community life. Indeed, supervised release may be so far off in the future that a current challenge to the reasonableness or constitutionality of imposed release conditions may even be dismissed on ripeness grounds.[19]

It is little wonder, therefore, that a CRJ 'back-end' structure would appeal to an American TJ scholar. Indeed, in the United States, only in an isolated case like Maryland is there the possibility of true judicial sentence modification—a method found by one commentator worthy of widespread adoption because of its capacity for "changing the sentence without hiding the truth".[20] And only in certain tribal codes, but not under federal or state law, can a confined person petition the sentencing court itself for "parole".[21] Given the obvious importance of the reentry issue, the above jurisdictions would be worthwhile candidates for demonstration projects along the lines of a true reentry court, perhaps involving as well a law school clinical training program.[22]

The absence of an existing US legal structure for a true reentry court led Wexler to propose a CRJ model for American jurisdictions.[23] For present purposes, however, the recommendation includes urging CRJ jurisdictions *themselves* to consider administering their laws with a conscious application of TJ principles and thus to create a true reentry court.[24] The written provisions of the Spanish law regarding the *Juez de Vigilancia Penitenciaria* (what we are calling the CRJ) are particularly worthy of mention. In Spain, the CRJ monitors the offender through three correctional stages, and can grant, monitor, and revoke conditional release. From a therapeutic jurisprudence perspective, there are several attractive features of the Spanish law:

1. Conditional release authority resides in a single judge rather than a multi-member board, allowing for the possibility of developing a one-to-one relationship between the judge and the offender, thereby increasing the judge's motivational influence.

[19] David B. Wexler, Therapeutic Jurisprudence, Legal Landscapes, and Form Reform: The Case of Diversion, 10 Fla. Coastal L. Rev. 361,365(2009).

[20] Cecelia Klingele, Changing the Sentence without Hiding the Truth: Judicial Sentence Modification as a Promising Method of Early Release, 52 Wm. & Mary L. Rev. 465 (2010). An online version is available at http://ssrn.com/abstract=1576131 .

[21] Bruce J. Winick & David B. Wexler, The Use of Therapeutic Jurisprudence in Law School Clinical Education: Transforming the Criminal Law Clinic, 13 Clinical L. Rev. 605(2006) (discussing proposed tribal reentry court). An online version appears at http://ssrn.com/abstract=844386.

[22] Id. Another possible clinical program would be to facilitate a 'reentry moot court' for incarcerated persons about to face a parole board or other conditional releasing authority. See David B. Wexler, Retooling Reintegration: A Reentry Moot Court, 2 Chapman L. Rev. 191 (2010). An online version appears at http://ssrn.com/abstract=1526626 .

[23] David B. Wexler, Spain's JVP (Juez de Vigilancia Penitenciaria) Legal Structure as a Model for a Re-Entry Court, 7(1) Contemporary Issues in Law 1(2004).

[24] The first proposal came from Italy, and one of us (Wexler) served as co-author. S. Ciappi, et al, Therapeutic Jurisprudence. Riflessioni Su Di Una Concezione Postiberale Del Diretto E Della Pena, 12 Rassegna Italiana di Criminologia 355 (2001).

2. The judge's role begins at the time of incarceration (much earlier than when the offender becomes eligible for conditional release), allowing the judge, from the beginning, to monitor—and motivate—the offender's progress in the correctional environment.
3. Under the statute, if a prisoner has served a certain portion of the imposed sentence, is in the third (the highest) classification level, and has a good behavioral record and prognosis, conditional release should follow. Conditional release is not automatic once an offender serves a certain portion of the sentence (which would sap the system of motivational strength), nor does release lie in the unfettered discretion of the judge (which could lead to arbitrariness, helplessness, frustration and rage). Rather, a standard of "constrained discretion" seems to meet both therapeutic and justice objectives.
4. The judge can set appropriate conditions, including conditions for follow-up hearings, as part of the release process.[25]

In Europe and Latin America, there are a number of different models and patterns for a CRJ,[26] and some are likely to be more "TJ-friendly" than others. Moreover, the actual administration of such laws is likely to vary greatly, including to the extent the CRJ, expressly or more likely intuitively, engages in practices and techniques consistent with the recommendations of procedural justice and therapeutic jurisprudence. The potential for introducing TJ, however, is clear, and may be a very important step toward shifting societies toward a receptivity to rehabilitation—and to the eventual acceptance of DTCs.

Before ending this particular discussion, we should mention a closely related legal landscape where, in Anglo-American as well as Latin American and European systems, a TJ approach can be easily instituted. We refer to the confinement and release—usually the 'conditional release'--of persons found not guilty by reason of insanity. Typically, those confined patients, by statute, appear periodically before a judge who decides on continued confinement or conditional release. TJ writing has carefully detailed how a judge familiar with 'health care compliance principles' might structure the periodic review process so as to increase offender compliance with eventually imposed conditions of release.[27] The principals involved include communication style, respectful interactions, patient voice and behavioral contracting, involvement of the family, and a number of others.

In many jurisdictions, a judge, similar to the CRJ described earlier, will monitor and make discharge decisions regarding mental patients found not responsible for criminal acts.[28] If infused with TJ principles, these procedures can in essence constitute a back-end mental health court. Sweden has a unique system which, in a way, combines the mental health model with the criminal justice model: Sweden does not recognize an insanity defense, but seriously mentally ill offenders may, after conviction, be sent to a forensic psychiatric facility, where their eventual release—or 'outpatient commitment' to the community as a transitional measure-- is in the hands of a county administrative judge.[29] Accordingly, the Swedish system would also be a "TJ-friendly" one, where county administrative

[25] Rehabilitating Lawyers, supra note 4, at 17-18.
[26] The article from Panama in note 19, supra, notes somewhat similar courts in Brazil, Argentina, and Venezuela. Colombia has a similar structure, and France too has a judge who administers sentences. See Arie Freiberg, supra note 14.
[27] David B. Wexler, Health Care Compliance Principles and the Insanity Acquittee Conditional Release Process, in David B. Wexler & Bruce J. Winick, Essays in Therapeutic Jurisprudence 199 (1991). The text of that chapter (without references) is reprinted in Judging in a Therapeutic Key, supra note 9, at 213.
[28] For example, Colombia.
[29] Moa Kindstrom Dahlin et al, Mentally Disordered Criminal Offenders: Legal and Criminological Perspectives, 32 Int'l J. of Law and Psychiatry 377 (2009).

judges could be encouraged to apply TJ principles likely to improve offender compliance and their sense of having been treated fairly.

As the Swedish law illustrates, potentially TJ-friendly legal provisions may be unearthed even in provisions that fall outside the typical juridical pattern. It is therefore important for legal practitioners and scholars to canvass the law in their particular jurisdictions and to search for statutes that may be applied in a therapeutic manner.

We have already discussed not only some of the legal landscapes appropriate for initial TJ activity, but have also mentioned a number of the TJ practices and techniques that ought to be applied by judges operating in those favorable landscapes. Magistrate King has recently published an extensive bench book discussing the major techniques.[30] Before closing, we wish to summarize some of the most important of these, as well as return to the issue we mentioned at the outset of the chapter: that, in practice, many drug treatment courts, while properly applying a number of TJ practices, have in some important instances engaged in practices different from those recommended by the TJ literature. Since it is our view that adherence to the TJ practices will lead to the best results, in this final section we review some major TJ principles and urge their application both in general application and in those drug treatment courts already in existence as well as in those that will be created in the future.

Applying TJ principles in judging in DTCs

TJ emphasizes the value of ensuring that the law, legal institutions such as courts and tribunals and legal actors such as judges and lawyers take therapeutic values into account in their work. It also emphasizes the need for them to be informed by research concerning the processes by which these values may be promoted. DTCs and other species of what have commonly been known as problem-solving courts have a therapeutic purpose in that they seek to promote participants' positive behavioral change.

Accordingly, judges, lawyers and other professionals involved in these courts should be aware of the nature of positive behavioral change, the stages of the change process, practices that promote change and those that inhibit the change process. The actions of judges and lawyers should, as far as possible, be consistent with behavioral change principles and findings. However, as we shall discuss later, sometimes other values must trump therapeutic values in a DTC and the response of a judge must be determined in accord with those values.

It is widely acknowledged that in many cases improvements in individual health or behavior often occur due to the individual's own internal processes, without recourse to treatment.[31] In the area of behavioral change – such as desisting from substance abuse – it has been called "self-change" or "natural change".[32] Even in the case of offending there is evidence that desistance often occurs due to the individual's own efforts.[33] Of course, given that these individuals are commonly members of families and communities, there may also be family and social supports that uphold the individual's efforts to change.

[30] King, supra note 12.
[31] Carlo C. DiClemente, Natural Change and the Troublesome use of Substances: A Life Course Perspective, in William R. Miller & Kathleen M. Carroll (eds.), Rethinking Substance Abuse: What the Science Shows and What We Should Do About It 81 (2006).
[32] Harald Klingemann & Linda Carter-Sobell (eds.), Promoting Self-Change from Addictive Behaviors: Practical Implications for Policy, Prevention and Treatment (2007).
[33] Stephen Farrall, Rethinking What Works with Offenders: Probation, Social Context and Desistance from Crime 25 (2004).

DiClemente suggests that even where there has been external intervention to support behavioral change – such as in the case of substance abuse counseling – the process of change is a product of the individual's internal change processes and the treatment. He describes treatment as "a time-limited, circumscribed experience that interacts with and hopefully enhances the self-change process on the way to recovery."[34]

Writing in the context of the rehabilitation of people with substance abuse problems, DiClemente notes there are particular processes that the individual must undergo in effecting their behavioral change:

> Substance users have to become *concerned* about the need to change, become *convinced* that the benefits of change outweigh the costs provoking a decision to change, *create* and *commit* to a viable and effective plan of action, *carry out* the plan by taking the actions needed to make the change, and *consolidate* the change into a lifestyle that can sustain the change.[35]

The process of recovery from substance abuse is not necessarily smooth nor is it always sequential. Relapse and recovery from relapse are a natural aspect of recovery from substance abuse – a fact commonly acknowledged by DTCs.[36]

As with the case of treatment generally, a TJ approach to judicial and legal practice in DTCs, other problem-solving courts and in court based rehabilitation programs generally regards the intervention of the court as "a time-limited, circumscribed experience that interacts with and hopefully enhances the self-change process on the way to recovery".[37] It acknowledges the primary role of the individual as change agent. As Winick notes:

> [T]he problem solving judge cannot simply order the individual to recognize the existence of the [offending-related] problem and to obtain treatment. People must come to these realizations for themselves. Therefore, problem solving court judges must understand that although they can assist people to solve their problems, they cannot solve them. The individual must confront and solve her own problem and assume the primary responsibility for doing so.

It is questionable how far DTCs have applied this principle. As King points out, it is not one of the ten components said to be essential in a DTC.[38] It has been suggested that these courts developed on the basis of what was considered to be best practice rather than being guided by the processes by which people undertake positive behavioral change.[39] Concepts and practices that have been common in mainstream judging – such as the court as problem-solver and the use of imprisonment to promote compliance – have been transposed to DTCs but for a therapeutic purpose. The concept of the court as problem-solver is entrenched in the DTC and problem-solving court literature and in DTC practices. For example, Nolan reports that one DTC judge told the mother of a DTC participant: "What did I tell you? Didn't I tell you I'd give you a new daughter? Right out of the factory".[40]

[34] DiClemente, supra note 32, at 92.
[35] DiClemente, supra note 32, at 82.
[36] As to relapse, see Carlo C. DiClemente, Addiction and Change 181-185 (2003).
[37] DiClemente, supra note 32, at 92; Michael S. King, Should Problem-Solving Courts be Solution-Focused Courts, 80 Rev. Jur. U.P.R.. 1005 (2011).
[38] King, supra note 38.
[39] King, supra note 38.
[40] James J. Nolan Jr., Reinventing Justice: The American Drug Court Movement 10 (2001).

Practices that are regarded as coercive in mainstream courts – such as the use of imprisonment – are seen to be worthwhile and therapeutic when used by a DTC as they are seen to promote obedience in relation to program conditions which participants have consented to upon entering the DTC program.[41] The degree to which punitive practices are being used in DTCs and their impact is receiving increased attention in light of research findings from evidence based practices. However, DTCs commonly use other practices not known to conventional judging in an endeavor to solve participants' substance abuse – such as collaborative decision making about participants' rehabilitation needs and programs by a multi-disciplinary team and the use of various sanctions and rewards to promote participant compliance with those decisions. These are processes external to the individual and that do not usually involve them in decision-making concerning their rehabilitation.

TJ suggests that judging and legal practice in a DTC or other court program whose purpose is promoting behavioral change should be directed at supporting the participants' internal change mechanisms as they seek to accomplish the tasks needed for change and at providing the external supports – including treatment – that can help to uphold the individual's efforts.

The TJ approach to judging and legal practice in these courts sees these legal actors as facilitators rather than problem-solvers.[42] To suggest that it is the court, the judge, the lawyer, other professionals or a combination of them that solves the participants' problems is to discount the individual's change processes and their primary role in promoting change. It also does not acknowledge the subtle nuances of participant experience in these programs.[43] For example, individuals may have already begun the change process – the process of solving their problems – prior to entry into the court program, by developing and/or implementing change strategies. While in the court program they may on their own initiative devise and instigate strategies to address their substance abuse and other underlying issues. There may also be participants who will need to continue to refine and apply strategies to complete the change process long after their time in the court program has ended.[44] To suggest in such cases that it is the court that solves the problem is inconsistent with research concerning how behavioral change happens.

There is also a risk that judges and lawyers in therapeutic court programs who see themselves as problem-solvers may use strategies that inhibit participants' internal change mechanisms by undermining participants' confidence in their own strengths and their ability to effect change (self-efficacy). This approach can send a not too subtle message to participants that they must rely on others to effect change for them.[45] For example, a DTC judge who calls a participant a baby is likely to undermine the participant's self-efficacy.[46] Similarly, a judge who does not involve a participant in devising a plan to address his or her relapse, but simply tells the participant what to do to avoid relapse and informs him or her of the penalties for not complying or just imprisons him for a short period to promote compliance also may undermine self-efficacy.

[41] Admittedly, the periods of imprisonment imposed as a sanction for non-compliance in a DTC are significantly shorter than those commonly used by mainstream criminal courts and designed to address instances of willful noncompliance rather than continued drug use where enhanced treatment is a more appropriate response. As to the differences between the use of imprisonment in mainstream courts and DTCs, see: Peggy F. Hora & Theodore Stalcup, Drug Treatment Courts in the Twenty-First Century: The Evolution of the Revolution in Problem-Solving Courts, 42 Ga L. Rev. 717 (2008).

[42] King, supra note 12, at 4.

[43] King, supra note 38.

[44] King, supra note 38.

[45] King, supra note 12, at 3-4.

[46] A DTC judge was observed to call a participant a baby, see Nolan, supra note 41, at 10.

The TJ approach does not discount the weaknesses that DTC participants have shown in that they have committed offences as a result of a substance abuse problem that hitherto they have not been able to overcome. But it says these participants are also the source of strengths and possible solutions for their problems.[47] The court should acknowledge both aspects of their nature, involving participants' strengths in aid of the change process and facilitating them addressing their weaknesses. Judging that applies TJ in a problem-solving court has been compared to transformational leadership, an approach whereby leaders help inspire others to higher levels of achievement and satisfaction in their work or other activity.[48]

We suggest that *if* a TJ approach is taken in DTCs, family violence courts, community courts, mental health courts and the like, then they should not be regarded as problem-solving courts. The preferable term we suggest is "solution-focused court", for the court, court team and participants are working collaboratively to develop and implement solutions to the participants' offending related problems.[49] Here the participant is respected as a source of solutions and as the primary change agent, supported by the court team and external agencies.

Key TJ strategies the court would apply in taking a solution-focused approach would include:[50]

1. *Promoting participant choice wherever possible*. For example, participants should be given the choice whether to enter the DTC program and, if they are admitted into the program offered choice in relation to the treatment programs in which they engage.[51] Giving participants' choice promotes intrinsic motivation – doing something because it is interesting and satisfying rather than due to external pressures – which is associated with greater performance, health and wellbeing.[52] While the nature of the choice open to participants as to whether to enter the program may be very limited, due to the possible alternative of their case being processed in the conventional way (resulting in immediate imprisonment), it is the participant's own actions that have placed him or her in that situation.[53]
2. *Asking participants to formulate rehabilitation plans setting out their goals for their time in the program and beyond and the strategies they intend to pursue in order to achieve these goals.*[54] *The exercise has several benefits*.[55] For example, it not only promotes participant autonomy but also allows them to tap into deep internal sources of motivation within. It also gives the judge and court team the opportunity of making a more significant connection with participants by giving them an understanding of the dreams and sources of motivation of participants. It provides a basis for supporting the self-efficacy of participants – such as by congratulating

[47] King, supra note 12.
[48] Michael S. King, Problem-Solving Court Judging, Therapeutic Jurisprudence and Transformational Leadership, 17 J. of Jud. Admin 155 (2008).
[49] King, supra note 12; King, supra note 38.
[50] These strategies are discussed in greater depth in Bruce J. Winick, Therapeutic Jurisprudence and Problem Solving Courts, 30 Fordham Urb. L.J.. 1055 (2003); Judging in a Therapeutic Key, supra note 9; King, supra note 12, at 151-182. While the focus of our discussion is on the application of these principles by judges, lawyers should also be guided by them in representing clients in DTCs. See, Rehabilitating Lawyers, supra note 4 and Michael S. King, Therapeutic Jurisprudence and Criminal Law Practice: A Judicial Perspective, 31 Crim L.J. 12 (2007)..
[51] Winick, supra note 51, at 1072-1073.
[52] Edward L. Deci and Richard M. Ryan, Facilitating Optimal Motivation and Psychological Well-Being Across Life's Domains, 49 Can Psychol. 14, 15 (2008).
[53] Winick, supra note 51, at 1074.
[54] Winick, supra note 51, at 1085; David B. Wexler, Robes and Rehabilitation: How Judges can help Offenders Make Good, 38(1) Court Rev. 18 (2001). .
[55] King, supra note 49, at 167.

participants when they achieve a goal – and of engaging with participants when problems arise in order to tap internal sources of motivation to address the problems. According to Locke and Latham, having goals focuses attention and effort on activities directed to achieving those goals, and is energizing, promotes persistence and can otherwise contribute to performance through the discovery of knowledge and strategies directed to achieving the goals.[56]

3. *Including participants' rehabilitation plans as part of behavioral contracts*. Behavioral contracts are commonly used in health settings to promote compliance with treatment.[57] But they are also used in business, educational and family contexts. Their use in a court or other legal setting can produce a variety of benefits, including promoting compliance, according a participant respect as a person worthy of being a party to a contract with the court, promoting participant self-efficacy and giving the parties a reference point as to the obligations of the parties in relation to the DTC or other court program.[58] For example, a court can praise a participant and reinforce his or her self-efficacy as the participant fulfills a behavioral goal. If there has been a problem with performance, a court can refer to the participant's own goals as included in the behavioral contract as part of a discussion with the participant as to what happened and in facilitating the participant devising a prevention strategy.
4. *Having positive (but realistic) expectations concerning participant achievement*. In educational and business settings, positive expectations are associated with higher student and employee performance.[59] Having positive expectations may promote a form of interaction and a willingness to do more. Often participants in DTCs are people for whom the justice system and society generally have had low expectations. A negative response from justice system officials in the past may have helped to reinforce participants' low self-concept and self-efficacy. A TJ approach involving positive expectations and interaction with participants in a problem-solving court program may well have the opposite effect, promoting participant rehabilitation and improvement in self-efficacy.[60]
5. *Promoting self-efficacy*. Self-efficacy refers to a person's belief in his or her ability to function competently.[61] Research has found that it is significantly related to motivation and performance.[62] In the context of a DTC, self-efficacy refers to a participant's belief in his or her ability to recover from substance abuse and to lead a constructive, happy and law-abiding life in the community. This is particularly important given that the justice system may have reinforced participants' negative self-efficacy in the past.[63] Facilitating participants' formulation of their rehabilitation plans and relapse prevention plans (where necessary) and reinforcing their ability to implement them, having participants reflect on how they achieved particular goals, and praising them for that achievement and the use of behavioral contracts are some methods judges can use to promote participants' self-efficacy.

[56] Edwin A. Locke & Gary P. Latham, Building a Practically Useful Theory of Goal Setting and Task Motivation: A 35-Year Odyssey, 57 Am Psychol. 705 (2002).
[57] Winick, supra note 51, at 1084-1088; Wexler, supra note 55.
[58] Winick, supra note 51, at 1084-1088; Wexler, supra note 55; King, supra note 12, at 170-171.
[59] E.g., Nicole M. Kieran & Michael A. Gold, Pygmalion in Work Organizations: A Meta-Analysis, J. Organizational Behavior 913 (2000).
[60] See, Shadd Maruna et al., Pygmalion in the Reintegration Process: Desistance from Crime through the Looking Glass, 10 Psychol., Crime & L. 271 (2004).
[61] Albert Bandura, Social Foundations of Thought and Action: A Social Cognitive Theory (1986).
[62] E.g., Albert Bandura & Edwin A. Locke, Negative Self-Efficacy and Goal Effects Revisited, 88 J. Applied Psychol. (2003); Alexander D. Stajkovic & Fred Luthans, Self-Efficacy and Work-Related Performance: A Meta Analysis, 124 Psychol Bull 240 (1998).
[63] King, supra note 12, at 165.

6. *As far as possible avoiding a coercive and/or paternalistic approach to addressing problems with participants' performance while engaging in the DTC program.*[64] Problems should be seen as "a challenge along the way to permanent behavioral change".[65] While condemning the person for his or her relapse or taking a confrontational approach in order to promote compliance has the risk of undermining participant self-efficacy and promoting resistance to change, an approach that is empathetic to the participant's situation and that engages him or her in devising and implementing a relapse prevention strategy is likely to support internal motivation to change and self-efficacy. In taking the latter approach, the judge asks the participant to explain what happened in relation to the relapse or other problem with performance, demonstrates active listening while the participant is giving the explanation, expresses empathy for the participant's situation as appropriate, does not use confrontational tactics or otherwise engage with participant resistance, invites the participant to develop a strategy to prevent relapse or avoid the other problem in the future, and promotes the participant's self-efficacy in implementing the strategy. However, there may be occasions where such an approach has already been used without success or where other justice system values require a coercive approach to be used.[66] DTCs and similar courts not only seek to promote the rehabilitation of participants, they must also take into account other judicial values, including participant accountability, program integrity, the wellbeing of the court team and the requirements of statute and common law.[67] A court will often need to balance what is a reasonable time in which to allow a participant to become drug-free – including recognizing periods of relapse as a natural part of recovery – along with the need to promote participant accountability and program integrity. The outcome in some cases will be the termination of a participant from the program.
7. *The sensitive use of intrapersonal and interpersonal skills, including active listening and other listening skills, proper body language, selective use of language according to the therapeutic and other needs of the situation and methods of promoting dialogue with participants.*[68] The ability to manage one's own emotions and the emotions of others is also important. For example, a participant may be despondent when appearing in court following a relapse. Being empathetic in the judicial response is important in assisting a participant in addressing the relapse. Intrapersonal and interpersonal skills are essential to the proper use of the other techniques of solution-focused judging.
8. *The use of non-confrontational methods of engagement with participants in order to promote behavioral change – such as motivational interviewing techniques and persuasion*.[69] For example, where the judge, lawyer or court team wants a particular goal or strategy included in a participant's rehabilitation plan or relapse prevention plan, instead of simply imposing the condition, they could, where appropriate, acknowledge the value of existing strategies and make a suggestion that an additional goal or strategy be included. They could offer reasons in support of their suggestion. If the participant raises objections, then a process of persuasion could be used to try to reach agreement. Care needs to be taken to ensure that overuse of

[64] A more detailed discussion of this approach appears in King, supra note 12, at 160-162.
[65] King, supra note 12, at 160.
[66] King gives the example of a case where a participant was remanded in custody for consideration for placement in residential rehabilitation after the court had given the participant an opportunity of implementing her rehabilitation in the community but had been engaged in chronic relapse. The participant later acknowledged that this was the best course of action for her and successfully completed her court program: King, supra note 49, at 171.
[67] King, supra note 12, at 198-199.
[68] Winick, supra note 51, at 1068-1071; King, supra note 12.
[69] Winick, supra note 51; Judging in a Therapeutic Key, supra note 8; King, supra note 12, at 174-179.

persuasion does not lead to an undermining of a participant's self-determination and self-efficacy.[70]

Taking a solution-focused approach to judging is perhaps the most graphic illustration of a growing awareness in the judiciary of the importance of the interpersonal dimension of judging and the need for the exercise of intrapersonal and interpersonal skills appropriate to the task.[71] Such skills are not only necessary for therapeutic purposes but also for the performance of the basic technical functions of the court – such as the taking and interpretation of evidence, the making and delivery of decisions and the communication of those decisions to the parties and wider community (which, of course, may have therapeutic aspects).[72]

TJ Mission Statements

Once judges have a reasonably clear understanding of the principles and potential application of therapeutic jurisprudence, it is in our view very helpful to "legitimate" the invocation of those principles. One method that seems to have been quite successful is through the drafting, approving, and publishing of judicial "mission statements." Indeed, there are already a number of such statements that can be looked to for guidance.[73] These include, among others, the 2000 Resolution adopted in the United States by the Conference of Chief Justices & Conference of State Court Administrators, supporting the use of therapeutic jurisprudence principles,[74]and the 2004 Western Australia Country Magistrates' Resolution Adopting Therapeutic Jurisprudence.[75]The existence of such documents both encourages their use and, at the same time, insulates judges somewhat from criticism from those wary of innovation.

The mission—or 'vision'—statements, although often necessarily somewhat vague, will nonetheless lead to some rather concrete judicial "do's and don'ts." Consider, for example, the Vision Statement for District Court of Clark County, Washington.[76] That vision statement specifically embraces the use of principles of therapeutic jurisprudence to "make a positive change in the lives of people who come before the court." One guiding value is that "individuals are not condemned to a life of crime or despair by mental condition or substance abuse and that everyone can achieve a fulfilling and responsible life." Another is the belief that everyone, no matter whom, has something positive within their makeup that can be built upon.

A judge operating under this vision and with these guiding values should not regard the above language as mere fluff. Such a judge, for example, is unlikely to tell a woman –as one judge actually did-- that she is simply "no good as a mother." And even when imposing a severe sentence, such a judge is unlikely to say—as one judge did—that "you are a menace and a danger to society; society should be protected from the likes of you."[77] Instead, a judge committed to the vision statement should search for and comment on whatever favorable features might eventually be woven together by the offender to create a positive narrative for the future—even if he or she is now facing a substantial period of confinement.[78]

[70] King, supra note 12, at 174.
[71] Michael S. King, Realizing the Potential of Judging, 87 Monash U. L. Rev. 171 (2011).
[72] Id.
[73] See, e.g., the section entitled "Preliminary 'Codifications' of Therapeutic Jurisprudence Principles, in Judging in a Therapeutic Key, supra note 8, at 111-127.
[74] Id. at 112-114.
[75] Reprinted on p. 39 of the Canadian manual Judging for the 21st Century: A Problem-Solving Approach (2005).
[76] See Judging in a Therapeutic Key, supra note 9, at 124.
[77] Id. at 252.
[78] See Wexler, supra note 55.

These mission or vision statements, therefore, are most useful for reinforcing the TJ principles and in guiding judges in using them and, in fact, in contributing to their further development and refinement.

Conclusion

Earlier, we mentioned studies indicating greater satisfaction by litigants in judicial systems sensitive to procedural justice and therapeutic jurisprudence.[79] There is more good news: the increased satisfaction extends to judges sitting in courts with such an emphasis.[80] Professional satisfaction soars when judges feel they are doing some good, are appreciated, and are doing far more than insuring routine maintenance on a revolving door.

A desire for real professional satisfaction may well lead a number of judges to engage with TJ in their work. Many, when exposed to the TJ subject matter, will note that they have been doing some TJ all along—albeit implicitly, unsystematically, and without a name. But with a vocabulary, a literature, and a conceptual framework, those same receptive judges will find TJ to be more powerful and far more plentiful—they will expect to constantly see new potential applications and develop new practices and techniques.[81] (This dynamic character, incidentally, underscores the importance of judges remaining actively involved in the TJ project through the key websites and list serves--TJ is not merely a packet of materials to be learned and then applied; much of the growth in the field is now itself coming from practitioners, and all of us need to share information to keep up to date.)

There will always be some judges resistant to the approach, though rarely to the point of opposing its use by other judges. A technique one of us uses in general judicial training sessions is to present the material—for example, offenders are more likely to comply with probation conditions if they themselves have suggested them as a way of staying out of trouble--and then to present also the interesting psychological study on thought-suppression known as the 'white bear' study. The study demonstrated that when subjects were instructed 'don't think of a white bear', they were unable to keep the white bear from entering their thoughts.[82] After that study is presented, the judges are told that TJ is like the white bear--they can indeed decide on Monday morning to go back to business as usual—looking at

[79] Judge Roger K. Warren, Public Trust and Procedural Justice, 37 Court Review 12, 14-16(2000) (journal of American Judges 'Association, available online).

[80] See Deborah Chase & Peggy F. Hora, The Implications of Therapeutic Jurisprudence for Judicial Satisfaction, 37 Court Rev. 12 (2000) (journal available online); Hon. Peggy Hora & Deborah J. Chase, Judicial Satisfaction when Judging in a Therapeutic Key, 7 Contemporary Issues in Law 8 (2004); Deborah Chase & Peggy Fulton Hora, The Best Seat in the House: the Court Assignment and Judicial Satisfaction, 47 Family Ct. Rev. 209(2009).

[81] See Arie Freiberg, suggesting that a "pragmatic incremental" approach to practice "is of limited use if it cannot provide the basis for further development. What distinguishes the abstract theoretical approach from pragmatic instrumentalism is that only the former can provide the framework for the study of the relevant phenomena and act as a guide or blueprint for the future." Arie Freiberg, Therapeutic Jurisprudence in Australia: Paradigm Shift or Pragmatic Instrumentalism? 20 (2)Law In Context 1-18(2003). And British psychologist James McGuire notes that the social sciences provide an "evidence-base that, conveyed through the theoretical framework of therapeutic jurisprudence, may have a gradually increasing influence on legal procedures, roles, and rules with particular reference to criminal justice." James McGuire, Maintaining Change: Converging Legal and Psychological Initiatives in a Therapeutic Jurisprudence Framework, 4(2) Western Criminology Review 109(2003). The Western Criminology Review is an online journal.
For current examples of how the conceptual frameworks of TJ have led to important contributions from judges , lawyers, and other professionals, see David B. Wexler, From Theory to Practice and Back Again in Therapeutic Jurisprudence: Now Comes the Hard Part, available at http://ssrn.com/abstract=1580129

[82] Daniel M. Wegner & David J. Schneider, The White Bear Story, 14 Psychological Inquiry 326 (2003) (recounting the original thought suppression study).

their notes, reading standard probation conditions to the defendant from a form, etc.--but, now that they have heard about how TJ might suggest doing things a bit differently—and more effectively—perhaps the TJ white bear will in such instances regularly raise its head.

In our view, the time is ripe for the introduction of the white bear of therapeutic jurisprudence in many new jurisdictions. Interestingly, many nations, especially in Latin America, are undergoing, or have recently undergone, a shift from an inquisitorial to a more accusatorial system of criminal justice. The move has been inspired by an expectation that an accusatorial system (and the adversarial model) will bring more openness and transparency to the process and will serve as an antidote to corruption. We do not doubt those presumed advantages of the adversarial system. What we do believe, however, is that the advantages of the adversarial system are only part of the picture: the adversarial system, in fact, is under considerable fire at home. Contentiousness, stress, and an emphasis on winning at all costs—the 'litigation is war' attitude—often accompany the adversary system. In fact, it may well be that TJ and other similar perspectives of the comprehensive law movement[83] and of 'non-adversarial justice'[84] are actually *reactions to* the "culture of critique" and the excesses of the adversary system.[85]

To try to take advantage of the accusatory system and, at the same time, to minimize its likely negative side-effects, it seems to us that the best course of action is to adapt a TJ perspective at the very time a jurisdiction is undertaking a change toward the adversary model. Major change in the legal system—in whatever direction the change is—is always a stressful event, ' repealing' one's knowledge of the older law and requiring an intensive 'cramming session' to learn the new material. Stressful as it may be, resistance to change may be reduced if judges realize that, with a TJ component, they may reduce the negative aspects of the new system, may actually be able to do some good, and should eventually expect considerable heightened professional satisfaction. Therapeutic jurisprudence may indeed prove to be therapeutic for all concerned.

[83] Susan Daicoff, The Role of Therapeutic Jurisprudence within the Comprehensive Law Movement, in Dennis P. Stolle, David B. Wexler, and Bruce J. Winick (eds.), Practicing Therapeutic Jurisprudence: Law as a Helping Profession 465(2000).
[84] Michael King, Arie Freiberg, Becky Batagol, and Ross Hyams, Non-Adversarial Justice (2009).
[85] David B. Wexler, Therapeutic Jurisprudence and the Culture of Critique, 10 J. Contemporary Legal Issues 263(1999).

CHAPTER 2: BASIC PRINCIPLES OF DRUG TREATMENT COURTS: THE JUDICIAL COMPONENT. THE CANADIAN EXPERIENCE AND LESSONS LEARNED

Justice Paul Bentley, (Deceased.), Toronto Drug Treatment Court and Justice Kofi Barnes, Ontario Court of Justice

Introduction

The problem of criminal and other dysfunctional behavior spurned on by an addiction to illicit drugs is a global one. Several strategies have been employed across the globe in an effort to contain and, in some cases, with a hope to eradicate this problem. These strategies have been driven by a myriad of ideological and philosophical beliefs which have ranged from intensive law enforcement and punitive strategies to a wide range of treatment only interventions with various hybrids of both extremes.

Irrespective of one's philosophical beliefs on how drug addiction and drug related crime should be treated, the fact remains that drug addicts who commit criminal offences end up in the courts. These criminal offences victimize the public and compromise public safety. The affliction called drug addiction inflicts significant harm on the drug addict and results in costs to society in the form of lost productivity, dysfunctional families, increased medical care costs, increased law enforcement costs, criminal justice costs, etc. These facts are not in dispute.

Courts use legal tools to adjudicate the facts underlying the alleged drug addiction-driven offense and make determinations on guilt or innocence based on legal principles. It is undisputed that for persons for whom drug addiction is a primary cause of their criminal behavior, measures designed to hold them accountable that fail to address the underlying cause of such criminal behavior, namely, the drug addiction, and provide other holistic treatment interventions, are ineffective. In effect, the addicted offender simply serves his or her criminal sentence, returns to crime to support the drug addiction and the cycle of the criminal victimization of society, self-inflicted harm of the addict, deleterious social, health care, economic and other costs to society continues.

A strategy that does not include strategies to instill accountability and provide access to effective treatment and holistic rehabilitation is like pouring money into a bottomless pit with very minimal positive outcomes. This harsh reality has nothing to do with being hard or soft on crime or believing in the criminalization or decriminalization of drug use. At the end of the day, when society's safety net fails and criminal and other socially unsanctioned behavior is committed, the Courts become society's last resort. Within that reality, a strategy that combines legal case processing with effective treatment and holistic rehabilitation has been demonstrated to provide promising results and that is what drug treatment courts (DTCs) do.

This article is written from a very practical perspective. It is not intended to be a scholarly or academically rigorous discussion. Instead, we share our experiences and the lessons we have learned in implementing the DTC method in Canada.

The DTC Model

The first DTC was established in the United States in 1989 in Dade County (Miami). The Canadian experience with DTCs began with Justice Paul Bentley. He spearheaded the establishment of the first DTC outside the United States, which started in Toronto, Canada in December 1998.

This DTC was established in collaboration with many important stakeholders, which included the Federal Department of Justice, the defense bar, duty counsel, Toronto Public Health, the Centre for Addiction and Mental Health (CAMH), Community Corrections, Court Services and the judiciary. Representatives began meeting in the summer of 1997. The DTC began as a four-year pilot project funded by the federal government.

A DTC is a court specifically designed to supervise cases of drug-dependent offenders who have agreed to accept treatment for their substance abuse. These courts require the offender to deal with and accept responsibility for his or her addiction. A DTC is premised on the belief that drug dependency among offenders is not simply a law enforcement or criminal justice problem, but an overriding public health and societal concern. The uniqueness of DTCs lies in their ability and willingness to combine the traditional processes of the criminal justice system with those of the drug treatment community. The result has been a peculiar blend of treatment and judicial supervision, which is the essence of the DTC concept.

The DTC marriage of drug treatment and the court system shifts the approach of the court from legal to therapeutic. Judicial supervision of treatment, combined with immediate sanctions for non-compliance and incentives that promote compliance, encourages reduced drug use and is the cornerstone of the new approach. Instead of immediately revoking a drug offender's bail and putting him or her in jail when he/she has relapsed into drug use, the emphasis is on correcting behavior to help the offender stop using drugs. Through accountability and accepting responsibility for their own actions, offenders learn that they can indeed stop or at least reduce their substance abuse. The awareness that immediate consequences will flow from a contravention of the rules of the Court acts as a powerful incentive in ensuring compliance and reducing the offender's drug use. This approach is adopted in conjunction with active and frequent therapeutic intervention which helps transform what initially begins as an external motivation for change into an internal motivation for change; an essential ingredient for successful rehabilitation. Through the development of special relationships with community partners, DTCs have also been able to address issues of affordable housing, education and vocational retraining for their program graduates.

Accountability and Treatment

A DTC participant has a demonstrable drug addiction. This addiction is a primary cause of the participant's criminal behavior. The behavior that brings the participant into the criminal justice system is criminal behavior and therefore the biographical sketch of law enforcement, prosecution and many criminal justice actors is that of a criminal who perhaps has a history of past criminal behavior. This biographical sketch is informed by the offense committed and the circumstances surrounding the commission of the offense. This biographical sketch provides one picture of the DTC participant, i.e. the offender, to be held accountable for his or her crime.

The therapist, medical, psychiatric, substance abuse and other health services personnel see another side of the same DTC participant, which may include a history of trauma, ailing health, drug use, effects of social and family dysfunction, and perhaps some psychological trauma. This provides the biographical sketch that health services personal have of the participant, and therefore the participant is seen as a client to be treated.

Thus, two sides of the same person emerge: the offender and the client. The strength of the DTC method is that this holistic rehabilitation strategy brings together these diametrically opposed

perspectives to develop and implement a program designed to rehabilitate the "offender-client". This approach results in a holistic program designed to rehabilitate the offender-client without compromising the safety of the public in the process. The term "offender-client" is used for the remainder of our discussion to emphasize this holistic approach.

Best Practice Guidelines and Recommendations

The key principles that form the foundation of DTCs are shown at the beginning of this publication: The 13 Key Principles for Court-Directed Treatment and Rehabilitation Programs have fully informed our work in Canada since 1998.[1]

These principles are best practice recommendations for successful outcomes in a DTC; more to the point, Court rehabilitation programs that do not follow these key principles are not DTCs.

DTCs in Canada

As of 2012 Canada has 13 DTCs2. Six of these DTCs have dedicated funding which is provided by the Federal Government. These are located in Toronto, Vancouver, Ottawa, Edmonton, Winnipeg, and Regina. There are seven "non-funded" DTCs in Canada, located in the cities of Oshawa, Kitchener, London, Calgary, Moose Jaw, Windsor and Metro Toronto West (Youth).

Within the Canadian context, "dedicated funding "means there is funding specifically allocated to the DTC program. No "dedicated funding" means that no special funding is allocated to the DTC program and that existing resources are reallocated to establish the DTC. In effect, the participating partner agencies agree to provide "in kind" contributions to establish the "non-funded" DTC.

In response to the growing appetite for the establishment of additional DTCs in several Canadian cities, the method of establishing "non-funded" DTCs was developed by Justice K. Barnes3. It was utilized to establish Canada's first "non-funded" DTC: the Durham Drug Treatment and Mental Health Court and 2011, to establish the Metro Toronto West Youth Community Restoration Court.

This "in kind" funding approach is based on two closely related and intertwined principles, namely, "the same population principle" and "avoid net widening". Specifically this approach is based on the following assumptions:

a. Judges, prosecutors, defense lawyers, law enforcement and corrections have to process drug-addicted offenders on a recurring basis with or without a DTC;
b. Some drug addicted offenders are already accessing medical, psychiatric, substance abuse treatment, social and other rehabilitative services;
c. The primary characteristic of the DTC target population in Canada is the highly addicted chronic addict offender who frequently utilizes these services on a recurring basis, without

[1] Some jurisdictions may wish to extend the concept of substance dependency to include substance abuse or other substance use problems. For such jurisdictions, the concept of treatment services may be extended to include education and other approaches.

[2] There are six federally funded DTCs in Canada and 7 DTCs which function on the basis of "in kind" contributions from DTC partners. The number of DTCs is expected to increase dramatically in coming years.

[3] This "non-funded" Canadian DTC was established with the indispensable assistance of John Scott Crown Attorney for Durham Region, Mr. Paul McGarry, Director of Addiction Services at Pine wood - Lake ridge Addiction Services, and Mr. Rob Adams, Executive Director of the Durham Mental Health Services.

any measurable progress in eradicating, reducing or controlling the grasp, impacts and effects of the underlying addiction;

d. Due to the apparent ineffectiveness and high cost of an uncoordinated multiple access approach to dealing with the direct and indirect consequences of drug use, many criminal justice, substance abuse, medical, social services and other ancillary service providers should be interested in the intensively supervised, coordinated, integrated and holistically focused rehabilitation approach offered by DTCs;
e. Once the DTC method is explained and its positive outcomes are conveyed, these agencies and organizations should be interested in reallocating a portion of their resources, already being utilized to address the needs of the chronic addict engaging in criminal behavior, to establish a DTC;
f. Net widening is avoided and the target populations of the DTC is limited to those drug addicted offenders for whom traditional processes were not effective;
g. Drug addicted offenders for whom existing traditional processes, such as charge diversion and probation, had been effective or deemed to be effective are excluded.

The benefit of this method is that it allows interested jurisdictions to establish DTCs even if a request for funding is rejected or where dedicated funding was simply unavailable from any source. There is, however, a serious drawback, in that many non-funded Canadian DTCs have enrollment limits of typically five to fifteen participants at any given time. These low numbers make it very difficult for Canada's non-funded DTCs to adequately address the needs of the target populations in their jurisdictions. As a result, despite the benefits of this innovative funding approach, the best funding option remains adequate long-term sustained funding for a DTC.

The Legal Framework

DTCs in Canada operate without specific legislation creating DTCs. Instead, general provisions in the *Canadian Criminal Code* allow for the creation of DTCs. Section 720 of the *Criminal Code of Canada, R.S.C., 1985,c. C-46* and Section 10(4)(a) of the *Controlled Drugs and Substances Act, S.C. 1996, c. 19*, allow sentencing to be postponed, in order for the offender-client to engage in a treatment program.[4] Program rules and exceptions are set out in behavioral contracts called "Program Rule and Waiver Forms", which are signed by the DTC offender-client after receiving independent legal advice.

The Partnerships

The strong partnership between legal case processing and the active participation of the offender – client in drug addiction treatment and holistic rehabilitation programs, is a major component of the DTC method. This collaborative team approach is superior to working in silos, or in isolation. Canadian DTCs emphasize immediate treatment, case management and ongoing judicial supervision.

The DTC team includes the judge, addiction treatment provider, case manager, mental health treatment provider (Durham and Metro West), private defence lawyer, legal aid duty counsel (lawyer), Ministry of

[4] Section 720 of the *Criminal Code of Canada, R.S.C., 1985,c. C-46* and Section 10(4)(a) of the *Controlled Drugs and Substances Act, S.C. 1996, c. 19*

the Attorney General, Public Prosecution Service of Canada, Police, community partners and ancillary service providers such as housing and job training.

The emphasis is on adopting a non-adversarial approach to decision-making. In practice, this does not mean that there is no disagreement among the various partners. In fact, differing opinions expressed in an atmosphere of open frank and constructive discussion is a best practice. It is essential that such discussion occur in a cordial and constructive manner that is cognizant of the professional roles, responsibilities and boundaries of each member of the DTC team.

All Canadian DTCs provide a forum for these discussions to take place prior to the commencement of each DTC court sitting. These are usually called pre–court meetings. They provide an opportunity for all DTC team members to provide information on the DTC participant's progress and to engage in thorough and constructive discussions as to the next steps to be taken in the participant's treatment. These meetings are chaired by the DTC judge.

Despite their divergent roles, professional responsibilities, ethics and boundaries, all team members have one common goal: the holistic rehabilitation of the drug addicted offender-client in a manner designed to enhance his or her rehabilitation and the safety of the public. This common purpose, on most occasions, results in a general consensus among team members. The DTC Judge ensures that the team is always cognizant of this common purpose.

Due to the fact that the event that initiated the DTC process is a criminal offense or some other legal dispute, the DTC Judge makes the ultimate decision on the next steps after hearing the pre-court discussions and recommendations from DTC team members. It is a best practice for DTC judges to be receptive to the input of team members.

Eligibility Requirements

Eligible adult offender-clients are identified early. In most cases, almost immediately after arrest, a decision is made on whether an applicant is eligible for DTC. The decision on eligibility includes considerations of public safety and appropriateness for treatment. The objective is for treatment to commence as soon as possible.

Eligible offender-clients are typically non-violent, addicted to cocaine, crack cocaine, opiates, and/or ecstasy/crystal methamphetamine. Offender-clients charged with addiction-driven non-commercial drug offenses, non-violent property offenses or prostitution-related offenses are eligible.

A public safety and purposive approach is taken to the issue of non-violent offender – client. This means that all the circumstances of the offender-client and the crime are considered. For example, while offenses resulting in death or bodily harm maybe excluded, or an offender–client with a history of serious violence may be excluded, an offender–client charged with an offense which involved the commission of minor violence or one with a history of minor or dated violence may be deemed suitable. This is a rather simplistic example intended to demonstrate that a myriad of factors are considered under the category of "non-violent".

There must also be some demonstrable link between the commission of the criminal behavior and an addiction to drugs. Excluded offences include offences where commercial gain is the primary motivation, offenses of serious violence, sexual offenses, and residential break and enters.

The eligibility requirements for young persons include all the criteria for adults. For young persons, a demonstrable link to substance abuse short of addiction as a cause of the criminal behavior will also suffice. Most of Canada's DTC programs are adult programs. The Metro West Court applies the DTC method in rehabilitating drug-addicted youth. This DTC also deals with young persons who suffer from mental illness[5]. As a best practice, the key principles that comprise the DTC method are applied in a manner that recognises the level of maturity and development of young persons.

Treatment Delivery Model

Canada's DTC programs utilize non-residential or outpatient treatment programs. Residential programs are used when required. The Calgary DTC is the exception, with an early focus on residential treatment. The Calgary DTC focuses on high risk offender-clients.

Addiction treatment is delivered primarily by highly-trained addiction counsellors. Canada's heath care system is primarily a publicly funded system. This model allows the DTCs to refer offender-clients to other health service practitioners as required, in many instances at no additional cost to the offender-client.

DTC funding for the Canada's federally[6]funded courts is provided directly to non-profit organizations to deliver addiction treatment services. The DTC of Vancouver is the exception. The DTC of Vancouver is jointly funded by the federal and provincial governments and has its own dedicated treatment staff. The DTCs who do not receive direct funding either from the federal or provincial governments rely on "in kind" contributions from non-profit treatment agencies[7].

Program Flexibility and Community Partnerships

DTCs in Canada emphasize holistic rehabilitation. To achieve this objective, DTCs develop linkages with agencies and organisations in their community who provide ancillary services such as housing and job training to assist the offender–client in the rehabilitation process. DTC programs also ensure that the treatment programs are flexible enough to accommodate the needs of special populations, for example, on the basis of race, gender, culture, nature and type of addiction, or other special criteria. Program flexibility includes adjustments to the core treatment program or referrals to other agencies or organisations in the community better suited to provide the type of service needed.

Thus, the holistic rehabilitation of the DTC offender–client usually requires participation in other rehabilitative interventions in addition to the core addiction treatment. Linkages with community agencies who deliver these services are essential. The basic premise is that the DTC offender–client falls within the target population of many community agencies and thus DTCs referrals assist many community agencies in reaching their target population. Many community agencies find the integration, coordination of services and intensive supervision offered by DTCs to be helpful in achieving positive outcomes in a population that is usually difficult to rehabilitate. As a result, these community linkages

[5] This court was established by Mr. Justice K. Barnes in June 2011 and is called the Youth Community Restoration Court.

[6] The federally funded courts are in Toronto, Ottawa, Vancouver, Regina, Winnipeg, and Edmonton. Funding is provided primarily for addiction treatment. The contributions of the other partners such as the judiciary, law enforcement, prosecution, defence lawyers and probation are provided "in kind".

[7] DTCs in Oshawa, Windsor, Kitchener, Calgary, Toronto West, Moose Jaw and London rely on "in kind" contributions from non-profit agencies.

can be mutually beneficial to the DTC and the community agency with the offender- client and society as the ultimate benefactors.

General DTC Process and Procedure

The offender–client is arrested on allegations of committing a criminal offense. With the assistance of a lawyer, the offender-client makes a voluntary application to participate in a DTC program. This application is screened by the Crown[8] to determine whether the applicant meets the legal eligibility requirements. Applicants found to meet the legal eligibility requirements are then referred to the treatment provider for further screening.[9]

DTC applicants who are found to meet the legal eligibility requirements are assessed by the treatment provider to determine their eligibility and suitability for treatment. The treatment provider's assessments are discussed at the pre–court meeting by all team members. All team members share whatever information they have about the applicant and make recommendations to the DTC Judge on the next course of action.

The DTC Judge will conduct an in court interview with the applicant who has been found to be eligible and suitable to participate in the DTC program. Such in court discussions usually focus on providing a brief explanation of the main components of the DTC program and a discussion of other relevant issues. The DTC Judge will have the benefit of having received biographical and other information on the DTC applicant during the preceding pre-court meeting. This information greatly assists the Judge in the initial discussion with the DTC applicant.

We have found it most unhelpful to place significant weight on the initial responses that DTC applicants give to the question: "Why do you want to participate in this DTC program?" in assessing the extent of the applicant's commitment to seek treatment for his or her drug addiction. Any assurances by a DTC participant that he or she is ready for treatment must be taken with a grain of salt in the criminal justice process. Such an applicant, particularly if in custody, will have an opportunity to be released if accepted into the program. In addition, all successful offender-clients receive a non-custodial sentence. With these powerful incentives, it is unlikely that initial expressions of a desire to change in a Court setting are always sincere. The motivation at this phase of the process is typically external.

The DTC method recognises this reality and in the coming weeks, months and sometimes years, the objective is to use a coordinated strategy of therapeutic intervention, court supervision and support to transform what initially begins as an external motivation to obtain treatment into an internal one.

The DTC offender-client pleads guilty[10] and is placed on a DTC bail which is designed to encompass all aspects of the DTC program's expectations. The offender-client attends the treatment provider for a

[8] The Crown is the prosecutor. The provincial prosecutor is an Assistant Crown Attorney from the Ministry of the Attorney General. The federal prosecutor is from the Public Prosecution Service of Canada formerly the Federal Prosecution Service. Legal eligibility refers to eligibility criteria relating to the nature and circumstances surrounding the offence, the accused criminal record etc. The decisions on legal eligibility fall within the discretion of the Crown. The Crown acts as the DTC gatekeeper.

[9] Screening by the treatment provider will focus on assessing the nature of the applicant's addiction and other related issues

[10] In 1998, Canada's first DTC, the Toronto DTC, had two tracks for program participation. Track One was a pre plea(adjudication) model where DTC applicants charged with the simple possession of an eligible drug for personal use and who had no or minor criminal records, could enter the program without pleading guilty. Upon

more in-depth assessment. The results of this assessment are communicated to the Court. The DTC offender-client returns to Court and if found suitable, enters the DTC program. In most DTCs, there is a further assessment period[11] during which the DTC participant's suitability is further assessed.

Most DTC programs are twelve months in duration and upon completion the DTC offender-client receives a non-custodial sentence.

Fundamental Expectations

The fundamental expectations of DTC participants are of honesty and accountability. The focus is on compliance with the DTC program's expectations. Immediate abstinence is not required or expected. A series of "smart", therapeutically informed sanctions and incentives are utilized to ensure compliance and to achieve positive behavior modification. Abstinence is a requirement for graduation from the program

Sanctions

A system of graduated sanctions and incentives are used to encourage compliance. Some examples of sanctions utilised to encourage positive behaviour modification include: in-Court admonishment; more frequent Court attendance; more frequent urine screens; community service hours; essays; treatment contracts; revocation of bail, and delayed sanctions.

We have found delayed sanctions to be quite effective in motivating positive behavior. Sanctions for non-compliant behavior may be delayed for a short time period, usually five to fourteen days, to provide the offender–client with an opportunity to engage in a specific behavior(s) designed to further his or her rehabilitation. If the offender–client engages in the required behavior, the sanction is lifted, but if he or she fails to do so within the specified time period, the sanction is enhanced and imposed.

Incentives

Some examples of incentives include in-Court commendation; reduced Court attendance; relaxed curfew; certificates of achievement for completing each stage of the program; social outings; gift cards; "early[12] leave list": the offender- client is permitted to leave court early if fully compliant with program requirements since last Court date.

successful completion of the program their criminal charges were withdrawn. Applicants who were charged with more serious offences, had more serious criminal backgrounds and degrees of addiction were admitted under Track Two or the post plea (adjudication) phase and required to plead guilty. Upon successful completion they received a non custodial sentence. The regular non DTC criminal sentences for applicants who qualified to enter the pre plea track provided no incentive for these applicants to participate in a rigorous intensive treatment program like a DTC. As a result, DTCs in Canada have evolved to target the highly addicted and chronic offender-client who only qualifies for the post plea track. Canadian DTCs have in effect become post plea DTC programs.

[11] In the Toronto DTC this period is up to 30 days and can be extended in the appropriate circumstances

[12] DTC offender-clients are required to remain in the Court during a court session to learn from the experiences of other DTC offender-clients.

Graduation Criteria

The general graduation criterion for all DTCs is abstinence from illicit drugs. The specifics of this requirement vary depending on the DTC. An example of the variance in specific details is the period of complete abstinence from their "primary addictive drug": for example, 4 months. A period of complete abstinence from other drugs (including alcohol): for example, 1 month[13]. Some DTCs require abstinence from all illicit drugs and do not differentiate the required period of abstinence, prior to graduation, on the basis of the type of drug.[14]

Some common additional graduation criteria include stable and appropriate housing; full time employment or attendance at school, and appropriate lifestyle changes.

Final Disposition

DTC "graduates" receive non-custodial sentences. The sentences imposed usually include a probation order, which incorporates conditions designed to encourage and facilitate participation in aftercare programs.

Lessons Learned

Canada's experience with DTCs has yielded some lessons, some of these include;

- the importance of the interactions between Judge and the offender-client;
- consistency in assigned personnel increases effectiveness;
- importance of institutionalising the DTC;
- assigned DTC personnel must be suitable;
- an operational manual is a very good idea;
- adherence to the 13 key principles is essential;
- multidisciplinary training is ignored at a DTCs' peril;
- DTC practitioners should be aware of the potential for burn out;
- there is a distinction between the *eligibility* and *suitability* of a DTC applicant;
- anti-criminal thinking programs are a good idea;
- avoid net widening;
- program flexibility and collaboration with community resources are important;
- random urine screens are a smart practice;+
- evaluation is a best practice; and
- broadcast your successes.

Judge and the Offender-Client Communication

One-on-one, in-court, communication between the Judge and the DTC offender-client is an indispensable part of the DTC process. The Judge does not play the role of a social worker or therapist, but rather acts as a motivational coach who supports and encourages the therapeutic process. The Judge must show empathy, encourage, motivate and hold the DTC participant accountable. The Judge's language must reflect and promote these objectives. Paternalism should be avoided.

[13] Drug abstinence graduation requirements for the Toronto DTC.
[14] Drug abstinence graduation requirements for Toronto West DTC (youth).

Consistency in Assigned Personnel

DTC offender–clients have ongoing interactions with the judge and other DTC team members. Such frequent contact means that the DTC team members become very familiar with the offender-clients' personal history, characteristics, mannerisms, treatment history and progress. Such historical information, familiarity and knowledge ensure continuity and enhance the effectiveness of the DTC team.

Frequent rotations of DTC team personnel disrupts this continuity, results in inconsistent approaches, due to the inability of any team member to develop the required familiarity and understanding of each DTC participant. It destroys team dynamics, breeds lack of trust among team members and disrupts the overall effectiveness of the DTC method, which in turn adversely affects outcomes. The assignment of all members of a DTC team for twelve-month periods with consistent and designated team backups is a best practice.

Institutionalizing the DTC

It is also prudent practice to takes steps to ensure the institutionalization of the DTC in a courthouse to ensure that the DTC program continues even if a primary team member, usually the judge, leaves.

Suitability of assigned Personnel

While the interaction between the Judge and the DTC offender-client is crucial, other members of the team are also important. In addition to therapeutic interventions by therapists, DTC team members make important assessments and contributions to DTC offender-clients' treatment plans during various team discussions.

Comments made by DTC team members during court appearances can have significant impacts on the offender-client: for example, when the prosecutor praises the offender-client on his or her performance.

Members of DTC teams must understand the key principles of DTCs, be prepared to implement them and work together as a team. Not all persons have the necessary personality traits suitable for working in a DTC and therefore DTC personnel must be selected carefully. Assigning the wrong personality type to the DTC can have a significant detrimental effect on the DTC's effectiveness.

Operational Manual

It is also essential to have an operational manual for the DTC team, as this reduces the amount of disruption that inevitably occurs when a team member is changed.

Adherence to the 13 Key principles

Not all DTCs are created equal. Some DTCs produce positive outcomes, and there are those that do not produce positive outcomes. One of the primary reasons for such differences is the degree to which a DTC adheres to the thirteen key principles of the DTC method. Adherence to the key principles is a best practice.

Multidisciplinary training

Ongoing training of DTC personnel is a best practice. It ensures adherence to the key DTC principles and produces positive outcomes. One of the reasons why the Canadian Association of Drug Treatment Courts (CADTCP)[15] was formed was to provide opportunities for ongoing training for DTC practitioners. The CADTCP's professional services arm, the National Problem-Solving Court Institute (NPSCI), provides training and professional development opportunities for persons interested in and working in DTCs.

Avoid Burn Out

An important aspect of DTC training is learning how to avoid burn-out and to apply strategies designed to ensure that the treatment and court team actors continue to empathize with the offender–client while maintaining the degree of detachment necessary to maintain their own emotional, psychological and physical wellbeing, without compromising their effectiveness as DTC practitioners.

Eligibility versus suitability

Not every eligible DTC offender-client is suitable for participation in a DTC program. DTCs set specific benchmarks and hold participants accountable for compliance or non-compliance with these benchmarks. DTC offender-clients must have the cognitive ability to comprehend and participate. Thus, for example, a DTC offender-client with a severe cognitive impairment, which makes it impossible for him or her to understand the DTCs program's rules and expectations, is unable and unsuitable to participate in the DTC program.

An eligible offender-client's suitability for a DTC program can be determined by the DTC's ability to meet his or her particular treatment needs. There are instances where the DTC offender-client has a cognitive ability at a level suitable for participation in the DTC program but requires some additional mental health treatment services that a particular DTC is not equipped to provide and cannot access.

Another example of the eligibility-suitability dichotomy is where an eligible DTC offender-client is so committed to the criminal lifestyle (for example, a drug trafficker or dealer who continues to sell drugs to other DTC participants) that his or her participation is detrimental to other DTC participants.

There are a myriad of circumstances where an eligible DTC offender–client is not suitable for a DTC program. It is a best practice to have a thorough and ongoing assessment process and to develop community and other relevant linkages that equip your DTC with the ability to refer unsuitable participants to other more appropriate DTCs or other treatment interventions.

Anti-criminal thinking sessions

One of the main premises of the drug treatment court method is that drug addicted offender-clients commit criminal offences primarily to support their drug habits. This statement is primarily accurate but in keeping with the complexity of the human being, we have found this link to be a more complex relationship in some instances.

The drug addict must develop a number of skills to be an effective criminal. The degree of effectiveness of such criminal tendencies in many instances determines whether that drug addict will acquire the resources necessary to acquire his or next drug. We have found that in some instances, as drug addicts make progress in efforts to control their drug addiction, some may still miss the feelings associated with

[15] See www.cadtc.org.

their criminal behavior. To address this potential problem, we have found it prudent to introduce treatment sessions that address the issue of criminal behavior in DTC programs. We have found this to be effective in reducing criminal recidivism.

Different measures of success

The term "DTC graduate" can be misleading. In one sense, it recognises the successes of a DTC offender-client who has successfully navigated the arduous road of drug addiction recovery and met stringent program requirements for successful completion. It recognises the triumph of the human spirit over considerable adversity. On the other hand, it may not adequately convey the fact that recovery is a lifelong process. For the drug addict, recovery is a lifelong process of vigilance which can be easily lost with missteps, unlike acquiring a university degree that can never be taken away from the graduate who honestly completed all the prerequisites.

We have learned that the gold standard of the graduate who has met all program requirements is not the only measure of "success". DTCs cannot hold onto DTC offender–clients indefinitely and some offender-clients may take considerably longer than the expected duration of the DTC program to reach the gold standard of graduation. These offender–clients may, over the course of time in the program, reach a level of "substantial compliance" with the benchmarks of recovery from drug addiction. Some of these benchmarks are significantly decreased drug use; no criminal behaviour; increased social stability, and the acquisition of tools that transform the drug addict into a productive member of society.

It is prudent to have a way of recognising such success and to facilitate an effective transition to ongoing aftercare, particularly when the DTC offender–client has been in the program for some time and will need a further lengthy period to reach the gold standard of "graduation".

Avoid net widening

It is prudent to avoid net widening. We have found that there is no need to seek to capture offender – clients who are functioning successfully in less intensive treatment programs. It is important that the type of treatment intervention be one that is tailored to the circumstances and needs of the offender–client.

DTCs are intensive court-based treatment programs. The DTC method is one in a continuum of available treatment interventions and is intended to complement other effective treatment processes. DTCs in Canada target offender-clients who are at a high risk of returning to and continuing in drug use and criminal behaviour and for whom other treatment interventions have been unsuccessful[16].

Importance of collaboration and flexibility

DTCs do not operate in a vacuum. Successful DTCs work in collaboration with various community services and agencies to provide specialized treatment and services, such as specialized drug addiction treatment for concurrent disorders, pregnant addicts, culture specific treatment, gender specific treatment, psychiatric and medical treatment, job training, housing, and employment. It is clear that a holistic rehabilitative approach yields the best long-term results.

[16] See footnote 11

DTC programs must be flexible and innovative to ensure that their programs continue to address the needs of their targeted populations.

Incentives are important

Sanctions and incentives are important tools utilized by DTCs to encourage compliance with program expectations and rules. As important as sanctions are in ensuring compliance, incentives are also extremely important in efforts to instil behaviours promoting recovery. A large budget is not a prerequisite to an effective incentive program however the ability to be creative is indispensable.

Random drug tests

Metabolites from illicit drugs use remain in bodily fluids for finite periods. Urine screens that are not random allow offender-clients to time their drug use to coincide with days when metabolites for illicit drugs would have dissipated from the body and undetectable by many drug testing methods. Random drug tests make it difficult for offender–clients to manipulate test screen results by timing their drug use.

Evaluate and broadcast

At some point, someone will ask: "Is your DTC working?" Decide what information needs to be gathered in order to monitor and demonstrate the effectiveness of the program (including what comparator group to use and how to track it). Put in place a system in place that will facilitate both the gathering of information and the creation of useful reports. Develop benchmarks that assess the degree of your DTC's compliance with the key DTC principles and impacts on program outcomes.

Some benchmarks include impacts on retention in treatment; impacts on drug use; impacts on criminal behavior; impacts on the physical, emotional and psychological wellbeing of the offender-client and costs implications. Identify cost savings and impacts on familial relationships and other social relations. This is not an exhaustive list.

It is prudent practice for a DTC to broadcast the DTC's successes to stakeholders, policy and decision makers and the public. It is important for the community, served by the DTC, to know that the DTC is helping rehabilitate its drug-addicted offenders, keeping it safe and saving taxpayer's money. This ensures support for the DTC and helps it attract much needed funding and other resources needed to optimise the DTC's effectiveness.

Canada's DTCs by the numbers[17]

The following interesting and informative facts were collected by some Canadian DTC evaluators, and demonstrate that DTCs change lives and improve our communities.

DTC – an option of last resort

[17] This document was prepared by the CADTCP's National Research and Evaluation Institute, and specifically, by James Budd, Irene Hoffart, Dr. Cam Wilde, Dr. Michael Weinrath and Pamela Smith from a review of DTC evaluations of the Ottawa, Edmonton, Calgary and Regina DTCs.

- As many as 90% of DTC participants have a lengthy history of prior convictions; for example, in one Western Canadian DTC, participants had an average of twenty-four prior convictions.
- Up to 70% of DTC clients suffer from depression or anxiety disorders, as well as their addiction, with many also having symptoms of post-traumatic stress disorder, and acute or chronic health needs.
- In some jurisdictions, up to 95% of participants are unemployed upon entering the program, with 22% of participants reporting criminal activity as their sole source of income.
- 90% of participants tested on a level of risk inventory (LS/CMI) rated 'high' or 'very high' risk to reoffend.
- In some courts, 75% of participants had unsuccessful treatment experiences prior to entering DTC.
- 86% or more of DTC participants began using drugs before their 18th birthday, with some starting as young as age 12.

DTC is not an easier, softer way

- DTCs provide intensive treatment services, case management, and judicial supervision.
- DTC participants are released with a strict set of bail conditions, which include rules for curfew, living arrangements and limitations on people and places. In many cases, participants are subject to these conditions for a much longer period of time than their sentence would have been if they had not entered the program.
- Every week, DTC participants are required to attend court for 9-12 months or more.
- Residential treatment programs can last from thirty days to six months; some DTC programs provide 700 hours or more of outpatient treatment.
- DTC requires participants to provide random urine drug tests at least once or twice per week.
- To graduate, participants must have an extended period of abstinence; have no new criminal charges; have stable housing; and be involved in pro-social activity such as employment, education or volunteer work.

DTC reduces substance use and crime

- A western Canadian DTC tracked participants for up to eighteen months after graduation; over half had remained entirely crime free.
- Providing criminogenic treatment in DTC helps clients change their criminal thinking patterns and can reduce recidivism by 70%.
- A DTC in Ontario found that, in that city alone, DTC resulted in an annual reduction of $3 million[18] spent on drugs. Criminal activity required to support that drug use (goods stolen and/or drugs trafficked) is estimated at another $9 million, for a total savings of approximately $12million.
- One DTC reports frequency of drug use declining from an average of 28.5 days per month to only 0.8 days per month during participation in the program. Another in western Canada found about one-third of DTC participants remained clean and sober for a year or longer in the program.
- When a comparison was made between one DTC's participants and the court-involved clients of a residential treatment program, 100% of the DTC participants were abstinent at follow-up compared

[18] Canadian dollars.

to only 64% of those who had received only addiction treatment without the other supports and supervision of DTC.

DTC improves and saves lives

- DTCs help reunite families. Approximately 50% of DTC participants re-establish a connection with supportive family members after entering the program.
- DTCs providing employment/education preparation services show impressive outcomes of up to 75% of participants moving on to educational or employment activities.
- At least 61% of participants enter DTC with acute or chronic health issues. At any given time, as many as two-thirds of participants in some DTCs may be Hepatitis C positive. These issues are addressed through onsite health services located in some DTCs, community health care partnerships, and intensive case management.
- A western Canadian DTC administered Cantril's Life Ladder[19] – a simple scale measuring clients' quality of life perceptions – with 1 as the worst, and 10 as the best life. Clients' satisfaction with their lives overall improved from an average score of 1.8 on admission to 7.8 at graduation.

Conclusion

DTCs are part of a global effort to break the undisputed link between drug addiction and crime. An integrated and coordinated effort to achieve the holistic rehabilitation of the drug addicted offender-client without compromising but rather enhancing public safety in the process. It is an intervention that has yielded very positive outcomes and warrants serious consideration by jurisdictions across our globe.

[19] The Self-Anchoring Striving Scale, in Cantril, Hadley. Pattern of Human Concerns, 1965.

CHAPTER 3: BASIC PRINCIPLES OF TREATMENT FOR DRUG DEPENDENCE: TWO PERSPECTIVES

A PUBLIC HEALTH PERSPECTIVE

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In order to win acceptance and, once established, to have any chance of success, the drug court concept had to meet the conflicting requirements of the judiciary, public defender, prosecutor, police and providers of social services[1]

In this quotation, Public Defender Brummer the Public Defender with the Miami/Dade County's experimental Drug Treatment and Diversion Program (e.g., "Drug Court") eloquently summarized the challenges facing legal teams and health care providers in 1989. Over two decades later, despite the fact that drug users continue to constitute a large part of the prison population, prison systems lack appropriate treatment and rehabilitation programs for prisoners. It is estimated that 60-80% of prison inmates "were under the influence of drugs or alcohol during the commission of their offence, committed the offence to support a drug addiction, were charged with a drug or alcohol related crime or are regular substance users" (Belenko & Peugh).[2] Internationally, it is recognized (International Narcotics Control Board 2007[3], Article 14 of the United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances 1988[4] and Article 38 of the Single Convention 1961[5]) that the adoption of a health-oriented approach to drug use and dependence, rather than a criminal justice sanction-orientated model, is to be encouraged. Research shows that purely criminal justice sanctions have little or no impact on subsequent recidivism. What is the evidence that treatment works? What are the key principles to setting up a successful drug treatment court and, more importantly, what are the main challenges and barriers?

Drug dependence is a Disease

Drug dependence is a complex and multifactorial disorder involving cultural, biological, social and environmental factors. Drug dependence is as much a disorder of the brain as any other neurological or psychiatric disorder. The World Drug Report (United Nations Office on Drugs and Crime 2009) estimates that 38 million people in the age group 15-64 are drug dependent, but only 4.9 million of them receive evidence-based drug treatment and care.[6] Drug dependence requires treatment that involves a comprehensive multidisciplinary approach, including both pharmacological and psychosocial interventions.

Drug dependence is considered a chronic multifactorial health disorder that often follows a relapsing and remitting disease. "In many societies drug dependence is not yet recognized as a health problem

[1] Brummer, B H and Rodham H, *Miami's Drug Court: Leading the Way 1993 at p.1.*
[2] Belenko, S and J. Peugh. *Behind Bars: Substance Abuse and America's Prison Population.* New York National Centre on Addiction and Substance Abuse at Columbia University 1998.
[3] International Narcotics Control Board, EN/INCB/2007/1.
[4] United Nations Convention against Illicit Traffic in Narcotics and Psychotropic Substances 1988.
[5] United Nations Single Convention on Narcotic Drugs 1961, Article 38.
[6] UNODC *Treatnet* 2010 at p.1.

and a substantial proportion of people suffering from it are stigmatized and have no access to treatment and care".[7]

Drug use disorders are also associated with an increased risk of other diseases such as blood-borne viruses (HIV & AIDS), hepatitis B & C, tuberculosis, suicide, overdoses (intentional and accidental), self-harm and cardiovascular disease. Models of addiction will be discussed later in this chapter.

Drug Treatment

Since drug dependence is similar to other chronic diseases, it should respond to treatment with medications and other interventions.[8] There is a large amount of research literature on drug dependence treatment outcomes, (DATOS[9], DORIS[10] & NTORS[11]). Details of specific types of treatment and medication will be discussed below. Despite the evidence, many countries still deliver treatment that is more appropriate for acute care disorders, such as detoxification. "Like other chronic illnesses, the effects of drug dependence treatment are optimized when patients remain in continuing care and monitoring without limits or restrictions".[12]

Public Health Perspective

North American and European studies evidence the relationship between drug dependence and criminality (Hubbard[13], Gossop[14] & McKegany[15]). However, drug dependence is, as previously stated, a multifactorial disease with multiple consequences, not only relating to health.

> Drug dependence and illicit drug use are associated with health problems, poverty, violence, criminal behavior and social exclusion. Its total costs to society are difficult to estimate. In addition to the health costs and other costs associated with the consequences of drug use, drug dependence involves other social costs in the form of loss of productivity and family income, violence, security problems, traffic and workplace accidents and links with corruption. These result in overwhelming economic costs and an unacceptable waste of human resources".[16]

The U.S. National Institute on Drug Abuse (NIDA) has shown that the cost of drug dependence is comparable with the costs of other illnesses such as cancer or diabetes; an estimated US$484 billion against US$131.7 billion and US$171.6 billion respectively.[17] The figure for drug dependence includes

[7] UNODC *Principles of Drug Dependence Treatment* 2009 at p.1.

[8] McLellen A T, Lewis D C, O'Brien C P, *Kleber* H D *Drug Dependence, a Chronic Medical Illness. Implications for Treatment, Insurance and Outcome Evaluations* Journal of American Medicine Association 2000 at p 3

[9] NIDA *Drug Abuse Treatment Outcome Study* 2008

[10] McKegany N, Bloor M, McIntosh J & Neale J *Drug Outcome Research in Scotland Centre for Drug Misuse Research 2008*

[11] Gossop M, Madsen J & Stewart D *The National Treatment Outcome Research Study* Bulletin 5 2001

[12] McLellen et al *Drug Dependence, A Chronic Medical Illness. Implications for Treatment, Insurance and Outcome Evaluations* at p.18

[13] Hubbard *R Treatment for Drug Dependence* Association of American Physicians 1999

[14] Gossop et al NTORS 2001

[15] McKegany et al DORIS 2008

[16] UNODC *Principles of Drug Dependence Treatment* 2009at p 2

health care expenditures, lost earnings, costs of accidents and associated crime. This enormous economic burden affects everyone in society.

Relationship Between Public Health, Treatment And Criminal Justice

Doug Marlowe has written: "One approach has shown consistent promise for reducing drug use and criminal recidivism: an integrated public health-public safety strategy that combines community-based drug abuse treatments with ongoing criminal justice supervision".[18]

It was evident in Miami-Dade County and it remains evident today that drug abuse treatment agencies deal with and treat many of the same offenders/patients as the criminal justice system. Drug courts are an obvious example of where health and criminal justice can act together to both treat drug abusers and reduce criminal activity. The legal system provides regular court reviews, with praise for those doing well and sanctions for those failing to comply with the terms of their order.

The UNODC 2010 document, *From Coercion to Cohesion: Treating Drug Dependence through Health Care Not Punishment,* encourages countries to adopt a health-orientated approach to drug dependence, involving comprehensive social support and specific drug and psychosocial treatment. [19] "Moving from a sanction-oriented approach to a health-oriented one is consistent with the international drug control conventions. It is also in agreement with a large body of scientific evidence".[20] However, this article makes it clear that this approach is in direct contrast to compulsory treatment without the right of refusal.

A previous UNODC paper, *Custodial and Non-Custodial Measures: Alternatives to Incarceration,*[21] called for Governments to take multidisciplinary initiatives, such as drug treatment courts (DTCs), and recognized the work already being done in the U.S., Europe and Australia.

Key Principles And Challenges

In 1997, the U.S. Department of Justice produced *Defining Drug Courts: 10 Key components.*[22] In 1999, the UN and a panel of experts produced 12 Key Principles which set out the main components of any DTC[23]. In 2009, UNODC[24] and CICAD[25] produced documents on the principles of drug treatment and rehabilitation. How do these concepts come together, what are the potential barriers, and can one be adapted to the other?

Multidisciplinary ~~W~~working

[18] Marlowe D *Integrating Substance Abuse Treatment and Criminal Justice Supervision Science & Practice Perspectives 2003 at p 1*
[19] UNODC *From Coercion to Cohesion: Treating Drug Dependence Through Healthcare Not Punishment 2010*
[20] Ibid at p 2
[21] UNODC *Custodial and Non-Custodial Measures: Alternatives to Incarceration* 2006
[22] US Department of Justice *Defining Drug Courts: The Key Components* 1997
[23] UNODC 1999 *12 Key Principles for Drug Treatment Courts*
[24] UNODC *Principles of Drug Dependence Treatment* 2009
[25] Inter-American Drug Abuse Control Commission (CICAD) Secretariat for Multidimensional Security, Organization of American States. *CICAD Expert Group on Demand Reduction: Basic Principles of the Treatment and Rehabilitation of Drug-Abusing and Drug-Dependent Persons in the Hemisphere* 2009

It is perhaps the principle of multidisciplinary working that poses the biggest challenges. Health, social work and the criminal justice system will see each case as their "patient", their "client" and their" offender". In DTC pilots in the U.K, "Difficulties in the pilot schemes are a consequence of work on a difficult joint enterprise involving organizations with big differences in working styles, traditions and values. Multidisciplinary working was the biggest challenge".[26] Many of the difficulties can be eased and mitigated by joint training, memoranda of understanding, good communication pathways and on-going reviews and meetings. The role of an overall Coordinator who brings all the parties together cannot be overestimated.

Resources And Costs

Resources and costs are the next major challenges. Trying to recruit and retain likeminded and qualified staff from all professions was seen as one of the major barriers in the OAS publication, *Establishing Drug Treatment Courts: Strategies, Experiences and Preliminary Outcomes.*[27] Respondents stated that: "the lack of stable funding was the biggest obstacle they encountered".[28] Most respondents had to find funding from within existing resources, while some had received special start-up money or had governments commit ring-fenced, or earmarked three-year funding. Most said their projects were a mixture of federal and state funds, both judicial and mental health/addictions.

Respondents listed the following as some of the obstacles they faced:

- "Obtaining funding has been the largest obstacle to creating a viable and sustainable program. Educating the various stakeholders about the effectiveness of the drug treatment court remains a goal." [29]
- "Demonstrating that the program was not soft on crime";[30]
- "Resistance from those who believe that substance addiction is not a legitimate illness suitable for treatment – public education, exposure to DTC process and successes".[31]

Strategies to address these funding issues and bring (and keep) ideological and financial support involved education, positive evaluation results, encouraging the various stakeholders to attend graduations and sit in on court reviews, and reaching out to the local communities.

Funds also need to be available for on-going training, which is necessary to ensure smooth multidisciplinary working and a necessity to address turnover of staff.

Key Performance Indicators: Monitoring and Evaluation

Another key to DTC success is good clinical governance and key performance indicators. Pharmacological treatments must be safe and evidence-based, and delivered by adequately trained and resourced staff. Treatment should also be, if and where possible, integrated into existing health clinics, settings and systems to normalize their disease and avoid stigmatization. The client's progress can therefore be witnessed by the local community. Reduced recidivism and improved health and graduation rates are other key evaluation outcomes. Most respondents in the Cooper et al. publication cited recidivism and graduation rates as the most significant measures of effectiveness for their

[26] Eley S *Drug Treatment and Testing Orders in Scotland: Exploring Professional Perspectives on The Deserving and the Undeserving* University of Stirling at 3
[27] Cooper C., Franklin B & Mease T. *Establishing Drug Treatment Courts: Strategies, Experiences and Preliminary Outcomes Overview and Survey Results* 2010
[28] Ibid at p. 100

programs.[29] An ability to demonstrate cost savings both to the criminal justice system and the local community is essential to ensuring continued government and community support. Reduced petty crime, housebreakings and the production of law-abiding community members are key to local support. "It has provided a significant dollar savings to our community by offering treatment to the group of chronic and hard core addicts that had been responsible for a disproportionate amount of crime and placing a disproportionate amount of stress on community services like the police, emergency and hospital services".[30]

Addressing those with special needs

As stated in both the UNODC and OAS key principles, treatment needs to be accessible to all, and specialist services are required for those with special needs, such as juveniles, female offenders and the mentally ill. This will be an added resource and training requirement. Treatment must also fully respect the human rights of those involved, without discrimination on grounds of age, gender, race, religion or political affiliation. This topic will be discussed further in Chapter 9.

Conclusion

Many countries are looking for alternatives to incarceration for drug use and related crime. The UN Office on Drugs and Crime has said that: "Treatment as an alternative to criminal justice sanctions is specifically encouraged in the international drug control conventions and it has been found more effective than imprisonment in encouraging recovery from drug dependence and reducing drug related crime."[31]

Marlowe states that DTC clients achieve significantly greater reduction in drug use, criminal recidivism and unemployment than did individuals on standard probation or intensive probation.[32]

At the heart of a DTC is the principle that it is more effective for criminal justice agencies to work together with social work, health and addiction services in dealing with those responsible for drug related crime.

[29] Cooper et al *Establishing Drug Treatment Courts: Strategies, Experiences and Preliminary Outcomes* at p 106
[30] Ibid at p110
[31] UNODC *From Coercion to Cohesion: Treating Drug Dependence Through Healthcare Not Punishment* 2010 at p11
[32] Marlowe D *Integrating Substance Abuse Treatment and Criminal Justice Supervision,* Science and Practice Perspectives 2003 at p.8.

CLINICAL PERSPECTIVES ON DRUG TREATMENT PROGRAMS AND ANCILLARY SERVICES

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Substance Abuse As The Presenting Symptom

Substance abuse is an illness. It runs a chronic course with periodic lapses and relapses before the individual finally achieves a sustainable, drug-free, quality life. Sufficient scientific evidence has shown that drug dependence is a brain disease in which changes occur in the structure and neurochemistry of the brain of the drug user.

We know that any abuser finds it difficult to achieve a substance-free life with just one single admission to a treatment program. Many face challenges after completing a program and struggle to maintain a drug-free life, with many lapses before they finally achieve this goal or succumb into full relapse. The role of treatment services is to facilitate the recovery process in an accessible environment that provides opportunities based on individual needs.

Drug treatment services should be comprehensive and should address the holistic needs of the individual. The outcome of the treatment services depends on quality care standards. Quality care, in turn, depends on how comprehensively treatment services are provided.

Court-supervised treatment applies the principles of Therapeutic Jurisprudence, focusing on helping offenders solve their problems and their underlying drug-dependence. It offers alternatives to incarceration and improved chances on their way to a drug free, quality and productive life. (1, 2, 17)

Quality Treatment Services And Importance Of A Bio-Psycho-Socio-Cultural Approach

The understanding of underlying causal factors behind why patients became the victims of various substances has changed over the years. Many theories have evolved, from a failure of moral values to multi-factorial etiology. We now accept that it is a combination of all factors. Causal factors are unique to each individual and therefore cannot be applied to everyone. (1)

The concept that drug abuse is caused by a combination of bio-psycho-socio-cultural factors has had a significant impact on treatment services. When substance abusers become offenders, their problems are no longer just substance abuse. Many, at this point, have been abandoned by their families or caregivers due to intense emotions generated by these abusers and their behaviors. Therefore, treatment must encapsulate all aspects of a substance abuser by addressing his or her areas of needs through a holistic approach.

Commitment and Dedication

Development of program and treatment services involves a multisectoral and multidisciplinary team approach, with strong dedication and commitment from both professional treatment providers and the administrative and political hierarchy. Drug abuse is a public health issue and it should be a priority concern for everyone—not just treatment providers, professionals and experts. Strong dedication from a committed team determines the sustainability and quality of the treatment services, especially in developing countries where availability of resources has always been a challenge. Treatment services will be more viable and successful if all concerned have a shared vision and collective responsibility,

backed up by an inter-agency memorandum of understanding that sets out the roles and responsibilities of each.

Goal of Treatment

The ultimate goal of treatment is to achieve a substance-free and quality life. Recovery from substance abuse is a process. Evidence-based medicine proves that substance abuse is a chronic disease.

It is the task of the treatment providers to create an environment where substance abusers can find themselves, readjust their lives, and find ways of dealing with their drug-seeking behavior and involvement with the law (or criminal involvement). Many existing substance abuse treatment programs adopt their own eligibility criteria. While these criteria accommodate those who are eligible, some categories of substance abusers are often excluded from entering the program. Any substance abuser who is denied entry to a treatment program because of these restrictive criteria may well enter the criminal justice system at some time in their drug-abusing period. The ultimate goal of treatment is total abstinence, through maximizing motivation and aiming for relapse prevention.

There are four primary goals of addiction treatment:

1. Reduction of drug and alcohol use;
2. Increased personal health;
3. Improved social function; and
4. Reduced threats to public health and safety.

Quality Care and the Importance of a Family Support System in the Recovery Process

Our experience has shown that many family members give up hope and sometimes are no longer willing to support drug abusers. Most drug-dependent persons are then marginalized and socially excluded.

For an offender with substance abuse problems, we need to address two basic issues: their underlying substance abuse problem, and the criminogenic risk of committing an offence. These drug-dependent offenders have little understanding of the connection between the two issues. Reestablishing and maintaining close relationships with members of the family and initiating family therapy could increase the probability of long-term abstinence and reduce the risk of relapses. (13, 18)

Quality Drug Treatment Services

A mental health policy and plan is essential to the coordination of all services and activities related to mental health. Without adequate policies and plans, mental disorders are likely to be treated in an inefficient and fragmented manner (WHO).

There is an absolute need to include organization of comprehensive substance abuse services and quality improvement in national mental health policy. Some elements are essential in determining the quality of the programs offered. Accessibility and structured services are major elements in designing treatment services, with a special emphasis on capturing all types of substance abusers, including gender differences, minority and diversity differences, and juvenile needs. Each program must have a clear written policy for establishing its target population, a minimum standard of quality care, goal and principles of treatment, and services offered (including referral services, networking with ancillary services and inpatient services). The National Institute on Drug Abuse has adopted thirteen principles of drug abuse treatment for criminal justice populations.

It is challenging to maintain the best standards of first world quality when the program is implemented in a third world setting, due to limited and unevenly distributed resources. Every substance abuse program should adhere to available quality assurance guidelines and standards. CICAD and PAHO developed minimum standards in providing care for abusers. Minimum standards should be culturally and economically appropriate for each country based on the situational needs. (6, 12, 16)

Drug Treatment Courts

The process of treatment provided under supervision of drug treatment court is essentially the same as in regular treatment program, with certain exceptions such as regular urine testing, and application of its results to strengthen behavior modification by judicial sanctions and rewards.

Judicial monitoring system plays a very important role for those drug dependent persons who transit from the drug treatment in general, to drug treatment in a drug court. Drug courts and its treatment is one of the essential programs to offer as an alternative.

Screening/Assessment

Screening in drug courts primarily involves two steps: legal and medical screenings for admission to the program. Legal screening is the first step to determine eligibility to enter a drug court and is based on legal criteria established by legislation in some jurisdictions. The severity of the offense, and/or social enquiry reports by probation officers or social workers can assist the court in determining initial eligibility.

Legal screening is followed by detailed and comprehensive assessment interviews given by treatment providers. The purpose of clinical screening is to assess the participant's readiness to participate in the treatment program. Inclusion of both objective and subjective means of screening makes the assessment more comprehensive in understanding the individual's problem of drug abuse and association with criminal behavior.

Assessment can identify not only the necessary information regarding types, duration, pattern, and degree of dependency, but also the participant's underlying bio-psycho-social, interpersonal, and family issues. There are many screening tools available today, such as ASI, DAST, ASSIST, TCUDS II, and so forth. The decision and choice of which instruments and numbers to use should be based on many factors including, but not limited to, fiscal reality, culture, age and gender appropriateness, and psychometric properties of accuracy, reliability and validity.

The assessment stage serves to identify the participant's family structure and dynamic, possible history of physical and sexual abuse, academic achievement and literacy level, employment and skills, mental illness and health, disabilities, history of arrest and convictions, personality structure and coping mechanisms, housing, career expectation, problem areas and strengths, past history of rehabilitation and social support system. The high prevalence of co-occurring disorders in drug-dependent offenders makes it advisable to take further history and choose the appropriate tools to identify mental health disorders.

Interviews with family members, significant others, colleagues and concerned individuals is very helpful in verifying the severity of the problems and determining which services should be included in the case management plan.

Application of a bio-psycho-socio-cultural approach is very important when taking a comprehensive history to plan individual's treatment program. The treatment provider needs to understand how an

individual became a drug user, at what stage of his life, and what vulnerability factors and or circumstances which transform a drug abuser into an offender sometime in his or her life.

It needs to examine the factors that made the offender to continue his drug-seeking behavior, and also explore his coping skills and his stressors in chronological order throughout his developmental age. Basically, treatment providers should have a holistic and complete picture of the participant's life from the day he was born up to the day of assessment.

This will help the treatment provider understand the participant's underlying pathogenesis—how he become a drug abuser and later become an offender, and why he could not disengage from the cycle of drug abuse. This information could be utilized in the counseling process and will, in fact, help the drug-using offender to understand himself and lead him to recovery.

Assessment should be done by a trained health professional, preferably a social worker, a nurse, a psychologist or psychiatrist, or a team of health professionals and substance abuse counselors.

There is an absolute need to include a general and systemic physical examination following the comprehensive history taking, in order to identify the physical complications of substance abuse and co-existing physical illnesses. There is a strong link between substance abuse and HIV/AIDS, Hepatitis B and C and tuberculosis. Laboratory tests and other investigations should be made available and easily accessible where indicated. (7, 9, 13, 15, 18)

Prompt Admission and Availability of Treatment Modalities

Prompt admission after assessment and the availability of both inpatient and outpatient treatment and rehabilitative services and programs for every client with specific needs is very important. Those with an intact support system may do well in outpatient settings, whereas those with a poor support system will do better in inpatient settings.

Drug Testing

Drug testing is the most essential key component of the drug court program. In most cases, it is mandatory for offenders to remain drug free while they remain in the program.

Urine testing is an essential element for the success and progress of the offenders in that it determines the degree of compliance and ensures motivation and abstinence. Frequency of urine testing is to be determined by many factors, including type of substance abused and the program phase. Rewards can be used as behavioral modification. A minimum of twice weekly testing is recommended for effective monitoring.

Drug court treatment programs should have written policies and protocols for the frequency of drug testing, sample collection, analysis, and result reporting mechanisms, with agreements or contracts for compliance with drug testing requirements and release of information. These policies should include well-coordinated strategies for dealing with non-compliance, which may include missed tests, manipulation and adulteration attempts. Both qualitative and quantitative drug screening should be available to effectively monitor the participant's compliance and to deal with challenges to the results.

A well-structured schedule of rewards and sanctions to reinforce positive behaviors and discourage negative behaviors should be incorporated into drug testing and treatment programs. (8, 12) Rewards and sanctions applied in drug treatment court should be scheduled and executed in all cases in a manner to avoid any perception of unfairness or bias after discussion with all members of the legal and treatment teams.

Quality Care and Components of Treatment Services

Treatment services must include combinations of services covering the participant's bio-psycho-social issues in order to be as effective as possible. Treatment services are out-patient and/or inpatient based, as well as court monitored.

Treatment services should cover a wide range of mental health and other health issues, as well as social, literacy, vocational, financial, homelessness, housing, spiritual and legal assistance needs.

Specific treatment services can include counseling, relapse prevention and continuity of care. Treatment programs should also make provision for crisis intervention and detoxification where necessary. Crisis intervention includes management of acute intoxication, management of overdose and withdrawal, and management of medical and psychiatric complications.

Detoxification

Detoxification is essential for certain types of drugs, like opium and heroin. Detoxification is the preparation and stabilization phase before the substance abuser enters a longer rehabilitation process, and is a medically supervised treatment process with trained health professionals.

The need to treat and effectively manage withdrawal symptoms is based on the type of substance being abused and its potential to induce withdrawal after discontinuation of abuse. Detoxification is done in a hospital or health care facility where all necessary services are readily available to deal with complications arising from severe withdrawal symptoms and adverse medical emergencies. Generally, the most widely used approach is slowly to taper off the substance of abuse or to use substitute medications that have characteristics similar to the drug itself.

The duration of detoxification varies from three to five days to several weeks, depending on the type of substance being abused, the duration and severity of abuse, and the individual. Detoxification basically deals with the acute physiological effects of substance abuse.

Drug Court programs should have access to health care facilities and emergency services to deal with medical emergencies such as acute intoxication, overdose and acute medical and psychiatric complications. Prompt referral and transportation services to effectively deal with such emergencies must be in place.

Medication-assisted or Substitution Therapy

Substitution therapy is an option following detoxification for abusers of powerful narcotic substances like opium derivatives or heroin. Opium agonists like Methadone, partial agonists like Buprenorphine, and synthetic opiate antagonists like Naltrexone are used. These programs require close monitoring and highly regulated guidelines for both abusers and health care professionals. Evidence indicates that abusers who participate in maintenance programs experience decreased drug use and decreased crime. (1, 7, 13)

Counseling Services

Drug abuse rehabilitation services involve the application of a wide range of counseling, individual and group therapies focusing on various dynamic and cognitive behavioral approaches, and motivational enhancement therapy for increasing retention in treatment. Family and marital counseling and therapies should be offered where indicated. In Jamaica, the Drug Court (Treatment and Rehabilitation of Offenders) Act requires counseling for a minimum of six months. The duration of counseling services differs from one program to another. Most drug court treatment programs require six months to over a year with negative drug testing, in order to graduate the participant.

Relapse Prevention and Continuity of Care

Research indicates that the first three to six months after treatment are the most vulnerable period for relapse. Continuity of care should be provided through individual and group counseling on a scheduled basis. This could be achieved through the assistance of community support groups, peer support or self-help groups, or NA or AA. Relapse prevention is the most important aspect of continuity of care. Its objectives are to teach the abuser how to avoid negative emotions and temptations, social pressures or triggers, and interpersonal conflicts, and to provide skills and training in how to effectively deal with these stressors when faced. It is a psycho-educational cognitive behavioral self-management approach. (7, 18)

Other General Health Services and Programs

Substance abuse is associated with human immunodeficiency virus (HIV) infections, Hepatitis B and C, Tuberculosis and sexually transmitted infections (STIs). Accessibility and availability of services, screening, testing and diagnosis and treatment and monitoring should be integrated. (14, 20)

Co-occurring Disorders

The presence of both drug abuse and mental health disorders is referred to as co-occurring disorders. Personality disorders, psychosis, mood disorders (such as bipolar disorder, depression and generalized anxiety disorders), and post-traumatic stress disorder can be found in drug abusing offenders. An estimated one-third of drug court participants have co-occurring disorders. The presence of co-occurring disorders increases the risk of arrest. Drug court participants who have symptoms of co-occurring disorders may need specialized treatment by mental health professionals. Some participants with underlying features of personality disorders present with problems of severe interpersonal relationships, which affects their participation in the treatment process and at times, creates tension among participants. Referral for treatment of co-occurring mental disorders and other physical health issues to appropriate health facilities or clinics is also critical. If possible, all treatments should be well coordinated and integrated. (7, 13)

Ancillary Services

Integrating ancillary services into treatment strengthens the motivation of the offenders, enhances the effectiveness of the recovery process, and prevents relapse. Many offenders with substance abuse problems also have problems with homelessness, hunger, unemployment, poor academic achievement and/or low literacy and vocational skills. Food packages, meals, and arrangement of transportation services or bus passes should be included in social management. Interagency coordination and accessibility, and availability of ancillary services determine success of compliance and hence reduce the reoffending rates of program graduates. Therefore, multisectoral networking with involvement from governmental and non-governmental agencies, as well as municipal, charity and faith-based organizations is essential to provide for the needs of offenders. (7, 13, 19)

Application of rewards and Sanctions in Treatment Services

Rewards and sanctions are imposed not only in the court setting but also in the treatment program as tools of behavioral modification and positive reinforcement. Creative methods of rewards and sanctions are based on many indicators such as motivation, compliance, progress, and results of drug tests, punctuality, and achievement during the phases of treatment.

Application of these methods helps treatment providers to help participants to remain focused, motivated, and engaged, and to steer desired behavior (7, 12, 16). The National Institute on Drug Abuse (NIDA) states that effective rewards and/or sanctions are swift to follow a participant's actions; generally perceived as being fair; and graduated or escalating (especially for sanctions). Appropriate rewards for positive behavior are generally more effective in generating desired behaviors than sanctions for transgressions.

Treatment Services for Special Populations

Treatment services provided must be comprehensive in meeting the special needs and sensitivities of populations such as adolescents, women, tribal or ethnic groups, and minorities and populations of different cultural backgrounds. Comprehensive therapeutic interventions should be sensitive to all barriers, and culturally appropriate to the specific needs of the particular special population. (4, 10)

Female offenders in particular have a unique and complex set of needs that should be accounted for in an effective drug treatment setting. Women in treatment have higher rates of program completion and more effective outcomes when residential programs are able to accommodate children; when outpatient treatment offers family therapy and services, as well as individual counseling; and when treatment includes a comprehensive set of support services aimed at addressing special needs of women.

Performance Indicators, Evaluation and Quality Drug Treatment Services

Evaluation and development of performance indicators play a very important role in measuring the success of the program. Despite differences in many drug court treatment programs in different jurisdictions, the ultimate goal is to achieve the objective of delivering treatment services to the target population.

Success in drug court treatment services should be measured by not only on the absolute statistical value but also by qualitative indicators. Perhaps this is the area in which almost all drug court programs face enormous challenges in collecting the data needed to measure success. In fact, evaluation methodology, development of performance indicators and estimated budget should be included during the initial planning phase even before the program commences. Such well thought-out planning will avoid missing opportunities to collect data and to identify control groups to conduct scientific research based evaluation.

Evaluation of process, outcomes, cost effectiveness and benefits of the program determine overall quality of the treatment services to achieve desired goal of the program.

The purpose of developing performance indicators is for drug courts to have the ability to provide research-based indicators to supplement program evaluations. (21) The establishment of clear performance expectations results in a reduction of uncertainty about how to measure drug court performance and establishes the foundation for an ongoing process of program monitoring and improvement. (22)

Performance indicators would be varied based on different jurisdictions, goal and objectives of drug court treatment services and population served. For example, critical performance indicators for Florida's Drug Courts include recidivism, retention in treatment, sobriety and units of service. (21) Many drug court programs develop performance indicators to measure ancillary services such as employment status, educational and literacy services, housing, mental health, medical and dental health, anger management, case management, parenting, transportation, HIV counseling and testing, day care and birth of drug-free babies. (21, 22, 23)

Recovery in drug abuse is a process. Likewise, the concept and theory of evaluation of drug courts is also evolving and therefore challenges and controversies are to be expected.

However, there is no doubt that evaluation and performance measures of any drug treatment program will definitely steer the direction and development of the program and its ability to achieve its intended goal of providing quality services with a vision to bring help offenders with substance abuse problems ems who would otherwise be incarcerated to become responsible and productive citizens of society.

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CHAPTER 4

IMPLEMENTING A DRUG TREATMENT COURT: TWO EXPERIENCES

A BOTTOM-UP APPROACH TO DEVELOPING A DRUG TREATMENT COURT: THE CASE OF GHENT

Judge Jorn Dangreau and Prosecutor Annemieke Serlippens, Ghent, Belgium

As other chapters in this publication note, a drug treatment court (DTC) is a court designed to supervise cases of drug dependent offenders who have agreed to accept treatment for their substance abuse. It is a unique, systematic and coordinated approach to the management of offenders with substance abuse difficulties.[1] The uniqueness of DTCs lies in their ability and willingness to combine the traditional processes of the criminal justice system with those of the drug treatment community. The result has been a blend of treatment and judicial supervision that stands as the essence of the DTC concept. Drug treatment courts import a new culture in the criminal justice system, with the initiative often coming from local judges, prosecutors and/or treatment professionals.

In this chapter, we shall review how the DTC in Ghent evolved in the Belgian legal system, and look at its operations, the advantages it has brought, and the challenges it has faced since its introduction in May 2008**.** We conclude with some recommendations to those who may wish to set up a DTC in their own jurisdiction.

The Belgian Legal System

Belgium uses the continental law system, which means that the investigation is led by the Office of the Prosecutor and is non-adversarial. It is a written and confidential investigation. The prosecutor has absolute freedom to conduct the investigation and to decide on the outcome, to dismiss a case, to file charges before the court or to use alternatives (principle of opportunity). The criminal file is the key element.

Once the investigation is complete (written file), the public prosecutor has a wide range of possibilities: He or she can decide that there is not enough evidence and dismiss the case; he/she can determine that there is enough sufficient evidence but a court proceeding would not be suitable (e.g., a young first offender who indemnifies the victim – if he comes before the court, he will have a criminal record, which will cause him problems finding work), in which case, the prosecutor can dismiss the case (that is, e.g. the condition that the victim of the crime is indemnified); or, as a fourth option, the prosecutor can start a mediation procedure.

Only in the last case will an adversarial hearing be held and the judge becomes involved. The prosecutor summons the accused to appear on a certain day in court. The accused, the victims, the prosecutor and the judge have equal access to the written file, which was compiled under the leadership of the

[1] See Key Component/Principles, Page 121.

prosecutor. Everybody has the right to claim that the investigation is not complete and ask for further investigation (this occurs in a minority of cases). The judge determines whether further investigation is necessary. In most cases, however, the judge hears the case on the first day, in the presence of the victim, the prosecutor and the accused, and a judgment is rendered on the same day.

The Classical Approach to Drug Abusers

Belgian drug legislation is based upon three starting points:

- The need for prevention for non-users and non-problematic drug users;
- The need for care and resocialization for problematic users;
- Repression for the producers and dealers.

Within this philosophy, the legislation offers several possibilities of referring the problematic drug user to treatment, regardless the seriousness of the crime that he committed or the criminal history of the person. The drug legislation gives the judge a broad range of possibilities (from no sanction to five or ten years imprisonment).

However, under the classical approach to drug abusers, the public prosecutor had no real means of diverting drug abusers to treatment. Only in the case of drug-related crimes with an identified victim could the alternative measure of mediation be used. If the offender is prepared to indemnify the victim and willing to tackle his drug problem, he may be sent to treatment by a 'mediation officer' (a kind of probation officer who works for mediation in the public prosecutors' office). A kind of contract is set up between justice and the offender, and for six months, the mediation officer will follow up on the case. If the offender does what he promised, the case will be closed and can never be opened again (which is stronger than a case which is dismissed). If he fails, he will be sued before the court.

For drug abusers who are abusing drugs without drug-related criminality, or if there is no identified victim, this mediation procedure cannot legally be used. In the classical approach, the public prosecutor has no means of sending drug abusers to treatment, and probation officers or mediation officers cannot work on the level of the public prosecutor without a legal frame. The only possibility is to ask the police to send an offender to treatment and then ask the offender to prove this with a document in the written file. The problem is that a referral to treatment is not a police task and follow up is not possible.

In the classical approach, then, if follow-up is necessary, the only possibility open to the prosecutor is to sue the drug abuser in court.

When a drug-dependent offender was charged by the Office of the Public Prosecutor, the judge's classical approach would be the same as in other cases, that is, he will hear the case and render a judgment on day one. When the offender has a drug problem, the judgment would most likely be a conditionally suspended imprisonment, meaning that the offender would not have to go to prison if, for a certain period of time, he met the conditions he agreed upon.

In this classical system, the case (based on the written file) was heard and on the same day a judgment was handed down. However, the offender walked out of the courtroom and had to wait for at least

three to four months before he was invited by the Probation Board to discuss the conditions imposed on him and was sent to the treatment providers.

If he failed to meet his conditions, the Probation Board had to make a report on the offender's non-compliance and transfer the file to the Office of the Public Prosecutor. The public prosecutor could then file charges against the non-compliant offender and ask the judge to revoke the suspension of the imprisonment.

The Failure Of The Classical Approach

Over the years, the Justice Department, the prosecutors, and the judges came to realize that the classical system was failing. They realized that a response from the police, the Public Prosecutor's Office and the courts toward drug users should be the *ultimum remedium* (last resort). These actors are, after all, not the appropriate people to formulate an answer to a social phenomenon such as drug use. Besides, they are no longer capable of doing so, due to the growing overload of the criminal law system in general and the prisons in particular. Alternative measures should therefore be used to refer as many drug users as possible to drug rehabilitation, where the root of the problem will be tackled.

Drug (ab)use is no longer a justice issue, but became a social and public health issue. Concerning drug related crimes, belief grew that by tackling the underlying drug problem, recidivism could be reduced**.**

The experiences of the prosecutors were that there was need for a kind of go-between between treatment and prosecutor in order to refer drug abusers to treatment under the supervision of the public prosecutor. Drug abusers should not be sent immediately to court. The prosecutors considered that there was need for a different measure for drug abusers with a follow-up system. If that failed, the second step would be to bring the drug-dependent offender before the court.

The judges' experience was that the system of the conditionally-suspended imprisonment was not able to get drug-dependent offenders clean, and that the system failed to meet its own objectives or the objectives set by policy-makers.

They saw that the defense lawyer and the accused said the accused was willing to enter treatment just to avoid immediate imprisonment, and the drug offender was thus able to abuse the system. They also found that in general, the conditions set were not appropriate for the accused, and that once a judgment was rendered, the role of the defense lawyer ended. In short, the whole procedure seemed to be a very large investment with no net gains for society, as in the end the offender continued to be addicted.

New Directions

Out of this awareness came several possibilities for referral to drug rehabilitation that were developed at different levels of the criminal justice system. The justice system in Belgium is centrally organized. There are twenty-seven judicial districts, and in every district, there is a court and an office of the public prosecutor. Within the existing legal framework, the offices of the public prosecutor and the courts can set up pilot projects without changing legislation. Two pilot projects were developed in the judicial district of Ghent over the last years: *'Proefzorg'* on the level of the Public Prosecutor in 2005, and the

drug treatment court itself in 2008. This was made possible because Ghent has a well-organized drug treatment system, and because the city provided support in the form of a drug steering committee, with representatives of the city, the police, the office of the public prosecutor, and treatment providers. The pilot projects also had scientific support from the University.

***PROEFZORG*: An Alternative Measure Used by the Prosecution**

In 2005, the Public Prosecutor's Office of Ghent introduced *Proefzorg* as a pilot project. *Proefzorg* is an alternative measure that can be used by the prosecution for drug-using offenders who come in contact with Justice only because of their drug abuse. *Proefzorg* is the first step in diverting drug abusers to treatment. It is located in the prosecutor's office so that at the end of the procedure, if the offender succeeds in *proefzorg,* the case will be dismissed and the offender will have no criminal record. If the offender fails in *Proefzorg,* the second step will be a court proceeding. *Proefzorg* exists alongside the mediation procedure used in the classical system described above, which is still used for drug offenders who committed drug-related crimes with an identified victim.

The pilot project was written by justice system officials (a public prosecutor from Ghent and a former mediation officer of Ghent) together with representatives of the treatment sector and presented to the Minister of Justice. Two new actors were created: the *Proefzorgmanager* (in the Justice Department), who forms the bridge, or liaison, between the criminal justice system and the treatment services, and the two treatment coordination centers, which serve as the contact points for Justice, perform the intake procedure and refer the offender to the most appropriate treatment center.

The objective of *Proefzorg* is to divert drug dependent offenders to treatment rapidly (through early intervention); efficiently (minimal obstacles and maximum cooperation between the judicial authorities and the treatment services), and effectively (positive outcome). The aim of *Proefzorg* is to avert recidivism and to stimulate the reintegration of the offender into society.

A prosecutor who decides to start a *Proefzorg* procedure sends the written file to the *Proefzorgmanager*. The *Proefzorgmanager* invites the offender into his office and interviews him or her about his or her drug problem and other possible related problems. Based on the estimated severity of the drug problem, two types of *Proefzorg* are available: short-term and long-term.

The short-term *Proefzorg* is for non-problematic drug-using offenders who have no indications of problems in other life spheres. The procedure consists of one interview in a coordination center, with the goal of introducing the person to the treatment services. If the outcome of the treatment is positive, the file is dismissed. If the result is negative, the individual will be prosecuted before the court.

The long-term *Proefzorg* is for problematic drug users who also have problems in other spheres of their lives and who have a record of previous drug-related cases. The offender will have three intake interviews in a coordination center, and then is referred to the most convenient treatment center. Justice follows up with written reports to the *Proefzorgmanager* for a period of six months. Again, if the outcome is positive, the file is dismissed, but with a negative outcome, the offender will be prosecuted in court.

When an offender fails in his *Proefzorg* procedure, the public prosecutor will file charges against the offender and the case will be heard at a court hearing. Because the Office of the Public Prosecutor started to centralize those cases in which crimes were committed because of an underlying use drug problem, the court hearings were loaded up with such cases. As stated earlier, it became painfully clear that the classical approach was not able to give an adequate response to the offenders.

An evaluation was conducted of the first two years of the *Proefzorg* pilot project. [2] From the 388 files that were analyzed, only 3% failed in the short version *Proefzorg* (40%) and 36% in the long version (60%). *Proefzorg* was evaluated as being sufficient to make up for the prosecutor's inability to divert drug offenders to treatment. Before *Proefzorg,* the prosecution had no means of diverting drug abusers to treatment and conducting a follow-up unless he brought them in front of the court. With the introduction of *Proefzorg*, there was an appropriate answer for each offender. Based on 41 semi-structured face-to-face interviews and one focus group with police, judicial authorities, treatment services and drug users, a process evaluation was conducted of the adequacy of the design, the structure of the project and the role satisfaction of the participating actors. There is strong evidence of a successful cooperation between the criminal justice system and the treatment services. Most of the respondents were pleased with their role and had a positive attitude towards the project. The critical elements (the standard form for feedback, the role of the *Proefzorgmanager*) were recommended as an example for developing or optimizing other alternatives. On the other hand, there were some bottlenecks: the lack of sufficient treatment capacity (especially crisis centers) hinders fluent diversion from criminal justice system into treatment centers.

The former Minister of Justice decided to implement the Ghent *Proefzorg* system in the Belgian judicial system, and formulated an initial proposal on how to do so. This procedure is still pending.

DEVELOPMENT OF THE GHENT DTC

Confronted with the failure of the classic court hearing, a judge and a prosecutor from Ghent decided to study drug treatment courts in the United States and Canada. They received a bursary in 2007 and went to visit different DTCs. It became clear to them that there is no such thing as a manual on DTCs: most of the DTCs they visited differed from one another in order to cope with their respective local situations.

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Returning from their study trip, they were convinced that it was feasible to implement the principles of the DTC in the existing Belgian legal system.

It is important to emphasize that – as in most countries -- the Belgian criminal justice system is organized centrally by the central government. As a consequence, the system can only be changed when a political and democratic process takes place in Parliament and the necessary adaptation of the existing legislation is voted. Because this political process takes a great deal of energy, is very time consuming, and its outcome is uncertain, the judge and the prosecutor decided to focus on the possibility of implementing the DTC principles[3] without the need to alter the existing legislation. They did this together with representatives of the Defense Bar and representatives of treatment providers.

[2] DE RUYVER, B., COLMAN, C., REYNDERS, D. e.a., *Een brug tussen justitie en drughulpverlening. Een evaluatie van het proefzorgproject*, Antwerpen, Maklu, 2008, 199 p

[3] Key component/principles of DTC. See p. 1.

The focus of their approach was how to develop and put in place a court-supervised treatment without the need to change the legal system.

As long as the procedural aspects of the legal system are respected and the criminal law itself is obeyed, the courts have the opportunity to organize their way of operating themselves. Of course, they are bound to give an annual report on their functioning to the High Council of Justice.

After drafting a text in which they outlined their thoughts, they started to discuss the creation of a DTC in the court of Ghent with the local actors (the bar, treatment providers, judge and prosecutor, street corner workers, Probation Board and others). Discussions went on for eight months, and in the end, they were able to develop a consensus text with clear commitments of every actor. They presented the consensus document to the Minister of Justice, in order to receive funding to employ the key person in the project, namely, 'the liaison', who would be the bridge between the court and the treatment providers.

After receiving this funding, the President of the Court gave them permission to establish a pilot in the Court of Ghent. The pilot itself demanded more efforts and energy from the individual Judge and Prosecutor, the clerk of the court and administrators. Besides the permission of the President of the court, much goodwill was needed from everybody involved. The Ghent Drug Treatment Court was introduced in May 2008.

Key Elements in the Implementation of The Ghent DTC

The Ghent DTC is a specialized chamber within the Court of First Instance that offers the accused the possibility to work on his or her (drug) issues under the supervision of that chamber. Within the DTC, the Public Prosecutor and the judge are specialized in drug issues, and each hearing is attended by a liaison. The liaison is a care provider who establishes a link between the justice department and the drug rehabilitation services. The liaison assists the accused/client to find the most appropriate type of rehabilitation for that specific accused/client. The liaison also helps with further referrals within the drug rehabilitation field.

Hearings

A case is dealt with through different hearings: an introductory hearing, an orientation hearing, a follow-up hearing and a closing hearing.

First, the accused is summoned to an introductory hearing. When the accused recognizes the facts that he is being accused of and the drug issue itself, the judge examines whether he is willing to do something about his problem. If not, the case will be immediately treated in the traditional way. Otherwise, he will be brought in contact with the liaison attending the hearing on the day of the introductory hearing to agree upon a date of appointment with the liaison.

Together with the liaison, the accused develops a rehabilitation program that focuses not only on the drug issue itself but also on all other aspects of life, such as work, debts, and housing. The liaison informs the accused/client about the existing drug rehabilitation possibilities (e.g., outpatient care or residential care) and their precise content. Together, they develop a treatment program adjusted to the specific issues of the accused/client.

Two weeks after the introductory hearing, the accused/client attends an orientation hearing during which he presents and clarifies the treatment program prepared in consultation with the liaison. All actors discuss and evaluate the program. If the Court accepts the program, the actual execution of the

program will be monitored. The liaison will continue to assist the accused during the length of the program.

The accused/client must appear in Court at least every two weeks during the first months to demonstrate that he is strictly following the agreed treatment plan. After that, at least once a month, follow-up hearings are held, which he must also attend. Those hearings allow the same actors (judge, Public Prosecutor's Office, defense lawyer) to closely monitor the accused/client for six to twelve months. The rehabilitation program can be adjusted to the accused/client or adapted when the program is not working properly. The Court asks the offender to bring the results of urine testing. We allow the offender to get the test done (producing the urine sample under supervision) with a doctor of his choice.

If a urine test is positive, this might lead to further discussion and eventually to an alteration of the rehabilitation program. A person in out-patient therapy might, for example, have to go into residential care. It could also be that the offender will have to come to court hearings more often and produce more urine tests, with the agreement that when the test is positive, there will be a final hearing.

The sentence and the conditions that could possibly be imposed are determined during the final hearing. The advantage is that, concerning drug related issues, the legal landscape is favorable.

LESSONS LEARNED

A scientific process evaluation of the Ghent DTC was conducted by the University of Ghent in 2000 – 2011.[4] A public tender was awarded in 2012 for more scientific evaluation, particularly an impact evaluation study. This study will conduct comparative research into the effects of a traditional settlement in court compared with an alternative settlement in the DTC.

We summarize below the strengths of the Ghent DTC, based on the process evaluation and our own experience. We also look at the challenges that lie ahead, and conclude with some recommendations for others who may wish to develop a DTC in their own jurisdictions.

Strengths of the Ghent DTC:

Stakeholders' Experiences

Overall, all actors involved are satisfied with the DTC, but they are not blind to certain weaknesses.

An analysis of the actors' experiences with regard to their core tasks shows that all parties concerned are satisfied with their role in the DTC. Moreover, the DTC project encourages a good relationship between the justice department and the rehabilitation services.

Clients' Perceptions

In general, the clients of the DTC are favorable to the project as well. They mainly consider the DTC as an opportunity to get their lives back on the right track and to make something of their future. They emphasize the interactive character of the DTC. The clients of the DTC also appreciate the humanity of

[4] C. Colman, B De Ruyver, F. Vander Laenen, W. Vanderplasschen, E. Boekaert, S. De Keulenaer, S. Thomaes: ***De Drugbehandelingskamer: Een andere manier van afhandelen - Het proefproject geëvalueerd*** Antwerpen, Maklu, 2011, 164 p

the judge. Finally, they attach great importance to the liaison, especially because of the relationship of mutual trust they can establish with the liaison.

Role of the Liaison

The new actor, the liaison, is without doubt the cornerstone of the DTC project. We may even say that without the liaison, the project will never succeed. The interviews with all parties concerned show that the liaison is an important link between the Justice Department and the drug rehabilitation services. The liaison ensures that the judge imposes conditions adjusted to the possibilities of the accused and/or the rehabilitation services. After all, the liaison and the client prepare an individual program taking the client's specific situation into account. They consider not only the drug issue itself, but also possible problems affecting other aspects of life that maintain or even strengthen the drug issue. This is the only way to effectively counter the accused's drug issue.

The Complex Issues Of DTC Clients Demand A Versatile Approach

A case study of one out of three DTC cases shows that the rehabilitation program usually covers multiple aspects of a participant's life. Apart from having problems with illegal drugs and alcohol, many persons accused are unemployed, have mental health issues and high debts. The efforts that clients make for each of these and other aspects by searching for assistance and support, including, for example, starting outpatient drug treatment, following a training course with the Flemish Public Employment Service (VDAB) and accepting debt mediation (which means renegotiating debts after personal bankruptcy). All of this help in overcoming their problems contributes to their social reintegration and could lead to a reduced sentence. Clients are responsible for proving those commitments in front of the judge by presenting stamped attendance certificates.

Successfully fulfilling the planned treatment plan is no sinecure: about one in three initiated DTC programs have a positive outcome. Although this is not a spectacular number, this means that by establishing the DTC, it was possible - in the short term and without enforcement of the sentence - to improve the lives of a substantial number of problematic drug users who otherwise would have received a traditional judgment.

The Justice Department Pays Attention To The Reality Of Drug Use

Unlike in other cases, the judicial actors also take into account the reality of drug use and the possibility of relapse during a drug rehabilitation program. After all, a relapse is inherent to the drug issue. Through the DTC, the judge tries to actively counter the periods of relapse that problematic users experience, keeping in mind that a relapse does not necessarily entail an immediate suspension of their participation in the DTC program. A relapse can be part of the healing process, as it may be used to raise or strengthen the offender's awareness of the seriousness of his problem. After a period of relapse, it will be easier to convince the offender to alter his or her rehabilitation program in a stricter way.

CHALLENGES

DTC Requires More Time In The Short Term, But Will Probably Imply A Gain In Time In The Long Term

Through interviews and focus groups, the various stakeholders underlined that they spend more time on a case during DTC hearings than during traditional hearings. Nevertheless, this investment of time is

considered meaningful given the long-term effects of the work (decrease in drug use and crime, improvement of other aspects of life). A comparison of the follow-up periods for probation and DTC cases has shown that the follow-up period in probation is longer than the one for DTC cases. This difference indicates that it is difficult to estimate which form of settlement, traditional or probation, will require more time and energy in the end.

The Job Description of the Liaisons Needs to be Clarified

The task description of the liaisons is a significant weakness: how the liaison works with the other stakeholders and especially with the probation officers, does not always seem to be clear to the actors in the field. The same goes for the professional secrecy of the liaisons towards the probation officers and the judge. Some care providers wonder if information is passed on to the Justice Department.

We also note the heavy workload of the liaisons, especially during the early stages of the program when the treatment plan is being drafted. Still, the liaisons consider their task worthwhile, precisely because it allows personalized assistance.

The DTC project – unintentionally – puts greater pressure on the capacity of the rehabilitation services

For some years, the Ghent region has been confronted with the limitations of the already extensive rehabilitation possibilities. The referrals coming from the DTC project put even greater pressure on the rehabilitation capacity. Several drug rehabilitation centers currently have waiting lists, which may hamper the referral of the DTC clients. This does not match the aim of the DTC to provide a fast and efficient referral to treatment. If the capacity issue cannot be solved in the short term, the DTC project could become a victim of its own success. After all, the proper functioning of the DTC depends on the speed and the quality of the referrals.

LESSONS LEARNED/RECOMMENDATIONS

If you are considering setting up a DTC, we suggest looking at the following issues to see whether your system deals with problematic drug users in an effective way:

- Is the criminal justice system able to constructively respond to the complexity of (illegal) substance addiction?
- Can it cope with the realistic situation of relapse?
- Can it cope with the fact that there is the need for trial and error within the scope of different treatments?
- Is recidivism prevented by the way your legal system deals with crimes committed by problematic drug users?
- What is the cost-benefit of the approach of the existing legal system? What are the costs? what are the results?
- Does mere imprisonment appear to solve the problem?

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When considering the answers to these questions, you will probably find that your legal system is indeed dealing with the problem, but might be able to deal with it in a better way. It is our experience that, as long as the underlying complicated drug problem is not solved, people tend to keep on having judicial problems.

Analyze your own legal system: A plea for bottom-up approach

If you are convinced that your legal system is dealing with problematic drug users in the right way, there is no need to change your system. The 'you' in the previous sentence can be anyone who is part of the legal system. Dysfunctions can be detected at all levels of the judicial system (investigation-prosecution, defense, judge, and execution of the judgment). Quite often those dysfunctions stay at the level where they were discovered, leading to frustration of the person that encounters them. This may be, for example, a policeman who is always encountering the same problems with the same persons even after those persons went through the legal system and after a judgment is rendered.

The Ghent DTC was a bottom-up local initiative by individuals. It only takes one person to start an initiative to improve the way of handling problematic drug users. The moment that person starts cross-discussions with the other actors about the problems, everybody will have a "helicopter" overview that most likely will lead to the insight that the classical legal approach fails to deal with problematic drug users in an efficient and effective way.

DTCs were first implemented in the United States. After gradually and continuously spreading within the United States, they started to spread to other countries, mainly those with a common law system. Rarely do we see the development of DTCs in countries with a continental law system. Two reasons can be mentioned for this trend: (1) the feeling of superiority of one legal system to the other system (our system works perfectly, there is no need for alteration); and/or (2) the feeling of superiority of one society above the other society (we do not have that kind of problem).

This became quite clear when we presented the development of our DTC (the first in continental Europe) to the drug coordinators of all countries of the European Community, where we discovered that much of the reluctance and criticism of DTCs stems from the fact that they were developed in the United States and because of that are regarded as not transferable to the European situation.

The reluctance towards further implementation of DTCs is also induced by the fact that almost everywhere, efforts were made, and this went hand in hand with changing the legal system toward common law principles. Apparently, people think that implementation of a DTC goes hand in hand with the adaptation of some of the principles of the common law system. This view makes a top-down approach inevitable. With that approach, the development of a DTC will likely require many changes to the legal system itself and of course a majority of policy makers that are willing to change the system. The problem that results is that it may be hard to implement the DTC in your local community as it will be forced upon local actors by a central government.

Focus On Key Principles Rather Than On The Specific Legal Process

In our humble opinion, that is a wrong starting point. When thinking of implementing a DTC, the *focus should be on the key principles, and not on the legal system.* Before adapting or changing the legal system or the law, it seems to be essential to analyze your own legal system in light of the key principles. It is our strong belief that it should be possible to find a way to adapt most of the key principles in the existing legal system. When able to follow this approach, it will enlarge the acceptance of the DTC project in your community because you stay within your own cultural and legal framework. In every country, even when they have the same legal system, there are differences in the way defense lawyers, prosecutors, judges and treatment providers will handle cases and the way they will interact. If you are able to work within the traditional legal process, whatever it may be, and the way most cases are handled, it will be easier to convince "stakeholders "of the need for another approach.

A wide range of actors should be involved

Many actors need to be involved in a local, bottom-up approach to creating a DTC: the criminal justice leadership, the city government, treatment providers, and defense lawyers.

Once one person becomes convinced that the way the legal system deals with drug dependent offenders has to be changed, he/she should contact other local professionals to discuss his findings. This will spur discussion and the search for solutions.

Often, however, the individuals are operating on 'islands', making it very hard to find the right partners with whom to discuss the matter, and it may take some time before the right persons are able to sit together. You should determine all possible actors involved or to be involved in the future. This will make you aware of the possible involvement of a range of individuals and organizations. Meeting them and showing interest in how they function will raise mutual interest and understanding.

Establishing periodic meetings will enhance communication and will induce trust among the different organizations. Once there is interest in investigating the possibility of implementing a DTC locally, you need to discuss the matter further with the right people, who at a minimum include judges, prosecutors, defense lawyers and treatment providers.

Discussing the matter is not enough. It is essential that every person is able to speak for an organization. It is no use having a person from treatment who believes strongly in the need for change when he has no authority with treatment providers. It is no use having a public prosecutor who is not able to convince the head prosecutor of the need for change, and so forth. However, it is clear that merely establishing contacts with other actors can give you authority within your own organization.

Our experience is that the following were very useful in setting up the DTC in Ghent:

- Involving judges and other judicial officials in the DTC process early on to provide a first-hand look at operations and strengths.
- Ongoing meetings, evaluations and training keep officials involved and maintain their "stake" in the process.
- Inclusion of any positive evaluation report on DTCs can be valuable in gaining judicial support.
- Reference to the growing international success of the DTC approach.

The importance of local government

The public health issue is unavoidably a city issue, in view of the DTC's need for all of the local resources. Often political authorities are necessary to take financial decisions. Given the often rapid changes in local politics, a memorandum of understanding signed by the government and the opposition is very important for the continuity of the financial support and the stability of the DTC program.

On the other hand, as we noticed, the introduction of a DTC often is a very rational move which makes it easy to convince every political party. It is surely not a 'soft' approach to the drug-dependent criminal.

Drug-related criminality in particular is, in most cases, a local (criminal and public health) issue. The drug problem will not only bring a local increase of crime but also local nuisance (e.g., needles in playgrounds, people begging ...), housing problems, employment problems, local welfare problems, and so forth.

Because drug dependency involves a broad range of problems, we need all of the local resources involved into the process of getting the lives of drug dependent offenders back on track**.**

In this respect the local government can have or should have a leading role and be the engine of change by bringing together all of the local actors in a structural way.

The coordinating role of the city

It might be wise to appoint a 'drug coordinator' on the level of the city, aiming to bring together all partners in order to discuss local drug policy, highlight dysfunctions and propose solutions. In this way, the city can provide for the needed coordination of the different actors and try to gather them on neutral ground.

The city could also provide the financial means to establish a coordinator between the different drug treatment centers and the other agencies or force them to be organized in such a way that one person can speak for all of the organizations that have the same goal. Rehabilitation centers and the other agencies should not be regarded as competitors but as complementary to each other.

By taking this coordinating role, the city can establish the kind of local dynamics that are essential for the local community and for future development of a DTC. The structural reflection amongst judges and other involved persons can speed up the process of understanding and mutual trust and can be the perfect starting point for the development of a DTC.

Drug addicts need a broad range of resources: they need to be treated for their addiction as well as underlying conditions, including mental health (estimated to affect 80% or more of the addicts in the criminal justice system), and many other problems, such as housing, welfare, literacy, and job training. One of the key lessons our experience has taught us is that most frequently substance abuse is but the presenting problem, with many other underlying problems needing to be addressed. Underlying conditions, or risk factors, may include negative personal associations and social pressure, negative emotional states, lack of adequate educational or employment opportunities, a lack of safe and adequate housing, and co-occurring mental health/addiction disorders, among others.

Concerning co-occurring disorders, DTC's may want to adopt an integrated approach that draws on treatment methods for both drug addiction and psychiatric disorders. Integration of agencies is especially important here - not only drug treatment, but also psychiatric treatment providers, physical health providers, housing agencies, employment agencies, and so forth. Screening and assessment should address the possibility of co-occurring disorders and be able to assign treatment appropriately. Treatment can include both medication and cognitive-behavioral therapy.

Treatment Of Drug Addiction Must Be Seen As A Community Issue, Not Simply A Criminal Justice One

Considering the wide range of problems a drug-addicted offender can encounter a wide range of various agencies and organizations (government, NGO, community) need to be in place to provide the essential support for drug court programs. City leadership can play a major role in spearheading and coordinating the support of these local services, which need to work together collaboratively rather than each on their own island. Ideally, these services should be in place when the program begins.

The importance of social embedment of the DTC should not be underestimated. It is very important to develop awareness in all sectors of the community that treatment of addiction for drug dependent offenders is a community issue, not simply a criminal justice one. It is also essential to let the community know what these programs are doing, and what impact they are having on public safety, public health and community well-being.

Drafting a consensus text amongst the local actors

The actors that need to be involved are the prosecutor, the judge, the bar, the treatment side and the probation office. Every actor will undoubtedly have his or her own input during the discussions. In this way the development of the DTC will be balanced and tailor-made to your own local situation (culturally and legally).

We discussed the text on the functioning of our DTC on a regular basis for eight months and discovered that in the beginning, there was a great deal of misunderstanding and lack of trust, mainly between the lawyers and the treatment providers. Mainly this arose because the treatment professionals were not familiar with the judicial language that the lawyers used, while the lawyers were not familiar with the language of the treatment providers. It took time to convince them that we had a common goal and to fine tune both viewpoints.

Take the text to the policy makers

The implementation of a DTC is an adventure undertaken together with all of the other actors, which starts with a consensus text between the actors and many unexpected things will happen once started.

Once you manage to develop a consensus text agreed by all the key players, the search for financial support can start. In our experience, it is a very strong signal if you can go to policymakers as a team (with representatives of all actors involved) and with a detailed solution for improving the way of dealing with drug dependent offenders. Because the approach is essentially multidisciplinary, many policymakers will accept the value of it. It will be easier to convince them that the investment of tax money will have a positive outcome.

Bottom-Up "Grass Roots' Approach Should Shield The DTC From The Impact Of Political Instability At The Top

Because no further extended legislation is needed and the project starts on a small scale, it is easier to persuade policymakers to make the necessary investment. At the same time, a scientific evaluation of the pilot project can be ordered to objectify the merits.

Using a bottom up approach, the creation of the DTC is less dependent on the policymakers themselves. Political instability will not affect the future existence of a DTC that is supported by the local actors. The importance of networks of practitioners that policy makers cannot stop regardless of changes in leadership must be stressed. The various treatment service agencies, together with all other actors, will provide a framework that will enable programs to survive changes in leadership. Involving NGOs or similar structures can provide crucial stability, and a Memorandum of Understanding among agencies can ensure continuity.

Be creative and flexible

Legal systems and the actors involved in them tend to be very conservative. If you want to implement a DTC in your own legal system, it will demand considerable creativity and flexibility. Once the legal framework is set out, it is essential that different actors get involved in the process of establishing a DTC as soon as possible.

There is no use trying it on your own

If you want to establish a DTC, there is no use trying it on your own. If you want to have a well-functioning system, you need to gain the trust of everybody you will encounter once the DTC is implemented. If, for example, the treatment providers do not trust the way the court is dealing with the

drug offender, they will be very reluctant to share any information, making it impossible for the system to work as it should.

If the public prosecutor does not want to adapt his policy towards drug dependent offenders, almost no cases will be brought in front of the DTC. If a defense lawyer is not familiar with the way a DTC functions, he will not be able to give proper assistance to the drug dependent offender. If the judge wants to apply DTC principles, he needs to be able to do so in the right setting and in cooperation with the public prosecutor and defense lawyer.

Sustainability, Continuity And Stability: Strategies To Promote On-Going Communication And Program Refinements

Whereas in the beginning, the further development of the DTC depends a lot on the individuals who were negotiating the project, it is essential to create structures to give the project sustainability and stability.

As there is no such thing as a manual on a DTC that can prepare you for all of the interagency , policy as well as operational issues entailed, be prepared to encounter many difficulties during the operational phase. It is essential that the different stakeholders gather periodically in order to discuss the problems that may arise.

In Ghent, we implemented different kinds of reflection groups. There is a steering committee where judge, prosecutor, bar and people from treatment side gather on a regular basis. There is also a steering committee on treatment to help to develop further on the function of the bridge between the justice department and the treatment providers.

All of the problems that arise can be discussed in an open way. By doing this the different solutions that emerge will be supported by the local actors.

Experience shows that there is need for an ongoing reflection on how things can be improved. The problems of drug dependent offenders may not be narrowed down to problems with illegal substances. On the contrary, quite often you may notice that the focus primarily has to be on another life domain. Most of the time, the drug dependent offender has to cope with housing problems, problems of unemployment, general administration problems, and financial problems.

Appeal to local agencies

It is essential to strive to have a broad social embedment of the DTC. Together with the team, you need to gain the trust of the different local agencies needed as well as for them to understand the different approach the court will be using.

By doing this, you create local dynamics that are hard to stop. At the same time, you gain more support from local policy makers and trust from central policymakers.

In the long run, you will need to promote the creation of memoranda of understanding between the different agencies, in order to make sure that the situation is clear-cut and that tax money is allocated in an efficient way.

It happens, for example, that outpatient drug treatment has a division to help people with housing problems. It is sounder to evolve to a situation where outpatient drug treatment can make an appeal to existing housing agencies to help them sort out the housing problem without a lot of administration involved.

The role of the city government in spearheading the creation of memoranda of understanding cannot be underestimated. The structured approach of the DTC can induce understanding that cooperation in a coordinated way is essential and, in and of itself, cost effective.

Provide Training (Multidisciplinary And Specialized) For The Different Actors

The DTC approach calls for ongoing training of the different actors. For continuity's sake, it is wise to develop special training for each of the actors involved. The development of a detailed manual for the judge, the prosecutor, the liaison and defense lawyer will ensure continuity and stability.

Because the focus lies on a multidisciplinary approach, it is wise to provide some multidisciplinary training as well as specialized training sessions. This will help overcome the bottlenecks in relations between the criminal justice system and the health services. Such multidisciplinary trainings can lead to a good knowledge of the other actors and their procedures, which is of course beneficial for the functioning of the DTC.

Everybody has to have broad notions of the content of each other's job. That means that the training has to focus both on processes and procedures, and also on addiction, the effect of addiction on the brain, cognitive functions and how people act and comply with directives. Multidisciplinary training will affect how the criminal justice system needs to relate to these offenders, the expectations for their performance, and the services/support they will need.

Other potential issues

The physiological and psychological causes of addiction may need to be addressed when linking DTC participants to appropriate services during the screening and assessment phase. It is also important to examine the role of appropriate rewards/sanctions (possibly offered on a graduated scale) in maintaining compliance with the expectations of the court and treatment providers.

Because the DTC offers the possibility of court-supervised treatment, it is obvious that the roles of the various actors will differ considerably from their roles in normal court proceedings. Every actor should be aware of the fact that his attitude and way of addressing the offender can contribute to the healing process. Precautions should be taken to ensure that the attitude of one of the actors does not interfere with the carefully established relation between the drug offender and another actor. In this respect, it is very important to know how the different treatment programs are functioning. .

It is also good to give every actor the opportunity to conduct a training and besides that to create mutually interesting trainings, for example motivational interviewing techniques.

Contacts with international organizations such as NADCP, IADTC, American University, and CICAD/OAS provide a lot of interesting information and insights into a better way of dealing with drug dependent offenders. It is very important that every actor keep on investing in means of improving the way problematic drug users can be helped. The international approach helps to spread good practices amongst professionals.

Collect Data and Explore Them Scientifically

Maintaining ongoing public and political interest requires that you demonstrate the long term effectiveness of the DTC approach. To do so, you need to seek scientific help and determine together with them which data you will collect.

It is important that the classical approach is monitored well and compared to the DTC approach. Not only the simple cost of court proceedings should be monitored but also the long term gains for society, such as employment, avoiding prison, avoiding recidivism, the cost of crime, and trust in the judicial system.

In our opinion, the little extra cost of DCC court proceedings will be gained back by the efficiency of the DTC proceedings.

The results of a well-grounded evaluation should be enough to persuade the policymakers to invest more in the DTC approach.

Scientific evaluation is of course also important to determine problems and suggest solutions for difficulties encountered by the DTC. It can determine bottlenecks and reach solutions, and it checks whether the project meets the objectives and is operating as it was intended. By proposing clear results to the policy makers, the cost-effectiveness of the DTC approach and, thus, the need for further support can be proved**.**

Develop communications strategies

You need to organize ongoing communications about the DTC project, nationally as well as locally. In this way you can communicate local progress leading to a better local embedment which will induce the cooperation with other local agencies.

Good communications tend to be very beneficial in the local market leading to more interest from the public and other national organizations.

It is quite important as well to communicate the results of scientific evaluations to raise an ongoing political awareness and awareness of the public.

In addition to ongoing training and communication among professionals, it may be important to develop and maintain support among the public in order to ensure operational consistency. With public support for DTCs, it may be more difficult for changes in leadership or staffing to lead to regression in the court's philosophy.

CONCLUSIONS

The classic legal approach is very black and white. The message given to a problematic drug user will be quite simple: "You immediately have to stop using those illegal substances." Even in the classical legal approach, people will often have the opportunity of seeking treatment for their problem, but the message stays the same and does not correspond to the understanding that drug dependency is a chronic, relapsing disease that must be treated. Starting from this understanding, we have to rethink the way of dealing with people suffering from a drug dependency.

We have learned in Ghent that:

- Generally DTCs are more effective at reducing recidivism than the regular courts.
- They often deliver a better benefit/cost ratio and, in some cases, may be more cost-effective overall.
- The benefits go beyond cost and recidivism: DTCs result in health benefits to participants, family, and communities; and on the other hand in public safety benefits.

- DTCs represent a cooperative, rather than punitive and adversarial, approach to dealing with drug-dependent offenders.
- Existing evaluations have shown positive results.
- The DTC approach can help to restore the public's belief in the judicial system as well as promote recovery by (a) providing time for individuals to internalize external motivation; (b) the opportunity for an appropriate treatment plan can be developed, taking into account the reality of drug addiction (relapsing chronic disease)
- It is important to ~~p~~provide~~ing~~ positive incentives for program ~~-~~compliance, and sanctions for non-compliance;
- Every stakeholder has the same goal but uses different means to motivate the accused.

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A TOP-DOWN APPROACH TO CREATING A DRUG TREATMENT COURT: THE CASE OF THE STATE OF NUEVO LEÓN, MEXICO

Judge Jesus Demetrio Cadena Montoya. Superior Court Nuevo León, Mexico

Berenice Santamaría González. National Commission against Addictions, México

Luz M. García Rivas

This chapter ~~section~~ reviews Mexico's experience over the past four years since the drug treatment court (DTC) model began. It is our hope that the information may be useful for those interested in promoting this mechanism of therapeutic justice.

In 2008, Mexico began the process of reforming its criminal justice system. The States are engaged in a program of amendments that will change from the traditional (written) system to a system of oral proceedings.

The key factors that enabled Mexico to establish its DTC, and now to have similar projected initiatives under way in some States were: (a) international cooperation; (b) the political will, and the (c) effective collaboration among the various levels of government (networking).

Background

In the area of drug demand reduction, Mexico has had a very active policy internationally: It participates in regional and multilateral forums, and maintains a very close relationship with the United States, given the two countries' geographical proximity. Mexico has not simply shared information and technical assistance with other countries, but has also been proactive in identifying mechanisms that show positive results that can be evaluated and adapted to Mexican realities. That was the case with the DTC, which was a Federal Government initiative that resulted from the participation of officials of the Attorney General's Office (PGR[5]) and the Health Sector in the First Forum of European, Latin American and Caribbean Cities of the EU-LAC Drug Treatment City Partnerships program, held in Santo Domingo, Dominican Republic. The invitation to this event was received from the Inter-American Drug Abuse Control Commission (CICAD) of the Organization of American States (OAS) and the European Union in April 2008. The Forum offered the opportunity to participate in a workshop on alternatives to incarceration for drug-dependent offenders, where countries like the United States, Canada, Chile, Belgium, Brazil and others talked about the advantages of the DTC model and their own experiences. It became clear that the DTC model opened up prospects for bringing together the Health and Justice Sectors with excellent results in addressing the question of crime committed by individuals with addiction problems.

Assessment at the Federal level

[5] Produraduría General de la República, in Spanish.

The results of this experience were presented to the former Attorney General of the Republic in 2008, who had a particular interest in exploring new solutions to the problem of crime associated with drug use, focusing on the concept of addiction as a disease and policies that reflected respect for those afflicted with this disease When he learned of the benefits of this model, which had been documented in various sources of information, and of the experiences discussed in the exchange in Santo Domingo, the Attorney General issued instructions that efforts should begin to determine the viability of this approach in Mexico.

The National Center for Analysis, Planning and Information for the Fight against Crime (CENAPI [6]) of the Attorney General's Office began a technical and legal study of the feasibility of DTCs in the different states (local level). Two points were examined:

First, *identifying states with a system of oral trials*: since the interaction between the Judge and the participant is a precondition for a DTC, those states that did not have oral trials in which this interaction could occur were excluded.

Second, *the application of the procedure for "stay of trial on probation",* which allows for commutation of a custodial sentence. The feasibility study reviewed the Codes of Criminal Procedure of the different states, in order to examine the legal concepts that might allow for the DTC model. These concepts included the oral trial proceedings and a provision for stay of the trial in which permits the accused to be placed on probation. This meant that major, cumbersome reforms to the penal codes would not have to be undertaken in order to start a DTC.

Third: *CENAPI also carried out an analysis of crime rates at a national level and the relationship of crime to drug use*. According to 2011 data from the National Public Security System,[7] sixty per cent of crimes were committed by people under the influence of alcohol and/or drugs, or in order to obtain resources to acquire drugs. More than fifty per cent of these were not serious crimes, but rather were property crimes, such as simple robbery, damage to the property of others, and other minor crimes, which may result in preventive detention. The data also showed that most of those arrested were first-time offenders. This has a direct impact on the penitentiary system, as it contributes to the overcrowding of the prisons

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According to CENAPI's information, the relationship between the crime rates and prison overcrowding was studied at a national and state levels, in order to look at the impact of crime on prison overcrowding, and also to examine how drug use intensifies inside the prisons because of the average length of time needed to hand down a sentence, plus time served.

Mexico has an infrastructure of 420 prison centers, which have an installed capacity of 195,278 prisoners and a population of 242,174, which means an absolute prison overcrowding internal with 47,476 prisoners and 25% relative.

[6] CENAPI: Centro Nacional de Planeación, Análisis e Información para el Combate a la Delincuencia, in Spanish.
[7] The National Public Security System (SNSP) is the entity that provides the basis and data for coordination and distribution of powers, public security, including the Federation, states, Federal District and municipalities, under the guidance of National Public Security Council.

According to the Administrative Office of Prevention and Social Reintegration OADPRS[8], it was estimated that in 2012, at a national level, 94% of prisoners used drugs. This meant that 218,478 of the 242,174 prisoners in the country's 420 prisons were using drugs. The crime committed by most of the inmates who were dependent on any drug (more than 50%) was robbery (simple and violent). Forty per cent of prisoners had not been sentenced, which prevented them from participating in any of the reintegration programs inside the prisons.

In the health field, the Technical Secretariat of the National Council against the Addictions of the Federal Ministry of Health performed a study of the human and infrastructure capacities for addiction treatment in each state. The data from the 2002 National Survey of Addictions[9] (ENA), the Epidemiological Surveillance System, and information gathered by the State Centers against Addictions operating in each state were also taken into account. This information, together with the legal analysis that was done, determined that the State of Nuevo León, located in the north of Mexico, was the most appropriate candidate to start up the first pilot program of the DTC model.

The Former Attorney General of the Republic, a man of vision who had considerable political leadership at the time, presented the project to the Governor of Nuevo León, who recognized the advantages of the project and instructed his local Attorney General to coordinate the project in the state and serve as the link with the Federal Government during development of the project.

It was at this stage that the importance of political will and awareness of the importance of the ability of authorities to promote innovative schemes became evident. Without this push, supported by the earlier analysis, progress would have been much more complicated.

The results of the legal and health analyses gave the authorities support for the viability of the DTC modality. The data evidenced the need for a different way of addressing the relationship between drug use and crime, and of dealing with the many problems in court proceedings (slowness, delays, and costs), as well as with the increase in crime rates and the effects of re-offending. There was also a realization that the adversarial model was not the solution, given new, more conciliatory trends.

This same data analysis allowed us to sensitize the authorities to the view that the traditional system of punishment and incarceration, when applied to drug users, does not promote rehabilitation, but rather stimulates the use of drugs because of corruption, drug trafficking among inmates, and the prison environment. This led to the search for new alternatives and recognition of addiction as a health condition that requires an interdisciplinary and multidisciplinary approach favoring rehabilitation and reintegration schemes.

We therefore recommended that a detailed study be done of the conditions in which it was intended to implement such a DTC project, and that the authorities responsible for implementation be appropriately

[8] OADPRS: Órgano Administrativo Desconcentrado de Prevención y Readaptación Social, del Consejo de Seguridad Pública, in spanish.

[9] National Survey of Addictions 2002, National Council Against Addictions, National Institute of Psychiatry, Department of Epidemiology, National Institute of Statistics, Geography and Informatics, Mexico, 2002. (Encuesta Nacional de Addicciones, in Spanish).

sensitized so that they could become convinced promoters with enough technical tools to promote – and defend -- the project.

Preparations

Networking Among The Federal Government and Local Government

Work began in January 2009 to prepare for the startup of the first pilot DTC program. A multidisciplinary working group was formed under the coordination of CENAPI's Executive Director of Drug Demand Reduction; its members were federal officials from the justice and health sectors, along with Nuevo León officials from the Court of Justice, the Institute of Public Defenders, the Ministry of Health, and the Ministry of Public Security. Importantly, most of the success of the project was due to the attitude of cooperation and professional responsibility that prevailed in the group.

The experience of working with the federal government and the local government, with different political affiliations, as well as the well-organized effort and committed work of the various bodies involved, was exemplary, and unfortunately not very common, because political interests often prevail over the benefits that may accrue to society. The experience of the working group, with cooperation among people of different academic backgrounds and responsibilities, was very enriching for the project, because the multiplicity of visions led to a broader outlook on the project itself. Meetings of the group were held regularly, in which every participant had three specific tasks to solve, from the most specific analysis of legal issues, to the study of treatment methodologies to identify which were best adapted to the needs of the DTC model. The federal government established links and negotiated external support for visits to foreign DTCs, as well as technical assistance for the group. The heads of the government of Nuevo León and of the Attorney General's Office were kept informed of project progress and requirements, and provided the support needed to continue with development of the project.

International Visits, Technical Assistance and Resources

Another fundamental factor in the implementation of the first DTC model in Mexico was, without doubt, the international cooperation the country received at the time, and which it still receives. At the time, the working group received cooperation from CICAD, in the form of invitations to specialized drug court seminars under the EU-LAC project. These seminars took place in Santiago, Chile, and Ghent, Belgium in 2009, where Mexico had the opportunity to visit the courts and, above all, to interact with all the seminar participants. The total openness and willingness of the specialists involved in this subject was striking: They shared information and offered technical assistance. Additionally, through the government of the United States, the Department of State, and the US Embassy in Mexico, visits took place to different DTCs and treatment providers in San Diego, California, and San Antonio, Texas. A very fruitful relationship was established with the National Association of Drug Court Professionals (NADCP) in the U.S., through participation in NADCP conferences (Anaheim, CA., Boston, MA., Washington, DC) and the support of their experts.

Implementation

Thus, after many working meetings, participation in international congresses, and different training sessions given by international experts, a scheme was developed for implementation of the DTC pilot

program in the state of Nuevo León. As part of the cooperation with the government of the United States, six experts from that country participated in a one-week training program for the all of the staff that would operate the first DTC model in Mexico. The U.S. Office of National Drug Control Policy (ONDCP) showed special interest and support for the start-up of the DTC in Mexico from the beginning.

The first DTC in Mexico, which is described in detail in Attachment I, began operations in September 2009 in the municipality of Guadalupe, in the metropolitan area of Monterrey, Nuevo León. It was presided by a criminal court Judge, who was given jurisdiction by agreement of the local Court of Justice. Procedures manuals were prepared for both the court and for the drug treatment providers. These manuals have been modified over time in the light of the experience gained in the Court. The Federal Ministry of Health, through the National Council against the Addictions (CONADIC), provided resources to the state of Nuevo León for a treatment center dedicated, among other programs, to the care of DTC program participants.

Current Situation

In November 2012 the Supreme Court of Nuevo León announced the opening of four Drug Treatment Court in the municipalities of San Nicolas de los Garza and Monterrey, the state capital; programs in which the treatment will be the responsibility of the Coordination Department of Mental Health and Addiction of the Ministry of Health.

On April 8, in order to institutionalize the program and to be included in the annual work programs of the instances involved and to be fitted with budget of the Superior Court of the state, Ministry of Health, Attorney General, Public Defender Institute and Secretary of Public Security, signed a cooperation agreement in the field of Drug Treatment Court, this with the purpose of defining the powers of the operators.

As first results on June 21, 2011 the first 4 participants concluded the program, on March 16, 2012 the second generation, with 14 participants, on October 31, 2012, 14 more participants, while on June 19 the fourth generation with 15 participants concluded the program, over a total of 47 participants who successfully completed 18 months of treatment program.

Currently the Inter-American Drug Abuse Control Commission CICAD is conducting the Diagnostic Study for the Drug Treatment Court in the municipality of Guadalupe, Nuevo Leon, which will establish performance indicators appropriate for the DTC, considering that these indicators will be invaluable and will serve as immediate reference for the dissemination of the model in other states.

The role of the Federal Government through the leadership of well-informed political figures becomes important once again. The National Commission against the Addictions, whose head, was designated by presidential appointment in January 2011 to strengthen all Federal Government demand reduction actions, is leading the effort to promote the benefits of the DTC model in other states of the country. In those states that have progressed with reforms in oral court proceedings, the CONADIC promotes close working relations between the health system and the oral justice sector, in order to raise awareness of the social benefits of the DTC model as an effective means of drug demand reduction that has a significant impact on lowering recidivism and reducing drug use, and on decreasing overpopulation in

the prisons. The Commissioner has also taken on the work of strengthening international cooperation ties, which means that Mexico has important allies in continuing to boost this effort.

Current Issues/Observations

These types of programs face the difficulty of not having enough resources for infrastructure or for developing reinsertion strategies. This is due to the system of justice administration in Mexico, which is in the process of changing from the traditional system to an accusatorial system, according to the 2009 criminal law reform. This entails a number of different challenges and technical requirements, such as harmonizing criteria, adaptation of normative systems, training, and infrastructure and human resources.

Despite the fact that the DTC programs are part of the National Program for the Prevention and Treatment of Addictions, implementing a DTC involves many institutions and different regulatory and operational needs. A crosscutting policy is therefore being designed that will address the need to rehabilitate offenders so as to reduce criminal re-offending.

Some other issues are still pending, such as establishing ties with academic institutions that can propose research projects and produce publications to support the work that the DTC is doing. It is also very important to open up discussion in civil society to publicize the benefits of DTCs and to support subsequent efforts on the issue. There is much more to be done, but progress has been substantial. Mexico has learned important lessons from the work that has been done over these four years, which are now available to countries that are interested in its experience.

ATTACHMENT I. DRUG TREATMENT COURT (*TRIBUNAL PARA EL TRATAMIENTO DE ADICCIONES*), MODEL OF NUEVO LEÓN, MEXICO: Description

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This alternative justice mechanism allows for drug treatment, rather than a custodial sentence, for a person who committed a crime under the influence of a narcotic drug or psychotropic substance, or in order to obtain resources to acquire drugs, provided the crime was not serious and provided it carries a maximum prison sentence of no longer than eight years, including mitigating circumstances.

Given these eligibility criteria and other considerations that suggest that the candidate will make good use of the program, the Treatment Center will make a diagnosis that the accused is a person who abuses or is dependent on drugs or alcohol.

The relationship between the alleged crime and the addictive disorder may be established if, at the moment of the crime, the defendant was under the influence of alcohol or drugs, if the commission of the crime was a direct consequence of being under the effects of alcohol or drugs, or as a result of the indirect need to pay for these substances.

Through the Court Coordinator, the Judge will order that the person charged be evaluated. The order will be forwarded to the Treatment Center, to carry out the following:

(a) Conduct a preliminary interview with the candidate directed to detect negative consequences related to alcohol or substance use, as well as the ICD-10 (International Classification of Diseases) diagnostic criteria and as an auxiliary method the application of a toxicological test (urine test) to determine whether he or she is dependent on alcohol or drugs;

(b) Following the preliminary interview, conduct a clinical evaluation of the candidate to determine the treatment modality to be used; and

(c) Carry out a sociological investigation of the candidate that will include social, family, community, educational and employment records.

Defendants who may be considered to participate in the program will be people who have an addictive alcoholic, narcotic and/or psychotropic substances disorder. The crime for which they are charged must be contemplated in the chapter of the suspension of trial on probation in the State Code of Criminal Procedure.

The model operates on the non-adversarial criminal justice, under the figure of oral trials and the suspension of trial on probation; these are contemplated in the local procedural code, with specified formal and procedural requirements. This gives the Guarantees Judge the jurisdiction to hear these matters.

The suspension of trial on probation is a measure decreed by the Judge or the Court at the request of the accused and the defense, the purpose of which is to suspend the effects of the criminal trial, and to not pass sentence on criminal liability, subject to the following requirements:

I. There is no opposition by the Public Prosecutor or the victim;

II. The crime is not considered to be serious, in which case the maximum penalty is not more than four years of prison, including mitigating circumstances;

III. The defendant has not previously been convicted by final judgment for an intentional crime, or is not currently on criminal trial;

IV. In court before the Judge, the accused concludes an agreement with the victim (if any) to pay damages;

V. The defendant commits to fulfill the measures and conditions for program participation that the Judge sets.

In this context, those who meet the requirements for the suspension of trial on probation, referred to the local procedural code, will be considered eligible to participate in the program. [10]

[10] Procedural requirements may change according to the state in which the program is operating because each state has a procedural criminal law, however all local codes must adhere to the fundamental principles of federal

Drug treatment is provided under direct supervision by the court on a regular basis, through coordination between the health, security, and justice systems.

The detoxification and rehabilitation treatment for alcohol and drug addictions will begin once the participant has received information about the program, has agreed to receive treatment, and has signed an informed consent form. This has the purpose of providing the necessary personalized treatment for the particular addiction problem and related disorders.

The treatment will consist of various modalities:

a) A comprehensive diagnostic evaluation by the Treatment Center team (psychiatry, psychology, social work).

b) Psycho-pharmacological treatment if necessary according to the doctor's judgment for management of the intoxication, withdrawal or co morbid psychiatric disorders.

c) Individual psychotherapy of approximately 45 minutes per session, and with a frequency according to each phase of the program.

d) Group psychotherapy of approximately 90 minutes per session, and with a frequency according to each phase of the program.

e) Family psychotherapy lasting for 60 minutes and frequency according to each phase of the program and the needs of each participant

f) Group Family session, consisting in 2 hours session with the families of participants. The objective of this session is that the participants are the families of the participants only, and through their testimony provide feedback about how they handle the situation of the addiction.

g) If necessary, also has residential services and refers the participant to private institutions that offer the service (institutions in collaboration agreement with the Ministry of Health).

h) Performance of laboratory tests to detect substance use when the team of the Treatment Center considers it to be clinically necessary.

i) Alcohol detection test applied by the supervision official or treatment center staff, at any time when it is necessary.

j) Home visits by staff Treatment Center, when it is necessary.

The drug or alcohol detoxification and rehabilitation treatment lasts fourteen to eighteen months. Individual and family medical and psychological treatments are conducted according to criteria established and authorized by international organizations (World Health Organization and National

code. The scope of this measure means that, on the one hand, trying to avoid the negative effects for those who has the first contact with the criminal justice system, opening an space for social reintegration and, on the other hand, pursued download system to concentrate efforts on the most serious cases that require more properly a full trial. This position is consistent with the need to use the trial as an effective tool in criminal proceedings, and is both the objective function to generate diversified criminal responses according to circumstances.

Institute on Drug Abuse) for the management of disorders caused by abuse of or dependence on alcohol or drugs and/or psychotropic substances. [11]

Drug and alcohol treatment has five phases. The minimum duration of the first four phases is three months, and the remaining phase will last six months.

The Judge will give the accused various activities and tasks at each stage of the program. These activities and tasks, or their frequency, can only be reduced by unanimous agreement of the operators of the program, and when the participant shows a notable advance in the treatment process.

In the introductory hearing, the Judge will announce the obligations imposed on the candidate, with which he has agreed to comply. The candidate will then be told whether he fulfills the general and special eligibility requirements, the program admissibility criteria, and whether he has been recommended for admission by the operators of the program.

If the candidate complies with the eligibility criteria and is recommended by the operators of the program, the Judge will inform him of the program rules. The candidate must decide at that time whether he will continue with the program or whether he wishes the suspension of trial to be revoked. The criminal procedural code of the State sets out the obligations to which the accused must commit for a suspension of the trial on probation, in addition to the specific obligations that the Judge may impose.

Once a defendant has been admitted in the Program, the Judge will hold follow-up hearings in order to exert intensive supervision.

Prior to these hearings, a discussion of the cases or meeting of the operational personnel will take place, as a clear demonstration of the inter-agency nature of the Program. The Judge takes the leadership at these meetings, and receives detailed information on each case in order to establish a therapeutic relationship with the participant. During the meetings, the presence of the program operators and any officers involved in the cases that will be seen in the follow-up hearings is required.

The follow-up hearings will be held with the minimum frequency detailed below. However, hearings may hold more frequently, at the Judge's discretion, should he find it necessary:

I. Weekly during the first three months after admission to the first phase of the Program.

II. Weekly during the next three months, when the participant has been promoted to the second phase.

III. Every two weeks during the next three months, when the participant has been promoted to the third phase.

IV. Monthly during the next six months (fourth and fifth phase).

Special hearings may be held to solve emergency situations that may arise, such as:

[11] Based On *Neuroscience Of Use And Dependence Of Psychoactive Substances,* World Health Organization; And *Principles Of Treatment Drug Addiction. A Guide Based On Investigations.2nd ed.* National Institute on Drug Abuse.

I. Need to reevaluate a participant that requires a modification in the level of clinical care;

II. Issue orders for medical evaluation;

III. Grant authorizations to leave the jurisdiction of the court; or

IV. Any other circumstance that could benefit the participant in his rehabilitation process without interfering with his recommended clinical treatment.

Once the treatment has concluded, the Treatment Center and the Officers of Police Surveillance will certify to the DTC that the participant has completed the program satisfactorily.

The culmination of this process will take place in a hearing held by the Judge. After having evaluated the reports from the Treatment Center and the Police Probation Officers, and found them to be favorable that the participant has completed his rehabilitation process and that has not used drugs for three hundred days, the Judge will schedule a Graduation Hearing. That day, urine tests will be administered to all participants who are candidates for graduation. Cases of participants who test positive for drugs will be kept open, and the Judge will determine the corresponding sanctions.

CHAPTER 5: WHO SHOULD DRUG TREATMENT COURTS SERVE? MAXIMIZING THEIR OUTREACH AND POTENTIAL IMPACT

Douglas B. Marlowe

Introduction

No program should be expected to work for all individuals. Every professional discipline — from medicine to psychology to social work to criminology — has come to learn that interventions have target populations for whom they are most effective, and non-target populations for whom they may be ineffective, unduly costly, or even harmful. It is the sign of a mature profession that can match clients to the most appropriate services to optimize their outcomes and utilize resources most efficiently.

Drug treatment courts are no exception. More than two decades of research has identified which individuals respond best to the drug court model and yield the largest return on investment for taxpayers. These are the individuals who (1) have negative risk factors for failure in less intensive treatment or supervisory programs, and (2) are compulsively addicted to drugs or alcohol (Marlowe, 2012a). These individuals are commonly referred to as "high risk/high need" offenders or the "high value" cases. This terminology is borrowed from a Canadian school of thought in criminology known as Risk, Needs, Responsivity Theory or RNR (Andrews & Bonta, 2010; Taxman & Marlowe, 2006).

Among the most carefully studied and well validated paradigms in criminology, RNR correctly predicts that intensive programs such as drug treatment courts should produce the greatest benefits for offenders who have more severe antisocial backgrounds, clinical impairments or treatment-resistant histories (Lowenkamp et al., 2006). Such individuals typically require intensive monitoring and sustained treatment interventions in order to dislodge their entrenched, negative behavioral patterns.

On the other hand, low-risk and low-needs offenders who do not have these characteristics are less likely to be on a fixed antisocial trajectory, and are apt to improve their conduct following a criminal arrest. Therefore, intensive interventions may offer few incremental benefits for these individuals, but at a substantial cost (DeMatteo et al., 2006). Worse still, low-risk participants may learn antisocial attitudes and behaviors from spending time with high-risk participants, which can make their outcomes worse (Lowenkamp & Latessa, 2004; McCord, 2003; Petrosino et al., 2000).

High-risk participants

Among drug-involved offenders, the most reliable and robust risk factors for failure in standard correctional programs include:

- a younger age during treatment (especially younger than age 25);
- male gender;
- early onset of substance abuse or delinquency (especially by early adolescence);

- prior felony convictions;
- previously unsuccessful attempts at treatment or rehabilitation;
- a co-existing diagnosis of antisocial personality disorder (APD); and
- a preponderance of antisocial or substance-abusing peers.

Individuals with these high-risk characteristics typically perform relatively poorly in traditional correctional rehabilitation programs. Although they also tend to have relatively poorer outcomes than other participants in drug treatment courts, their outcomes are significantly better in drug treatment courts than in other types of correctional rehabilitation programs. Studies have revealed that drug treatment courts elicited significantly larger benefits compared to other programs for participants who were relatively younger, had more prior felony convictions, were diagnosed with antisocial personality disorder, or had previously failed in less intensive dispositions (Cissner et al., 2013; Lowenkamp et al., 2005; Fielding et al., 2002; Marlowe et al., 2006, 2007; Festinger et al., 2002). This finding also translates into greater cost savings for taxpayers. Drug treatment courts that served high-risk offenders returned approximately 50 percent greater cost benefits to their communities than those serving low-risk offenders (Bhati et al., 2008; Carey et al., 2008; Carey et al., 2012).

It is essential to bear in mind that, in this context, the term "high risk" refers to the likelihood that an offender will not succeed on standard supervision, and will continue to engage in the same pattern of behavior that got him or her into trouble in the first instance. In other words, it refers to a relatively poorer prognosis for success in standard rehabilitation services. For this reason, it is most accurately referred to as prognostic risk (Marlowe, 2009). The term "high risk" does not necessarily refer to a risk for violence or dangerousness. Most risk-assessment tools that are administered in routine criminal justice practice were validated against the likelihood that an offender will abscond on bond, violate the terms of probation or re-offend, and not against the likelihood of committing a violent act. Although assessment tools do exist to measure risk of violence, they are most commonly used when treating habitual sex offenders or conducting forensic evaluations in serious felony cases. They are infrequently used in routine criminal justice practice.

This distinction between *prognostic risk* and *risk of violence* is critical. Some drug treatment courts in the U.S. screen high-risk offenders out of their programs because they may perceive them (wrongly) as necessarily being a threat to others or somehow less worthy of the services. On the contrary, research indicates that the higher the risk level, the more appropriate it may be to refer the individual to drug treatment court if a community-based disposition is warranted and likely to be imposed in that case.

High-need participants

Individuals who are addicted to or dependent on drugs or alcohol commonly suffer from severe cravings to use the substance, and may experience painful or uncomfortable withdrawal symptoms when they attempt to become abstinent. These symptoms often reflect a form of neurological or neuro-chemical damage to the brain (Baler & Volkow, 2006; Dackis & O'Brien, 2005; Goldstein et al., 2009). Formal treatment is required for such individuals to ameliorate their cravings and withdrawal symptoms, teach them concrete skills to resist drugs and alcohol, and provide them with effective coping strategies to

deal with daily stressors and challenges (Chandler et al., 2009). Co-occurring conditions, such as mental illness and brain injury, are also common in this population and require substantial remediation (e.g., Ross, 2008). Research is clear that failing to provide an adequate dose and modality of treatment for addicted individuals is associated with significantly poorer outcomes (De Leon et al., 2008, 2010; Karno & Longabaugh, 2007; Vieira et al., 2009; Belenko, 2006).

It is unwarranted to assume, however, that because a person was arrested for a drug-related offense, he or she must be an addict or in need of formal substance abuse treatment. In the U.S., at least half (over 55%) of drug-involved offenders abuse illicit drugs or alcohol but are not addicted (National Center on Addiction & Substance Abuse, 2010; Fazel et al., 2006; DeMatteo et al., 2009). These individuals may repeatedly ingest drugs or alcohol under circumstances which are potentially dangerous to themselves and others, but their usage is largely under voluntary control.

Research reveals that formal substance abuse treatment can be contraindicated for such individuals. Placing non-addicted substance abusers (especially youthful ones) into residential or group-based substance abuse treatment has been associated with significantly higher criminal recidivism and substance abuse (Lovins et al., 2007; Lowenkamp & Latessa, 2005; Szalavitz, 2010; Wexler et al., 2004). Perhaps spending time with addicted peers unduly normalizes the drug-using lifestyle, or perhaps treatment requirements may interfere with participants' engagement in productive activities, such as work, school or parenting. Whatever the rationale, it appears that providing too much treatment is not merely a potential waste of precious resources. It can also lead to negative side effects **in which outcomes may be made worse.**

Drug treatment courts require their participants to complete an intensive regimen of substance abuse treatment, clinical case management, self-help recovery groups and adjunctive rehabilitation services (NADCP, 1997). For individuals who are not addicted to drugs or alcohol, this investment of resources may not be justified and may expose the participants to greater contact with drugs and drug-using accomplices. As will be discussed later, evidence suggests these individuals may be better served by alternative programs that do not rely predominantly on formal substance abuse treatment to achieve their desired effects.

Reaching the target population

Eligibility criteria for some of the earliest drug treatment courts in the United States were not appropriately targeted to the high risk/high need offender population. Largely in an effort to avoid appearing "soft on crime" and to gain the buy-in of prosecutors or other stakeholders, some of the earliest drug courts began as pre-plea diversion programs for first-time offenders charged with simple drug possession. The goal, however, was not to remain fixed on this low-severity population, but rather to expand and focus the admissions criteria once the programs proved their worth and research identified the best populations to serve.

In the ensuing two decades, drug treatment courts in the U.S. have met with mixed success in reaching their target population. On one hand, the clear national trend has been to dig deeper into the criminal justice system to serve offenders with more serious criminal histories. The pre-plea diversion model now accounts for less than 8 percent of all drug courts in the U.S. (Huddleston & Marlowe, 2011). In its

place, most drug courts now follow a post-adjudication or post-conviction model for individuals who plead guilty and are sentenced to probation or are charged with a violation of probation. In addition, a reentry model of drug court is becoming increasingly prevalent, which serves individuals returning to their communities from jail or prison.

On the other hand, research has uncovered a good deal of variability in the clinical severity and risk level of drug court participants. In some studies, low-risk participants accounted for nearly 30 percent of the sample in felony drug courts (Fielding et al., 2002) and approximately half of the sample in misdemeanor drug courts (Marlowe et al., 2006). A few studies have found that nearly one third of misdemeanor drug court participants did not exhibit evidence of a clinically serious substance use disorder (DeMatteo et al., 2009; Marlowe et al., 2004).

This has important ramifications for drug policy in the U.S. and perhaps other counties. Although drug courts have clearly been proven to reduce crime and substance abuse, these positive outcomes have not always been justified by the investment of resources. In many evaluations, drug courts have proven to be effective but not necessarily cost-effective (Downey & Roman, 2010). This is because drug courts that treat low-severity populations may not, in fact, be offsetting serious crimes or reducing the use of jail or prison beds. A drug court that treats offenders charged with simple drug possession, for example, is unlikely to impact jail or prison overcrowding because such individuals are unlikely to receive an incarcerative sentence to begin with (Sevigny et al., 2013).

It is unclear what lessons, if any, these experiences in the U.S. may offer to our countries. Much of the increase in the U.S. arrestee population has been fueled by drug-possession cases, and in some jurisdictions offenders may be sentenced to jail or prison for simple drug possession. Because arrest and sentencing practices are often quite different in other countries, there may be less of a concern that large numbers of lower-risk, drug-possession cases will be referred to drug treatment courts.

Facing huge budget deficits, many U.S. states are now seriously grappling with this issue. For example, the Georgia Department of Audits and Accounts (2010) was recently given the task of determining whether drug courts were working and saving money for the state, with the possibility of reducing funding if the results were not demonstrably favorable. In a report released in September of 2010, the conclusion was that Georgia drug courts were in fact reducing crime, cost 72 to 80 percent less than most other sentencing options, and produced net economic savings of approximately $18 million for the state. The recommendation was to further expand these programs to reduce the state's correctional budget deficit. In contrast, the Florida Office of Program Policy Analysis & Government Accountability (2010) concluded that drug courts in that state that received State funding must serve more serious offenders in order to produce net cost savings.

Providing treatment for everyone who needs it is an undeniably laudable goal. However, policymakers must make decisions in light of limited resources that can produce the greatest good for the greatest number of citizens, and offer the greatest protections to public safety. If drug treatment courts are to reach their highest potential, they must target their eligibility criteria not to the populations that are easiest to serve, but those that are hardest to serve and pose the greatest challenges to their communities. As will be discussed, less costly options may be utilized to meet the needs of other offender populations.

Eligibility and Exclusion Criteria

Reaching the appropriate target population requires drug treatment courts to think critically and strategically about their eligibility and exclusion criteria. In the U.S., as in some other countries, admission to drug court is often denied to individuals with certain types of criminal backgrounds. The most common exclusionary criteria are for offenders with a history of violence and drug dealers or manufacturers. The obvious intent of these limitations is to protect public safety and deny services to unpalatable individuals.

Whatever the political appeal of these exclusions, they do not appear to be justified by the research evidence. Several studies have found that drug courts that admitted violent offenders were equally effective with these individuals as with other participants (Carey et al., 2008; Carey et al., 2012; Rossman et al., 2011; Saum & Hiller, 2008; Saum et al., 2001). Similarly, studies have reported impressive results for drug courts that served addicted offenders charged with drug dealing or possession with the intent to distribute drugs (Cissner et al., 2013; Marlowe et al., 2008). If these types of offenders are to be released to community supervision (and many of them are), then drug treatment court may in fact be the best place for them.

At a minimum, there appears to be no empirical basis for limiting drug court participation to individuals charged solely with drug offenses, such as possession or public intoxication. Drug courts that have expanded their eligibility criteria to serve drug-addicted individuals charged with non-drug crimes (such as theft and property crimes) have yielded nearly twice the effects and cost benefits as those accepting only drug-possession offenders (Carey et al., 2008; Carey et al., 2012; Bhati et al., 2008). The important consideration appears to be whether the individual is high risk and high need as defined earlier, and not simply the nature of the current criminal charge or the offender's prior criminal record.

Alternate tracks

In some communities, the drug treatment court may be the most effective, or perhaps only, program serving as an alternative to incarceration that has staff members with expertise in treating drug-involved offenders. Under such circumstances, it might be appropriate for the program to expand its eligibility criteria to reach needy individuals who would not otherwise fall within its ideal target population.

If this is the case, then it is generally advisable for the program to make substantive modifications to its operational model to accommodate the divergent needs and risk level of the participants. For example, research indicates that low-risk participants can be managed safely and effectively on a drug court track that does not require frequent status hearings before the judge (Marlowe et al., 2006, 2007; Festinger et al., 2002). The low-risk participants performed at least as well, and sometimes better, when they were supervised instead by clinical case managers who reported on their progress to the judge and requested court hearings only as needed to address poor compliance in treatment. Not only does this arrangement reduce the supervisory burdens on the court, it also reduces the degree of contact between the high-risk and low-risk participants. As was noted earlier, mixing high-risk and low-risk offenders together can lead to negative side effects for the low-risk individuals because they may adopt antisocial attitudes or values.

Similarly, some studies have reported successful outcomes when offenders received gradually escalating punitive sanctions for positive drug tests and other infractions, without placing a central emphasis on formal substance abuse treatment (Harrell & Roman, 2001; Hawkin & Kleiman, 2009; Kilmer et al., 2012). Generically referred to as coerced abstinence programs, these interventions may be better suited and more cost-effective for non-addicted substance abusing offenders.

It is beyond the scope of this Chapter to discuss in detail how such alternative tracks might be structured. Other resources are available that review the relevant research in this area and offer practical suggestions for developing and administering alternative regimens (Marlowe, 2009; Marlowe, 2012b).

Conclusion

Drug treatment courts combine the best practices of intensive substance abuse treatment with criminal justice supervision. Not surprisingly, therefore, they elicit the most effective and cost-effective outcomes for participants who require both elements of the intervention. Delivering treatment or supervision services to individuals who do not require those services is a potential waste of scarce public dollars, and has been known to cause negative side-effects in which crime and substance abuse have actually increased.

In recent years, drug treatment courts in the U.S. have made meaningful efforts to identify their target population and alter their admissions procedures to better reach these individuals. Some critics might argue that the pace of change has not been rapid or decisive enough. But in the scheme of things in the criminal justice system, twenty five years is a short span of time for any program to take hold across a country or the world, marshal dozens of empirical studies to identify its target population, and then align its fundamental model with the requirements of that population. One would be hard pressed to name another program that has made equivalent progress within such a short period.

Regardless, more can and should be done to hone eligibility criteria for drug treatment courts. The programs should align their admissions criteria with the empirical evidence demonstrating superior effects for high risk and high need individuals, as these concepts were previously defined. Moreover, there is no empirical basis for across-the-board exclusions of offenders who have been charged with non-drug offenses, including property, theft, drug dealing and even violent offenses. If such individuals are legally eligible for and likely to receive a community-based disposition, then making participation in drug treatment court a condition of that disposition may be justified on public health and public safety grounds. Finally, where it may be appropriate or necessary to receive lower risk or lower need individuals into the program, drug treatment courts should adapt their regimens for these individuals so as to conserve resources and reduce any avoidable contacts with their higher-risk and higher-need peers.

If drug treatment courts do not take these matters into their own hands, the decisions might be made for them by policymakers or other stakeholders who may not have equivalent knowledge about the research literature or evidence-based practices. If government oversight bodies reduce or revoke funding for drug treatment courts, or impose arbitrary eligibility criteria that are inconsistent with best practices, drug treatment courts may have no one to blame for this but themselves.

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CHAPTER 6: ADDRESSING THE NEEDS OF YOUTH AND YOUNG ADULTS

Michael F. Nerney

Introduction

Although this publication focuses primarily on issues relating to the planning and implementation of DTCs for adults, the critical need to institute these programs for youth cannot be overstressed. Virtually every country that provided information on adult DTC activity in the 2010 CICAD/OAS – AU publication[1] highlighted the pressing need for adaptations of the DTC concept to address the needs of their country's youth. We know from both research and experience that developing effective responses to drug use among adolescents and young adults requires special strategies that address the developmental and other needs with which young people are struggling and that the classic adult DTC approach requires major modification to be meaningful for youth. This chapter discusses relevant findings regarding the developing adolescent 'brain" and other considerations that bear on these efforts.

The adolescent brain

Once adolescents have come into the juvenile justice system, the usual mechanisms that guide the assessment process are activated. A thorough examination of each adolescent's legal problems, alcohol and substance abuse issues, physical health, family structure, and educational needs enables staff to begin building the treatment plan that will effectively address the deficits facing each adolescent. This chapter will focus on formulating and enacting changes within the treatment practice that address the more complicated nature of adolescent brain development, especially as it relates to social, emotional, and cognitive growth during the ten to twelve years of adolescence.

New research shows us that adolescent brains are not simply immature versions of adult brains. In fact, we now know that adolescents perceive and experience emotions unlike adults: they use different parts of their brains for different kinds of problem solving, they assess and make decisions about risk-taking through a different set of neural mechanisms, and they perceive themselves and the world around them through a different filtering system than adults.

As children approach puberty, a combination of chemicals prompts important changes to occur in the brain. Kisspeptin, a powerful hormone, signals the endocrine system to produce pituitary growth hormone as well as testosterone in males, and estrogen in females. These chemicals initiate the physical growth spurt, along with the primary and secondary sex characteristics that will develop boys into young men and girls into young women.

Physical growth and sexual maturation create significant changes in the brain, both structural and chemical, that influence social, emotional and cognitive development. Genetics, as well as environmental factors like nutrition, will influence the timing of puberty, but for most adolescents, these

[1] Caroline Cooper et. al. Establishing Drug Treatment Courts: Strategies, Experiences and Preliminary Outcomes. Organization of American States and School of Public Affairs, American University. April 2010.

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changes begin around 12 years of age for boys, and a bit earlier for girls. These changes end around 23 - 25 years of age for males, and about 21 years of age for females.

By the time puberty is knocking at the door of the human brain, the brain has already undergone remarkable changes. During the time frame from birth to age ten, these young brains will have doubled and even tripled in size. As they approach eleven or twelve years of age, these brains will have one billion or more gray matter cells in the prefrontal cortex, and nearly that many more scattered across the rest of the brain.

At this point, while most of the explosive brain growth is finished, there will still be small centers of the brain that continue growing, as well as some remarkable cell migration within the brain. Trillions of new connections will be created across the entirety of the brain. As adolescents begin to develop physically and mature sexually, they also begin to acquire social, emotional, and cognitive experiences and skills. Over the ten to twelve year time period of adolescence, neural networks, central structures, and complex hubs of brain activity become larger and stronger through practice and repetition. At the same time that well-used pathways are growing and strengthening, other less-utilized gray matter pathways are being pruned away, disconnected, or merged into other systems. This is the process of neural streamlining that researchers describe as "growing a grownup brain". Generally this process begins lower down in the brain stem and sweeps upwards from the rear of the brain towards the front, ending at last in the executive center of the brain, the prefrontal cortex.

Here is the part of the brain that is the home of reason, logic, induction, deduction, abstraction, extrapolation and problem solving. It is fascinating that this crucial part of the brain is still "under construction" throughout most of the teen years. For the greatest number of adolescents, it will not be until 21-22 years of age that female adult brains emerge, and 23-25 years of age that male adult brains emerge. As the gray matter of the brain trends down, white matter, the underlying superstructure of the brain, trends up. This prolonged process, while often frustrating to adults who want teens to "act like grownups," is crucial to maintaining the brain's remarkable plasticity. A brain that was fixed and static in adolescence would be unable to flex, learn, and adapt: exactly the qualities they will need to successfully make the changes that treatment will require.

Located physically beneath the prefrontal cortex and the cerebrum is the limbic center. All of the emotions that human beings experience are generated in this part of the brain. With the help of central structures like the Amygdala, the Nucleus Accumbens, and the Anterior Cingulate Cortex, the adolescent brain generates, amplifies, and transmits emotions to the rest of the brain.

Because adolescent brains have far more gray matter cells than adult brains, the emotions of adolescents occur with much greater intensity. What is stressful or anxiety-producing for adults is twice and stressful for adolescents. What creates annoyance or irritation in adults can create anger and resentment in adolescents. What saddens adults has the potential for serious depression in adolescents. And what delights adults can make adolescents excited and elated.

The important principle here is that adolescents have more powerful and more frequently changing emotional states than adults, and that this is absolutely normal developmentally. A number of adolescents have had childhood traumas, nutritional deficiencies, second hand exposure to dangerous drugs, or early onset of drug and alcohol use themselves. Many adolescents do not have the appropriate adult role models, or the proper environment necessary to support them in becoming emotionally competent.

While both genders struggle with emotional intensity, there are some gender-based differences. Boys' brains are more responsive to the release of adrenaline, and may be quicker to anger and act out. This

is an important factor in helping boys become competent in anger management. Girls may also struggle with anger management, but another brain difference may provide a different kind of risk for girls. For reasons that are not completely understood, but are clearly linked to hormonal changes, female brains show a reduced capacity for the synthesis of serotonin, an important compound for emotional stability. This begins to happen in girls at about 13 years of age, and the reduction in serotonin synthesis may range from 30 percent and up to 50 percent lower levels. Teen age girls may, in fact, have a biological risk factor for depression.

It is critically important to understand this risk factor in light of the ongoing struggle that adolescents have demonstrated with depression and suicide.

Assessing and responding to the realities of adolescent depression is made more complicated by the fact that many adolescents who enter the juvenile justice system already have a history of physical, emotional, or sexual abuse, often in combination. Multiple factors have been identified that increase the likelihood of abuse occurring. These include, but are not limited to, addiction and abuse of drugs and alcohol on the part of parents, caregivers, siblings and others with access to children made vulnerable through lack of parent-child bonding; abandonment; and ineffective supervision. New scientific data demonstrate the impact that early trauma has on brain development. A substantial percentage of adolescents have been subjected to such traumas. Assessing participants in treatment for trauma, then designing and providing specific treatment components to address traumatic life events and circumstances, is essential to successful recovery.

Adolescents in treatment need adults who understand the intensity and frequency of adolescent emotions, who can effectively model emotional management and regulation, and who can help the adolescents in their care acquire emotional competencies. Such emotional competencies include the ability to identify the emotions that one is experiencing; the capacity to verbalize these emotions to others; the internalization of emotional management skills; the capacity for self- regulation; and the development of empathy. It is also important that adults create opportunities for adolescents to practice these skills, get the appropriate feedback from staff, and practice some more. More than any other factor, social and emotional competencies are indicative of vocational and interpersonal success.

Risk-taking

Researchers at the University of Pittsburgh recently discovered a change in the number of brain receptor sites related to risk taking in adolescents. At about age 13, additional sites develop in the reward areas of teen brains, but the level of dopamine, the primary neurochemical messenger of reward, remains unchanged. Researchers believe this means that the same risk taking behaviors of preteens will no longer serve to generate reward in the brains of teens. By and large this means that newer, higher risk behaviors are needed for adolescents to achieve a feeling of emotional reward. This is probably why we see an increase in risk taking and thrill seeking behavior starting around age 13.

It is likely that there is an evolutionary aspect to this, and that without this drive, we as a species would not have progressed as we have. Some cultures seem to have a good understanding of this and build in rites of passage for young people. These rites of passage, while often perceived as frightening and risky by those about to face them, nonetheless have built-in adult supervision and safety features. When these options do not exist, adolescents quickly discover high risk behaviors on their own, and seek them out in their communities. Of course, the available risky behaviors often include unsafe physical, criminal, chemical, and sexual activity. Since these changes in the brain are developmentally normal and to be expected, it is important adults working with teens in any setting, including the treatment setting, offer elements of risk taking that are structured and safe, but satisfy the adolescent need for the emotional reward of risk taking.

Adolescent treatment plans must therefore include safe opportunities for excitement, exhilaration and adventure. It is not always necessary for the treatment center or the juvenile justice system to provide a complete array of risk taking opportunities, since there may be existing programs in the local schools or in the community that could be accessed. Understanding that the structure and chemistry of adolescent brains drive a higher desire for risk-taking for emotional satisfaction also helps inform adults about the language that we use with adolescents. In alcohol and substance abuse educational programs in particular, we can see that talking about alcohol and drug dangers in a way that emphasizes the risk factors might not be a deterrent, but might inadvertently be an inducement to use.

Social bonding

In survey after survey, adolescents tell us how important their peer relationships are, while at the same time how stressful it is for them to maintain and keep those relationships in balance. Many adolescents in treatment lack functional families, and as a result they may suffer from low self-esteem and have poorly developed or non- existent social skills. These adolescents, like most of their peers, have strongly felt needs for social bonding, peer acceptance and peer inclusion. A successful treatment program will find ways to assist them in acquiring a skill set that will help meet those needs.

An accurate evaluation of adolescent social skills is essential for the planning process that will fill in the deficits that many adolescents have in peer selection, social engagement, relationship building and maintenance, and empathetic response. Helping adolescents learn how to successfully terminate unhealthy relationships is equally important. As adolescents acquire and practice these skills, it becomes easier for them to apply them in social situations outside of treatment, and to use these skills to form new, pro-social relationships in the post-treatment phase.

Problem solving

Other interesting research tells us that while adolescents are often good at problem solving, they do best when they feel emotionally safe. In fact, the activity in the prefrontal cortex of an adolescent brain is a wonder to behold. (Ask an adolescent to help you connect your Blu-Ray to Netflix, and before you know it, the connection is made, the High Definition picture resolution has been maximized, and the Surround-Sound system has been hooked up as well.) But when an adolescent is in the midst of an emotional crisis (the boyfriend/girlfriend breakup; the parent/child confrontation; the coach/athlete argument; the teacher/student clash; the BFF fight), then the prefrontal cortex takes a back seat to the emotional center. As a result, adolescents are far less likely in these situations to use logic and reason as part of their decision making process, and much more likely to rely on less functional impulsive behaviors driven by strong emotional intensity.

Under emotional stress, adolescent brains often produce a chemical that disconnects pathways to the prefrontal cortex (the center for thought, logic and reason). At the same time, activity in the limbic center (the emotional center) is heightened, increasing feelings of anxiety, agitation, anger and impulsivity. This is why smart teens under an emotional load may sometimes act in not-so-smart ways. Trained treatment staff, who promote emotional safety, recognize emotional crises, and use techniques such as therapeutic time outs and recovery rooms (rather than demanding that adolescents simply "think this through right now"), are critical to promoting growth and progress in adolescent clients.

Last but not least, as adolescents get better at participating in treatment and adhering to the structure and guidelines of the program, the adults working with them should make note of and communicate their appreciation for the small, incremental, positive changes they see on a daily basis. Adolescents are much more likely to improve when adults who they like and admire see their improvement and comment positively about those changes. Adolescent brains are more vulnerable to drug and alcohol

addiction than are adult brains, but the very plasticity that creates this vulnerability gives them the strong potential for growth, change, and recovery.

CHAPTER 7: GATHERING MEANINGFUL DATA, ASSESSING PROGRAM EFFECTIVENESS~~,~~ AND PROGRAM AND PARTICIPANT IMPACT

Caroline S. Cooper

How do we measure the impact of drug treatment court programs? How do we determine the "success" of participants? The success of the program? And how do we convey what these programs are accomplishing to the larger community? Authors of other chapters in this publication have addressed these questions from various perspectives, highlighting a range of "performance measures" applicable to their respective disciplines as well as audiences to whom this information needs to be conveyed. The message is clear: Drug Treatment Courts must compile and disseminate a range of information on multiple levels to describe the services they are providing, the individuals they are serving, and the impacts they are achieving. In most instances, this information must be presented with a comparison of comparable elements for the traditional process.

To date, most outcome evaluations of drug treatment courts have looked primarily at various aggregate statistical measures of "recidivism" to assess the value of the program. Most of these recidivism analyses compare various cohorts of drug court participants – usually graduates – to purportedly similar cohorts of probationers. The results have almost invariably shown that drug court graduates as a whole have lower recidivism rates than non-drug court probationers. That finding, coupled with the lower per ~~-~~client cost for a drug treatment program compared with the cost for incarceration, has prompted many policy makers to support the drug treatment court concept.

A major flaw in most drug court evaluations to date, however, is that they do not link participant performance – currently measured primarily in terms of recidivism – to (a) the nature of services being provided and other aspects of program operations – which, in the U.S., vary significantly among programs – or (b) the nature of addiction and other needs presented by individual participants.

Moreover, recidivism reductions and cost savings present only a small picture of the potential impact a drug treatment court can have on the individual participants as well as the larger criminal justice, public health and other systems impacted, let alone the larger community. It is well known that substance abuse affects many sectors in addition to public safety: public health; employment; family functioning, to name a few. What performance measures should then be applied to develop an adequate empirical base for assessing the multi-dimensional impact of drug treatment court programs for individual participants? For the local justice system? For the local community? And, given the variations in terms of design and operations among programs, how can meaningful comparisons and aggregate conclusions be drawn from the experience of multiple drug court programs?

This chapter suggests five critical and interrelated performance measures to apply to drug treatment courts to address these issues and develop a construct for evaluation studies that obviates the limitations of many of the previous analyses. The proposed evaluation strategy combines an assessment of:

(1) the degree to which purported drug treatment courts reflect fidelity to the drug court model as reflected in the Key Components/Key Principles adopted in the U.S. and by the International Association of Drug Court Professionals;

(2) the degree to which programs are operating as they were intended;

(3) the degree to which "evidence-based practices" are being applied;

(4) the degree to which drug treatment courts are reaching and retaining their targeted populations, and

(5) the impact of the drug treatment court on individual participants through a "before" and "after" look at their individual situations.

This proposed approach will avoid the significant methodological problems raised by many current drug court evaluation strategies which: (a) focus on comparisons of selected cohorts of DTC participants (usually graduates who are "successful") with artificially created comparison groups constructed of probationers, which often include a mix of "successful" and "nonsuccessful" offenders; (b) do not correlate the progress – or lack thereof -- of drug court participants with the services being provided and/or the needs they present, and (c) overlook the positive rehabilitative progress of many drug treatment court participants who may not achieve "graduation"/"successful" status.

Suggested performance measures

A. **Assessing the Quality of the Program**

Adequately assessing the quality of drug treatment court programs requires focusing on three critical areas:

(1) whether the program is adhering to the "key components"/"key principles" formulated both in the U.S. and internationally for drug treatment court programs ;

(2) whether the program is operating as intended, both in terms of procedures and services; and

(3) whether the program is applying evidenced based practices to its operations and services.

Does the program design reflect the "Key Components"/Key Principles" for drug treatment courts?

The past two decades have witnessed an explosion in the number of programs that call themselves "drug treatment courts" in the U.S., and a significant growth in these programs outside of the U.S. Since there is no universally recognized accrediting body that certifies a program as a "drug treatment court", the articulated ten "key components" applicable to drug treatment courts in the U.S. and the thirteen "key principles" articulated for drug treatment courts outside of the U.S. provide the value framework for determining whether programs are, in fact, "drug treatment courts" regardless of the name they have taken.

The "key components" and "key principles" summarized below, are similar; the key principles address three additional areas: the need for case management to promote the individual's "reintegration" into the community; the need to address mental health needs of participants; and the need for ongoing aftercare services.

Key Component 1: Drug Courts integrate alcohol and other drug treatment services with justice system case processing.
Key Principle 1: Integrated justice/health care system processing of common casework.

Key Component 2: Using a nonadversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights.
Key Principle 2: Non-adversarial approach to case problem solving by the judge, prosecutor and defense.

Key Component 3: Eligible participants are identified early and promptly placed I the drug court program.
Key Principle 3: Prompt and objective identification and program placement of eligible offenders.

Key Component 4: Drug courts provide access to a continuum of alcohol, drug and other related treatment and rehabilitation services.
Key Principle 4: Access by participants to a broad continuum of treatment and rehabilitation services.

Key Component 5: Abstinence is monitored by frequent alcohol and other drug testing.
Key Principle 5: Objective monitoring of participants' compliance through substance abuse testing.

Key Component 6: A coordinated strategy governs drug court responses to participants' compliance.
Key Principle 6: Coordinated strategic response to program compliance and non-compliance by all disciplines involved (police, prosecution, probation, treatment, social workers, and court).

Key Component 7: Ongoing judicial interaction with each drug court participant is essential.
Key Principle 7: Ongoing direct judicial interaction with participants.

Key Component 8: Monitoring and evaluation measure the achievement of program goals and gauge effectiveness.
Key Principle 8: Program performance monitoring and evaluation (of both process and impact).

Key Component 9: Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations.
Key Principle 9: Ongoing inter-disciplinary education of the entire Drug Court team.

Key Component 10: Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court effectiveness.
Key Principle 10: Partnerships for program effectiveness and local community support.

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Key Principle 11. Ongoing case management including social re-integration support.

Key Principle 12. Adjustable program content for groups with special needs (e.g., mental disorders).

Key Principle 13. Post treatment and after-care services should be established in order to enhance long term program effects.

It is suggested that each of these components/principles be assessed in terms of: "fully achieved"; "partially achieved/needs attention to…..", or "not achieved." Applying this assessment template to individual drug court programs will yield the raw data that will provide a foundation for identifying areas that need to be improved in order to fully reflect the drug court model, as well as constructing a typology to permit comparison among drug court programs in terms of the degree to which they reflect

the key components/key principles. This comparative framework will be fundamental to subsequent inquiries regarding participant performance and program "success". It will also provide a framework for assessing the degree to which programs that call themselves "drug courts" or "drug treatment courts" are actually operating as drug courts or drug treatment courts – e.g., the prevalence of drug court programs reflecting "fidelity to the model."

Maintaining "fidelity to the model" has become a major challenge for many drug courts in the U.S., where judges have come to frequently rotate the assignment, and turnover of other personnel is frequent, with little orientation provided regarding the fundamental concepts of addiction, the recovery process, the therapeutic jurisprudential principles upon which the drug court model is based, and the paradigm shift from traditional roles that is critical for DTC team members when they join the drug court program.

Once an assessment is made of the degree to which a program design reflects the values of the key components/principles, that is, a determination of whether the program is, in fact, a "drug court", then a second area of evaluative inquiry needs to be made: Is the program operating as intended? Do the operations comport with the design?

Is the program operating as intended? Is the program design being carried out through the operations of the program?

While the key components/key principles provide the guidelines for drug treatment courts, the degree to which these guidelines are actually put into practice is the key to assessing the likelihood that the program will have its intended outreach and impact. A classic process evaluation should be undertaken to determine whether the anticipated services are actually being provided in the manner and timeframe intended. If, for example, the program design provides for a "broad continuum of treatment and rehabilitation services" (Component/Principle 4) but, in terms of operation, there is no differentiation in actual services provided to reflect the results of individual substance abuse assessments, gender, and other factors presented by individual participants, the likelihood of effective services to program participants is greatly diminished. The third area of inquiry should center upon whether the program is applying evidence-based practices.

Is the program applying evidence-based practices?

The term "evidence-based practice" has received considerable attention during the past several years as applied to substance abuse and mental health treatment programs, and has been frequently used without a solid definition. For the purposes of this publication, we use "evidence-based practices" to refer to practices for which there is some statistical or other empirical basis that supports the potential effectiveness of the practice for the purpose it is being applied.

Applying the principle of evidence-based practice to drug treatment courts raises an interesting anomaly: how to balance the use of accepted practice with the creativity and the continual paradigm shifts that implementing a drug treatment court requires? The development of the Miami drug court model reflects the multi-agency collaboration that was necessary to accommodate this challenge. The actual design of the program introduced a very different – and not evidence-based-- approach for dealing with drug-addicted offenders by suspending the criminal justice process while the offender participated in a judicially-supervised treatment program (in other words, a referral to treatment under a program of court monitoring rather than the traditional referral out to treatment without further court involvement). At the same time, however, the Miami drug court model was heavily grounded in maintaining the legal and constitutional rights of program participants and applying well-tested, evidence-based principles of substance abuse treatment, with the gradual introduction of case

management and ancillary support services that are critical to sustaining recovery but that, at the time, had not been provided for criminal justice offenders and were not widely recognized as critical services to provide.

As applied to drug treatment courts, evidence-based practices would have the following characteristics:

- a program design that is based on accepted/supported practices in both the justice and treatment systems involved;

- meticulous and ongoing observation and analysis of the operation of the program, the services being provided, the degree to which they are conforming to evidence based practices, and to which their core elements are having the intended impact; and

- using the results of this ongoing analysis (i.e., the process evaluation activity discussed above) to promptly modify program operations and services to address unanticipated consequences or impacts identified.

For example: if the program design calls for frequent drug testing (Component/Principle Five) but the tests are not observed or the requisite chain of custody for specimens is not clearly delineated and/or complied with, the drug testing function is not comporting with evidence based practices relating to drug testing and the utility of the tests as well as the integrity of the program is seriously in doubt.

Consistently assessing the application of evidence-based practices to both the design and ongoing operation of drug treatment courts through this assessment process should promote both (a) program integrity that can transcend differences in the way various programs operate, and (b) consistency in program operations that can overcome personnel turnover and changes in agency leadership. It can also promote more meaningful comparisons among programs, as well as assessments of the "success" of participants in them.

B. Assessing program impact

Once the quality of the program can be documented, attention can then turn to the impact the program is achieving. Critical issues relating to this inquiry include:

(1) Is the program reaching its intended audience/target population? And is this population reflective of the "high needs/high risk" population DTCs need to target? (See Chapter 5~~6~~)

(2) What effect is the program having on the substance abuse and other needs presented by the participants? And how does this effect compare with their situation prior to entering the drug court? With that of other individuals who progressed through the traditional justice system process?

Is the program reaching its intended audience/target population?

To determine whether the program is reaching its intended audience both qualitative and quantitative data must be analyzed.

First: the number, demographics, and criminal justice/treatment history of drug treatment court participants compared with the number, demographics and criminal justice/treatment history of the population intended for the program to serve; and

Second: the percentage this number represents in comparison with the universe of potentially eligible participants.

Accepting the premise that drug addiction is a chronic relapsing condition reflected in well over fifty percent of the cases coming into the court systems of most countries, the basic measure of program impact must be: "Is the program reaching the population(s) who need to be served by the DTC? vs. who the program is currently reaching? To adequately address this measure, the universe of persons who should be potentially eligible for the program needs to be identified, and then the percentage of these individuals who (a) actually enter and (b) remain in the program tracked on an ongoing basis.

Eligible offenders who are *entering* the program

In terms of the percentage of eligible offenders who enter drug court programs in the U.S., experience indicates that there is a large discrepancy between the universe of individuals who are eligible to participate in the drug treatment court and those who do actually participate. What accounts for this discrepancy? And what measures need to be instituted to expand the outreach of drug treatment court programs so that those who need the program (e.g., the "high risk/high need") actually participate?

In the U.S., we have learned this fallout affecting the percentage of drug court eligible offenders who actually enter drug treatment court programs may be due to a number of interrelated factors, including:

(1) lack of procedures for systematically reviewing the potentially eligible program population(s) as soon as they can be identified rather than having them randomly referred as they may subsequently come to the attention of someone familiar with the DTC program who feels it may be beneficial;

(2) the subsequent application of subjective "suitability" criteria by one or more agencies involved to determine whether an offender, eligible on the face of his/her record, is actually a "good candidate"[2];

(3) target populations that are too restrictive and/or do not correlate with the evolving characteristics of the criminal justice system history, current offenses, and other characteristics of the offenders in the jurisdiction who can currently benefit from the program, and

(4) lack of meaningful incentives to attract participants, particularly when compared with the likely outcome of their cases if they do not participate in the program.

Eligible offenders who are *being retained* in the program

Most outpatient drug treatment programs available to justice system-involved offenders have a maximum duration of ninety days, with a substantial percentage of dropouts occurring during the first thirty days. DTC programs, on the other hand, are designed to provide twelve to fifteen months of sustained substance abuse treatment and other services. For drug treatment courts to have effect, therefore, eligible offenders must both *enter* and *remain* in the program.

To date, however, very few evaluations of drug treatment courts have looked at the demographics and clinical characteristics of those who remain for various periods of time in the program, the length of time they remain even if they do not "graduate", and the reasons for their not being retained. Such

[2] The U.S. experience has shown that it is very difficult to predict who will be "successful" in a DTC program, particularly because of the intensive support the program provides and the powerful role played by the drug court judge whom many participants have commented has been a major force in keeping them in the program and their ultimate recovery. The *evidence* points to the importance of accepting all participants who meet criminal justice, clinical and other articulated criteria for program eligibility and to ensuring, through ongoing monitoring and case management that the services they are receiving adequately address the substance abuse and other needs they present.

information is critical to identifying the demographic and clinical characteristics of those who "fail" the program as well as those who remain and the length of time they participate, so that appropriate modifications may be made in program practices and services to prevent or reduce this fallout. This information is also essential in documenting the impact of program services and resources expended, even if participants do not complete the program.

Anecdotally, a number of U.S. drug court judges have reported that participants who have remained in the drug court for some period of time -- even if they did not graduate - have had significant sober periods, have made progress in other areas of their recovery and, not uncommonly, have subsequently succeeded in becoming drug-free after leaving the drug court.

Assessing participant impact: Who is the program serving and what is the impact? Developing a "Before" and "After" Snapshot

While statistics on recidivism by drug treatment court participants and graduates provide a quick and very clear picture of the impact drug courts have on public safety – a major factor underlying the massive funding these programs have received in the U.S. – these statistics present only a small dimension of the overall impact that drug courts have on participants. Since the demographics and clinical picture of drug court participants varies dramatically, both within programs and among them, recidivism data per se are relatively limited in terms of conveying program impact without some additional information on the background of the participants who are being measured and particularly, their lives prior to entering the drug court and afterward.

As noted earlier in this chapter, substance abuse affects many domains relating to the functioning of the individual addict and the resulting impact on other sectors of the community, including public safety, family functioning, the workforce, and public welfare. For this reason, more useful measures of participant impact should focus on a "before" and "after" picture of the participants themselves. Developing a "before" snapshot for each participant might explore:

- the number of contacts the participants had with the justice system in the three years prior to entering the drug court;
- the frequency with which they were using drugs and the drugs they were using;
- the amount of money they reported spent daily/weekly on drugs;
- the living situation of the participants at time of program entry;
- whether these participants were parents of minor children, and, if so, how many of these children were living with the participants, or had been removed from their care;
- the employment status of the participants prior to entering the drug court;
- their educational status;
- their medical condition and instances of prior hospital emergency visits for the three years prior to program entry should also be part of the snapshot.

There are other measures that can be added to the list above, particularly those that relate to local issues that have generated the development of the drug court or reflect other outcomes that need to be reported. One such measure that has been used In the U.S. has been the birth of drug free babies. – an

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outcome that has had tremendous public health, societal and economic implications.[3]

To measure the "after", these same questions can again be asked: what is the situation of the participants at three months, six months, and so forth, following entry into the drug court? At time of termination?

Whether or not the participant "graduates" from the program, tracking this information will provide a "face" for the participants being served by the programs, and will help to document the wide range of needs they present, the services they are receiving, and the multi-dimensional impacts the programs are having, as well as the resources needed to sustain them.

The application of the five performance measures suggested in this chapter to drug treatment court programs, regardless of the country in which they are operating or the population(s) they are serving, should provide a framework for more systematic and meaningful assessment and comparison of these programs and the impacts they are achieving. With this foundation, all who are working with drug treatment courts can have a broader basis for exploring the issues they are encountering, and assessing their operations and impact on a multi-national level. The information exchange and synergy promoted by this dialogue can be instrumental in sustaining the quality and impact of these programs now and in the years ahead.

[3] See FREQUENTLY ASKED QUESTIONS FACT SHEET SERIES: **Costs Associated With the Birth of Drug and/or Alcohol Addicted/Exposed Infants~~?~~** (Conversely, what cost savings are associated with the birth of a drug free baby?). Bureau of Justice Assistance (BJA) Drug Court Clearinghouse. American University. November 10, 2004.

CHAPTER 8: THE IMPORTANCE OF INTERNATIONAL COOPERATION IN THE DEVELOPMENT OF DRUG TREATMENT COURTS

Anna McG. Chisman

International cooperation on drug policy began a century ago with the adoption of The Hague Opium Treaty in 1912, which was signed by the Great Powers. Several multilateral accords to control dangerous drugs have been agreed to since then, and there are three currently in force.[1] The Conventions have been signed and ratified by almost all the member countries of the United Nations, currently standing at 186.

All of these Conventions include the explicit goal of preventing harm to individual and public health. The Conventions ban the possession of and trafficking in plant-based drugs such as cocaine, opium, heroin, and marijuana, and synthetic drugs such as Ecstasy, LSD and methamphetamines. They also place strict controls on the non-therapeutic use of prescription medicines such as Oxycodone. The international conventions all allow for, indeed encourage, the treatment and rehabilitation of drug-dependent people, and the 1988 Vienna Convention specifically provides for "measures for the treatment, education, aftercare, rehabilitation or social reintegration of the offender" as an alternative to conviction or punishment, or in addition to conviction or punishment of drug offenses. Drug treatment courts, with their emphasis on providing medical and social care for drug-abusing offenders, fall squarely under the international conventions.

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Drug treatment courts also reflect our new understanding of addiction as a disease that can be successfully treated. For much of the twentieth century, drug addiction was poorly understood, but over the last fifteen or twenty years, scientific research has shown that drug dependence is a chronic, relapsing disease similar to diabetes, asthma and hypertension.[2] This finding has led to a reassessment of drug treatment, and an increased recognition by treatment professionals, and indeed, the general public, that relapse into drug use is common among recovering addicts.

International bodies such as the United Nations Office on Drugs and Crime (UNODC), the European Commission, the Organization of American States' Inter-American Drug Abuse Control Commission (CICAD/OAS), the World Health Organization/Pan American Health Organization and the Colombo Plan have adopted and promoted dissemination of the research finding that drug dependence is a disease, and have crafted world-wide and regional policies accordingly. They have helped translate science into policy and practice in their member states. Through their technical cooperation programs, international organizations have encouraged governments around the world to make substantial improvements in their substance abuse treatment efforts by training drug treatment counselors, setting in place quality standards of ethical care, and monitoring treatment outcomes as a means of disseminating good practices.

[1] United Nations Single Convention on Narcotic Drugs, 1961, as amended by the 1972 Protocol. United Nations Convention on Psychotropic Substances, 1971. United Nations Convention against Illicit Traffic in Narcotic Drugs and Psychotropic Substances, 1988.

[2] U.S. National Institute on Drug Abuse. Drugs, Brains, and Behavior: The Science of Addiction. NIH Pub Number: 10-5605. Published: April 2007. Revised: August 2010. http://www.drugabuse.gov/publications/science-addiction

Shortly after the establishment of the first drug treatment court in the United States, UNODC and CICAD/OAS presented the question of alternatives to incarceration for drug-dependent offenders to their member states, with the intention that the DTC model might be adopted by other countries. The initial reaction was not encouraging. Nonetheless, in 1999, UNODC convened an international expert group that developed twelve "success factors" underlying court-directed treatment and rehabilitation programs.[3] That same year, the late Paul Bentley, DTC Judge in Toronto, Canada and one of the authors of the present publication founded the International Association of Drug Treatment Courts (IADTC) to bring together experts from around the world who believed that DTCs could offer an effective alternative to imprisonment for drug-dependent offenders. CICAD/OAS included DTCs in the agenda of a major project financed by the European Union[4], and thus enabled judges, prosecutors and treatment providers from several Western Hemisphere and European countries and cities to look at whether – and how—a DTC model could operate in their own countries.

International cooperation on DTCs has been important in four ways:

- many international and national agencies have provided tangible support for the process of starting up or enhancing a DTC;
- face-to-face communication among key players has helped governments, judges and prosecutors understand the detailed operations of DTCs;
- research projects and data collection have helped document the effects of DTCs, and
- international organizations have encouraged member governments to recognize addiction as a disease.[5]

CICAD launched the Drug Treatment Court Program for the Americas in 2010, and since then, the Province of Salta in Argentina, and The Bahamas, Barbados, Colombia, Costa Rica, the Dominican Republic, El Salvador, Jamaica, Mexico, Panama, Peru, and Trinidad and Tobago approached CICAD to implement or expand the DTC model. During 2012 and 2013, pilot projects were launched in Costa Rica (Pavas and San José), the Dominican Republic (Santo Domingo), Trinidad and Tobago (San Fernando) and Argentina (Province of Salta). As of the time of publication, additional pilots are ready to be launched in Panama, Barbados, and Mexico. Jamaica has had two pilot drug courts in operation since 2000 and is ready to launch three more. In 2012, the Government of Chile adopted drug treatment courts as its official policy, and has expanded DTCs around the country. Mexico has one pilot project operating in the State of Nuevo León, and is expected to expand the model to five more states. Canada continues to increase the number of its drug treatment courts in the various provinces, while the United States has overnearly twohree thousand DTCs and another 1,122 other problem-solving courts (mental health

[3] UNODC. Report of the Informal Expert Working Group on Drug Treatment Courts. Vienna, 1999. http://www.unodc.org/pdf/lap_report_ewg_casework.pdf

[4] EU-LAC Drug Treatment City Partnerships. April 2008 – December 2010. See http://www.cicad.oas.org/Main/Template.asp?File=/reduccion_demanda/eulac/forum_exchanges/santodomingo/santodomingo_eng.asp

[5] CICAD Expert Group on Demand Reduction. Basic Principles of the Treatment and Rehabilitation off Drug-Abusing and Drug-Dependent Persons in the Hemisphere. October 1, 2009, incorporated into the Hemispheric Drug Strategy, May 2010. http://www.cicad.oas.org/reduccion_demanda/eng/basic_principles_drug_treatment.pdf

courts, community courts, reentry courts, veterans courts and DWI courts) in operation in all fifty states and territories. Bermuda and the Cayman Islands were pioneers in this effort.

These initiatives have received strong backing from CICAD/OAS, and bilateral support from the Governments of Canada, Chile and the United States, as well as technical assistance and training provided, with the significant support of the U.S. Department of Justice, by the American University in Washington, D.C., the U.S. National Association of Drug Court Professionals (NADCP), and the Center for Court Innovation (CCI), and the International Association of Drug Treatment Courts (IADTC), and the Canadian Association of Drug Treatment Court Professionals (CADTCP). This joining of many technical and policy forces around the concept of DTC has been a key factor in spreading DTCs around the world.

Of no less importance has been the face-to-face discussions among judges and policy-makers afforded by international meetings and exchange visits, which helped answer many questions about the feasibility, desirability or success of DTCs. Judges from different countries have been able to speak directly to other judges about their concerns, and doctors have talked to other doctors about shared solutions to shared problems. This peer-to-peer communication made possible by international organizations has been very significant in developing an international consensus on DTC and therapeutic justice.

A third, very important factor has been the research and documentation produced in countries like Australia, Canada, Chile and the United States on the impact of DTCs on reducing recidivism and drug use among offenders. The pooling of knowledge and research findings has helped countries develop advocacy positions, policies and procedures for new drug courts. An important lesson for new drug courts is the need to set in place information systems that can document their cases and follow through on their graduates, to determine the effect of DTC on reducing recidivism and repeated drug use, and in order to demonstrate accountability to their funders.

A fourth factor leading some countries to embrace the idea of a DTC has been that they are searching for an alternative to incarceration in order to solve their very practical problems of prison overcrowding, high levels of drug use among arrestees and prisoners, and high rates of crime and violence often associated with drugs.

International and cross-border cooperation in the twenty-first century is grounded in the full recognition that each country has its own culture, traditions, world view and ways of treating illness, crime and other social ills, and that solutions that may be successful in one country may not be viable in another unless adapted. The development philosophy of international organizations such as the OAS and the United Nations is that a member state must discover its own needs and construct its own solutions. A country that does not claim ownership of an idea or project will not ultimately commit its own funds or personnel to it, and the idea or project will not be sustainable over time. The role that international cooperation plays is to support and facilitate that country's development of its own solutions, provide appropriate training, and to some limited extent, funding.

This is the kind of enlightened technical cooperation that is being provided to new drug treatment courts in the Western Hemisphere. Working together, countries are recognizing that a society that has no mechanism other than incarceration for dealing with young, poor and unequal drug-dependent offenders will have little chance of breaking the revolving cycle of drugs, crime and imprisonment. The authors of this publication are convinced that the alternative to incarceration described in this book offers national and local governments and court systems a positive way of addressing the consequences of the intersection of drugs and crime.

CHAPTER 9: DRUG TREATMENT COURT PROGRAMS: SUSTAINABILITY, TRAINING AND ADVOCACY

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Introduction

This chapter discusses the sustainability of Drug Treatment Courts (DTCs), and what is needed to implement and promote them as stable public policy programs at a national level. We shall illustrate the process by looking at the experience in Chile, emphasizing what we have called stages of public policy creation, and will highlight the need for training and promotion as key to maintaining a sustainable program over time.

The process of implementing DTCs in Chile was lengthy and characterized by various difficulties. Nevertheless, the program is now part of national policy and is intended to be expanded throughout the country, as a program aimed at the rehabilitation of offenders by promoting the use of alternative to custody, and of the therapeutic justice approach based on problem-solving court models.

Chile's DTC program started in 2004 with a pilot program in the city of Valparaíso. This first program came about because of the commitment of all stakeholders--that is, judges, prosecutors, defense attorneys, and technical experts, such as those from Paz Ciudadana Foundation, the National Council for Drug Control (CONACE), and the Ministry of Health (Droppelmann, 2010).

Since then, eighteen DTCs have been created nationwide, and are currently operational. Since 2008, one of these DTCs has been assigned to dealing with young offenders at the Downtown-North Metropolitan Public Prosecutor's Office, in cooperation with the National Service for Minors (SENAME), a government agency in charge of young offenders.

The current operation of DTCs is made possible through a 2008 financial collaboration agreement between CONACE and the Public Prosecutor's Office, through an annual grant of funds to hire professionals to conduct these programs. Ongoing cooperation among all the organizations engaged in the program is also important. These organizations include the Ministry of Justice, the Public Prosecutor's Office, the Criminal Public Defender's Office, SENAME, CONACE, and other technical agencies.

The DTC implementation process in Chile has been ongoing for seven years, and has provided significant experience that may serve as an example for other Latin American countries.

Stages of creation of a public policy: The specific experience of DTCs in Chile

The DTC formation process in Chile included several stages of policy-making that were not exclusive to this program, but could be applied to any creation of this kind. Ideally, the process should include a visualization of the problem and its introduction into the public agenda; policy design; decision-making; implementation; public policy sustainability, evaluation and monitoring (Bellettini, 2005). We can look at the Chilean experience as a way of guiding the creation of policies such as this one, and identifying the factors that are significant in promoting sustainability over time. Each of these stages is described below.

[6] Paz Ciudadana Foundation is a nonprofit organization in Santiago, Chile, involved in helping improve criminal justice policies in the area of crime prevention, criminal justice and resettlement of offenders.

Visualizing the Problem and putting it onto the Public Agenda

The first part, *visualizing the problem and putting it onto the public agenda*, entails documenting the specific problem to be addressed and describing how the program will address it. It also requires examining the successful options that have been used and internationally- and nationally-to address the problem: in this case, drug use by offenders.

Chile commenced a very significant area of study around the connection between drugs and crime, beginning in the 1990s[7], encouraged by international research of this type that began earlier (during the 1980's).

Apart from drug use prevalence studies, the first study using the I-ADAM[8] methodology was carried out in 2005. This study uses a questionnaire and urine tests in order to detect drug use by arrestees. The research showed a strong connection between these two variables--that is, using drugs and committing a crime. Although not all drug users commit a crime, the study showed that a high percentage of offenders use drugs: 73.3% of arrestees in the 2005 study had used at least one drug during the period near his or her detention.[9]

In February 2005, Law Number 20.000 came into force, establishing specific new types of drug crimes, such as drug processing and production, sale of precursor chemicals, trafficking in narcotic drugs and psychotropic substances, and other related crimes. This, in turn, generated an intense academic discussion on the offenses, and also forced agencies to gather more specific statistical information on the new crimes.

Documenting these developments provided a framework for then including the problem of offender drug use in the public agenda, a fundamental to creating specific public policy programs for these particular offenders. In order to disseminate awareness about this problem in a better way, it is necessary to work with the media, conduct seminars with international experts, and implement expert committees for discussion and to develop suitable program responses.

Policy Design

Once the problem has been introduced, the creation of a program of this type goes to a second stage, known as *policy design*. At this point, comparative studies are fundamental as they allow for the identification of successful methodologies that have been used to address the problem identified In the Chilean context, a DTC model program was considered in order to provide drug-using offenders with treatment. This design was an adaptation of the Miami DTC model, but had an objective similar to that of the original program[10], namely, "to reduce criminal recidivism related to drugs by diverting offenders using drugs to rehabilitation" (Droppelmann, 2010).

[7] Paz Ciudadana Foundation began this area of study in 1997.

[8] Hurtado, Paula. (2005) *Consumo de Drogas en Detenidos. Aplicación de la Metodología I-ADAM en Chile (Drug Use in Arrestees. Using I-ADAM Methodology in Chile).* Paz Ciudadana Foundation. Santiago, Chile.

[9] In 2010 Paz Ciudadana Foundation updated the I-ADAM study in Chile, and concluded that 69.3% of arrestees from South Santiago had used at least one drug when arrested. This was confirmed by urine tests as offenders were detained in the police station (Study/Press).

[10] Drug Treatment Courts started in the 1990's ~~80s~~ in the United States, following the lead of t~~. T~~he first one ~~was~~ created in Miami in 1989.

One of the main concerns was to identify the appropriate legal framework for the program. As we learned from comparative evidence, DTCs generally adopt one of two models: a pretrial model, where charges are dismissed by the court once the treatment has been completed, and a post-sentencing model, where participants can receive a lesser conviction once they finish their treatment. In Chile, taking into account the current legal framework, the need to test models in pilot programs, and the time needed for possible legislative modifications, it was decided to use the existing legal framework, through the "Conditional Suspension of the Proceedings" found in Articles 237-240 and 245-246 of the Chilean Law on Criminal Procedure. This legal tool is an alternative to the traditional criminal procedure, by means of diversion. The proceedings are suspended for a period of between one and three years, during which time the offender has to comply with specific conditions, particularly upon being diverted to special programs. First-time offenders and misdemeanor[11] defendants can access this alternative through the ordinary criminal justice procedure. Apart from the legal requirements, defendants must also comply with a number of clinical eligibility requirements in order to choose to enter DTC programs, which might include a diagnosis of problematic drug use, or to rule out dual diagnosis of drug dependence and mental health disorders.

To plan for *implementation*, a pilot program aimed at adults began in Valparaíso in 2004. This pilot made it possible to test the model, identify its strengths and weaknesses, and promote knowledge about the program nationwide. This stage of implementation of a pilot program was quite fruitful, as it also made it possible to conduct a suitable follow-up study and solve any problems that occurred during the pilot operational period. After that, pilot programs started to spread rapidly to other cities, and currently, eighteen DTCs are operating in our country.

Although the pilot implementation encountered some problems we will detail later in this chapter, it is necessary to emphasize that the first pilot program helped to establish DTCs and promote them as a stable public policy. In this respect the pilot period has been fundamental to promote the program by spreading the word and carrying out studies in order to assess its operation (Espinoza et al., 2011) or examining the prospects for and cost of expending DTCs (Morales et al., 2012). These can be conducted by the justice or health officials and academia, among others.

In addition to publicizing the program and the results of the pilot project, training is also essential to this process, especially during the program implementation stage. All of the stakeholders must learn about and follow the DTC model in order to testify to its effectiveness[12]. Training makes it possible successfully to incorporate DTCs into judicial systems that have a more traditional and coercive approach. It also makes it possible to expand understanding of the benefits of rehabilitation (therapeutic justice) and the measures and sanctions that can be used in the non-custodial system.

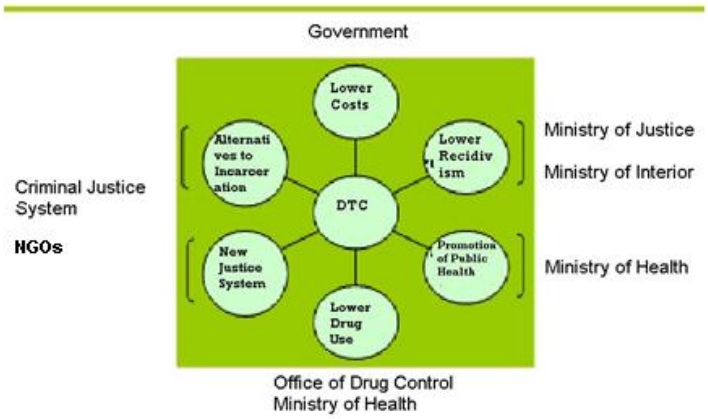
Decision-Making

In general terms, the policy design stage is complete, because DTCs are now operating, interdisciplinary working groups have designed procedures manuals, and the needed experience and strategic alliances have been created. However, the design is not enough, and it is necessary to continue working at the policymaking stage. Therefore, the third stage refers to decision-making, primarily through private or public organizations with some influence on the Government. This requires generating evidence about the benefits of the program for the different organizations as a way of creating institutional support. The Chilean example considered the benefits as shown below.

[11] For probable custody sentences of not more than three years.

[12] Paz Ciudadana Foundation, as a specialized technical organization, carries out training on DTC model.

Figure 1: Benefits of DTCs for each agency



Source: Paz Ciudadana Foundation.

Once the benefits have been identified, strategic alliances were then created among public and private agencies to make decisions about the program. This organizational support allowed Chile to enter into cooperative agreements, such as the current agreement between CONACE and the Public Prosecutor's Office signed in 2008. This agreement, which provides funds for hiring staff needed to carry out the program, can be renewed each year. There are also agreements and alliances for technical support.

Implementation

The fourth stage of the policymaking process entails the *implementation of the program*, either at a regional or a national level. Chile is just now entering this stage, as it has both the experience of pilot programs and government support to spread the concept nationwide. Implementation must involve all available resources, organizational support, a coordinating body, manuals of appropriate procedures, and technical support for training professionals and stakeholders, and must take into account the need for external evaluation aimed at measuring the impact of the program.

Policy Sustainability, Evaluation and Monitoring

The last stage of the process is *policy sustainability, evaluation and monitoring*, which is premised on recognition that the stability of a program over time is the result of careful monitoring and evaluation, in order to ensure that program operations are consistent with the program design and to measure its impact. This effort will generate a sustainable policy that can adapt over time to possible amendments, but still maintain favorable results.

Training: A fundamental Requirement for the DTC

Training is fundamental to establishing and stabilizing DTCs, and is included in the ten guiding principles for DTCs: "Continuous interdisciplinary training promotes effective planning of DTCs and their operation" (NADCP, 1997). Therefore, promoting the program through training and knowledge is essential so that the program can operate successfully on a national scale. It has been said of training that "drug treatment courts represent a fundamental change in criminal justice and treatment systems;

because of this, all members of the team must understand basic aspects of each of their functions" (Safer, 2004).

Therefore, training is not only essential in installing this type of program, but it is also a way of guaranteeing the long-term quality of DTCs, as professionals require new knowledge and ongoing training (Droppelmann, 2008).

Training should be in two areas. The first is on the general DTC model, and includes reports on implementation, flowcharts of procedures, drug dependencies and hearing performance (Droppelmann, 2008). The second is directed to giving specific guidance to every stakeholder on detailed roles and tasks.

An Educational Manual was published in 2010 in Chile, making it easier for the stakeholders (judges, prosecutors, defense attorneys, psycho-social teams, and coordinators) to obtain the required knowledge. The Manual covers the main aspects of DTC training, and includes audiovisual materials, such as recorded hearings and interviews with key actors, to better illustrate how the model operates, and the roles that each of the actors plays (Droppelmann, 2010).

A training course should cover many subjects, but we will discuss only those issues that we are interested in emphasizing.

First, the importance of educating stakeholders about the original DTC model, including guiding principles and basic elements that a typical program must have: integration between the justice system and the health system, an interdisciplinary team, a professional diagnosis of problematic drug use, judicial monitoring including regular hearings, a plan of incentives, and intervention geared to rehabilitation and social integration (Droppelmann, 2010). Ongoing training in this regard will make it possible to spread the model in a faithful way without decreasing its quality or its effectiveness.

Another important area is the formation of a DTC coordination team. The creation of the team is essential, as the program is based on a non-adversarial justice model in which the actors work toward treating and rehabilitating the offenders. Keeping this in mind, we emphasize the following roles and functions of the main actors – an essential focus for training – laid out in the educational materials:

- The role of the judge is to lead the DTC program, as he/she must expand his or her range of actions to encompass the promotion of rehabilitation. To this end, some essential qualities for a DTC judge are: Be impartial and consistent. Listen to participants. Be empathetic. Have knowledge of drug dependence issues Be willing to work in groups Focus on conflict resolution

Prosecutors must adapt their traditionally adversarial role and promote the rehabilitation of the defendant. They, too, need to be trained in drug dependence issues, be willing to work in teams, and focus on problem-solving. Defense attorneys must also adapt their own role: while this does not mean they have to leave aside their role as defense counsel, they must guide their performance toward the rehabilitation of the defendants through the identification of relevant cases for the program, the explanation and guidance to both the defendant and the team on significant issues, the promotion of trust among the management team, and the monitoring of the process.

Treatment of DTC participants is carried out by a case management team, formed by a psychologist and a social worker. They must possess suitable training, given that their main role is to manage DTC cases from the very first investigation until the offender graduates, including a continuous follow-up during the suspension of the proceedings. Besides conducting research into cases, they must coordinate - along

with the treatment center - the confirmation of the diagnosis, and, if the participant does not attend voluntarily, he/she must be persuaded and encouraged to do so. After defendants enter the rehabilitation program, the team must monitor their participation and coordinate the delivery of information by the treatment center. Finally, once defendants graduate from the program, the case management team must support participants through their reintegration process.

In short, we emphasize that training is essential to the implementation and continuity of the program. As we have seen here, training must provide basic content in order for actors to understand the DTC model, as well as their respective roles and functions in this program. The "drug treatment courts should promote educational opportunities, encourage working group members to continue being trained, and give training - whenever possible - to both new members and more experienced ones as well" (Safer, 2004).

Problems Identified during the Initial Implementation and future alignments of the drug treatment court program

The application of the DTC model to Chilean circumstances was beneficial in the sense of promoting better understanding about the relationship between crime and drugs and drug treatment, rather than just crime and punishment. It also made it possible to identify critical issues that may help identify certain problems that may hamper the proper development of the program. The difficulties of the Chilean process can be summarized in three areas. First, the number of people who, due to their legal profile, can access the DTC; second, the lack of an organization that will enable DTCs to stop operating as a pilot program; and finally, the ongoing need for interagency coordination.

The number of people who, due to their legal profile, can access the DTC

The first issue is the most important, since no program can continue to operate over time without a large target population eligible for the program. In Chile, the lack of participants is due to the very limited legal profile imposed on criteria to access the program, namely, only first-time offenders are admitted. Consideration is being given to amending the law to encompass offenders who have more complex criminal profiles, such as those who reoffend with more serious crimes, especially those who commit property crimes and have a higher prevalence of drug use. [13]

Need for an Organization to coordinate implementation of the program regionally and/or nationally

Along with amendments to the law, the Chilean DTC program must take the important step of ceasing to operate as a pilot program and become a public policy program. To do so, a solid institution must be created as a central coordinating unit, either regional or national, to support the DTC programs, assure program operations, development and assessments. Such an organization is currently being developed, under the institutional framework of the Ministry of Justice. This will permit the program to expand nationwide, with the important premise of maintaining fidelity to the original model.

Need for Interagency Coordination

Finally, we know that DTCs are a clear example of interagency coordination and that their creation has never been an easy task. Therefore, it is necessary to create the circumstances in which all organizations that in some way take part in or influence the program are in coordination. This task will be ongoing and must be given priority by the coordinating unit. Guaranteeing inter-organizational coordination is a basic requirement for these programs to remain functional over time.

[13] According to the I-ADAM study carried out by *Paz Ciudadana Foundation*, 2010.

Conclusions

Making a public policy program sustainable is not an easy task, as both its creation and its continuity depend on the development of the policy making process and on the initiative's historical and social context. A policy does not emerge from the national and international context in isolation, and its implementation and its development over time are permeated by this context.

Nevertheless, there are actions that a public policy of this kind cannot omit if it is to be effective: ongoing monitoring and evaluation to identify the operation and the impact of the program, so that the program may be modified and adapted to its context; ongoing training for all stakeholders; and inter-agency coordination, and promotion of the program as an efficient rehabilitative tool.

It is also important to identify critical themes relating to each country's reality and individual needs. This chapter used the Chilean experience as an example of an adaptation of a successful program, which was implemented in a way that might seem very different from other settings. Watching for and knowing about other forms of program operation and implementation makes it possible to not only encourage similar experiences, but also contribute to the overall knowledge of the DTC model.

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DRUG TREATMENT COURTS
KEY COMPONENTS/PRINCIPLES

In 1995, the U.S. Department of Justice asked the National Association of Drug Court Professionals (NADCP) to assemble a multi-disciplinary group of professionals involved with the development of drug treatment courts to define the essential elements of these programs. With over 75 programs then underway since the Miami program began, it was becoming increasingly clear that some definitional framework was needed to ensure that these programs – revolutionary at the time – developed in a manner that built on the interdisciplinary, treatment focused approach of the Miami program. The result was "Defining Drug Courts: the Key Components", published in 1997. Two years later, an Expert Working Group convened by the United Nations in 1999 adopted the principles of the ten "Key Components", adding three additional *principles* to the US "key components" to address case management, individualized treatment and aftercare services.[14] These key components and key principles are summarized below.

Key Component 1: Drug Courts integrate alcohol and other drug treatment services with justice system case processing.
***Key Principle** 1: Integrated justice/health care system processing of common casework.*

Key Component 2: Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights.
***Key Principle 2:** Non-adversarial approach to case problem-solving by the judge, prosecutor and defense.*

Key Component 3: Eligible participants are identified early and promptly placed in the drug court program.
***Key Principle 3:** Prompt and objective identification and program placement of eligible offenders.*

Key Component 4: Drug courts provide access to a continuum of alcohol, drug and other related treatment and rehabilitation services.
***Key Principle 4:** Access by participants to a broad continuum of treatment and rehabilitation services.*

Key Component 5: Abstinence is monitored by frequent alcohol and other drug testing.
***Key Principle 5:** Objective monitoring of participants' compliance through substance abuse testing.*

Key Component 6: A coordinated strategy governs drug court responses to participants' compliance.
***Key Principle 6:** Coordinated strategic response to program compliance and non-compliance by all disciplines involved (police, prosecution, probation, treatment, social workers, court).*

Key Component 7: Ongoing judicial interaction with each drug court participant is essential.
***Key Principle 7:** Ongoing direct judicial interaction with participants.*

Key Component 8: Monitoring and evaluation measure the achievement of program goals and gauge effectiveness.

[14] The 13 Key Principles for Court-Directed Treatment and Rehabilitation Programs.1998.

Key Principle 8: *Program performance monitoring and evaluation (of both process and impact).*

Key Component 9: Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations.
Key Principle 9: *Ongoing interdisciplinary education of the entire Drug Court team.*

Key Component 10: Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court effectiveness.
Key Principle 10: *Partnerships for program effectiveness and local community support.*

Key Principle 11. *Ongoing case management including social reintegration support.*
Key Principle 12. *Adjustable program content for groups with special needs (e.g., mental disorders).*
Key Principle 13. *Post treatment and after-care services should be established in order to enhance long-term program effects.*

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SCHOOL OF PUBLIC AFFAIRS, AMERICAN UNIVERSITY

American University, located in Washington, D.C., was chartered by Act of Congress in 1893 and is accredited by the Middle States Association of Colleges and Secondary Schools. The University's six schools and colleges have a current enrollment of approximately 11,000 graduate and undergraduate students and offer 53 bachelor's programs, 73 master's and doctoral programs, and three levels of law degree programs.

Although it is first and foremost an academic institution of higher learning, American University has a lengthy and recognized record of pragmatic, real-world contributions, and community service and outreach activities are vital elements of its core Mission.

Ranked among the top schools of its kind, American University's School of Public Affairs offers education in the fields of political science, public administration, public policy, and justice. Created in 1934 to train leaders involved with implementing the "New Deal" under President Franklin Roosevelt, the School of Public Affairs has grown into one of the top schools of public affairs in the nation with a focus on public policy and public service.

The Justice Programs Office (JPO), a component of the University's School of Public Affairs, was established in 1989 to carry on the University's justice system administration, technical assistance and research programs, which had been housed since 1972 at the American University Law School. The JPO's mandate is to help carry out the community outreach mission of the School of Public Affairs: "to apply the tools of scholarship and professionalism to the design and conduct of public programs."

The JPO is staffed by a small core group of full-time research faculty and staff associates, and a larger group of part-time JPO Senior Fellows – formally recognized senior practitioners in a variety of specialties related to public administration – who work with JPO faculty and staff on projects in direct support of state and local government agencies. This cadre of faculty, staff and Senior Fellows is supplemented, as necessary, by outside consultants and by AU academic faculty in the disciplines of law, public health, economics, social~~computer~~ science, public administration, and other specialties. Most of the technical assistance, training and research activities of the JPO are sponsored by the federal government, notably the University's nationally recognized, state courts-focused technical assistance programs, which are sponsored by the U.S. Department of Justice. Additional short-term projects are undertaken on a direct contract basis with state and local governments or with foreign governments.

THE ORGANIZATION OF AMERICAN STATES

The Organization of American States (OAS) is the world's oldest regional organization, dating back to the First International Conference of American States, held in Washington, D.C., from October 1889 to April 1890. At that meeting the establishment of the International Union of American Republics was approved. The Charter of the OAS was signed in Bogotá in 1948 and entered into force in December 1951. The Charter was subsequently amended by the Protocol of Buenos Aires, signed in 1967, which entered into force in February 1970; by the Protocol of Cartagena de Indias, signed in 1985, which entered into force in November 1988; by the Protocol of Managua, signed in 1993, which entered into force on January 29, 1996; and by the Protocol of Washington, signed in 1992, which entered into force on September 25, 1997. The OAS currently has 35 member states. In addition, the Organization has granted permanent observer status to 63 states, as well as to the European Union.

The essential purposes of the OAS are: to strengthen peace and security in the Hemisphere; to promote and consolidate representative democracy, with due respect for the principle of nonintervention; to prevent possible causes of difficulties and to ensure peaceful settlement of disputes that may arise among the member states; to provide for common action on the part of those states in the event of aggression; to seek the solution of political, juridical, and economic problems that may arise among them; to promote, by cooperative action, their economic, social, and cultural development; and to achieve an effective limitation of conventional weapons that will make it possible to devote the largest amount of resources to the economic and social development of the member states.

The Organization of American States accomplishes its purposes by means of: the General Assembly; the Meeting of Consultation of Ministers of Foreign Affairs; the Councils (the Permanent Council and the Inter-American Council for Integral Development); the Inter-American Juridical Committee; the Inter-American Commission on Human Rights; the General Secretariat; the specialized conferences; the specialized organizations; and other entities established by the General Assembly.

The General Assembly holds a regular session once a year. Under special circumstances it meets in special session. The Meeting of Consultation is convened to consider urgent matters of common interest and to serve as Organ of Consultation under the Inter American Treaty of Reciprocal Assistance (Rio Treaty), the main instrument for joint action in the event of aggression. The Permanent Council takes cognizance of such matters as are entrusted to it by the General Assembly or the Meeting of Consultation and implements the decisions of both organs when their implementation has not been assigned to any other body; it monitors the maintenance of friendly relations among the member states and the observance of the standards governing General Secretariat operations; and it also acts provisionally as Organ of Consultation under the Rio Treaty. The General Secretariat is the central and permanent organ of the OAS. The headquarters of both the Permanent Council and the General Secretariat are in Washington, D.C.

MEMBER STATES: Antigua and Barbuda, Argentina, The Bahamas (Commonwealth of), Barbados, Belize, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica (Commonwealth of), Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, United States, Uruguay, and Venezuela.