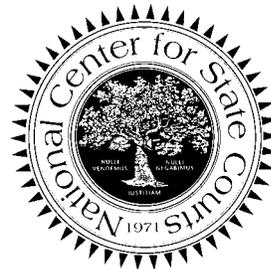


JUDICIAL EDUCATION ON SUBSTANCE ABUSE: PROMOTING AND EXPANDING JUDICIAL AWARENESS AND LEADERSHIP



FACULTY GUIDE

*A project of the American Judges Association and the National Center for State Courts
with funding from the State Justice Institute*



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American Probation and Parole Association
Conference of Chief Justices
Conference of State Court Administrators
National Association for Court Management
National Association of Drug Court Professionals
National Association of State Judicial Educators
National Council of Juvenile and Family Court Judges
National Judicial College

Special thanks to the National Association of Drug Court Professionals, the National Council of Juvenile and Family Court Judges and the National Judicial College for contributing materials from their courses to integrate into the curricular materials. In addition, we are appreciative of our contributing substance abuse treatment provider - Bacon Street in Williamsburg, Virginia - for providing their advice and expertise in the field throughout the development of the curriculum.

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Last, but not least, thank you to Sandra Thurston, Kathy Schwartz, David Tevelin and the State Justice Institute not only for providing the monetary resources to develop the curriculum, but also for providing great guidance and support throughout the process.

*Judicial Education on Substance Abuse:
Promoting and Expanding Judicial Awareness and Leadership*

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**JUDICIAL EDUCATION ON SUBSTANCE ABUSE:
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FACULTY GUIDE

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BACKGROUND INFORMATION

About the Project

Courts often become society's first opportunity to identify individuals with substance abuse problems. Every day judges and their staff are confronted by the problems of alcohol and other drug abuse in a variety of cases that appear in our nation's courtrooms. Courts are in a unique position to link these individuals to treatment programs and local drug treatment courts, where available and appropriate. In so doing, courts can contribute to the reduction in demand and use of drugs and help ensure the public's safety. The costs to society in terms of health, safety, and social and economic impact demand full court involvement to identify, confront, and address the abuse of alcohol and other drugs by defendants and other litigants.

In 2001, the National Center for State Courts (NCSC) received funding from the State Justice Institute (SJI), on behalf of the American Judges Association (AJA), to develop, demonstrate, and disseminate an educational curriculum on substance abuse for judges. On behalf of the AJA, the National Center developed a curriculum that is adaptable for various educational contexts at the national, state and local levels and appropriate for judges who deal with substance abuse issues in all types of cases. Through the project, the AJA sought to initiate a strategy to disseminate knowledge and expertise gathered in various disciplines to the judicial community. AJA hopes the curriculum will encourage judges in all types of courts to share current information and work with experts in other disciplines to develop new systemic approaches to address this large and challenging court population.

An advisory committee comprised of representatives from AJA, as the lead organization, and other national organizations (see below) convened twice to assist NCSC staff in curriculum design and provide on-going feedback on the curriculum to ensure it met the needs of the judiciary and judicial educators.

Participating Organizations

American Probation and Parole Association
Conference of Chief Justices
Conference of State Court Administrators
National Association for Court Management
National Association of Drug Court Professionals
National Association of State Judicial Educators
National Council of Juvenile and Family Court Judges
National Judicial College

Additionally, input from addiction treatment specialists was sought to ensure the accuracy and timeliness of information on aspects including pharmacology and treatment modalities. Two pilots of the curriculum with judicial audiences were conducted in the fall of 2002.

We acknowledge that several excellent judicial education curricula exist, dealing with a variety of substance abuse issues, most notably the curricula of the National Judicial College, the National Council of Juvenile and Family Court Judges and the National Drug Court Institute. The intent of this project is not to replace those curricula, but to bring their content to a wider audience of judges and courts.

NOTES TO THE TRAINER

Curriculum Objectives

The objectives of the curriculum are to:

- ◆ Generate an awareness of substance abuse issues arising in a variety of cases that appear in the courts
- ◆ Identify how the judicial role places judges in a unique position to respond both to the litigants and the community as they struggle with substance abuse issues
- ◆ Provide a basic understanding of the nature of substance abuse, addiction and recovery, and treatment modalities
- ◆ Assist the judge with the development of strategies and tools for responding (when in the courtroom) to parties with substance abuse problems
- ◆ Encourage judges to initiate and engage in an on-going dialogue, with other judges, lawyers, and interested community leaders, regarding the evolving role of the judge in substance abuse issues and problem-solving approaches generally

General Assumptions

Although quantitative and qualitative research has demonstrated the beneficial aspects of therapeutic drug courts and other problem-solving courts, the goal of this program is not to create additional drug courts or problem-solving courts.

The program is intended as a primer on a subject that, hopefully, will encourage judges to seek additional information and instruction on substance abuse and judicial roles.

Overview of Curriculum Components

- ◆ Substance Abuse Awareness (approximately 20 minutes) – This module raises awareness regarding the nature, prevalence, and cost of substance abuse and how the judicial role places judges in a position to respond to substance abuse issues to benefit the litigants, the community and the court.
- ◆ The Nature of Addiction, Basic Pharmacology and Recovery (approximately 1 hour, 15 minutes) – This module is intended to provide participants with a basic overview of the key concepts of substance abuse and addiction, as well as components of successful recovery and treatment delivery programs.
- ◆ Strategies and Tools for the Courtroom (approximately 1 hour, 10 minutes) – This module is designed to assist judges to apply substance abuse and addiction information in their work on the bench.

General Guidelines for Using the Curriculum

Audience

The curriculum is meant to serve as an introductory session for judges who handle all case types. It explores the nature of alcohol and other drug abuse as well as the dynamics of recovery in the court context. We strongly urge that training facilitators conduct a learning needs assessment to determine the general level of knowledge of the prospective participants prior to presenting the curriculum. This information will be critical to faculty in adapting and focusing their presentation of the material.

Venue

The curriculum will be appropriately delivered at state or local judicial conferences. Portions of the curriculum may also be adapted for national judicial conferences or for presentation to other audiences (for instance, Module 1 could be adapted for legislators).

Length

The curriculum, as presented, includes approximately three hours of material (with one 10- to 15-minute break). A preliminary needs assessment conducted among selected state judicial educators, judges, and potential pilot test sites indicated that a half-day (three-hour) presentation would likely be necessary at the outset before it would be possible to obtain a commitment for a full two-day seminar.

The curriculum is comprised of three modules that are purposely designed to be somewhat “elastic” to accommodate user needs. Thus, the curriculum can easily be expanded to a longer program. The three modules are intended to be used in conjunction with each other and will likely have some overlap in presentation (especially depending upon whether the presentation is presented as a half-day, one-day, or two-day program).

Faculty/Presenters

The curriculum is designed for presentation by two knowledgeable experts – a judicial officer and an addiction/treatment specialist (either a doctor or addiction counselor). We encourage training facilitators to select presenters with a strong working knowledge of the covered topics so that they can add their own ideas and experiences to the material. Past experience with facilitation and presentation also will be valuable.

Materials

The content provided in this Faculty Guide is intended as a framework for presenting this material to a judicial audience. The content includes the information considered most important (given a relatively short presentation length) by a group of knowledgeable practitioners (including judges, court administrators, treatment providers, and judicial educators). We encourage you to consider some augmentation to add content specific to your local laws and practices to increase the relevance of this material for specific audiences.

In addition, each participant should receive a notebook of training resources (see Participant Materials section of the curriculum). The amount of resources was kept purposefully small, but once again, augmentation with other resources may be considered. Relevant handouts for participant exercises are included with the content for the respective modules and are referenced in the Faculty Notes.

NOTE: For your convenience, the full Faculty Guide and most Participant Materials have also been provided on the accompanying CD in Adobe Acrobat Reader and/or Microsoft Word document format. If you wish to access the PDF (Acrobat) documents but do not have Adobe Acrobat Readers installed on your computer, a free download of the software is available at <http://www.adobe.com/products/acrobat/readstep2.html>.

Equipment Needs/Technology Requirements

The presentation slides were developed using PowerPoint (Microsoft Office 2000). The PowerPoint files are included (in the PowerPoint directory) with the curriculum materials on the accompanying CD. The presenter will need access to a laptop with Microsoft PowerPoint (or if PowerPoint is not installed, a PowerPoint Viewer should be installed for viewing PowerPoint presentations), an LCD projector and a screen (large enough for the audience to see clearly).

NOTE: For your convenience, an executable file - PPView.exe – is also included in the PowerPoint directory on the accompanying CD should you need access to a PowerPoint Viewer. Installation directions can be found at the end of the Faculty Guide.

For those who do not have access to an LCD projector, copies of the overhead slides are available for loan from the National Center for State Courts' Library by calling Circulation at 1-800-616-6164.

Due to the colorful nature of the slides, if changes are made and new copies of the slides are printed as handouts, we recommend that you print in “pure black and white” format (a print option for PowerPoint) to ensure clear copies.

Evaluation

Evaluation is an important component of any educational presentation. A sample evaluation form (adapted from the form used by the project staff for the pilot presentations of the curriculum) is included at the end of the introduction. The evaluation form is included for your personal use in obtaining audience assessment of the presentation of this curriculum.

Feedback

Additionally, your feedback regarding your use and presentation of this curriculum is vital to our ongoing efforts to produce quality materials and curriculum appropriate to the issues and audiences in the judicial context. Please complete the enclosed Feedback Form (provided on the CD and at the end of the Faculty Guide) and return to the National Center for State Courts at your earliest convenience. Your input will be utilized to make our efforts more dynamic in the development and refinement of further curriculum, supporting research and materials.

Sample Evaluation Form

***Judicial Education on Substance Abuse:
Promoting and Expanding Judicial Awareness and Leadership***

EVALUATION FORM

INSTRUCTIONS: ***Please complete this form and return it before leaving.*** Your feedback and comments about the content and structure of this educational curriculum will be useful for future trainings. Please be candid; written comments are particularly helpful. Where choices are given, circle the category that best describes your response.

Overall, how would you rate today's program?

1 2 3 4 5
 Poor Fair Average Good Excellent

Did the program meet your expectations?

1 2 3 4 5
 Not at all A Little Somewhat Met expectations Exceeded

How would you rate the overall usefulness of the content of the following segments of the program:

	Not helpful		Somewhat helpful		Very helpful
Module 1: Substance Abuse Awareness					
Content	1	2	3	4	5
Presenter(s)	1	2	3	4	5
Module 2: Addiction 101 – Basic Pharmacology and Recovery					
Content	1	2	3	4	5
Presenter(s)	1	2	3	4	5
Module 3: Strategies for the Courtroom					
Content	1	2	3	4	5
Presenter(s)	1	2	3	4	5

Was the format used for the program the best way to deliver the information and engage participants in the material?

1 2 3 4 5
 needed more good balance needed more
 interaction & educational presentation
 discussion

Which content was most useful for you?

Which content was least useful for you?

How useful did you find the materials in the curriculum support packet?

1	2	3	4	5
Not helpful		Somewhat Helpful		Very Helpful

What other materials would have been helpful to include?

What did you like most about this educational curriculum?

What suggestions can you make for improvements to the content or structure of the curriculum?

How would you categorize your knowledge of substance abuse issues prior to attending today's program?

1	2	3	4	5
No Knowledge	Minimal	Some	Moderate	High

To what extent will you be able to apply what you learned to your work?

1	2	3	4	5
Not at all	A little	Some	Regularly	Extensively

If you feel you will apply what you learned, please provide specific example(s):

Do you feel that a program like this one would be helpful to other judges?

Yes _____ No _____ Why?

Please provide below information regarding your current judicial assignment:

We value your comments and thank you for your cooperation in providing feedback about this educational session.

Module 1

Substance Abuse Awareness

- Presenter:** Judicial officer (with substantial experience in handling substance abuse cases and a working knowledge of substance abuse pharmacological and treatment issues).
- Length:** The timing for this introductory module will vary from 20 minutes to 1 hour depending upon considerations such as the experience of participants and overall length of the program. The times listed in the faculty notes are based on a 20-minute presentation.
- Purpose:** This module is intended to raise awareness regarding the nature, prevalence, and cost of substance abuse and how the judicial role places judges in a position to respond to substance abuse issues to benefit the litigants, the community and the court.

Objectives

After completing this module, participants will:

- ◆ Recognize the challenges substance abuse brings to litigants' lives and understand the significance of accountability
- ◆ Identify the economic impact of substance abuse
- ◆ Describe why the judicial role is unique in addressing substance abuse and is indeed part of an effective solution

Instructional methods

Lecture with PowerPoint slides
Individual/small group activities
Facilitated discussion

Participant Handouts

Curriculum and Module 1 Objectives
Module 1 PowerPoint Slides

Faculty Notes

The material presented in this module is intended to provide an overview of the problem of substance abuse. The slides include a significant number of statistics to provide evidence of the problem. **Please note that you are not expected to read every statistic** (this would become very boring and monotonous to the participants). We suggest, instead, that you focus on the high points, moving quickly through the materials and referring participants to the slides for further details.

We also encourage you to insert personal anecdotes from your experiences that will add interest to the material.

Depending on the level of experience of the audience, much of this information may not be new. The pre-training learning assessment will provide insights into the level of expertise of the participants. If the knowledge is high, this opening module can be framed as confirming what participants already know. If additional time is available, you could also pose questions to the audience about their experiences.

Additional Faculty Resource Materials

An excerpted version of the “Mechelle Letter” is provided to read during Slide 5 of Module 1. A full copy of the letter also is included in the faculty materials for reference.

You may also wish to refer to the judicial satisfaction data in the participant materials that shows that judges who are more engaged in these types of court approaches report higher levels of satisfaction with their positions.

In addition to national data on the costs of substance abuse presented in Slide 13, data on individual state spending on substance abuse also is available in: “Shoveling Up: The Impact of Substance Abuse on State Budgets,” The National Center on Addiction and Substance Abuse at Columbia University, 2001. State-by-state tables are available at: http://www.casacolumbia.org/usr_doc/statebystate.html

Module 1:
PowerPoint Slides with Faculty Notes

**Module 1:
Faculty Resources**

FACULTY RESOURCE (MODULE 1): MECHELLE'S LETTER EXCERPTS
(To be read for Slide 5)

My name is Mechelle,

I am a 37-year old woman, recovering from 20 years of drug abuse. When I made it to court, I was living at the animalistic level – no home, no income, no job, no car, no confidence and no hope.

I was raised by the state and had a great fear of courts and judges. The last time I saw my parents was as a child in a courtroom. I was raised in numerous foster homes and abused in a number of ways in those homes – physically, sexually, and emotionally. At 16 years old, I was raped by a man who threatened my life – and I got pregnant! I started using drugs immediately after the rape. [Since then, I have been] convicted of 2 felonies, and later picked up for my third felony – retail fraud – and a violation of my probation!

That's how I found out about the drug treatment program -when I went before the Judge and he enrolled me. By the time I'd reached the program, I was contemplating suicide. Treatment gave me the tools I need to stay clean; but I couldn't have done it alone. The program supplied the structure and guidance I needed to get grounded in my recovery.

I know he doesn't like to take credit, but I need to tell you what he has done for me. He helped restore my faith in the system – I no longer fear judges. His genuine kindness and concern was what I'd been looking for all my life. He's also the first positive male role model in my life who didn't abuse me or want something from me. He's shown me there are good men in the world; and the staff women of the program were always there when I was in pain and needed someone to talk me through it.

Without that kind of judge and the program he enrolled me in, those of us chemically dependent continue the cycle of going to jail, getting out and doing the same thing over and over again. I'm very grateful I was fortunate enough to get in. Before that, I didn't even know I had a problem. The denial was sooooo deep – I had a \$300-a-day habit; I'm grateful I didn't die from it first!

Today I'm an active member of a 12-Step program that teaches me a new way to live. I no longer have to use, no longer have to cheat or steal. Today I'm a responsible, productive member of society – I have a home, a job, and am going to school. And I have a goal and purpose in life – to help others who suffer from the disease of addiction.

FACULTY NOTE: This is excerpted from an actual letter received by a judge who presides over a drug treatment court. Permission was granted by the judge to use excerpts of this letter in the curriculum.

**FACULTY RESOURCE (MODULE 1): MECHELLE'S LETTER FULL VERSION
(FOR REFERENCE ONLY – DO NOT READ THIS VERSION)**

My name is Mechelle,

I am a thirty seven year old woman, recovering from twenty years of drug abuse. When I made it to diversion court, I was living at the animalistic level, no home, no income, no job, no car, no confidence, and no hope.

I was raised by the state of California since I was two or three years old. I grew up with a great fear of courts and judges. The last time I saw my parents as a child was at this young age in a courtroom. I would meet them at 16 years old. I was raised in numerous foster homes and the Children's Shelter in San Jose, CA. Throughout my childhood, I was sexually, physically, and emotionally abused. When an adult foster brother was caught abusing me, it had been going on for some time. I was four or five. They moved me out of the house immediately. They never told me I was the victim, they never punished him. They didn't explain anything to me, instilling in me, I was the bad person. I was dirty. I wasn't any good. The abuse didn't stop with him. It continued throughout my childhood. My therapist has since told me, by then I had victim stamped on me and predators picked up on that. My last foster home was physical abuse every day for years. I don't remember one day where I wasn't abused in that home. I would show the bruises to my caseworker. They never did anything to help. Further instilling into me I wasn't worth saving or protecting.

I met my biological family when I was sixteen. First my father, I lived with him for about a month, then my Grandmother, then Great Grandfather, from one family member to another each place lasting about a month. By them shipping me from one to another had convinced me I wasn't worth anything. Needless to say, I've had abandonment issues that go back as far as I can remember. Each time I was moved from each home, I was enrolled in a different school, so between the ninth and half of the tenth year in high school – I was enrolled in nine different schools, between San Francisco and Los Angeles.

At sixteen years old I was raped by a man who threatened my life. From this my son was conceived. I had not been sexually active – voluntarily, prior to this. So I had a child before I even had a boyfriend. In my young mind, I was risking more rejection for giving birth to a bi-racial child. I could not tell anyone, except my twin sister, the circumstances behind my pregnancy. I felt so guilty, rape victims do, and I did not trust my family enough to tell them. After the rape, two weeks later I moved from the San Francisco Bay area to Los Angeles where my mother was, because I was afraid I'd run into him again. My first doctor app. was when I was seven months pregnant. That's when my mother found out. The first doctor I saw chewed me out so bad for being sixteen, unmarried and pregnant I left his office cring [sic] and never saw him again. Again deeper instilling I was absolutely no good. I started using drugs immediately after the rape. I don't know how in the world I gave birth to a healthy baby boy. But I thank God, today thank he is healthy! I need to tell you I hold no resentments towards my son for how he was conceived. I tell you this because people tell me, "how could you keep him!" things like this. I have a georgeous [sic], kind, loving, gentle, caring twenty year old young man, whom I love with all my heart. David is currently in Los Angeles County Jail due to the nature of the disease of addiction.

My drug use started with alcohol and pot. Soon progressed to cocaine, LSD, and heroin. I've used percription [sic] drugs, every drug I can think of, I've used. I've overdosed, I've contracted serimal

[sic] hepatitis, I've come very close to death many times and still couldn't stop. I've done many immoral and illegal things to support my habit.

Seven years ago I moved to Michigan to get away from the drugs. I thought that my use would stop there. Of course, it didn't. At that time, I couldn't see I had a problem. I didn't know addiction is a disease. My first five years here in Michigan I went straight down hill. At thirty-two I was convicted of two felonys [sic]. In September of 94 I was picked up for retail fraud – another felony, my third. This was a violation of my probation.

That's how I found out about SADP. I went before Judge XXX and was enrolled. Upon entering treatment, I felt like the lowest piece of trash on the face of the earth. By the time I'd reached the program I was contemplating suicide. I knew an overdose of heroin would be painless. In treatment I learned I have a disease, obsessive and compulsive behavior. That I am not a bad person. Treatment gave me the tools I needed to help me stay clean.

Judge XXX tells me I did it. I got clean, but I couldn't have done it alone. SADP supplied the structure and guidance [sic] I needed to get grounded in my recovery. Anytime I needed anything, they were there. I was living in a using environment, I relapsed at sixty day's clean, and they came the next day and moved me. I was terrified I was going to jail because of my relapse. Remember I told you I have a fear of judges from childhood. Judge XXX was so kind and understanding, he told me he had faith I could do this, that gave me the strength to persevere.

I know he doesn't like to take credit – but I need to tell you what he has done for me. He has helped restore my faith in the system. I no longer have that fear of judges. His genuine kindness and concern was what I'd been looking for all my life. I've told him before, though he's not old enough, he's the father figure I never had. He's also the first positive male role model in my life, who didn't abuse me or want something from me. He's show me there are good men in the world.

The women [staff] of SADP have been great. When I wasn't feeling good, I would call them and whoever was on the other end talked me thru the pain. I can't tell them or thank them enough for what they have done for me.

Without this program, those of us chemically dependent, continue the cycle of going to jail, getting out and doing the same thing all over again. We don't get the help we need. I am so happy to hear there's going to be a SADP program for men. Our prisons are so overcrowded with men that have drug related offenses. This program is what our country needs.

I'm very grateful I was fortunate to get into SADP. Before this I didn't even know I had a problem. The denial was so deep. I'm grateful I didn't have to die with a three hundred dollar a day habit.

Today I am an active member of a Twelve Step program that teaches me a new way to live. I no longer have to use, no longer have to lie, cheat, steal. Today I am a responsible, productive member of society. I have a home, I chair meetings at the women's K-Pep, I used to chair meetings at the treatment center.

I'll be starting school in May. I am employed at XXXX Residential Treatment Center.

Today I have a goal and purpose in life. I help others who suffer from the disease of addiction.

PS. Today I have a little over two years clean. Life is good!

**Module 1:
Participant Handouts**

***JUDICIAL EDUCATION ON SUBSTANCE ABUSE:
PROMOTING AND EXPANDING JUDICIAL AWARENESS AND LEADERSHIP***

*A project of the American Judges Association and the National Center for State Courts
with funding from the State Justice Institute.*

Courts are often society's first opportunity to identify individuals with substance abuse problems. Every day, judges and their staff are confronted by the problems of alcohol and other drug abuse in a variety of cases that appear in our nation's courtrooms. Courts are in a unique position to link these individuals to treatment programs and local drug treatment courts, where available and appropriate. In so doing, courts can contribute to the reduction in demand and use of drugs and help ensure the public's safety. The costs to society in terms of health, safety, and social and economic impact demand full court involvement to identify, confront, and address the abuse of alcohol and other drugs by defendants and other litigants.

The objectives of the curriculum are to:

- ◆ Generate an awareness of substance abuse issues arising in a variety of cases that appear in the courts
- ◆ Identify how the judicial role places judges in a unique position to respond both to the litigants and the community as they struggle with substance abuse issues
- ◆ Provide a basic understanding of the nature of substance abuse, addiction and recovery, and treatment modalities
- ◆ Assist the judge with the development of strategies and tools for responding (when in the courtroom) to parties with substance abuse problems
- ◆ Encourage judges to initiate and engage in an on-going dialogue, with other judges, lawyers, and interested community leaders, regarding the evolving role of the judge in substance abuse issues and problem-solving approaches generally

This curriculum was developed under a grant from the State Justice Institute to the National Center for State Courts, on behalf of the American Judges Association. The AJA and NCSC recognized the need to partner with a variety of national organizations in designing this curriculum. Representatives from the following organizations participated in the development of the curriculum:

American Probation and Parole Association
Conference of Chief Justices
Conference of State Court Administrators
National Association for Court Management
National Association of Drug Court Professionals
National Association of State Judicial Educators
National Council of Juvenile and Family Court Judges
National Judicial College

Module 1: Substance Abuse Awareness

This module is intended to raise awareness regarding the nature, prevalence, and cost of substance abuse and how the judicial role places judges in a position to respond to substance abuse issues to benefit the litigants, the community and the court

Objectives

After completing this module, participants will:

- ◆ Recognize the challenges substance abuse brings to litigants' lives and understand the significance of accountability
- ◆ Identify the economic impact of substance abuse
- ◆ Describe why the judicial role is unique in addressing substance abuse and is, indeed, part of a solution

Module 2: The Nature of Addiction, Basic Pharmacology, and Recovery

This module is intended to provide participants with a basic overview of the nature of addiction and substance abuse, as well as the components of successful recovery and treatment delivery programs

Objectives:

After completing this module, participants will be able to:

- ◆ Define substance abuse and addiction
- ◆ Describe the cycle of addiction
- ◆ Examine the pharmacological aspects of substance abuse and the wide breadth of substances abused
- ◆ Identify potential substance abuse when it presents in court
- ◆ Recognize the different treatment modalities available
- ◆ Identify barriers to treatment and recovery
- ◆ Recognize the varying treatment needs of special populations (e.g., men vs. women, different ethnic groups, juveniles, persons with alternative sexual orientation, different cultural groups, Native Americans or Alaska Natives, persons with HIV, persons with co-occurring mental disorders)

Module 3: Strategies for the Courtroom

This module is designed to assist judges in developing strategies and tools for responding to substance abuse issues from the bench.

Objectives:

After completing this module, participants will be able to:

- ◆ Develop relevant questions a judge can ask from the bench that may elicit information regarding a litigant's use of drugs and alcohol
- ◆ Develop strategies to effectively apply substance abuse and addiction information
- ◆ Develop a bench resource guide on substance abuse for personal use
- ◆ Identify substance abuse resources in the community and strengths and gaps in local substance abuse services

Module 2

The Nature of Addiction, Basic Pharmacology, and Principles of Recovery

Presenter: Treatment Provider

We strongly urge training coordinators to identify a knowledgeable treatment provider in your local community to present the material in this module. The faculty notes are not intended to support the presentation of this information by a novice.

To identify an appropriate individual, you may wish to contact your state's chapter of the American Society of Addiction Medicine (see list of contacts on-line at <http://www.asam.org/>) or the National Association of Alcoholism and Drug Abuse Counselors (see list of state contacts on-line at <http://naadac.org/affiliates/>) for a recommendation of an appropriate expert in your area. The Substance Abuse Mental Health Services Administration (SAMSHA) website also has a Treatment Facility Locator that may provide contacts in your area (www.findtreatment.samsha.gov/facilitylocator.doc.htm)

Length: 1 hour, 15 minutes (this time could vary from 1 hour to 1 day, depending upon considerations such as selection of faculty, experience of participants, and overall length of program)

Purpose: This module is intended to provide participants with a basic overview of the nature of addiction and substance abuse, as well as the components of successful recovery and treatment delivery programs.

Objectives

After completing this module, participants will be able to:

- ◆ Define substance abuse and addiction
- ◆ Describe the cycle of addiction
- ◆ Examine the pharmacological aspects of substance abuse and the wide breadth of substances abused.
- ◆ Identify potential substance abuse when it presents in court
- ◆ Recognize the different treatment modalities available
- ◆ Identify barriers to treatment and recovery
- ◆ Recognize the varying treatment needs of special populations (e.g., men vs. women, different ethnic groups, juveniles, persons with alternative sexual orientation, different cultural groups, Native Americans or Alaska Natives, persons with HIV, persons with co-occurring mental disorders)

Instructional Methods

Lecture with PowerPoint Slides

Facilitated Discussion
Possible Individual Activity (see below)

Participant Handouts

Module 2 Objectives (See Module 1 Handouts)

Module 2 PowerPoint Slides

Participant notebook materials also include several items regarding commonly abused drugs, as well as principles of treatment to which the faculty may wish to refer.

Faculty Notes

The expansiveness of the subjects of addiction, treatment and recovery do not permit a completely thorough exploration in this limited context. However, the curriculum suggests the critical education content for a basic education program. You may have additional insights about the material and can adapt the slides to meet your individual presentation needs and style.

The closing slides in Module 2 (see slides on “Commonly Abuse Drugs”) are intended to inform judges about the unique characteristics of addiction to specific substances that may have implications for the behavior and accountability of court participants. You may want to consider co-presenting this material with the judicial officer to emphasize these elements. A discussion with audience members about their experiences with court participants under the influence of the various drugs also could be facilitated.

This module includes a large amount of material. Please plan your time carefully.

Additional Faculty Resources

You may wish to consider additional activities to expand this module.

Sample Activity: One suggestion is administering a “drug abuse quiz.” A sample quiz is included. You could use this tool (or one you develop yourself) to raise the awareness of participants of some of the myths of substance abuse and treatment.

NOTE: Questions and answers for the “drug abuse quiz” were excerpted from both the ACDE: The American Council for Drug Education’s “Drug Awareness Knowledge Quiz” (the full version of their interactive online quiz can be found at <http://www.acde.org/youth/quiz.htm>), and the “Alcohol and Other Drugs and the Courts” curriculum by Hon. Peggy Fulton Hora, Alameda County Superior Court, Hayward, CA..

Module 2:
[PowerPoint Slides with Faculty Notes](#)

**Module 2:
Faculty Resources**

DRUG AWARENESS KNOWLEDGE QUIZ

Do you know what drugs people are using today and what those drugs can do? Test yourself and find out what you know. You may be surprised by some of the answers!

1. The most commonly abused drug in the U.S. is:
 - Marijuana
 - Alcohol
 - Cocaine
 - Heroin

2. More people die each year in the U.S. as a result of:
 - Alcohol
 - Tobacco
 - Heroin
 - Cocaine

3. About 1/3 of alcoholics have a co-existing mental health disorder.
 - True
 - False

4. Marijuana is much stronger today than it was 10 years ago.
 - True
 - False

5. The number one risk factor for alcoholism is childhood sexual abuse.
 - True
 - False

6. The high from a typical dose of crack lasts:
 - 1 hour
 - 30 minutes
 - 5 minutes

7. Physiological responses to drugs and paraphernalia may occur as long as 10 years after the person stops using.
 - True
 - False

ANSWERS TO THE DRUG AWARENESS QUIZ

Here are the answers to the seven questions asked on the Drug Awareness Knowledge Quiz.

1. The most commonly abused drug in the U.S. is:
Alcohol
2. More people die each year in the U.S. as a result of:
Tobacco
3. **FALSE** Fully 65% of women alcoholics and 44% of men have the dual diagnosis of alcoholism and a co-existing mental disorder such as clinical depression, phobic disorder, or panic disorder.
4. **TRUE** Marijuana is much stronger today than it was 10 years ago.
5. **FALSE** The number one risk factor for alcoholism is genetics. About 80% of alcoholics have an alcoholic family member. Identical twins have a 74% concordance with alcoholism compared to 32% of fraternal twins.
6. The high from a typical dose of crack lasts:
5 minutes
7. **TRUE** Physiological symptoms from viewing a “crack” pipe, passing one’s old dealer or seeing drugs can elevate respiration, heart rate and dilate pupils even after 10 years of abstinence.

**Module 2:
Participant Handouts**

Module 3

Strategies and Tools for the Courtroom

- Presenter:** Judicial Officer (with possible assistance from Treatment Provider)
- Length:** 1 hour, 10 minutes (this time could vary from 1 hour to 3 hours depending on the small group activities)
- Purpose:** This module is designed to assist judges to apply substance abuse and addiction information in their work on the bench.

Objectives

After completing this module, participants will be able to:

- ◆ Develop relevant questions a judge can ask from the bench that may elicit information regarding a litigant's use of drugs and alcohol
- ◆ Develop strategies to effectively apply substance abuse and addiction information
- ◆ Develop a bench resource guide on substance abuse for personal use
- ◆ Identify substance abuse resources in the community and strengths and gaps in local substance abuse services

Instructional Methods

Lecture with PowerPoint Slides
Facilitated Discussion
Scenarios with Small Group Discussion

Participant Handouts

Module 3 Objectives (See Module 1 Handouts)
Module 3 PowerPoint Slides
Personal Action Plan (Print on colored paper for easier reference by faculty)
Scenarios (Print on colored paper for easier reference by faculty)

Faculty Notes

At the end of this module, individuals will be asked to complete a “personal action plan” identifying some things they will do as a result of attending this program. You should consider drawing participants' attention to the action plan guide in the materials during this module.

This module includes a small group exercise and discussion of a series of scenarios (covering aspects of substance abuse in different judicial contexts). Please read and study the scenarios as well as the additional notes on the PowerPoint slides to be prepared to facilitate the discussion among participants.

A critical concept that you should convey through this module is the importance of information gathering in making informed judicial decisions. Some judges may be very hesitant about asking the types of questions from the bench that are outlined in these materials (although

many judges regularly do ask these types of questions). Stress to the participants that this is information that they should have – not necessarily how they should obtain that information. In obtaining information, the concept of coordinating and collaborating with other entities (such as probation, service providers, etc.) also is appropriate to emphasize. You may wish to examine the concept of collaboration as you discuss the bench considerations and the scenarios.

Judicial access to useful resources is another concept that you should convey through this module. We recommend in the materials that participants consider developing a bench book on substance abuse that they can use for reference. Some suggested materials to incorporate into the bench book are included in the participant materials. Judges also should be encouraged to seek out resources in their own communities (for instance, times and locations of 12-step meetings, lists of local treatment providers).

Remember to have participants complete the evaluation form prior to the end of the session.

Additional Faculty Resources

Some judges may be uncomfortable with some of the judicial activities suggested in this module. Resources exist that support these activities, however, to which you may wish to refer.

Reference is made in the presentation to the Trial Court Performance Standards. Faculty unfamiliar with the Standards may wish to view the full document on-line at http://www.ncsconline.org/D_Research/TCPS/index.html.

The Conference of Chief Justices and the Conference of State Court Administrators drafted a joint resolution in support of problem-solving court approaches (attached) that encourages the judiciary to examine the applicability of practices in drug treatment courts and other problem-solving court models to the work of courts generally.

Module 3:
[PowerPoint Slides with Faculty Notes](#)

**Module 3:
Faculty Resources**

FACULTY RESOURCE (MODULE 3): TRIAL COURT PERFORMANCE STANDARDS

NOTE: Could also be used as a participant handout

TRIAL COURT PERFORMANCE STANDARDS

The full text of the standards with commentary is available on-line at:
http://www.ncsconline.org/D_Research/TCPS/index.html

Standard 3.5: Responsibility for Enforcement

The trial court takes appropriate responsibility for the enforcement of its orders.

Commentary. Courts should not direct that certain actions be taken or be prohibited and then allow those bound by their orders to honor them more in the breach than in the observance. Standard 3.5 encourages a trial court to ensure that its orders are enforced. The integrity of the dispute resolution process is reflected in the degree to which parties adhere to awards and settlements arising out of them. Noncompliance may indicate miscommunication, misunderstanding, misrepresentation, or lack of respect for or confidence in the courts.

Obviously, a trial court cannot assume responsibility for the enforcement of all of its decisions and orders. Court responsibility for enforcement and compliance varies from jurisdiction to jurisdiction, program to program, case to case, and event to event. It is common and proper in some civil matters for a trial court to remain passive with respect to judgment satisfaction until called on to enforce the judgment. Nevertheless, no court should be unaware of or unresponsive to realities that cause its orders to be ignored. For example, patterns of systematic failures to pay child support and to fulfill interim criminal sentences are contrary to the purpose of the courts, undermine the rule of law, and diminish public trust and confidence in the courts. Monitoring and enforcing proper procedures and interim orders while cases are pending are within the scope of this standard.

Standard 3.5 applies also to those circumstances when a court relies upon administrative and quasi-judicial processes to screen and divert cases by using differentiated case management strategies and alternative dispute resolution. Noncompliance remains an issue when the trial court sponsors such programs or is involved in ratifying the decisions that arise out of them.

Standard 4.5: Response to Change

The trial court anticipates new conditions and emergent events and adjusts its operations as necessary.

Commentary. Effective trial courts are responsive to emergent public issues such as drug abuse, child and spousal abuse, AIDS, drunken driving, child support enforcement, crime and public safety, consumer rights, gender bias, and the more efficient use of fewer resources. Standard 4.5 requires trial courts to recognize and respond appropriately to such public issues. A trial court that moves deliberately in response to emergent issues is a stabilizing force in society and acts consistently with its role of maintaining the rule of law.

Courts can support, tolerate, or resist societal pressures for change. In matters for which the trial court may have no direct responsibility but nonetheless may help identify problems and shape solutions, the trial court takes appropriate actions to inform responsible individuals, groups, or entities about the effects of these matters on the judiciary and about possible solutions.

FACULTY RESOURCE (MODULE 3): CCJ/COSCA RESOLUTION

**CONFERENCE OF CHIEF JUSTICES
CONFERENCE OF STATE COURT ADMINISTRATORS**

**CCJ Resolution 22
COSCA Resolution 4**

In Support of Problem-Solving Courts

WHEREAS, the Conference of Chief Justices and the Conference of State Court Administrators appointed a Joint Task Force to consider the policy and administrative implications of the courts and special calendars that utilize the principles of therapeutic jurisprudence and to advance strategies, policies and recommendations on the future of these courts; and

WHEREAS, these courts and special calendars have been referred to by various names, including problem-solving, accountability, behavioral justice, therapeutic, problem oriented, collaborative justice, outcome oriented and constructive intervention courts; and

WHEREAS, the findings of the Joint Task Force include the following:

- The public and other branches of government are looking to courts to address certain complex social issues and problems, such as recidivism, that they feel are not most effectively addressed by the traditional legal process;
- A set of procedures and processes are required to address these issues and problems that are distinct from traditional civil and criminal adjudication;
- A focus on remedies is required to address these issues and problems in addition to the determination of fact and issues of law;
- The unique nature of the procedures and processes encourages the establishment of dedicated court calendars;
- There has been a rapid proliferation of drug courts and calendars throughout most of the various states;
- There is now evidence of broad community and political support and increasing state and local government funding for these initiatives;
- There are principles and methods grounded in therapeutic jurisprudence, including integration of treatment services with judicial case processing, ongoing judicial intervention, close monitoring of and immediate response to behavior, multidisciplinary involvement, and collaboration with community-based and government organizations. These principles and methods are now being employed in these newly arising courts and calendars, and they advance the application of the trial court performance standards and the public trust and confidence initiative; and
- Well-functioning drug courts represent the best practice of these principles and methods;

NOW, THEREFORE, BE IT RESOLVED that the Conference of Chief Justices and the Conference of State Court Administrators hereby agree to:

1. Call these new courts and calendars “Problem-Solving Courts,” recognizing that courts have always been involved in attempting to resolve disputes and problems in society, but understanding that the collaborative nature of these new efforts deserves recognition.
2. Take steps, nationally and locally, to expand and better integrate the principles and methods of well-functioning drug courts into ongoing court operations.
3. Advance the careful study and evaluation of the principles and methods employed in problem-solving courts and their application to other significant issues facing state courts.
4. Encourage, where appropriate, the broad integration over the next decade of the principles and methods employed in the problem-solving courts into the administration of justice to improve court processes and outcomes while preserving the rule of law, enhancing judicial effectiveness, and meeting the needs and expectations of litigants, victims and the community.
5. Support national and local education and training on the principles and methods employed in problem-solving courts and on collaboration with other community and government agencies and organizations.
6. Advocate for the resources necessary to advance and apply the principles and methods of problem-solving courts in the general court systems of the various states.
7. Establish a National Agenda consistent with this resolution that includes the following actions:
 - a. Request that the CCJ/COSCA Government Affairs Committee work with the Department of Health and Human Services to direct treatment funds to the state courts.
 - b. Request that the National Center for State Courts initiate with other organizations and associations a collaborative process to develop principles and methods for other types of courts and calendars similar to the *10 Key Drug Court Components*, published by the Drug Courts Program Office, which define effective drug courts.
 - c. Encourage the National Center for State Courts Best Practices Institute to examine the principles and methods of these problem-solving courts.
 - d. Convene a national conference or regional conferences to educate the Conference of Chief Justices and Conference of State Court Administrators and, if appropriate, other policy leaders on the issues raised by the growing problem-solving court movement.
 - e. Continue a Task Force to oversee and advise on the implementation of this resolution, suggest action steps, and model the collaborative process by including other associations and interested groups.

Adopted as Proposed by the Task Force on Therapeutic Justice of the Conference of Chief Justices in Rapid City, South Dakota at the 52nd Annual Meeting on August 3, 2000.

**Module 3:
Participant Handouts**

*JUDICIAL EDUCATION ON SUBSTANCE ABUSE:
PROMOTING AND EXPANDING JUDICIAL AWARENESS AND LEADERSHIP*

PERSONAL ACTION PLAN

Consider the information presented during today's session and how you can incorporate it into your work when you return to your jurisdiction

List three items (facts, strategies, information) about which you heard in the program that were new to you and that you will share with others when you return home:

- 1.
- 2.
- 3.

List sources of information on substance abuse treatment that you would like to investigate, or encourage your support staff to acquire information about, in your community when you return home:

List three ways you would like to enhance your judicial work in the area of substance abuse:

- 1.
- 2.
- 3.

CHARLIE & MARY

by Hon. Peggy Fulton Hora, Alameda Co. Superior Court, CA

After a whirlwind romance, Charlie and Mary eloped to Las Vegas three years ago. Charlie has always been jealous throughout their relationship and complains about Mary's family and friends. She has gradually withdrawn from them to placate Charlie and because she grows frustrated hearing her mother call Charlie "that alcoholic bum." Charlie pays all the bills, controls the checkbook and gives Mary a household allowance. They have one car, Charlie's, and he drives her shopping or she takes the bus.

After Mary became pregnant last year and became focused on the impending birth, Charlie began to feel left out and started to brood and withdraw. After one weekend of heavy drinking, he grabbed Mary's arm very hard and accused her of having an affair with her Ob/Gyn. Mary was more frightened than hurt and agreed to switch to a woman doctor. That evening Charlie brought Mary flowers, apologized and said his jealousy was based on the depth of his love for her.

After their daughter, Charlene, was born, Charlie began complaining about Mary's housekeeping, her cooking and her unavailability to him. She was always "too tired" to spend time with him, and he began to resent the baby. Charlie became more verbally abusive to Mary as the months wore on. He was drinking a six-pack each weeknight and a case on weekends.

Charlene, who is now 18 months old, fell one afternoon and cut her forehead. Mary got a ride to the hospital from her neighbor, Sam. When Charlie got home from work and found Mary gone he was furious. He drank until he heard a car outside. He saw Sam dropping Mary off in front of the house and rushed outside in a rage. He pulled Mary out of the car and roughly removed Charlene from the car seat. Charlene began to cry and, while trying to comfort her daughter, Mary was kicked in the back by Charlie. The neighbor, Sam, attempted to intervene, and Charlie punched him in the mouth.

Charlie has been charged with battery on Sam, domestic assault on Mary and child endangerment. Mary is seeking a civil protective order for herself and her child and is asking that Charlie receive counseling for his drinking, as she believes this is the cause of his violence.

Discussion Questions:

What are the different courts that might see this case? How many different court orders might be issued by different judges? Which order has priority? Any prerequisites to modifying a "no contact" restraining order? Are there prerequisites placed on Charlie? On Mary?

What, if anything, should Mary's doctor have done when she "dropped out" of prenatal treatment? What obligations, if any, do physicians have to report domestic violence? Had Mary been badly injured by Charlie during either incident so as to require a visit to the ER, would the physician's obligations be any different?

Should you dispel Mary's belief that alcohol "causes" Charlie's violence? If so, how, and who should dispel it? What type of counseling, if any, does Charlie need? If he is court-ordered to counseling for violence and AOD abuse, which should come first? What type of counseling, if any,

would you order for Mary and Charlene? What is the effect, if any, on children who witness family violence? Should Mary be prosecuted for child endangerment because she didn't leave Charlie?

Is Charlie an alcoholic? How do we know? How will the judge find out? What should the judge do?

THERESA

by Hon. Patricia Bresee, San Mateo, CA

Theresa, age 20, has once again been arrested for possession of methamphetamine (meth). This is her second arrest as an adult and came as a result of a “bust” of a house in which Theresa and her 3-year-old son, Marcus, appeared to be living. Also in the house were Brandon, Theresa’s current boyfriend, who is the alleged father of her unborn child (due in three months); Brandon’s brother, Hans; Hans’s girlfriend, Lisa; and Lisa’s three children. Substantial quantities of meth were seized, as well as some drug paraphernalia and \$1,200 in \$20 bills. Theresa denies involvement in any selling but acknowledges that she smokes marijuana and snorts meth on occasion. Three bindles of meth were found in her purse. The children were removed and turned over to the county welfare department, and petitions on each of them to make them dependents of the court have been filed in juvenile court.

Theresa has a history of runaways as a teen and was declared a ward of the juvenile court herself as a result of a sustained petition alleging possession of marijuana for sale. She was placed in a series of group homes and was terminated from juvenile probation when she turned 18.

DISCUSS:

- 1. How do you solve a problem like Theresa’s?**
- 2. What other information do you need?**
- 3. What collateral issues should be investigated?**

ASSIGNMENT:

Assume Theresa has entered a nolo plea. Prepare recommendations, including the amount of jail time, if any, you wish to have the judge impose. What conditions will you impose on Theresa if the petition is sustained? What do you suggest her reunification plan look like? Does your perspective change if you are the CPS worker, probation officer, or judge? In what way?

ALICE

by Hon. Peggy Fulton Hora, Alameda Co. Superior Court, CA

Alice, 26, is before you for sentencing after being found guilty of driving under the influence of cocaine. This is her first contact with the criminal justice system. The test taken at the time of the incident showed a blood alcohol level of .04 as well as a metabolite for cocaine.

At trial, testimony revealed that the officer's attention was drawn to Alice's car when it swerved dramatically on the freeway. The officer further testified that, after the stop and during the investigation, Alice's partner, Mark, who was a passenger in the car, blurted out that he had hit her while she was driving and that's why the car swerved. Mark was so intoxicated that the officer arrested him for being drunk in public, but not for hitting Alice since the officer could see no marks on her and Alice refused to make a citizen's arrest.

At the sentencing hearing, the district attorney recommends "a standard, first-time disposition." Defense counsel agrees with the recommendation. **As the treatment provider, what is your recommendation? If you were the judge, do you accept the "standard first"?**

Same facts, except Mark says she turned around to hit the kids in the back seat and that's why she swerved. **Any different result?**

Same facts, except Alice has a prior conviction for child endangerment based upon her refusal to leave Mark, whom the children have witnessed beating her. **Any different result? What if the child endangerment was based on Alice leaving the children home alone at night and in a filthy condition? What if the prior was for battery on another woman? For another AOD offense?**

Any different result if the charge involved marijuana (at a low level commensurate with claims of one-time use the previous day) vs. cocaine (at a level indicative of recent use and likely impairment)? Why?

What else do you want to know?

CLIFFORD

by Hon. Peggy Fulton Hora, Alameda Co. Superior Court, CA, and John Marr, MS, Las Vegas, NV

Clifford is 32 years old and an assistant manager in a department store at the local mall. His father was an alcoholic who was abusive to the family. His mother tried her best, albeit unsuccessfully, to shield her children from her husband. Clifford has one sister from whom he is estranged. Clifford married young and had one child, whom he sees sporadically. He has been divorced for nine years but has a live-in girlfriend, Athena, who works as a bartender at the trendy new cigar bar in town.

Clifford pled “no contest” to his second DUI about six months ago. His BAC was .14. Your jurisdiction requires formal probation for this offense in addition to fines, penalties, DUI school, license suspension, test conditions, and a no-alcohol clause.

A petition to revoke Clifford’s probation has been filed based on his failure, on two occasions, to report and test as directed by the probation officer. Clifford appears in court and tells you he missed the tests because of inventory and a hideous work schedule.

What penalty, if any, do you impose for Clifford’s missed tests?

Clifford is back on a second petition. The PO tested him because he appeared at the probation office extremely hyper, fidgety, and exhibiting the symptoms of a bad “cold.” The “On Track” presumptive urine test was negative, but the PO, based on his suspicions, sent the sample to the lab. A GC/MS test showed positive for a cocaine metabolite and THC. Clifford admits snorting a little cocaine Athena brought home to improve their sex life.

What penalty, if any, do you impose if Clifford admits cocaine use?

What do you do about the unadmitted marijuana use?

Instead, Clifford tells you that the test was positive because he had been to the dentist that day and Lidocaine was used during the dental procedures. You know that Lidocaine does not test positive on the GC/MS.

What penalty, if any, do you impose for lying?

Assume instead, that prior to the observed test by the PO, Clifford is caught trying to pour urine from a concealed bottle into the test cup.

Any different result?

NCSC Feedback Form

*Judicial Education on Substance Abuse:
Promoting and Expanding Judicial Awareness and Leadership*

NCSC Feedback Form

Please complete the following form after presenting the curriculum and return to:

Denise O. Dancy
Research Division
National Center for State Courts
P.O. Box 8798
Williamsburg, VA 23187-8798

Email to: ddancy@ncsc.dni.us or fax at: 757-564-2127.

1. To what type of audience did you present this curriculum (i.e., judges, court staff, probation officers, etc.)?
2. In what context was the curriculum presented (i.e., conference, staff training, CLE, etc.)?
3. What module or modules did you use? What kind of presenter(s) did you use (i.e., expertise in what field – judicial officer, treatment provider, addiction physician, etc.)?
4. If you used the full curriculum, did you expand on the curriculum or use in its 3-hour, 3-module format? If you did expand on it, how, and in what module(s)? What additional materials, information, or presenters did you incorporate into your expanded version?
5. What did you find most useful in the curriculum/particular module(s)? In the CD or other accompanying materials?
6. What did you find least useful in the curriculum/particular module(s)? In the CD or other accompanying materials?
7. Other comments or suggestions:

PowerPoint Viewer Installation Instructions

PowerPoint Viewer 97 for PowerPoint 97, 2000, and 2002 Users

This download is for users who don't have Microsoft PowerPoint®; it allows them to view PowerPoint 95, 97, 2000, and 2002 presentations.

The PowerPoint Viewer 97 allows people who use PowerPoint to share their presentations with people who do not have PowerPoint installed on their computers. When you post presentations on the Internet, you can include the PowerPoint Viewer to expand your online audience to people who might not have PowerPoint, or to those with different versions. You can use this viewer to view files created in both PowerPoint for Windows® and PowerPoint for the Macintosh.

Notes

- You can view and print presentations, but you cannot edit them in the PowerPoint Viewer.
- The PowerPoint Viewer supports all PowerPoint 97 and PowerPoint 95 features.
- Some PowerPoint 2000 and 2002 features are not supported by the viewer:
 - Picture bullets
 - Automatic numbering
 - Animated GIF pictures
 - Microsoft Visual Basic® for Applications (VBA) controls
 - ActiveX® controls are not supported by the viewer

FEATURES

- Provides full fidelity display of PowerPoint 95 and PowerPoint 97 files, including the animations, graphics effects, action settings, hyperlinks, and custom shows.
- Opens presentations saved in PowerPoint for Windows 2.0 or later and PowerPoint for Macintosh 3.0 or later.
- Supports printing of PowerPoint presentations.
- Allows printing and password protection for kiosk-style slide shows.
- In addition to running as a stand-alone application, the PowerPoint Viewer 97 is optimized for displaying PowerPoint presentations inside Microsoft Internet Explorer 3.x and above.
- PowerPoint presentations can be displayed within Netscape Navigator 2.x or higher.

SYSTEM REQUIREMENTS

- A personal computer with a 486 or higher processor
- Microsoft Windows 95, 98, or 2000 operating system, or Microsoft Windows NT Workstation operating system 3.51 (with Service Pack 5.x or later) or 4.0, or Microsoft Windows ME
- 7 MB of hard disk space (9 MB free for installation only)
- VGA or higher-resolution video adapter
- Microsoft Mouse or compatible pointing device

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2. Download the file from Tools on the Web by clicking the **Download Now!** at the top left of this page and following the instructions in the dialog boxes.
3. Close any Windows-based programs that are running.
4. Double-click the **Ppview97.exe** program file on your hard disk to start the setup program.
5. Follow the instructions on the screen to complete the installation.

INSTRUCTIONS FOR USE:

On the **Start** menu, point to **Programs**, and then click **Microsoft PowerPoint Viewer 97**. The viewer will start and allow you to choose a PowerPoint file to view.

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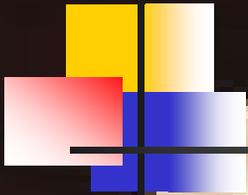
1. On the **Start** menu, point to **Settings**, and then choose **Control Panel**. Double-click **Add/Remove Programs**.
2. In the list of programs on the **Install/Uninstall tab**, find **Microsoft PowerPoint Viewer 97** and highlight it. Click **Add/Remove**.
3. In the **Microsoft PowerPoint Viewer 97 Setup** dialog box, click **Remove All**.
4. Confirm that you are certain you want to uninstall this software by clicking **Yes**.
5. Click **Restart Windows** or **Exit Setup** in the dialog box.

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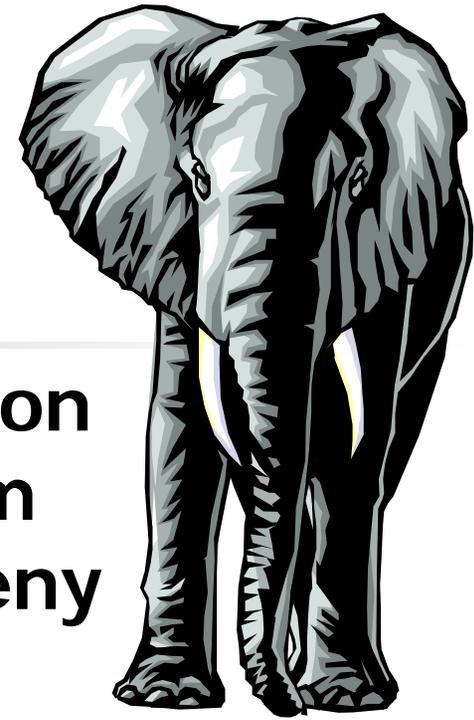
Judicial Education on Substance Abuse





Why is Substance Abuse Awareness Important to Me As a Judge?

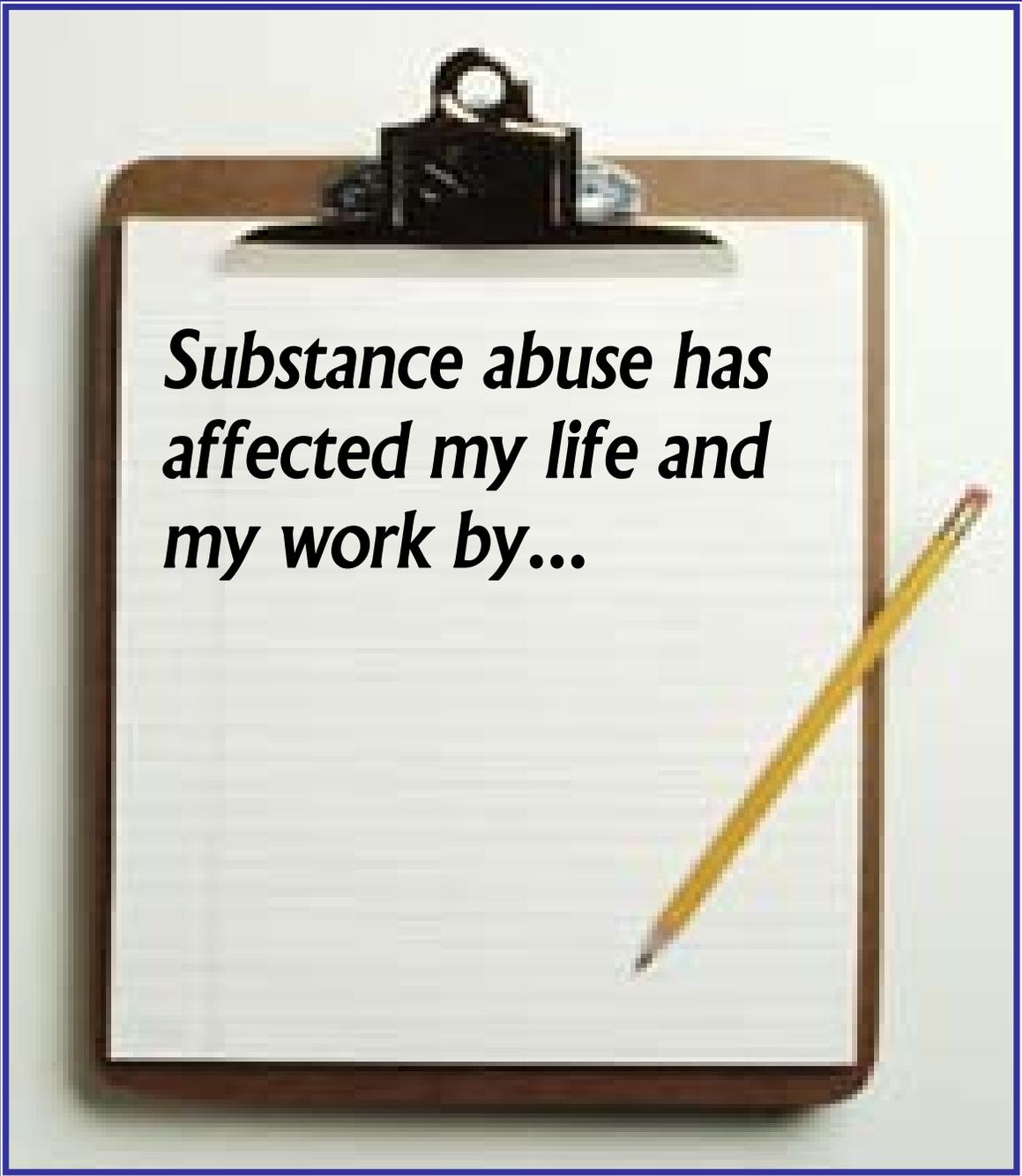
“The Elephant in the Living Room....”



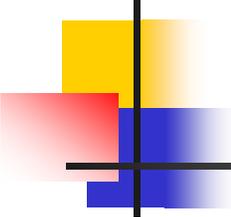
“Substance abuse and addiction is the elephant in the living room of society. Too many citizens deny or ignore its presence.

Abuse and addiction ... are implicated in virtually every domestic problem our nation faces: crime, health crippers and killers, child abuse and neglect, domestic violence, teen pregnancy, chronic welfare, the rise in learning disabled and conduct disordered children...”

**Take a
minute
and ask
yourself...**



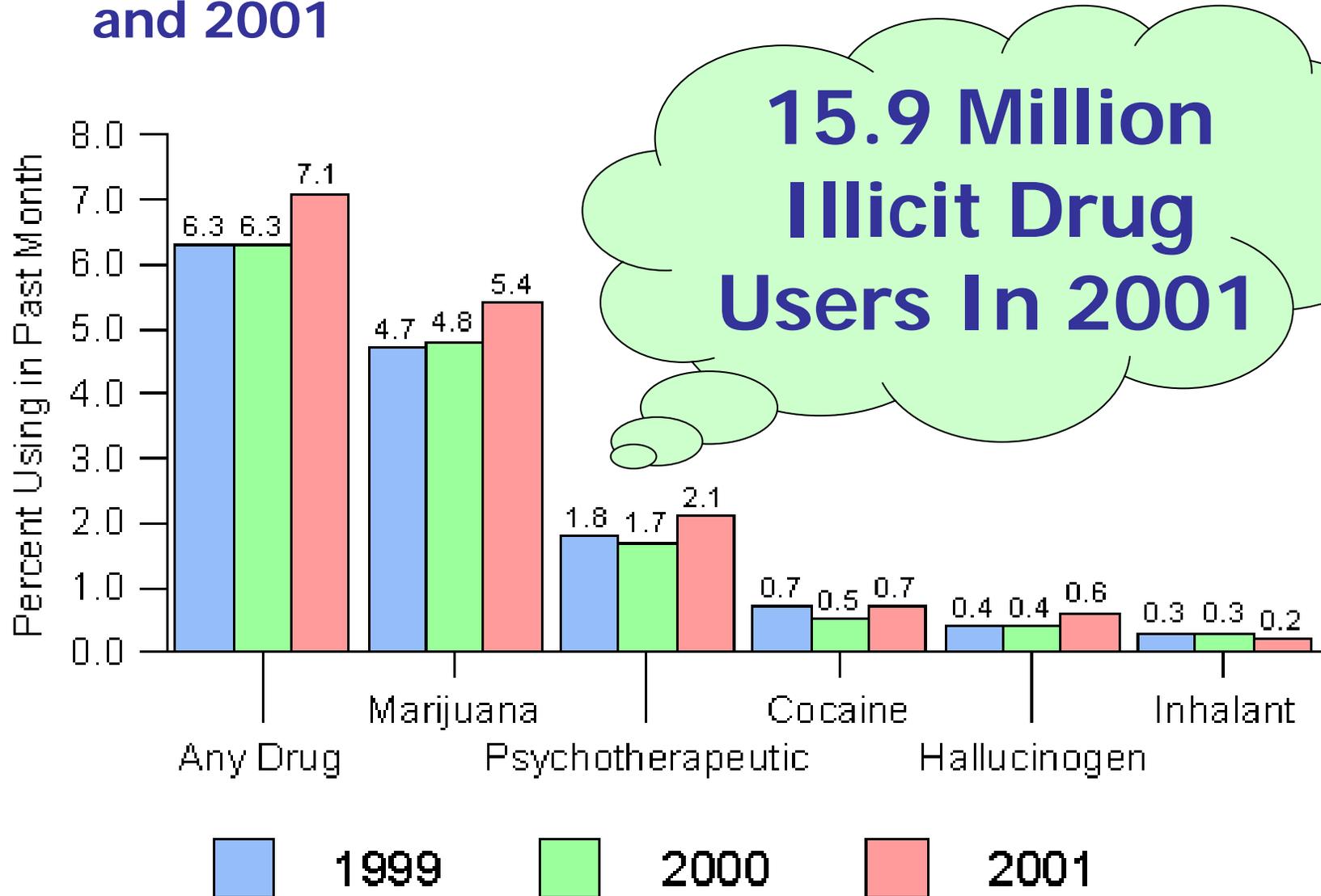
*Substance abuse has
affected my life and
my work by...*



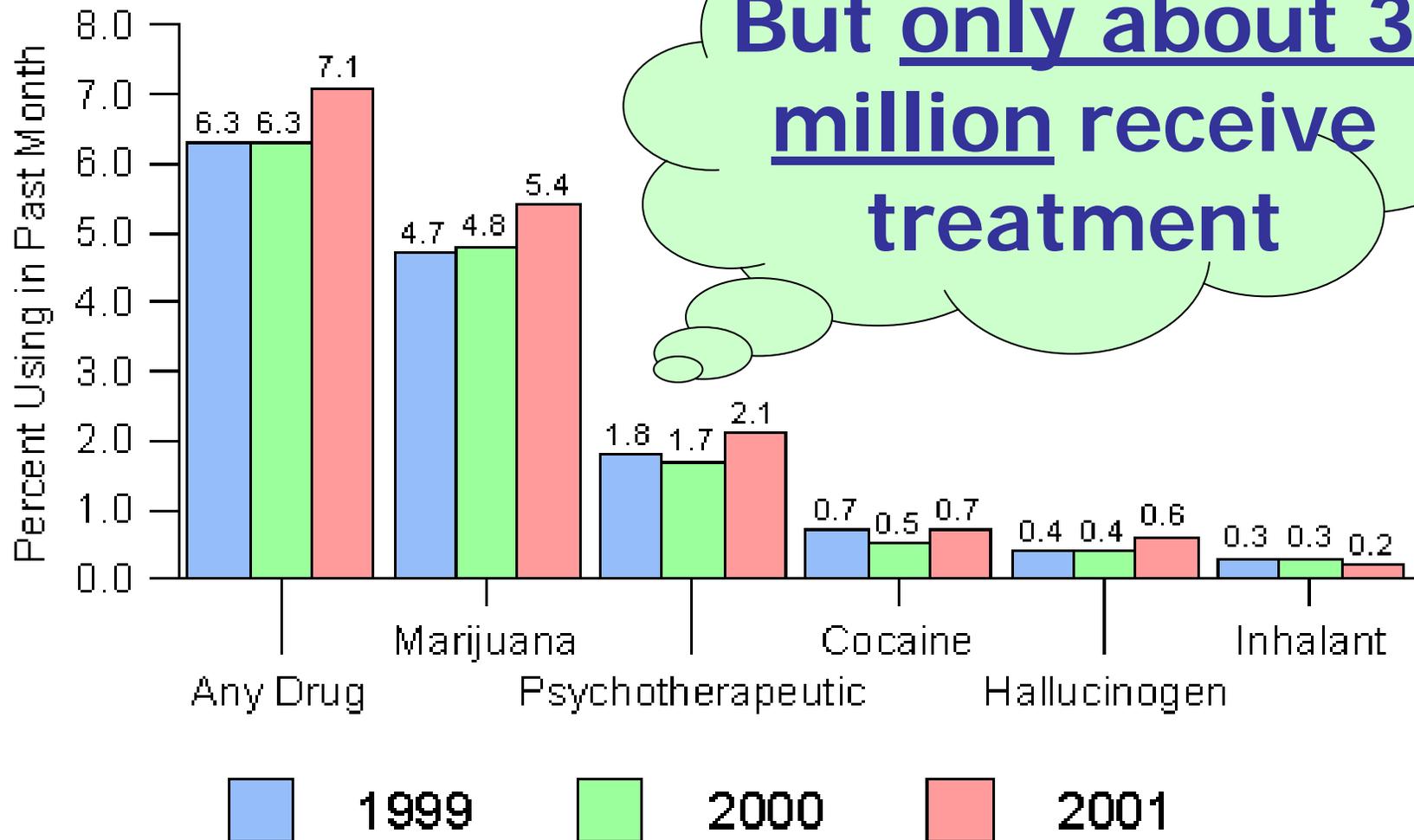
Substance Abuse...



Past Month's Illicit Drug Use by Persons Aged 12 or Older by Drug for 1999, 2000 and 2001



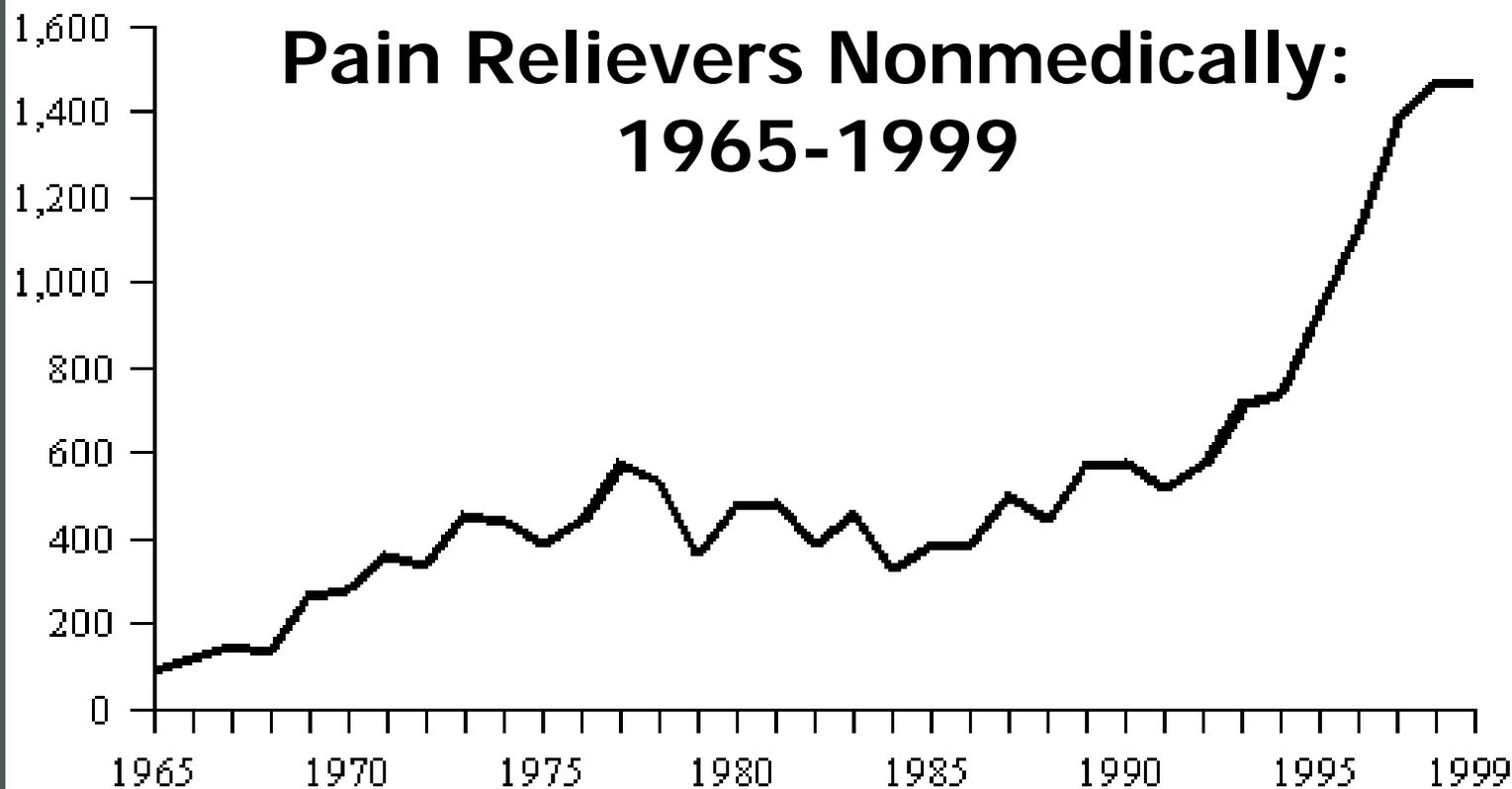
Past Month's Illicit Drug Use by Persons Aged 12 or Older by Drug for 1999, 2000 and 2001



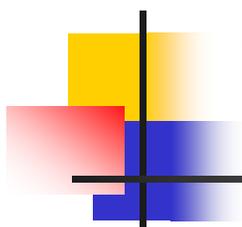
But It's Not Just "Illegal" Drugs

New Users in Thousands

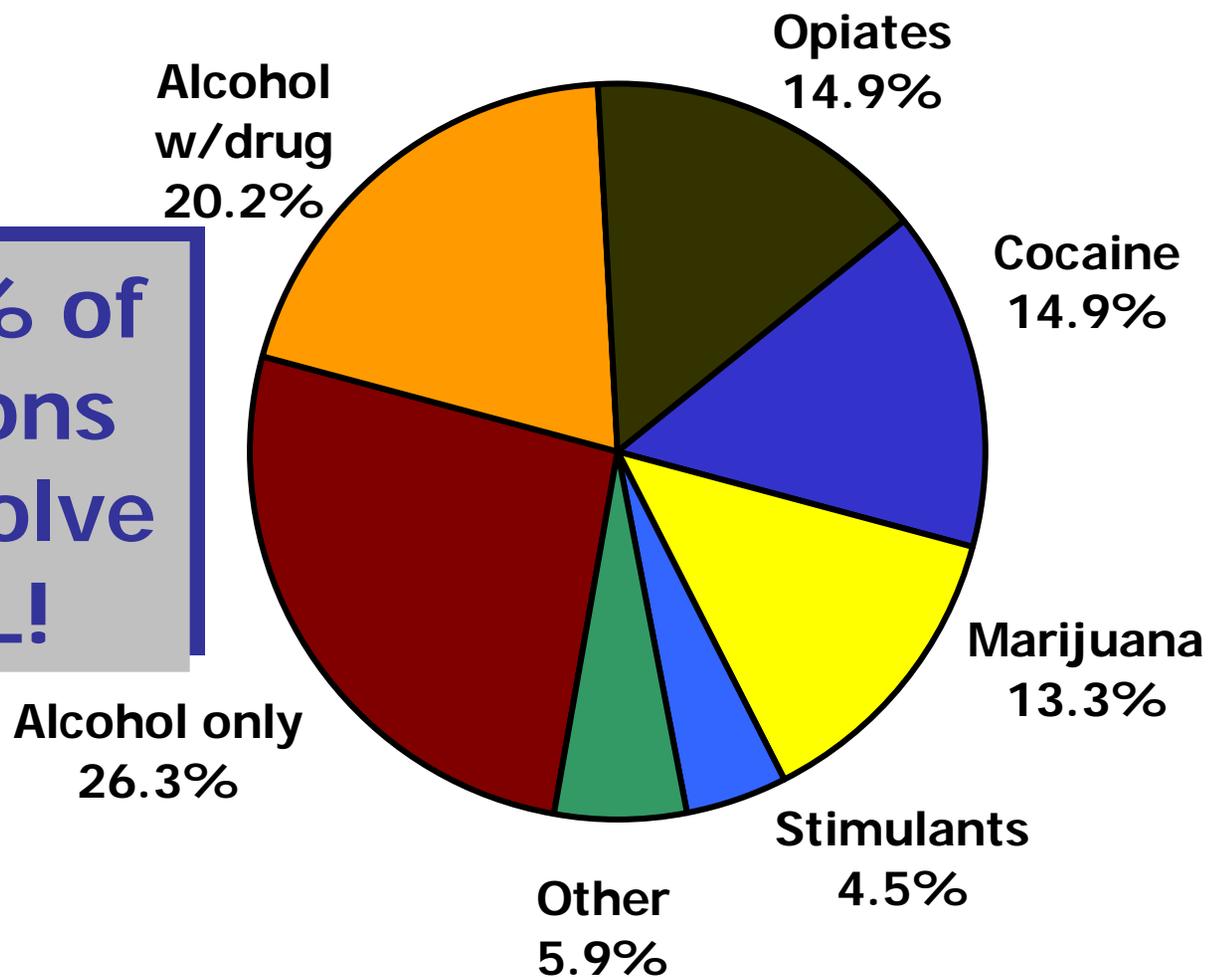
Annual Number of New Users of
Pain Relievers Nonmedically:
1965-1999



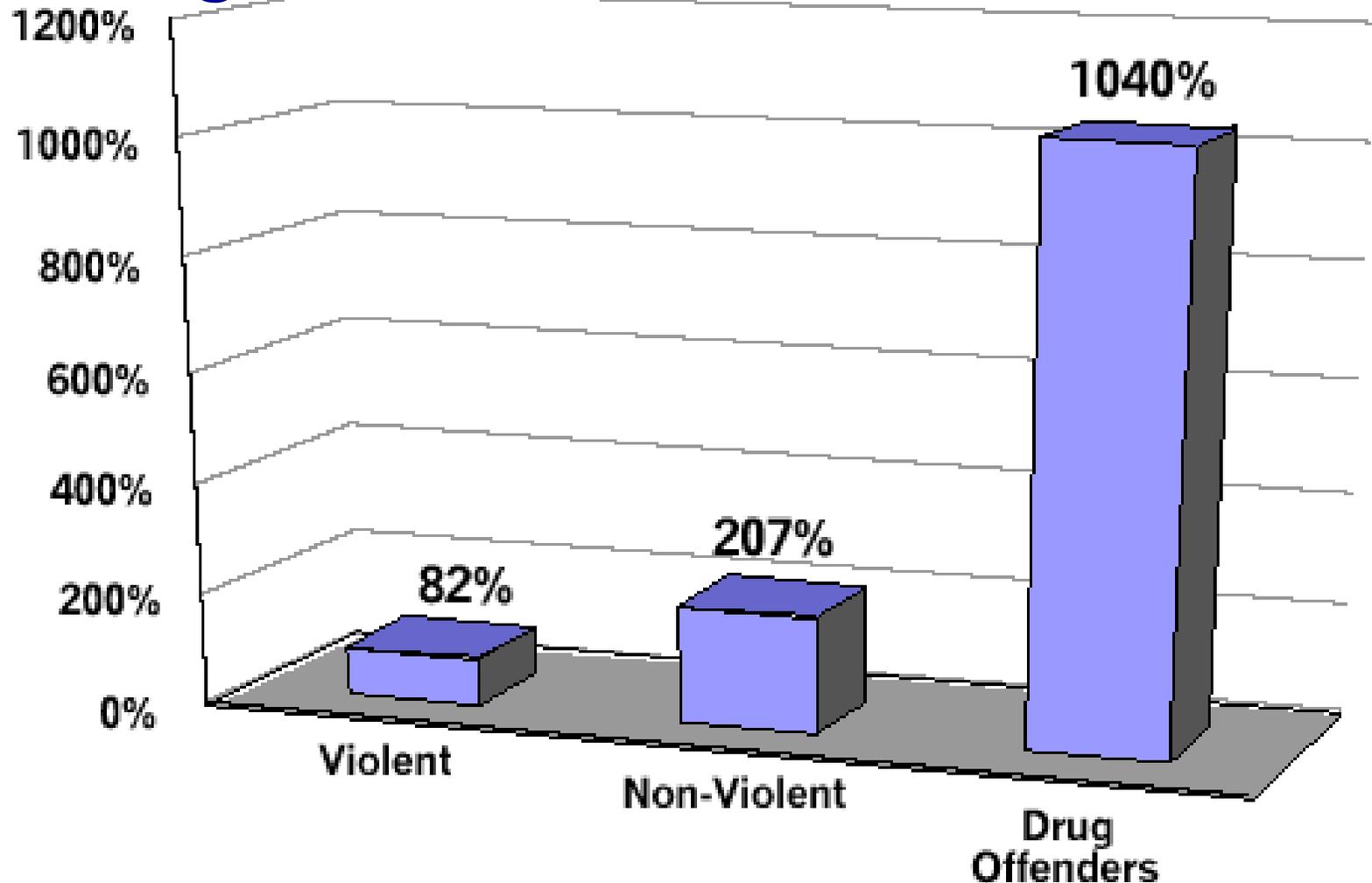
Primary Admissions to Treatment by Drug



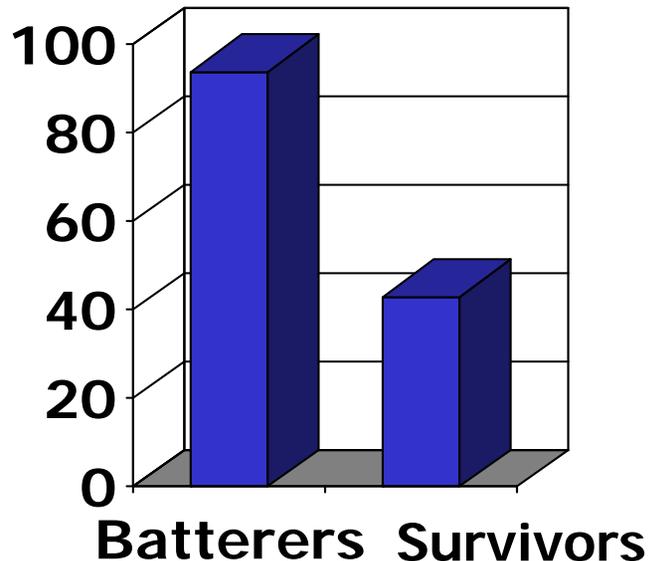
Nearly 50% of all addictions treated involve **ALCOHOL!**



Population of Offenders in Prison for Drug Offenses Increases 11-FOLD!



FAMILIES & SUBSTANCE ABUSE



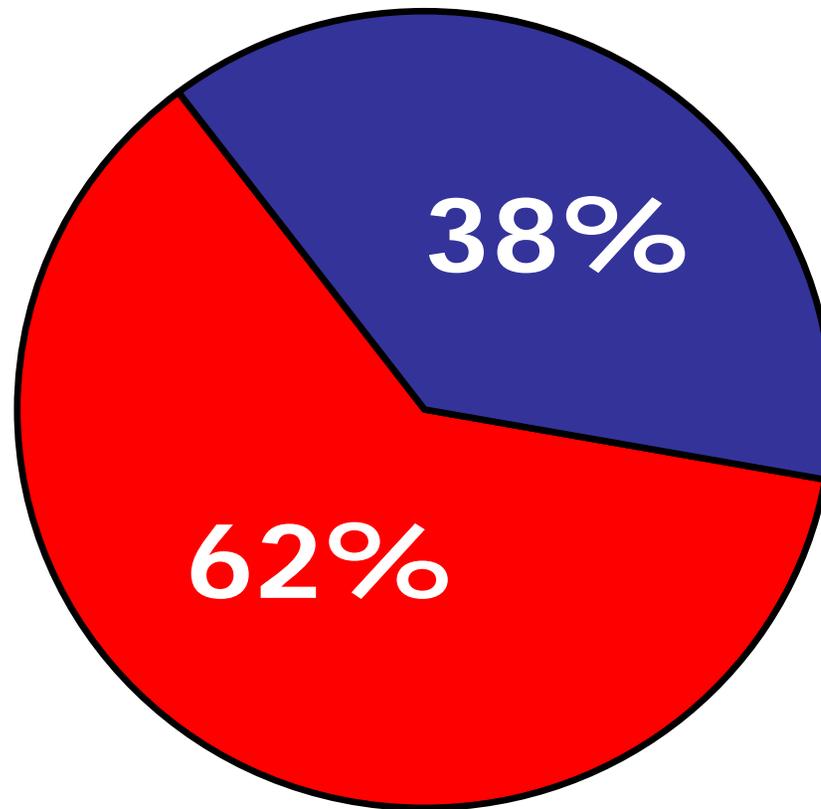
■ Percent who tested positive for any alcohol or other drug

Substance abuse is indicated in 81% of reported child abuse and neglect cases

The Costs of Crime Attributed to Substance Abuse...

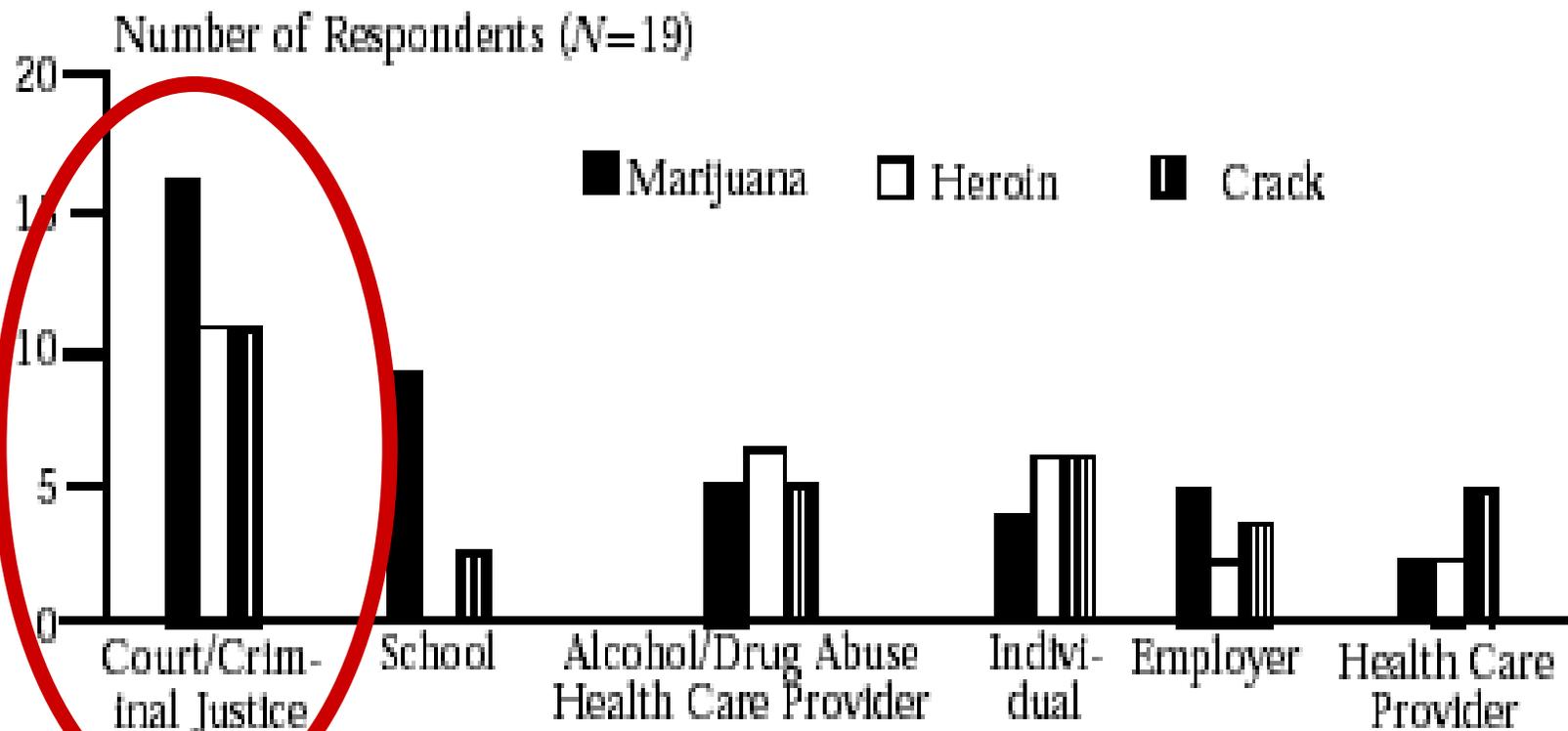
\$143 billion total

Crime-
Related
\$88.9B



Non-
Crime-
Related
\$54.5B

Criminal Justice Refers Largest No. to Treatment



Sources: Non-methadone treatment respondents

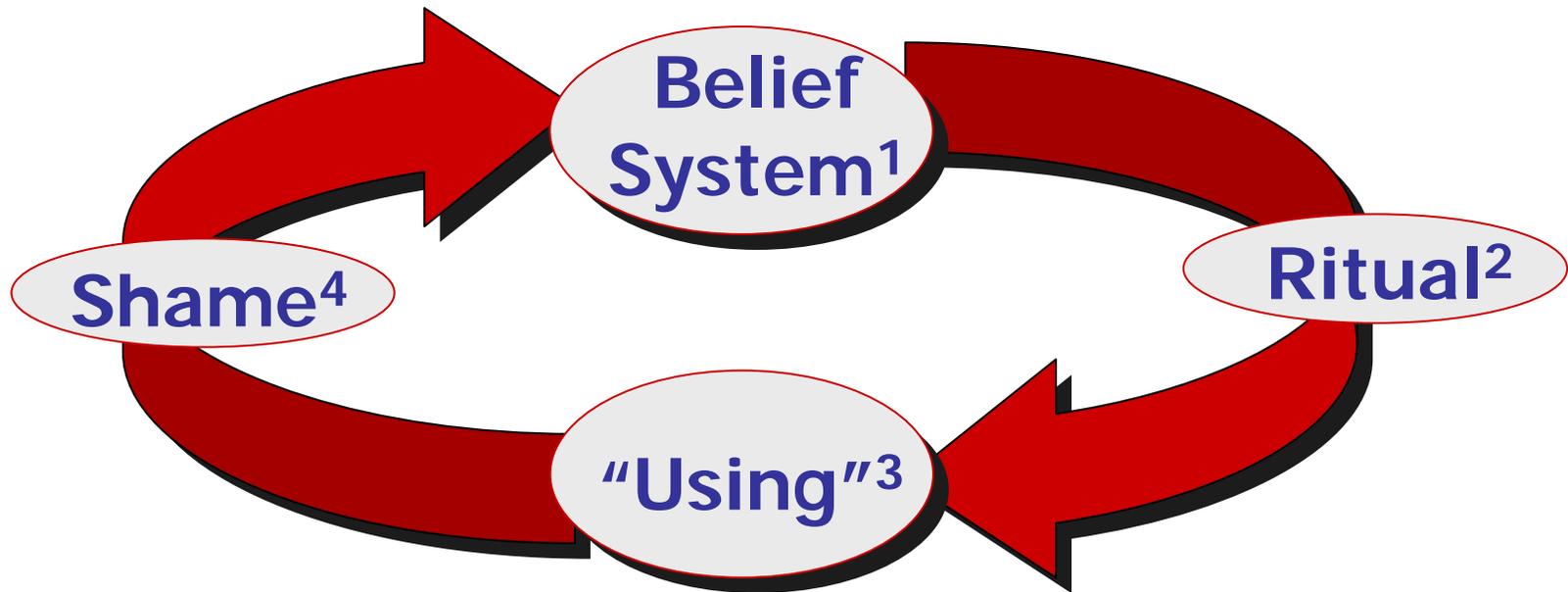
NOTE: Many respondents list more than one referral source.

“Using” → Addiction



Although a person may choose whether or not to initiate the use of psychoactive substances and/or alcohol, drug dependence is an involuntary result.

The "Cycle of Addiction"

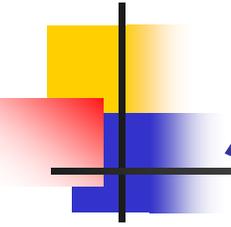


● ¹Trigger event/thought occurs

● ³Substance use occurs

● ²Routinized behaviors leading to use

● ⁴Shame sets in from use

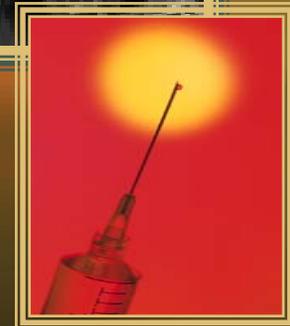
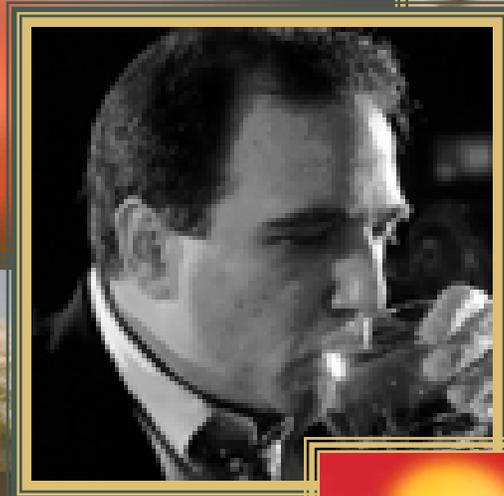
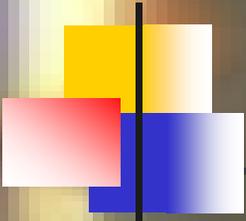


“An encounter with the criminal justice system...

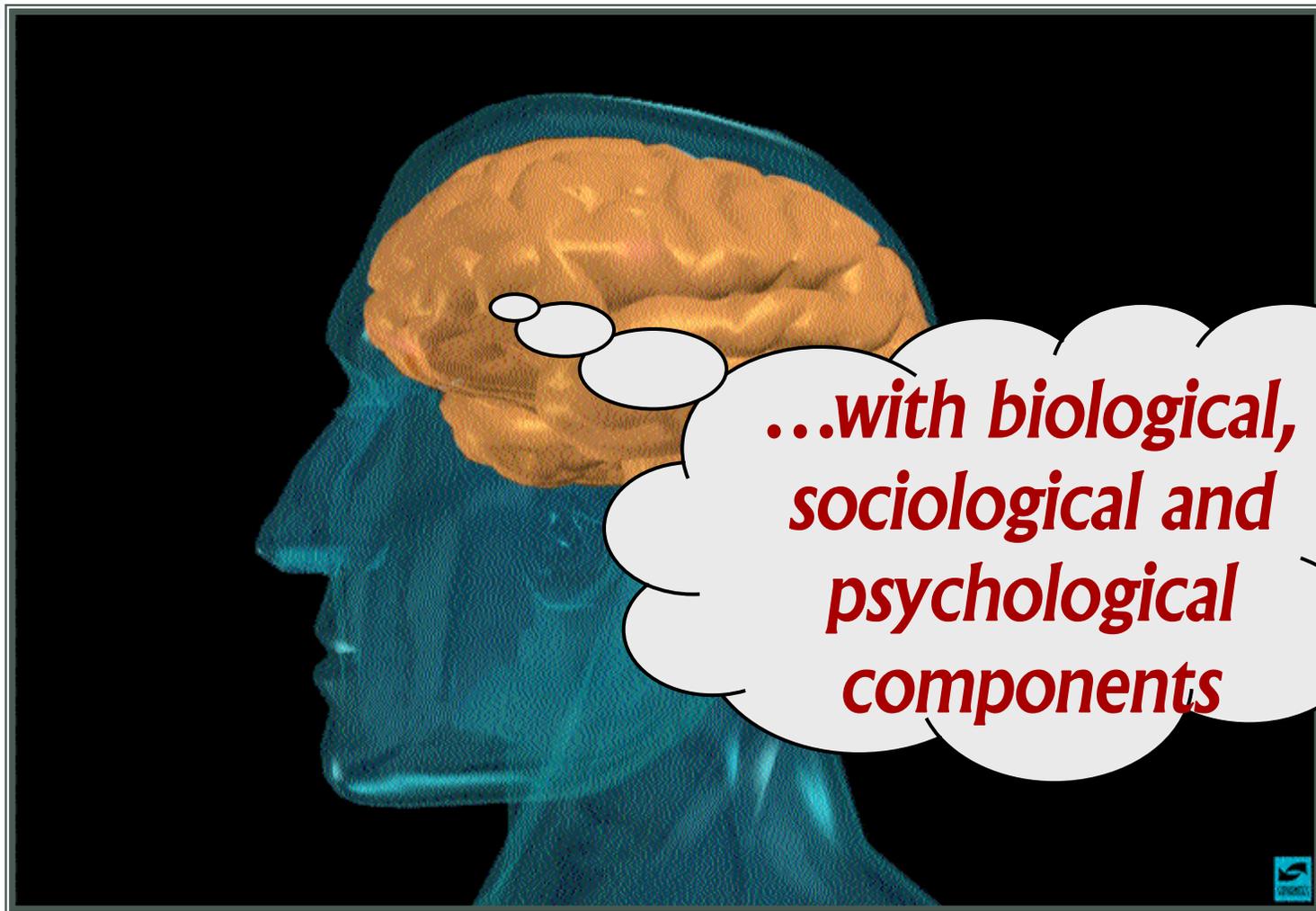
...provides a valuable opportunity to intervene in an individual’s life by identifying the clinical needs of substance abusers and then confronting them with the consequences of their own drug and alcohol use.”

“Responding to Substance Abuse: The Role We All Play,” 1999

Addiction 101: Basic Pharmacology and Recovery



Addiction is a Complex Illness

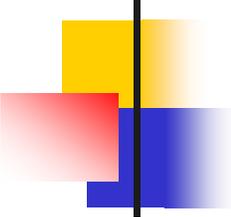


Nature of Addiction

- Loss of control
- Harmful Consequences
- Continued Use
Despite Consequences



*"That is not one of the seven habits
of highly effective people."*



Three “C’s” of Addiction

- **Control**

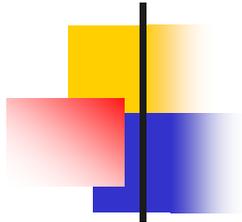
- Early social/recreational use
- Eventual loss of control
- Cognitive distortions (“denial”)

- **Compulsion**

- Drug-seeking activities
- Continued use despite adverse consequences

- **Chronicity**

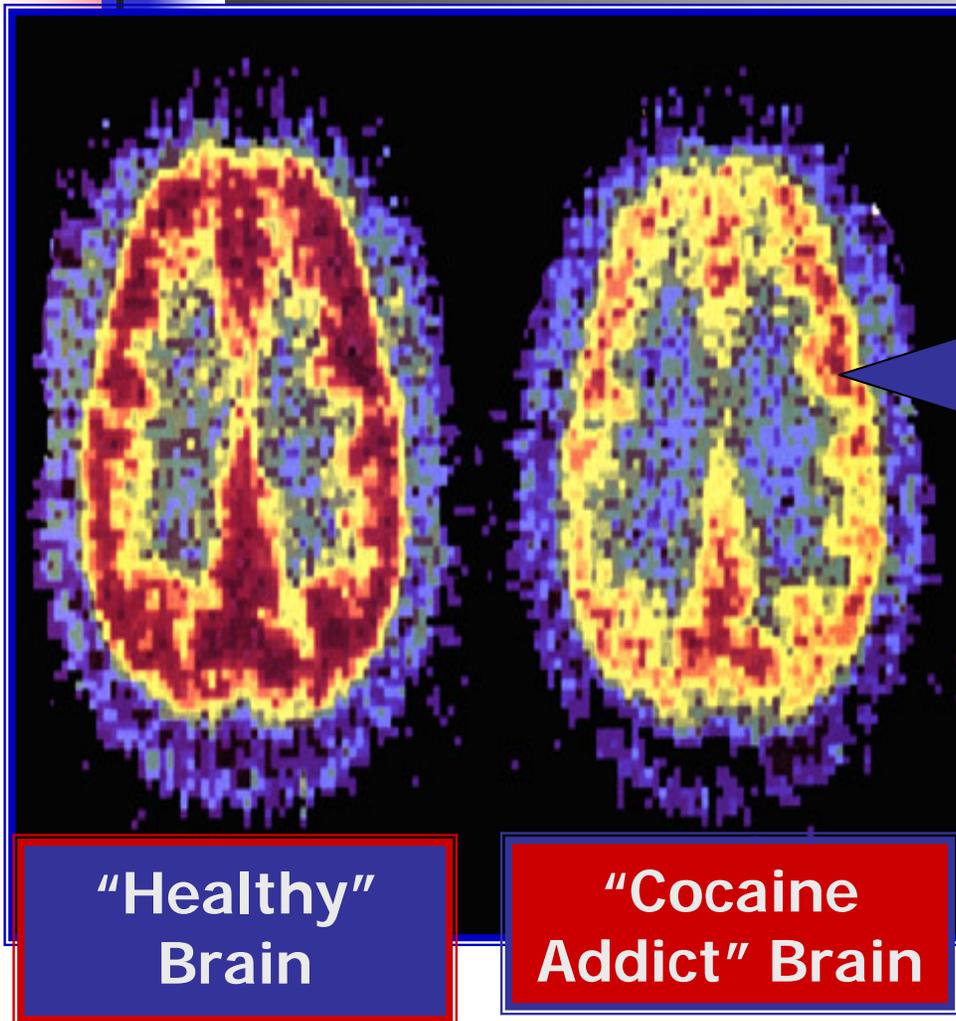
- Natural history of multiple relapses preceding stable recovery
- Possible relapse after years of sobriety



Addiction Risk Factors

- Genetics
- Young Age of Onset
- Childhood Trauma (violent, sexual)
- Learning Disorders (ADD/ADHD)
- Mental Illness
 - Depression
 - Bipolar Disorder
 - Psychosis

Addiction *is* a Brain Disease

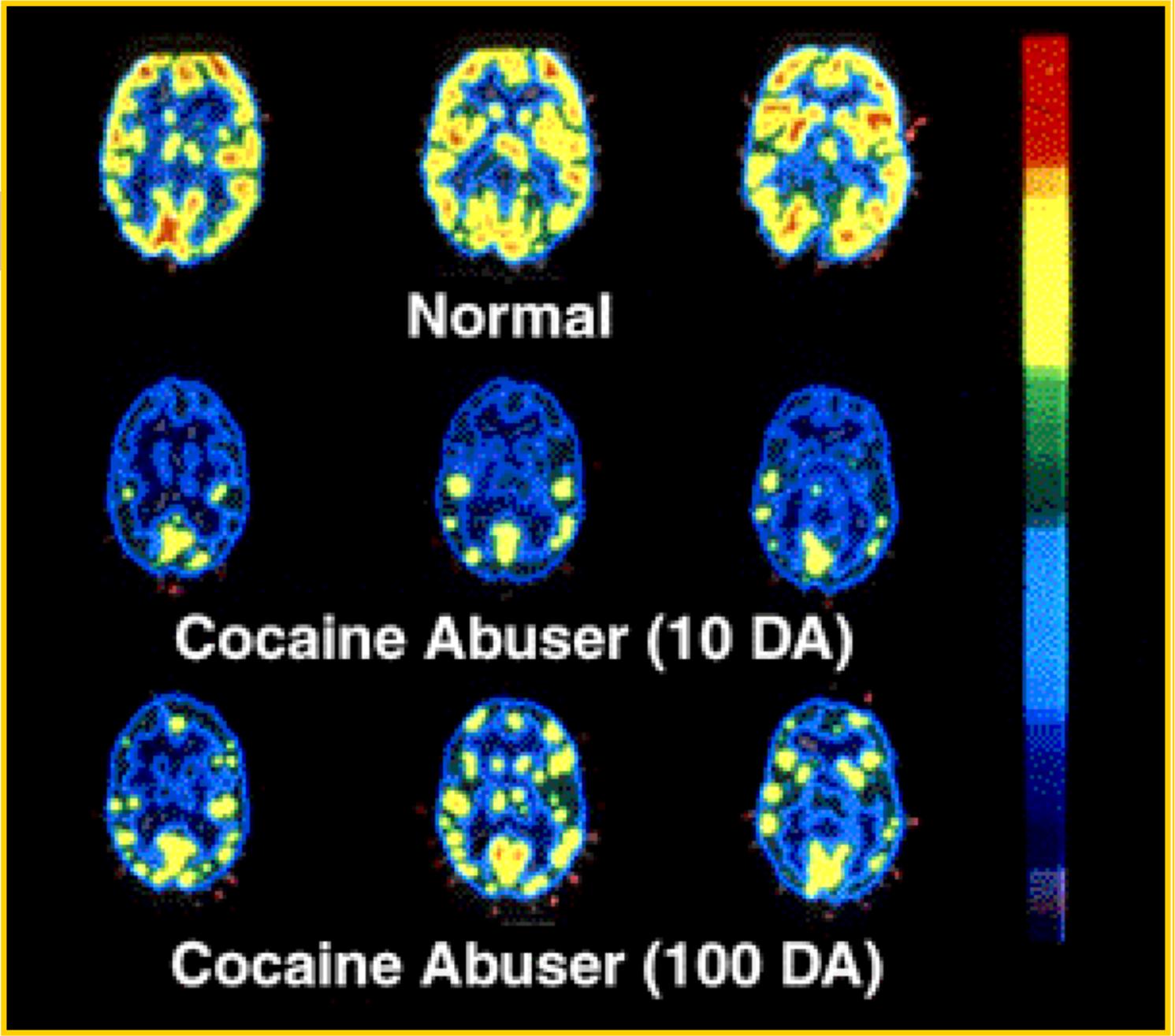
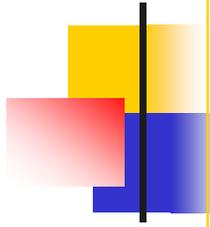


Prolonged Use
Changes

the Brain

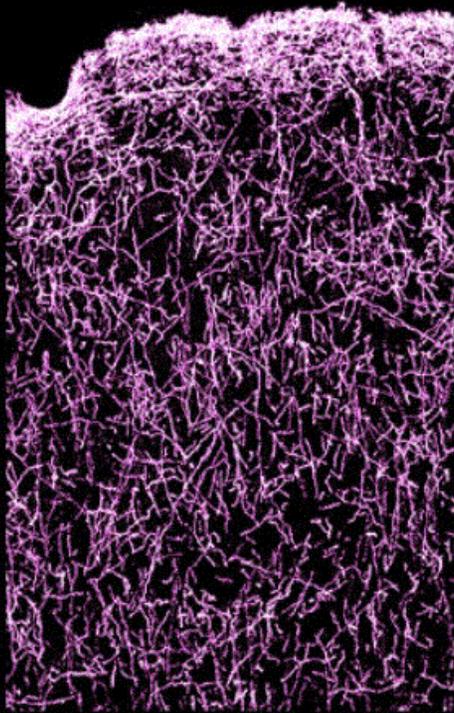
in

**Fundamental
and Lasting
Ways**

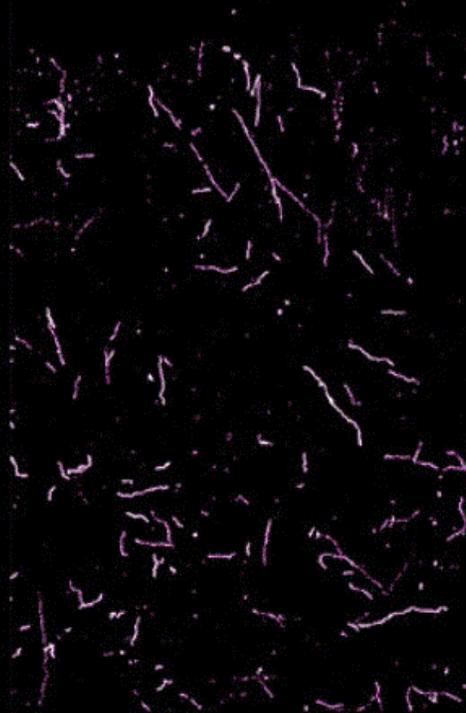


Serotonin Present in Cerebral Cortex Neurons

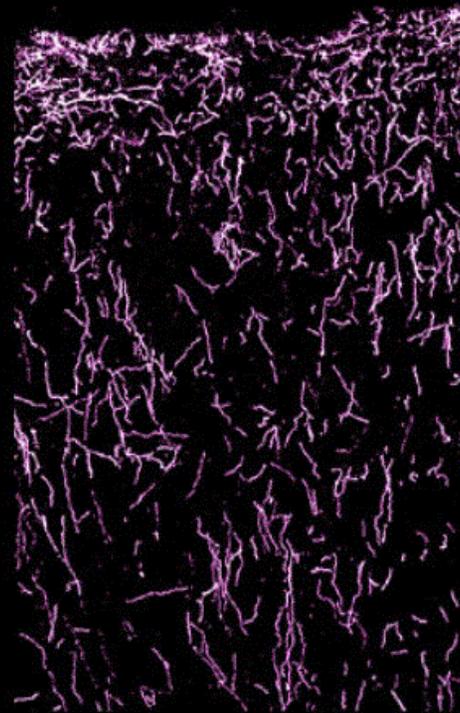
Normal

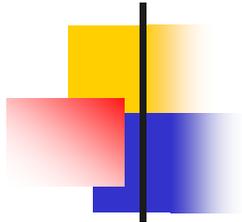


2 weeks after Ecstasy



7 years after Ecstasy





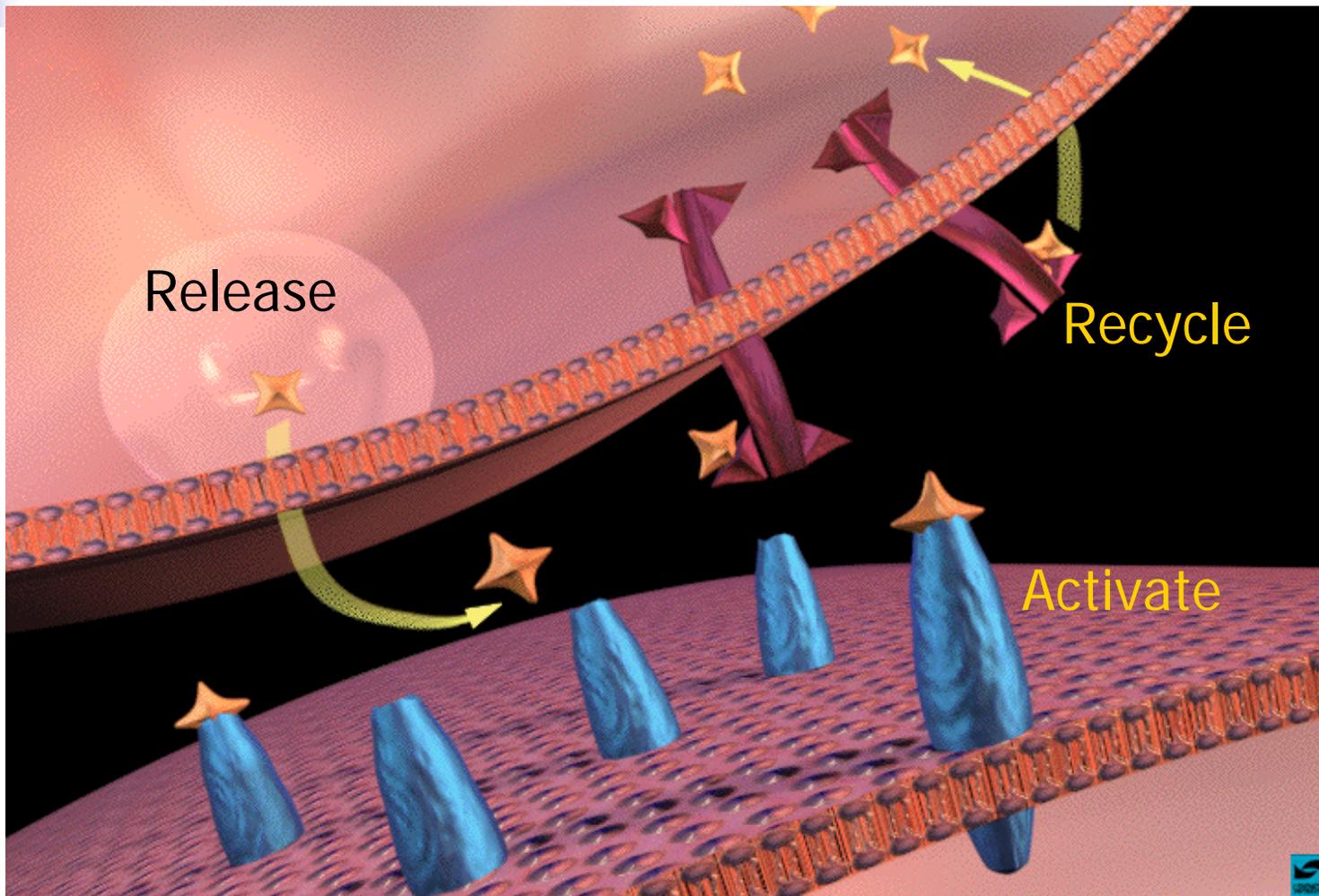
How Drugs Work

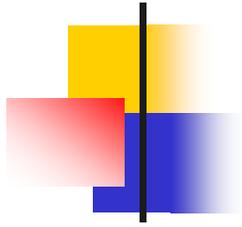
- **Interact with neurochemistry**

⇒ **Results:**

- **Feel Good – Euphoria/reward**
- **Feel Better – Reduce negative feelings**

Dopamine Spells REWARD

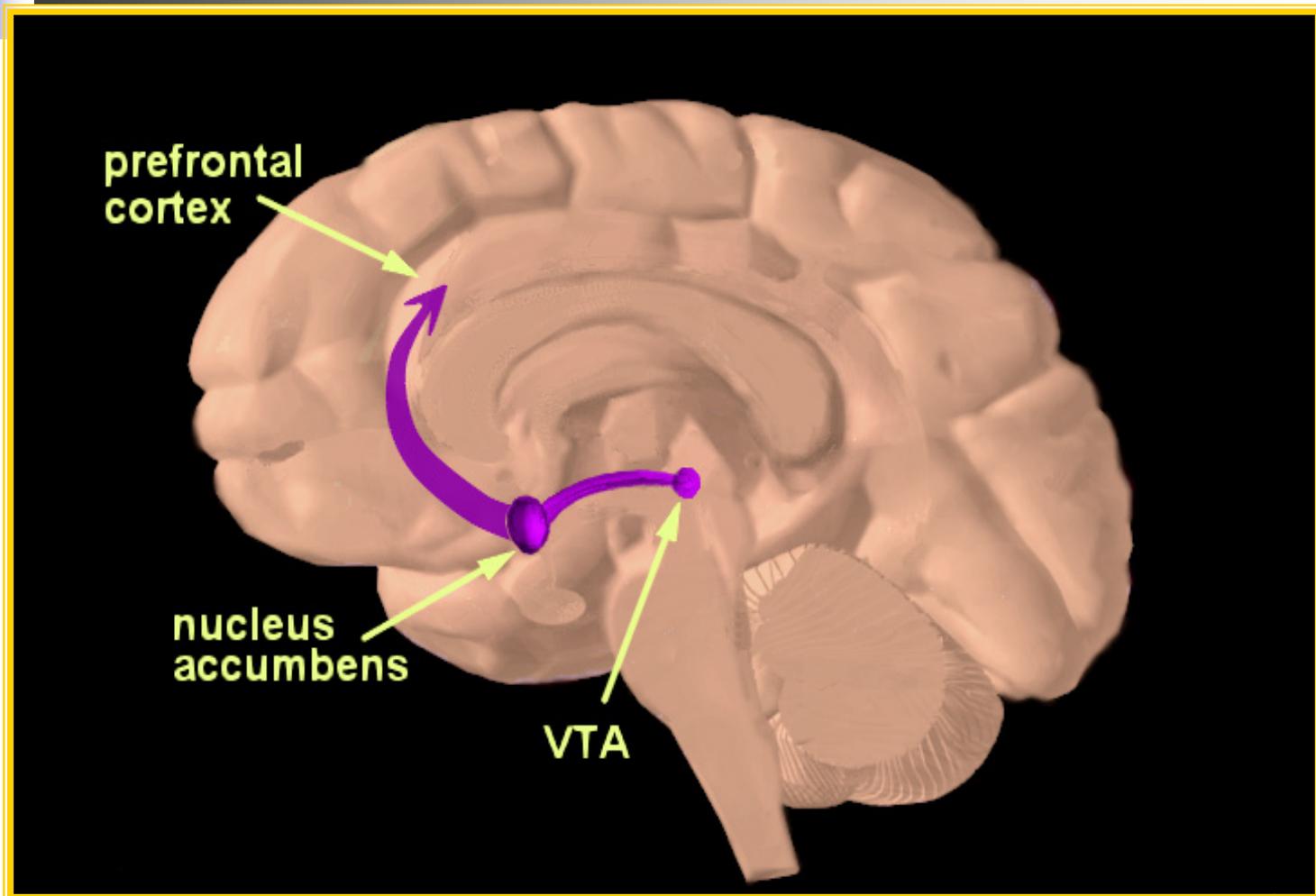




Natural Rewards

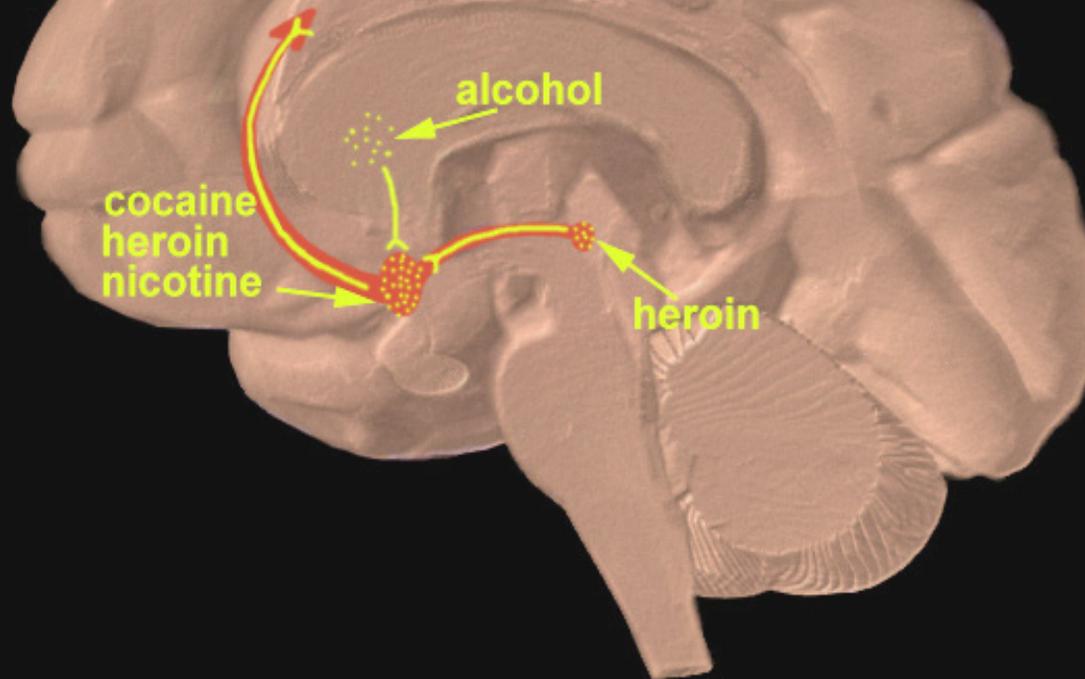
- Food
- Sex
- Excitement
- Comfort

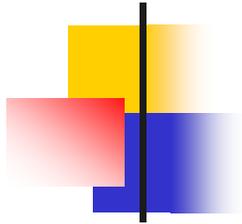
Brain Reward Pathways



Activation of Reward

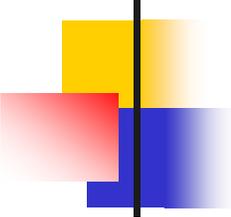
Activation of the reward pathway by addictive drugs



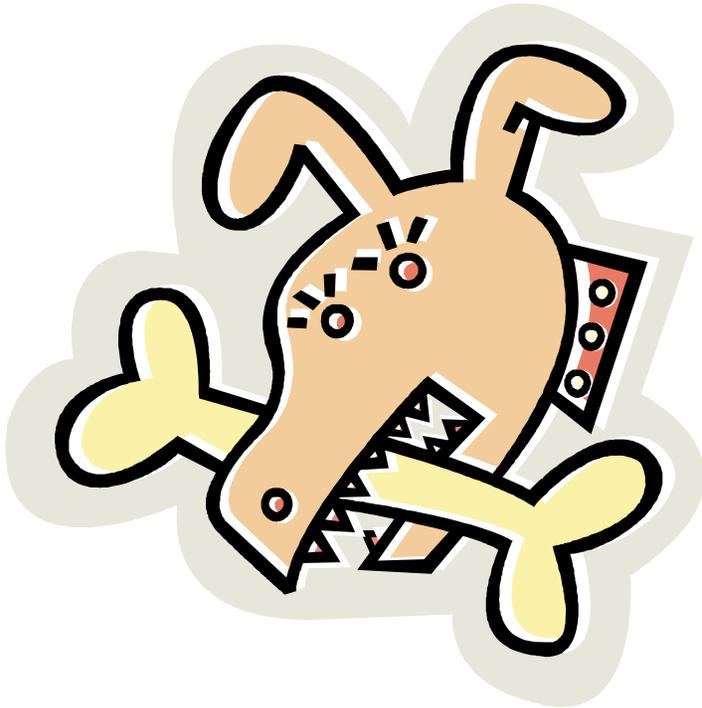


Behavior Pathways

- Rewarding behaviors can become routine
- “Subconscious” control of the behavior
- **Difficult to extinguish behaviors because people are not always aware when they are initiated**
- Resistant to change

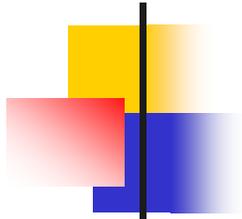


Addiction = Dog with a Bone



- It never wants to let go.
- It bugs you until it gets what you want.
- It never forgets when/where it is used to getting its bone.
- It thinks it's going to get a bone anytime I do anything that reminds it of the bone.

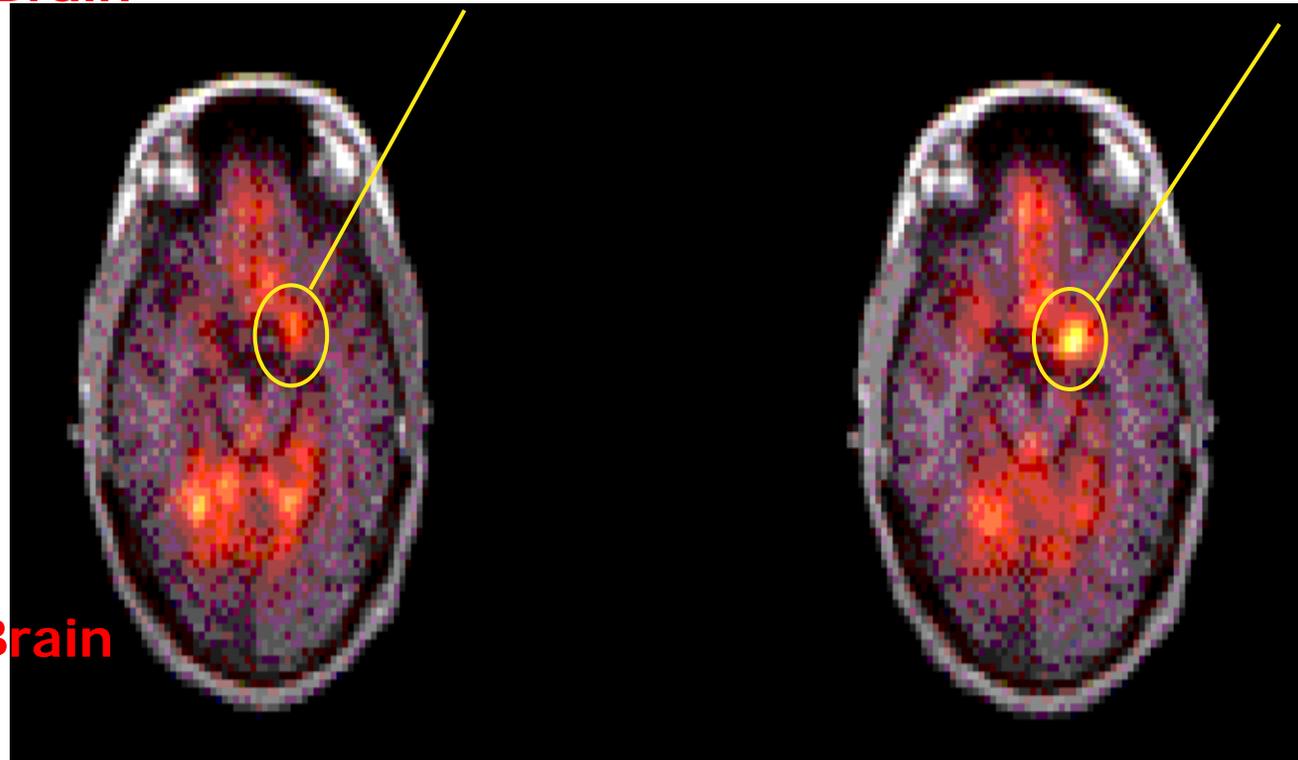
How Long Does the Brain Remember?



Front of Brain

Amygdala
not lit up

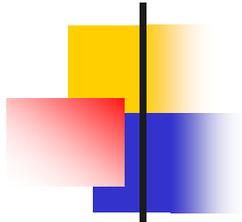
Amygdala
activated



Back of Brain

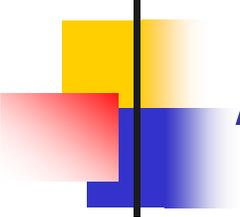
Nature Video

Cocaine Video



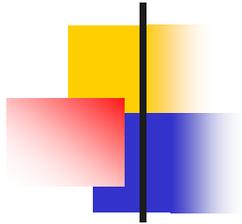
Cognitive Deficits

- Memory problems – short-term loss
- Impaired abstraction
- Perseveration using **failed problem-solving strategies**
- Loss of impulse control
- Similar performance to those with brain damage



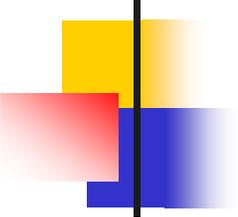
Common Characteristics of Addicts

- **Unemployment**
- **Multiple criminal justice contacts**
- **Difficulty coping with stress or anger**
- **Highly influenced by social peer group**
- **Difficulty handling high-risk relapse situations**



Common Characteristics...

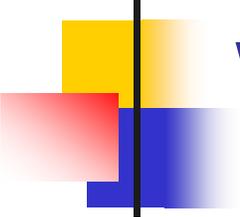
- **Emotional and psychological immaturity**
- **Difficulty relating to family**
- **Difficulty sustaining long-term relationships**
- **Educational and vocational deficits**



Violence



- **Alcohol disinhibits aggressivity**
- **Stimulants produce dose-dependent paranoia**
- **Opiate-seeking, but not opiates, produces violence**

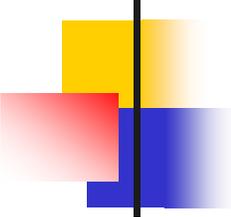


Who needs treatment?

13 to 16 million Americans need treatment for alcohol and/or other drug abuse in any year

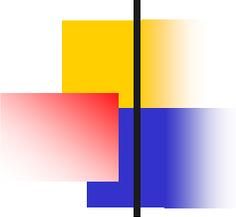
BUT...

Only 3 million receive care

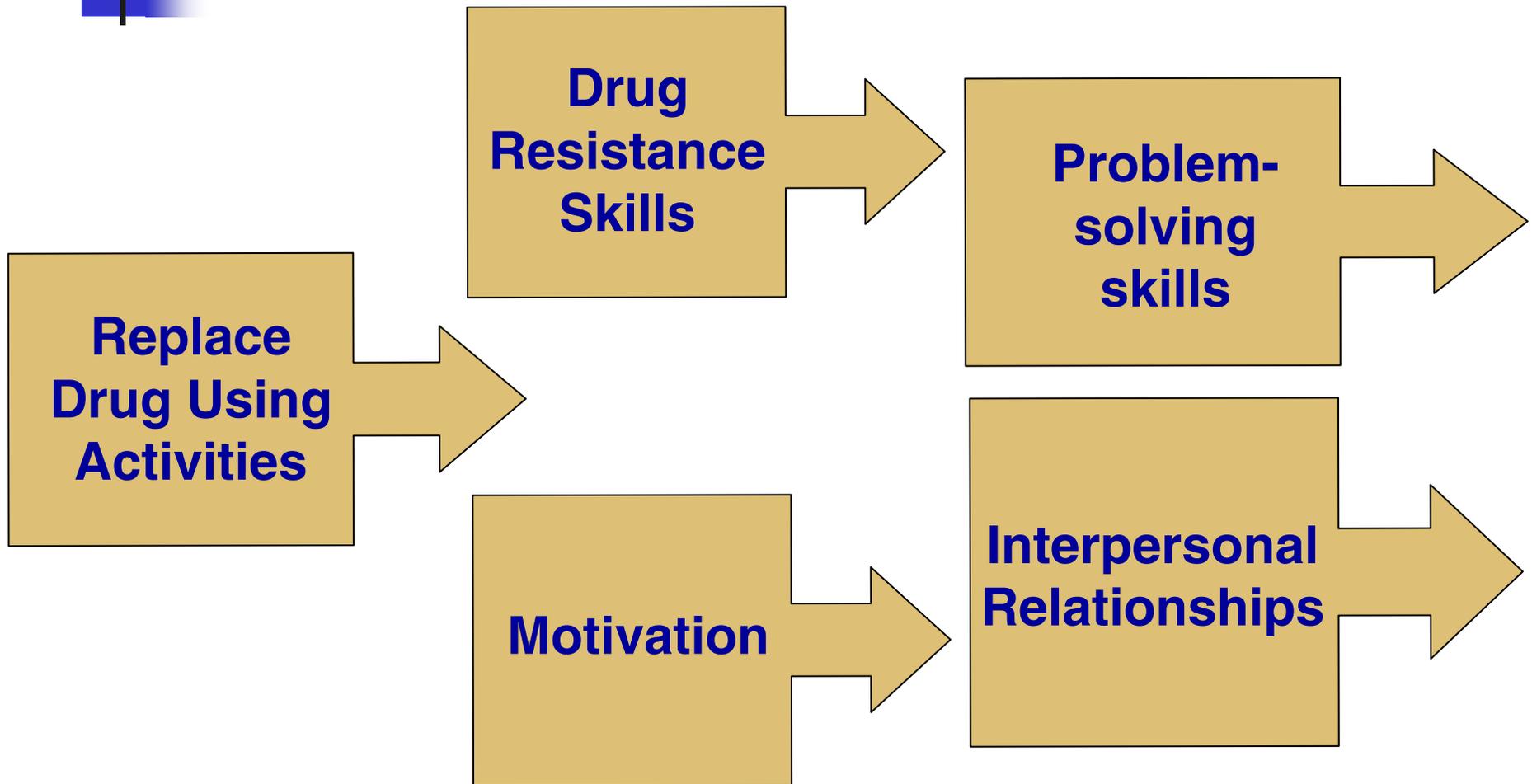


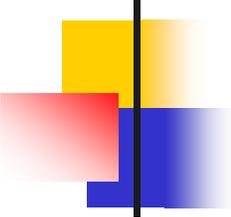
Matching Treatment to Individual's Needs

- No single treatment is appropriate for all individuals
- Effective treatment attends to multiple needs of the individual, not just his/her drug use
- Treatment must address medical, psychological, social, vocational, and legal problems



Counseling and Other Behavioral Therapies





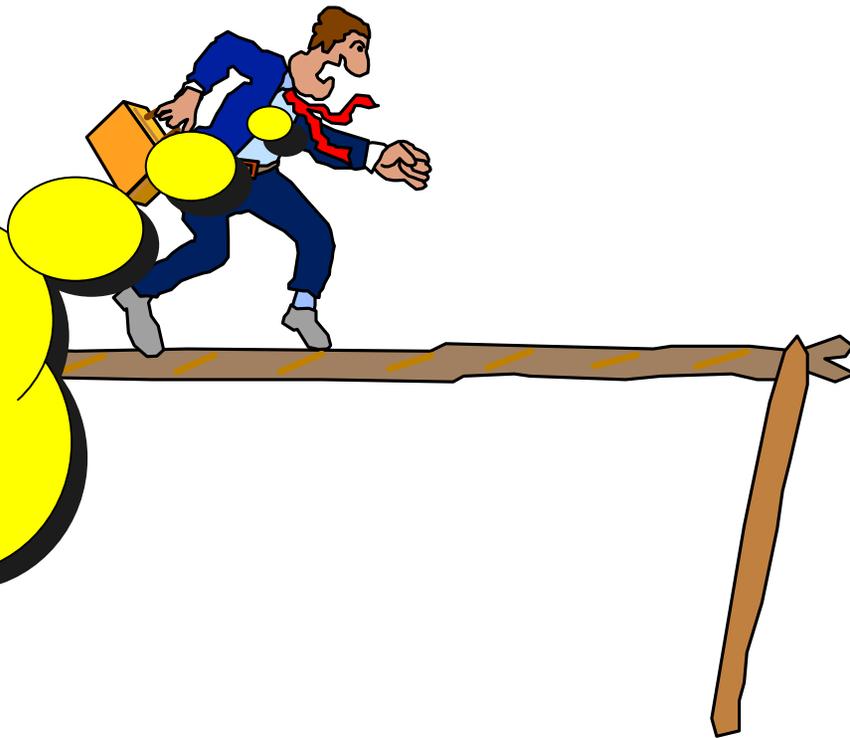
Abstinence

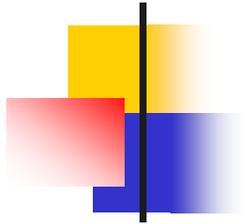
- Strictly speaking, abstinence is developed, not recovered
- It is an abnormal condition, signifying an internal defect (disease)
- Addicts want to be “normal,” that is, using drugs in control

Self-Control

- Addicts seek control, not abstinence

If I can have
just one, then I
will be normal,
just like my
friends





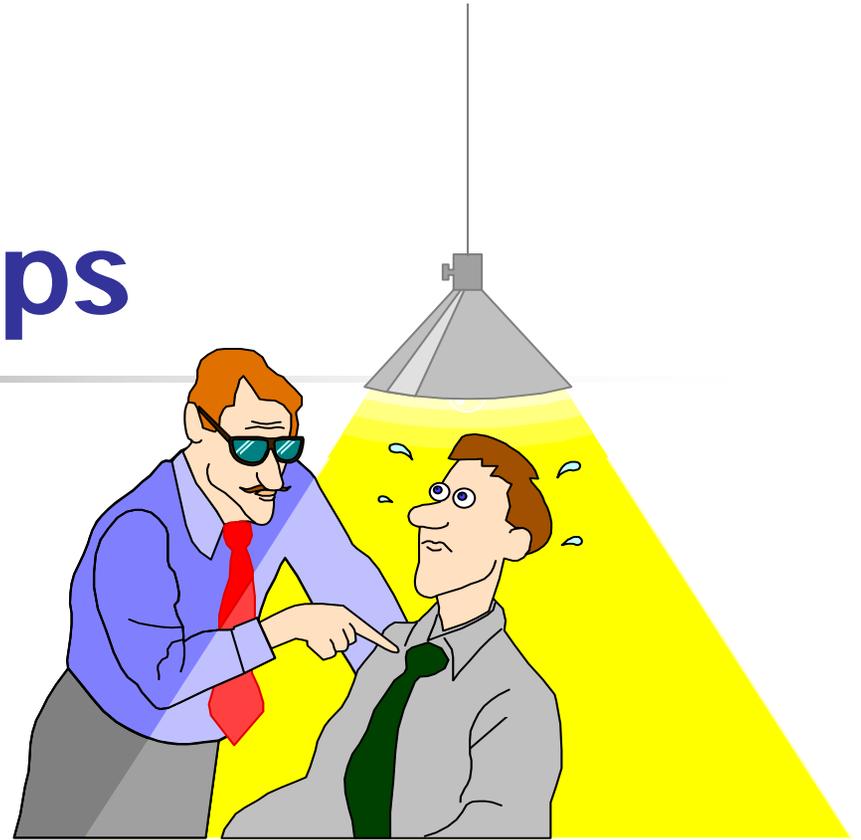
Self Help

- Complements and extends treatment efforts
- Most commonly used models include 12-Step (AA, NA) and Smart Recovery
- Most treatment programs encourage self-help participation during/after treatment

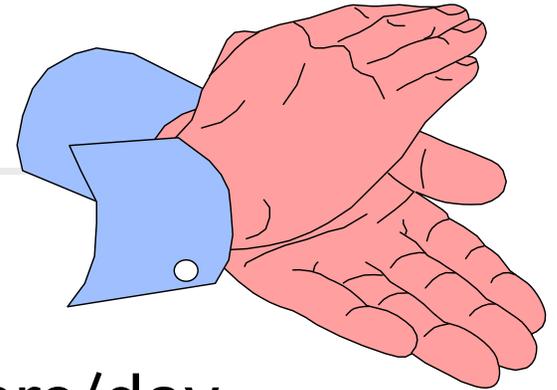
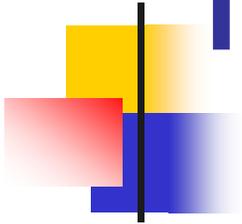
12-Step Groups

■ Myths

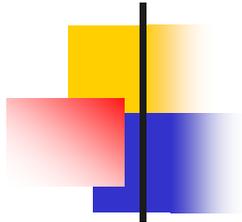
- Only AA can treat alcoholics
- Only a recovering individual can treat an addict
- 12-step groups are intolerant of prescription medication
- Groups are more effective than individuals because of confrontation



12-Step Groups



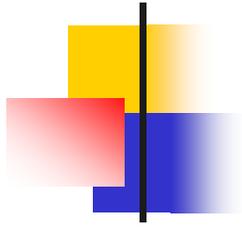
- Facts
 - Available 7 days/week, 24 hrs/day
 - Work well with professionals
 - Primary treatment modality is fellowship (identification)
 - Safety and acceptance predominate over confrontation
 - Offer a safe environment to develop intimacy



Medical Detoxification

Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.

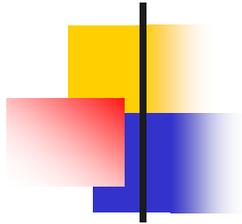
- High post-detoxification relapse rates
- **Not a cure!**
- A preparatory intervention for further care



Medications

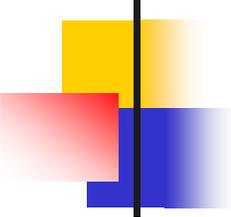
Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.

- Alcohol: Naltrexone, Disulfiram, Acamprosate, Odansetron
- Opiates: Naltrexone, Methadone, LAAM, Buprenorphine
- Nicotine: Nicotine replacement (gum, patches, spray), bupropion
- Stimulants: [None to date]



Public Health

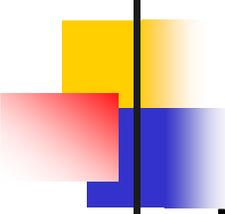
- Drug treatment is disease prevention
- HIV infection in injecting drug users
- >90% injection drug users are infected with Hepatitis C virus



How Long Should Treatment Last ?



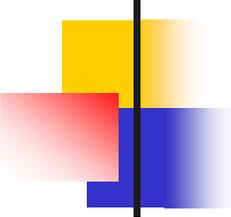
- Depends on patient problems/needs
- Less than 90 days is of limited or no effectiveness for residential/outpatient setting
- A minimum of 12 months is required for methadone maintenance
- Longer treatment is often indicated



Compliance & Chronicity

Chronic Illness	Medication Compliance	Relapse within 1 year
Diabetes	<60%	30-50%
Hypertension	<40%	50-70%
Asthma	<40%	50-70%
Diet or Behavioral Changes	<30%	

McLellan AT, Lewis DC, O'Brien CP, Kleber HD;
Drug Dependence, A Chronic Medical Illness, JAMA, Oct 4, 2000

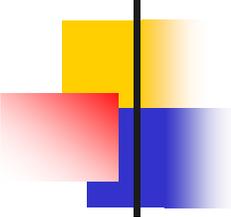


Coercion

Treatment does not need to be voluntary to be effective.

- Court-Ordered Probation
- Family Pressure
- Employer Sanctions
- Medical Consequences

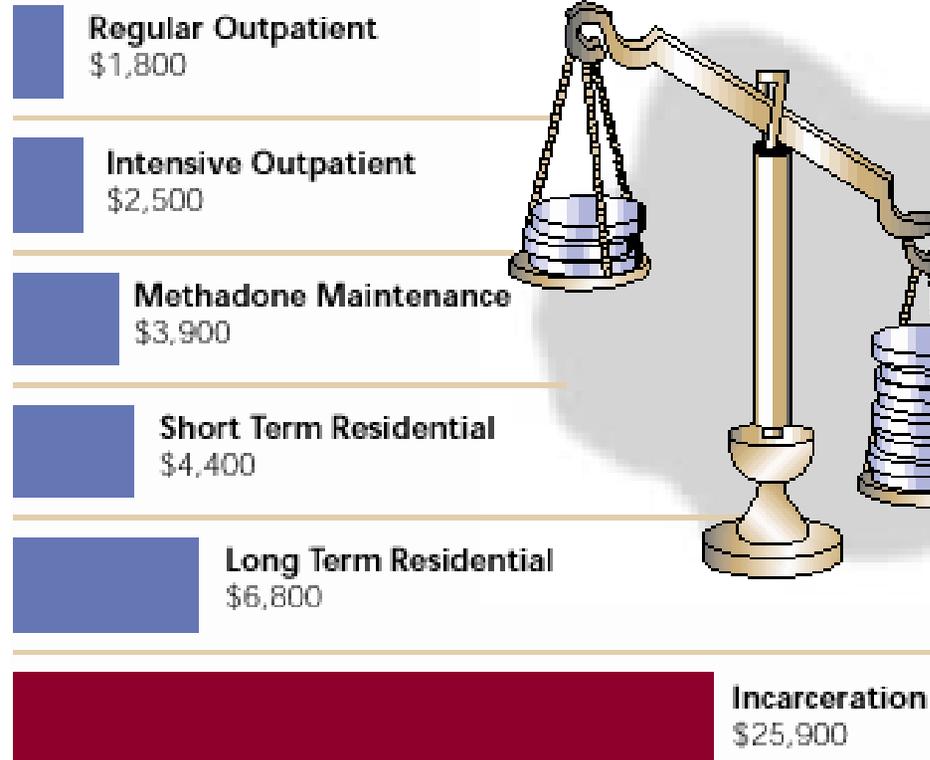




“Costly” or “Cost-Effective”

- **Expensive Incarceration:** Treatment is less expensive than not treating or incarceration
(1 year of methadone maintenance = \$3,900 vs. \$25,900 for imprisonment)
- **1:7 Rule:** Every \$1 invested in treatment = up to \$7 in reduced crime-related costs
- **Health Offset:** Savings can be > **1:12** when health care costs are included
- Reduced interpersonal conflicts
- Improved workplace productivity
- Fewer drug-related accidents

Weighing the Costs Annual Cost per Drug Addict

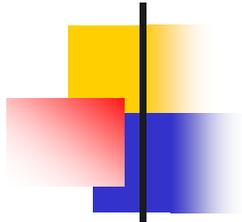


DATA SOURCES: Center for Substance Abuse Treatment 1997 *National Treatment Improvement Evaluation Study (NTIES)* (Rockville, MD: CSAT, 1997); Federal Bureau of Prisons. Data prepared by the Physician Leadership on National Drug Policy National Project Office.

What is Recovered in Recovery ?

- Abstinence
- Sense of Responsibility
- Range of Emotions
- Intimacy

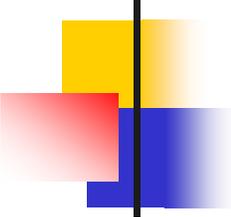




Phases of Recovery

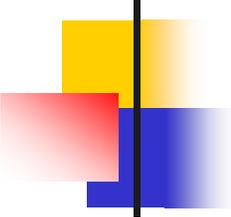
**Clinical Model Developed by Peter Banys, M.D.
VA Medical Center and
University of California at San Francisco**

- Crisis
- Abstinence
- Sobriety
- Recovery



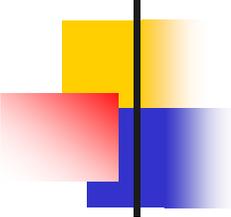
Compounding Issues in Recovery

- Socio-economic
- Single parent
- Ethnic
- Matriarch/
Patriarch
- Gender
- Religion
- Treatment
- Co-dependency
- Employment
- Domestic violence
- Living situation
- Extended family



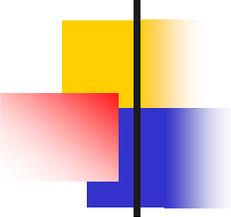
Dual-Diagnosis

- **Mood Disorder+:** For those with mood disorders, 24-40% have a co-occurring substance abuse disorder
- **Alcoholism+:** 65% of females and 44% of male alcoholics have co-occurring mental health disorder(s)
 - THE MAJOR ONE = DEPRESSION
19% of female alcoholics, 4x the rate for men
- **Addiction+:** 30-59% of women in treatment have PTSD, 2-3 times the rate for men
- **Prescriptions:** 1:7 women >64 years old takes medication for a mental health disorder



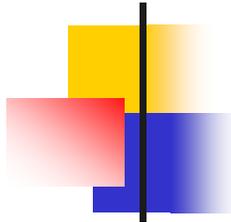
Treatment Effectiveness

- Drug dependent people who participate in drug treatment
 - Decrease drug use
 - Decrease criminal activity
 - Increase employment
 - Improve their social and intrapersonal functioning
 - Improve their physical health
- Drug use and criminal activity decrease for virtually all who enter treatment, with increasingly better results the longer they stay in treatment.



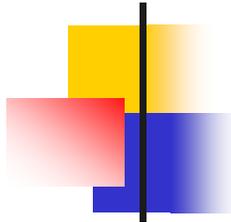
But...For How Long?

- One Year After Treatment
 - Drug selling fell by nearly 80%
 - Illegal activity decreased by 60%
 - Arrests down by more than 60%
 - Trading sex for money or drugs down by nearly 60%
 - Illicit drug use decreased by 50%
 - Homelessness dropped by 43% and receipt of welfare by 11%
 - Employment increased by 20%



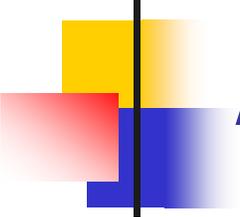
How Long...?

- Five Years After Treatment
 - Users of *any* illicit drugs reduced by 21%
 - Cocaine users by 45%
 - Marijuana users by 28%
 - Crack users by 17%
 - Heroin users by 14%



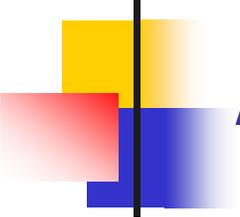
How Long...?

- Five Years After Treatment (continued)
 - Numbers engaging in illegal activity significantly reduced
 - **56% fewer stealing cars**
 - **38% fewer breaking and entering**
 - **38% fewer injecting drugs**
 - **30% fewer selling drugs**
 - **34% fewer homeless**
 - **23% fewer victimizing others**



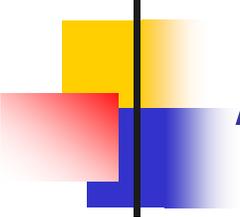
Myths of Addiction Treatment

- Myth of Self-Medication
 - Treating just the “underlying” disorders tends not to work
 - Depression doesn’t make you drink
 - BUT drugs do make you feel good (however, less and less over time)



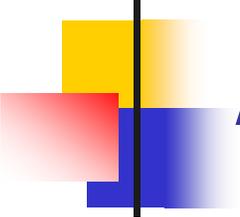
Myths of Addiction Treatment

- Myth of Self-Medication
- Myth of Character Weakness
 - Weakness or will power has little to do with becoming addicted
 - Educated, strong people succumb to the best drugs in the world



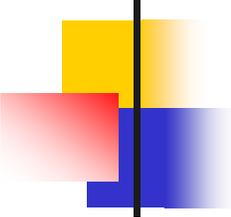
Myths of Addiction Treatment

- Myth of Self-Medication
- Myth of Character Weakness
- Myth of Holding One's Liquor
 - The "Wooden Leg" Syndrome predicts alcoholism, not immunity to alcoholism



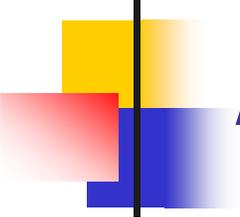
Myths of Addiction Treatment

- Myth of Self-Medication
- Myth of Character Weakness
- Myth of Holding One's Liquor
- Myth of Detoxification
 - Getting sober is easy
 - Staying that way is incredibly difficult



Myths of Addiction Treatment

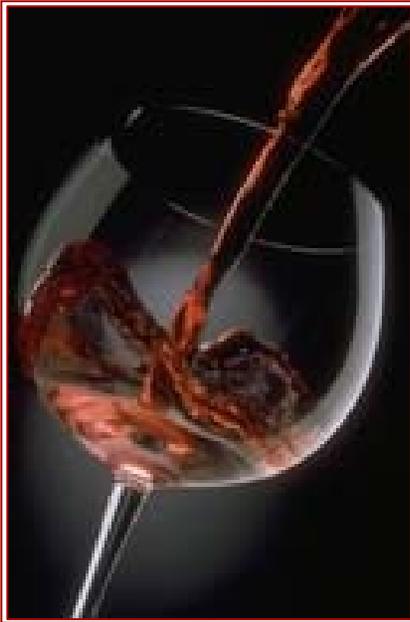
- Myth of Self-Medication
- Myth of Character Weakness
- Myth of Holding One's Liquor
- Myth of Detoxification
- Myth of Brain Reversibility
 - Addiction produces permanent neurotransmitter and chemical changes
 - "Kindling" increases risk of permanent paranoia and hallucinations (from alcohol and stimulants)



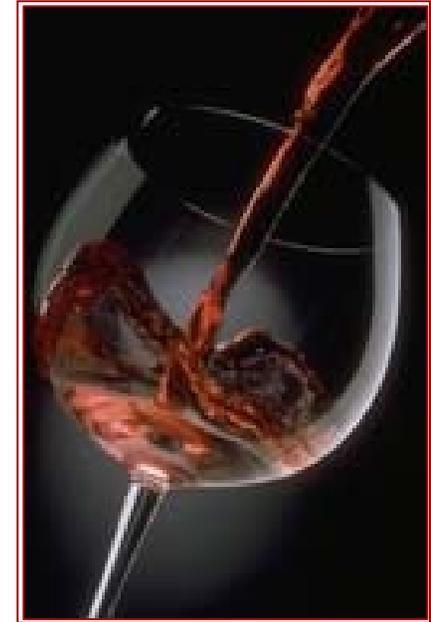
Facts of Addiction Treatment

- Addiction is a brain disease
- Chronic, “cancerous” disorders require multiple strategies and multiple episodes of intervention
- Treatment works in the long run
- Treatment is cost-effective

Commonly Abused Drugs:



Alcohol



Class of Drug:
Sedatives-Hypnotics

Related Issues:

- ✓ Detoxification
- ✓ Fetal Alcohol Syndrome (FAS)
- ✓ Loss of Judgment
- ✓ Suicide/Homicide
- ✓ DWI/DUI Concerns
- ✓ Poly-drug Use
- ✓ Legality Issues

Commonly Abused Drugs (continued):

Marijuana

Class of Drug:
Hallucinogens

Related Issues:

- ✓ A-motivational
- ✓ Arrested Development
- ✓ Memory/Learning Problems
- ✓ Long Detection Time
- ✓ Legalization
- ✓ Medical Use Issues
- ✓ Health Issues

Commonly Abused Drugs (continued):

Cocaine/Crack

Class of Drug:
Stimulants

Related Issues:

- ✓ High-relapse Potential
- ✓ High Reward
- ✓ Euphoria – Agitation - Paranoia – “Crash” – Sleeping – Craving
- ✓ Obsessive Rituals
- ✓ Risk of Permanent Paranoia
- ✓ No Medications Currently Available

Commonly Abused Drugs (continued):

Methamphetamines

Class of Drug:
Stimulants

Related Issues:

- ✓ High Energy Level
- ✓ Repetitive Behavior Patterns
- ✓ Incoherent Thoughts and Confusion
- ✓ Auditory Hallucinations and Paranoia
- ✓ Binge Behavior
- ✓ Long-acting (up to 12 hours)

Commonly Abused Drugs (continued):

Heroin

Class of Drug:
Opiates

Related Issues:

- ✓ Detoxification
- ✓ Medications Available
- ✓ Euphoria
- ✓ Craving
- ✓ Intense Withdrawal
- ✓ Physical Pain

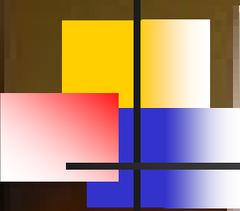
Commonly Abused Drugs (continued):

“New Drugs”



Club Drugs
Prescription Drugs

- ✓ Popular with Youth and Young Adults
- ✓ Significant Health Risks: Neuron Destruction with Ecstasy
- ✓ Users Believe They Know How to Reduce the Risks – WRONG!
- ✓ Availability Increasing



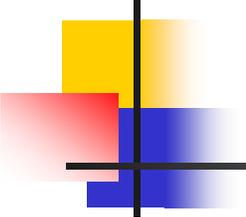
Practical Strategies for Today's Courtroom



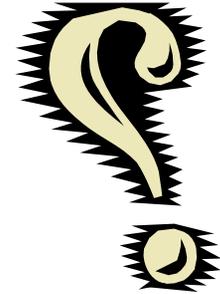
SJI



Module 3



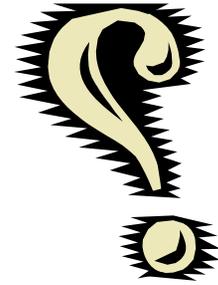
Bench Considerations



A. Introduction/Background

1. What grade did the litigant complete in school?
2. Is the litigant currently employed? When was he/she last employed?
3. Does the litigant own or rent a home? If not, with whom does he/she live?
4. Does the litigant have children? If yes, do they live with the litigant? If no, with whom do they live? Does the litigant have custody?

Bench Considerations (continued)...

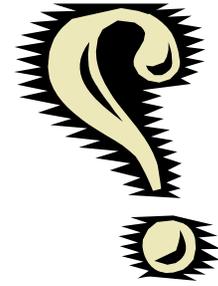


5. How old are the children? If they are school age, do they attend school?
6. Are his/her children involved with child protective services or the juvenile court system in any way?
7. Does the litigant have any significant debts/owe people money?

B. Substance Abuse

1. Has the litigant, his/her significant other, or child(ren) used alcohol or drugs (including marijuana) during the past six months?

Bench Considerations (continued)...

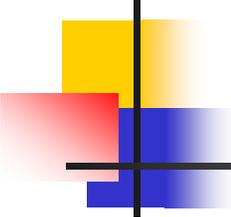


2. Has the litigant, significant other, or child(ren) been treated in an inpatient, outpatient, or other counseling program during the past six months?
3. If yes, is the litigant, significant other, or child(ren) suffering from an addiction to drugs or alcohol?
4. If the litigant has not been involved in treatment, would he/she be amenable to, or like a referral to, a treatment program?
5. Is the litigant taking any known medications presently?

“Weighing” the Court Performance Standards

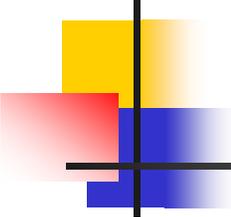


Against Substance Abuse...



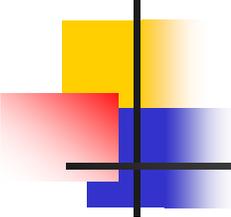
Standards...

- **Standard 3.5 Responsibility for Enforcement:** The Trial Court takes appropriate responsibility for the enforcement of its orders.
- **Standard 4.5 Response to Change:** The Trial Court anticipates new conditions and emergent events and adjusts its operations as necessary.



Possible Conditions of Orders

- Formal/court probation
- Jail/prison time
- Mental health
- Treatment (in/out)
- AOD – No alcohol or other drugs
- Urine tests
- Education/employment
- Search/seizure clause
- AIDS education
- Registration
- Medications
- Health (e.g., prenatal care)



Conditions should be ...

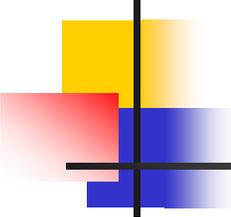
- Realistic
- Relevant
- Research-supported



Special Issues: Child Dependency



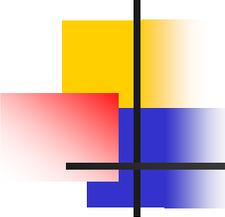
- Adoption and Safe Families Act (ASFA) time requirements for permanency
- What is the best interest of the children involved in the matter before you?
- Special issues regarding parenting skills
- Coordination with other jurisdictions
- Compliance with standards in Indian Child Welfare Act (ICWA) where Native American children/families are involved



AA and the First Amendment

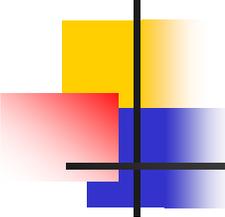
Griffin v. Coughlin, 88 N.Y.2d 674, 673 N.E.2d 98, 649 N.Y.S.2d 903 (1996), cert. denied, 519 U.S. 1054, 117 S. Ct. 681, 136 L. Ed. 2d 607 (1997).

Warner v. Orange County Dep't of Probation, 173 F.3d 120 (2d Cir.), cert. denied, 528 U.S. 1003, 120 S. Ct. 495, 145 L. Ed. 2d 382 (1999).



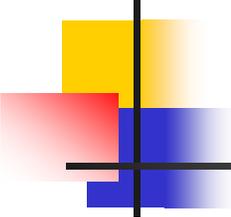
Verifying 12-Step Meeting Attendance

- Have attendance cards signed by the meeting secretary (usually people don't "secretary" more than once a week) or have them stamped with a distinctive (and hard-to-duplicate) stamp
- Check where and when they say they're going against your county's list of meetings
- Ask for their 30-, 90-, etc. day "chips"



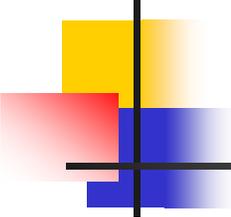
Verifying 12-Step Meeting Attendance (cont'd)

- Keep the 12 steps on the bench, ask what step they're on and quiz them
- Ask whether they're working through the steps with a sponsor and a workbook
- Make them choose a "home meeting"
- Ask whether they're doing service
- Ask if they're talking in meetings



Drug Testing

- What kind of test to order
- Defenses and myths
- Adulteration issues
- Monitoring/countermeasures



Group Discussion

- Scenarios
 - Charlie and Mary
 - Theresa
 - Alice
 - Clifford

Essentials in a “Bench Resource Guide”



1. **Drug guide** (slang terms, traditional names, medical uses, duration of effects, possible effects, signs of overdose, withdrawal symptoms)
2. **Information on drug testing** (including length of time drugs remain in system, possible adulteration methods and myths)
3. **List of drug conditions for diversion or probation**

“Bench Resource Guide (cont’d)...”



4. **Glossary of mental health/AOD terms**
5. **NIDA Handbook – *Principles of Drug Addiction Treatment* and other information on elements of effective treatment**
6. **Information on 12-step programs, including meetings (in neighboring areas of jurisdiction) and attendance verification method/form**

“Bench Resource Guide (cont’d)...”



- 7. List of useful websites**
- 8. Personal references/resources found helpful in understanding the recovery process.**

Other Resources Available to You

For additional
resources, turn
to the
“Webliography”
in Resource
Guide Section

ALCOHOL/DRUG WEBLIOGRAPHY

Prepared by Hon. Peggy Fulton Hora

AA World Services

www.alcoholics-anonymous.org

Home page of AA General Services Office

Addiction Treatment Forum

<http://www.atforum.com/>

Home page of Addition Treatment Forum

Al-Anon and Alateen

www.al-anon.alateen.org

Alcoholics recovery program

Alcohol and Drug Services

<http://www.adsvyes.com/>

Home page of Alcohol and Drug Services

Alcohol Doctor

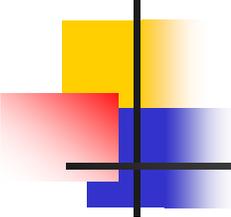
www.AlcoholMD.com

Provides online medical information about alcoholism

Locate treatment facilities nationwide

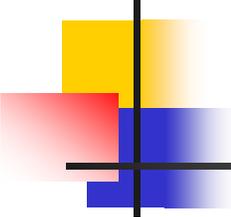
<http://www.findtreatment.samhsa.gov/facilitylocator.doc.htm>

The screenshot shows the SAMHSA Substance Abuse Treatment Facility Locator website. At the top left is the SAMHSA logo with the text "Substance Abuse & Mental Health Services Administration U.S. Department of Health and Human Services". To the right of the logo is the title "Substance Abuse Treatment FACILITY LOCATOR". Below the logo is a vertical navigation menu with buttons for: home, about the locator, quick search, detailed search, list search, file download, state substance abuse agencies, frequently asked questions, links, comments or questions, and mental health services locator. The "quick search" button is highlighted. To the right of the menu is a "Quick Search with Map It" section. It contains the text: "To locate the drug and alcohol abuse treatment programs nearest you, find your State on the map below and click on it." Below this text is a map of the United States where each state is labeled with its two-letter abbreviation. The map is blue with white outlines for state boundaries. The labels are: WA, OR, CA, NV, UT, AZ, NM, TX, MT, WY, CO, ND, SD, NE, KS, OK, MN, WI, MI, IA, MO, AR, LA, MS, AL, GA, TN, KY, WV, VA, PA, NY, NJ, DE, MD, DC, VT, NH, ME, MA, RI, CT, and FL.



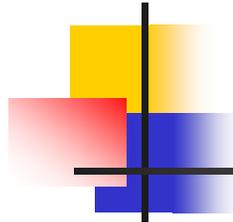
Educational Opportunities

- The National Judicial College
1 (800) 25-JUDGE www.judges.org
- Natl Council of Juvenile & Family Court Judges
(775) 784-6012 www.ncjfcj.unr.edu
- Natl Association of Drug Court Professionals/
Natl Drug Court Institute
1 (877) 507-3229 www.nadcp.org



Action Plan

- List three items (facts, strategies, information) that were new to you and that you will share with others
- List sources of information on substance abuse treatment that you would like to investigate, or encourage your support staff to acquire information about, in your community
- List three ways you would like to enhance your judicial work in the area of substance abuse



EVALUATION & FEEDBACK

A CHECK LIST FOR COUNTY OFFICIALS TO ASSESS JAIL CONDITIONS FOR WOMEN

DEVELOPED BY:

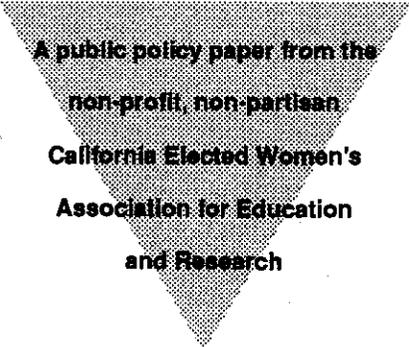
Judge Peggy Hora
Municipal Court of California
County of Alameda

IN ASSOCIATION WITH CEWAER:

Assemblywoman Dede Alpert
CEWAER President

Kate Karpilow, Ph.D.
CEWAER Executive Director

April 1995



A public policy paper from the
non-profit, non-partisan
California Elected Women's
Association for Education
and Research

Overview

The prison and jail population in this state has exploded in recent years, and with that comes problems of overcrowding, understaffing and a lack of understanding of the needs of the new generation of prisoners. Prison and jail officials are just beginning to recognize the distinct needs of female inmates and how they differ from those of their male counterparts.

This issue was a topic of considerable debate at the 1994 Supervisors' Retreat sponsored by CEWAER, the California Elected Women's Association for Education and Research. Discussion began as an offshoot of the supervisors' review of the just-released CEWAER policy paper, *Women and Substance Abuse*, co-authored by Municipal Court Judge Peggy Hora and Laurie Drabble, Executive Director of the California Women's Commission on Alcohol and Drug Dependencies. This policy paper underscored the need for adequate substance abuse prevention and treatment options for women, who are sometimes inappropriately treated or underserved.

Concern for how substance-abusing women, including substance-abusing pregnant and parenting women, are treated expanded to an analysis of how all women are treated in jail. The supervisors determined that, in most counties, no rigorous evaluation had ever been conducted to ensure that county jails provide basic health and safety conditions for incarcerated women.

As a result of this discussion, Judge Peggy Hora developed the following check list to assist county officials in analyzing jail conditions for women, including substance-abusing and pregnant and parenting women.

This check list can be used to guide an informal discussion or evaluation with jail officials or it can be used to structure a public hearing and organize staff and public testimony. Whatever approach you decide to take, CEWAER hopes this public policy tool will help ensure that basic health and safety conditions are provided in your county jail.

DOES YOUR COUNTY PROVIDE ADEQUATE JAIL CONDITIONS FOR WOMEN?

CONSIDER THE FOLLOWING:

PREGNANCY

- What prenatal care is available to pregnant women in your county jail?
- Are pregnant women housed on the bottom bunk?
- What exercise is available for pregnant women?
- Are extra fluids, sufficient time to eat and dietary supplements (such as those available through WIC — the Women, Infants and Children Nutrition Program) offered to pregnant, incarcerated women?
- What are the conditions, including necessary transportation, for OB/GYN visits, childbirth and delivery? Are there special considerations for "high risk" pregnancies?
- Are pregnant women or women in delivery handcuffed, shackled or hobbled?
- What is your county's in-custody miscarriage rate; and how does it compare to the general population, locally and statewide?
- Is immediate, reliable pregnancy testing and abortion information available at intake?
- Does your county post information regarding inmates' abortion rights as required by Penal Code Section 3406?

PARENTING

- How is "bonding" between infant and parent accomplished after an inmate delivers?
- Are there contact visits, parenting classes and/or a Teaching and Loving Kids (TALK) program for parents and children?
- Are parents provided information about their children, including Child Protective Services (CPS) status, when they are incarcerated? Is there a cooperative agreement between the jail and CPS to gather this information?
- Do parents have access to their children's foster parents by phone?
- What provisions are made for parents to attend juvenile court proceedings affecting their children?

ALCOHOL AND OTHER DRUG ISSUES

- What are the provisions for medically supervised drug withdrawal or methadone maintenance for inmates, including pregnant women?
- Is there in-custody alcohol or other drug treatment (such as Deciding, Educating, Understanding, Counseling and Education — DEUCE) available for women?

- Is there transitional or "half way" housing available to women who wish drug treatment?
- Are 12-Step programs (such as Alcoholics Anonymous, Narcotics Anonymous, Adult Children of Alcoholics and/or Al-Anon) available at least three times a week?

OTHER HEALTH/SAFETY ISSUES

- Is confidential and/or anonymous HIV testing available to inmates?
- Is comprehensive education on HIV available that specifically addresses prevention information for women?
- Is transportation provided to women who are released from custody after dark?
- Is extra clothing furnished to women during their menstrual periods?

EDUCATION

- Are skills or job training programs equally available to women and men? Is training in "non-traditional" jobs encouraged?
- Are literacy or English as a Second Language (ESL) classes available?
- Are GED classes available?

OTHER

- Are alternatives to incarceration programs (such as work furlough, work in lieu of confinement or weekend work) equally available to women and men?
- Are judges, defense lawyers and prosecutors aware of the programs available to women that are alternatives to incarceration?

ABOUT THE AUTHORS

Judge Peggy Hora was elected to the Municipal Court of Alameda County in 1984. She has served as that court's presiding judge and as president of California-Nevada Women Judges. Judge Hora has studied and lectured extensively on alcohol and other drug abuse and the courts, emphasizing the special needs of women offenders and perinatal substance abuse.

ABOUT CEWAER

CEWAER is a non-profit, non-partisan association that provides public policy research, skills training, educational workshops and networking opportunities for women leaders. Founded in 1974, CEWAER is the oldest and largest association of its kind in the nation. Our membership includes elected women serving at all levels of government. The association also values its members in the corporate, business and academic communities.

Currently, CEWAER is working on public policy projects in the areas of women's health, children's issues and education. In addition, CEWAER publishes reports that track and analyze the representation of women in elected office, as well as a quarterly newsletter.

CEWAER
 c/o California State University,
 Sacramento
 6000 J Street
 Sacramento, CA 95819-6100
 (916) 278-3870



ORDER FORM

PLEASE INDICATE WHICH DOCUMENTS YOU WOULD LIKE TO RECEIVE:

_____ Please send me the following publications from CEWAER's report on *Women and Substance Abuse*:
_____ Executive Summary (\$1.00) _____ Full Report (\$7.50)

A check must be enclosed with your order form.

_____ Please mail me the following publications from CEWAER's California Women's Health Project at *no charge*. CEWAER will process your request, and the reports will be mailed under separate cover from the California Research Bureau. Allow approximately three weeks for delivery.

Women's Physical Health in California: Inadequate Access

_____ Executive Summary only _____ Full Report

Women's Reproductive Health in California: Too Little, Too Late?

_____ Executive Summary only _____ Full Report

Women's Mental Health in California: Inadequate Attention

_____ Executive Summary only _____ Full Report

Women's Occupational Health and Safety in California: Safe at Work?

_____ Executive Summary only _____ Full Report

PLEASE COMPLETE THE FOLLOWING INFORMATION:

Name: _____

Jurisdiction/Organization: _____

Address: _____

City/State/Zip: _____

Mail this form to:

CEWAER
c/o CSUS
6000 J Street
Sacramento, CA 95819-6100

Please be sure to include a check made payable to CEWAER if you are ordering the *Women and Substance Abuse* policy paper or executive summary!

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California State University, Sacramento
6000 J Street
Sacramento, CA 95819-6100

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Sacramento, CA

ALCOHOL/DRUG WEBLIOGRAPHY

Prepared by Hon. Peggy Fulton Hora

12 Life in Recovery

www.12stepmag.com

A new 12-Step magazine

AA World Services

www.alcoholics-anonymous.org

Home page of AA General Services Office

Addiction Treatment Forum

<http://www.atforum.com/>

Home page of Addiction Treatment Forum

Al-Anon and Alateen

www.al-anon.alateen.org

Alcoholics recovery program

Alcohol and Drug Services

<http://www.adsyes.com/>

Home page of Alcohol and Drug Services

Alcohol Doctor

www.Alcoholmd.com

Provides online medical information (education and services) about alcoholism

Alcohol Policies Project, Center for Science in the Public Interest

www.cspinet.org

Home page of Center for Science in Public Interest which promotes health through education of the public regarding nutrition and alcohol.

Alcohol-Related Injury and Violence Literature Database

www.andornot.com/trauma

Contains bibliographic references to publications about alcoholism

American Academy of Addiction Psychiatry

www.aaap.org

Information on the field of Addiction Psychiatry

American Council on Alcoholism

www.aca-usa.org

A public education group about alcoholism

American Council for Drug Education

www.acde.org

Substance abuse prevention and education agency

American Foundation for Addiction Research (AFAR)

www.addictionresearch.com

AFAR is dedicated to fostering scientific research, understanding and disseminating the knowledge of the causes and nature of addictive disorders.

American Medical Association

www.ama-assn.org

Home page for the AMA

American University Justice Programs, Drug Court Clearinghouse

<http://www.american.edu/justice/aboutdrugcourts.html>

The Clearinghouse and Technical Assistance Project (DCCTAP) assists justice system officials and professionals in addressing issues relating to drug court programs in their jurisdictions.

Anonymous One

<http://www.anonymousone.com/main.htm>

“A recovery resource like no other”

Anonymously Yours Bookstore

<http://ay12steps.com/>

Recovery bookstore and gift shop

Arrestee Drug Abuse Monitoring (ADAM) Program

<http://www.adam-nij.net/>

Program tracks trends in the prevalence and types of drug use among booked arrestees in urban areas

Australian Drug Courts

<http://www.aic.gov.au/>

Home page of the Australian Institute of Criminology

Bill Nye the Science Guy (Episode 34--The Brain)

<http://www.billnye.com/core.html?flashtarget=core.html&noflashtarget=noflash.html>

Bill Nye the Science Guy home page providing a link to Episode 34--The Brain.
(Episode Guides, Life Science, Humans, The Brain.)

Brainplace

<http://www.brainplace.com/bp/default.asp>

All you ever wanted to know about the brain

Bureau of Justice Assistance (BJA)

www.ojp.usdoj.gov/BJA

Part of the U.S. government, BJA provides leadership and assistance in support of local criminal justice strategies to achieve safe communities

Bureau of Justice Statistics (BJS)

<http://www.ojp.usdoj.gov/bjs/>

Part of the U.S. government, BJS provides criminal justice statistics

California Association of Drug Court Professionals (CADCP)

www.cadcp.org

Home page of CADCP, a voluntary state organization for drug court professionals

California Department of Alcohol and Drug Programs

www.adp.state.ca.us

Home page of California Department of Alcohol and Drug Programs

California Drug Court Project

www.courtinfo.ca.gov/programs/drugcourts/

Home page of California Drug Court Project located in the Administrative Office of the Courts

California Narcotic Officers' Assn./Calif. Dept. of Justice

www.stopdrugs.org

Information on illegal drugs from narcotics officers.

California Society of Addiction Medicine

<http://www.csam-asam.org/>

Home page of physicians dedicated to improving treatment of alcoholism and other addictions.

California Women's Commission on Addictions

<http://www.cf1.org/CWCA/launch.htm>

CWCA is a statewide grassroots organization dedicated to the reduction, prevention of, and recovery from, alcohol and other drug related problems among women, their families and their communities.

Canadian Centre on Substance Abuse

<http://ccsa.ca>

A non-profit organization working to minimize the harm associated with the use of alcohol, tobacco and other drugs.

Centre for Addiction and Mental Health (Canada)

<http://www.camh.net/>

A public hospital providing care for people with mental health and addiction problems, a research facility, an education and training institute, and a community based organization providing health promotion and prevention services across the province of Ontario, Canada.

Center for Disease Control and Prevention (CDC)

www.cdc.gov

Home page for CDC

Center for Substance Abuse Prevention

<http://www.samhsa.gov/centers/csap/csap.html>

Home page of Substance Abuse Prevention a division of Substance Abuse, part of the Substance Abuse and Mental Health Services Administration (SAMHSA)

Center for Substance Abuse Research, University of Maryland

www.cesar.umd.edu

Home page of Center for Substance Abuse University of Maryland

Center for Substance Abuse Treatment (CSAT)

www.samhsa.gov/csap

Home page for CSAT a division of SAMHSA

CSAT Technical Assistance Publications (TAPs)

<http://www.treatment.org/Taps/>

Home page for Treatment Improvement Exchange TAP information

CSAT Treatment Improvement Protocols (TIPs)

<http://www.treatment.org/Externals/tips.html>

Home page for Treatment Improvement Exchange TIP information

Child Welfare League of America

www.cwla.org

Home page for Child Welfare League of America

Children of Alcoholics Foundation

www.coaf.org

National non-profit that provides a range of educational materials and services on parental substance abuse.

CoDependents Anonymous

www.codependents.org

Self-help 12 step organization to develop healthy relations

Community Anti-Drug Coalitions of America (CADCA)

<http://www.cadca.org/>

CADCA is a membership organization of over 5,000 anti-drug coalitions.

Community Tool Box

<http://ctb.lsi.ukans.edu/tools/tools.htm>

How to do the different tasks necessary for community health and development

Cornell University Medical College

www.med.cornell.edu/neuro/

Neuroscience web page of Cornell Medical College

Dads and Mad Moms Against Drug Dealers

<http://www.dammadd.org/mission.asp>

DAMMADD will pay citizens a cash reward for any tip that leads to the arrest and successful conviction of a drug dealer.

Dana Alliance for Brain Initiatives

www.dana.org/brainweb

Information on the brain relating to various conditions

Debtors Anonymous

www.debtorsanonymous.org

A fellowship of men and women who share a common desire to help others to recover from compulsive debting.

Drug Court Planning Initiative

<http://dcpi.ncjrs.org/index.html>

Home page for the Drug Court Planning Initiative, sponsored by the Bureau of Justice Assistance

Drug Court Technology

www.drugcourtech.org

Home page for Drug Court Technology

Drug Enforcement Administration

www.usdoj.gov/dea

Home page for the DEA, U.S. Department of Justice

Drug Strategies

www.drugstrategies.org

Non-profit research institution that promotes alternative approaches to the nation's drug problem

DSM IV

<http://www.behavenet.com/capsules/disorders/d4class.htm>

Diagnostic and Statistical Manual of Mental Disorders, Fourth Edition

Dual Diagnosis Anonymous

<http://www.swiftsite.com/mft/dda120.htm>

A 12-step program for people with co-occurring mental health disorders

Dual Recovery Anonymous

<http://draonline.org/>

An independent, twelve step, self-help organization for people with a dual diagnosis

Femina Women's Resources

www.femina.com/(use search engine, "addiction")

A search engine that deals with women.

Gam-Anon

www.gam-anon.org

Assistance with problem gambling

Gamblers Anonymous

www.gamblersanonymous.org

Self help 12 step group for compulsive gamblers

Gateway Recovery Center

<http://gatewayrecovery.org/main.htm>

A Montana treatment program with an excellent website

GHB information

<http://www.projectghb.org/>

Information on the drug GHB

Hazelden

www.hazelden.org

Publisher of books on recovery

Healthy Nations Initiative

<http://www.uchsc.edu/>

University of Colorado Health Science Center

Higher Education Center for Alcohol and Other Drug Prevention

<http://www.edc.org/hec/>

U.S. Department of Education website for drug and alcohol prevention

Indian Health Services

<http://www.ihs.gov/MedicalPrograms/Alcohol/index.asp>

The Federal Health Program for American Indians and Alaska Natives.

Indiana Prevention Resource Center

www.drugs.indiana.edu

Indiana clearinghouse for prevention technical assistance and information about alcohol, tobacco, and other drugs.

Institute on Behavioral Research

www.ibr.tcu.edu

To evaluate and improve the effectiveness of programs for reducing drug abuse and related problems.

Johnson Institute Foundation

<http://www.johnsoninstitute.com/html/history.html>

Improving the public's understanding of addiction as a treatable illness.

Join Together Online

<http://www.jointogether.org>

Information website on reducing substance abuse and gun violence.

Miami Coalition for a Safe and Drug-Free Community

www.miamicoalition.org

Miami-Dade Co. community strategy site related to social issues

Legal Action Center

www.lac.org

LAC fights discrimination against people with histories of addiction, AIDS, and criminal records and advocates for sound public policies in these areas.

LifeRing Recovery

<http://www.unhooked.com/>

A secular, 12-Step recovery program

Living Cyber

www.livingcyber.org

AA on line with chat rooms

Manisses Communication Group, Inc.

www.manisses.com

Mission to provide essential information to decision makers and service providers in mental health and addiction.

MedWeb

<http://www.medweb.emory.edu/MedWeb/>

Emory University Med Web

MedWeb is a catalog of biomedical and health related web sites maintained by Emory University.

Methamphetamine Campaign

<http://www.stopdrugs.org/methcrisis.html>

Information on methamphetamine

Methamphetamine Treatment Project (MTP)

www.methamphetamine.org

MTP is a multi-site initiative to study the treatment of methamphetamine dependence.

Metropolitan Atlanta Council on Alcohol and Drugs

www.macad.org

The Council on Alcohol and Drugs is a substance abuse prevention and education agency

Miami Drug Court

www.miamidrugcourt.com

Home page of the country's first drug court

Monitoring the Future Study, University of Michigan

www.isr.umich.edu/src/mtf/

Monitoring the Future is an ongoing study of the behaviors, attitudes, and values of American secondary school students, college students, and young adults.

Mothers Against Drunk Driving

www.madd.org

A non-profit organization that focuses on the effects of drunk driving and underage drinking and supporting those who are victims of those crimes.

Narcotics Anonymous

www.na.org

Self help 12 Step site for addicts

National Addiction Technology Transfer Centers

<http://www.nattc.org/>

A nationwide, multi-disciplinary resource that draws upon the knowledge, experience and latest work of recognized experts in the field of addiction

National Association of Addiction Treatment Providers

www.naatp.org

Represents almost 200 not-for-profit and for-profit treatment providers

National Advocates for Pregnant Women

<http://advocatesforpregnantwomen.org/>

Advocates for the rights of pregnant women and their children; protects pregnant women from being punished for their pregnancies

National Association of Alcoholism and Drug Abuse Counselors (NAADAC)

www.naadac.org

NAADAC's mission is to lead, unify and empower addiction focused professionals to achieve excellence through education, advocacy, knowledge, and standards of practice, ethics, professional development and research.

National Association of Drug Court Professionals (NADCP)

www.nadcp.org

NADCP is a voluntary membership organization that promotes and advocates for drug courts and providing for collection and dissemination of information, technical assistance, and mutual support to association members.

National Association for Children of Alcoholics

<http://www.nacoa.net/>

Our mission is to advocate for all children and families affected by alcoholism and other drug dependencies.

National Association of State Alcohol and Drug Abuse Directors (NASADAD)

www.nasadad.org

NASADAD's purpose is to foster and support the development of effective alcohol and other drug abuse prevention and treatment programs throughout every State.

National Center for State Courts (NCSC)

<http://www.ncsconline.org/>

The National Center is an independent, nonprofit organization dedicated to the improvement of justice.

National Center on Addiction and Substance Abuse at Columbia University (CASA)

www.casacolumbia.org

Inform Americans of the economic and social costs of substance abuse and its impact on their lives.

National Clearinghouse for Alcohol and Drug Information (NCADI)

<http://www.health.org>

NCADI is the world's largest resource for current information and materials concerning substance abuse.

**National Clearinghouse for Alcohol and Drug Information
Culture and Prevention: Putting Down Roots**

<http://www.health.org/features/multicultural/>

Providing culturally and linguistically appropriate materials and resources to prevent or reduce substance abuse.

National Council for Community Behavioral Healthcare

www.nccbh.org

Trade association of mental health and substance abuse providers

National Council of Juvenile and Family Court Judges (NCJFCJ)

<http://www.ncjfcj.unr.edu/>

NCJFCJ is dedicated to serving the nation's children and families by improving the courts of juvenile and family jurisdictions.

National Council on Alcoholism and Drug Dependence (NCADD)

www.ncadd.org

NCADD advocates prevention, intervention and treatment through offices in New York and Washington, and a nationwide network of affiliates.

National Commission Against Drunk Driving

<http://www.ncadd.com/>

Commission to reduce impaired driving and its tragic consequences by uniting public and private sector organizations and other concerned individuals who share this common purpose.

National Criminal Justice Reference Service (NCJRS)

<http://www.ncjrs.org/>

NCJRS is a federally sponsored information clearinghouse for people around the country and the world involved with research, policy, and practice related to criminal and juvenile justice and drug control.

National Drug Court Institute (NDCI)

www.NDCI.org

Promoting education, research and scholarship for drug court and other court-based intervention programs.

National Evaluation Data Services

<http://neds.calib.com/>

To increase scientifically-based analyses that answer vital questions in the substance abuse treatment field.

National Families in Action

<http://www.nationalfamilies.org/>

Its mission is to help families and communities prevent drug use among children by promoting policies based on science.

The National GAINS Center for People with Co-Occurring Disorders in the Justice System (GAINS)

<http://www.gainsctr.com/>

Information about effective mental health and substance abuse services for people with co-occurring disorders who come in contact with the justice system.

National Health Information Center

<http://www.health.gov/nhic/>

NHIC puts health professionals and consumers who have health questions in touch with those organizations that are best able to provide answers.

National Household Survey on Drug Abuse

<http://www.samhsa.gov/oas/p0000016.htm>

SAMHSA's National Household Survey on Drug Abuse is the primary source of information on the prevalence, patterns, and consequences of drug and alcohol use and abuse in the U.S.

National Institute on Alcohol Abuse and Alcoholism

www.niaaa.nih.gov

NIAAA supports and conducts biomedical and behavioral research on the causes, consequences, treatment, and prevention of alcoholism and alcohol-related problems.

National Institute on Drug Abuse (NIDA)

www.nida.nih.gov

NIDA's mission is to lead the Nation in bringing the power of science to bear on drug abuse and addiction.

NIDA Club Drugs

www.clubdrugs.org

Information on drugs used by young adults at all-night dance parties.

NIDA Marijuana

<http://www.marijuana-info.org/>

Resources regarding marijuana use, its effects and treatment.

NIDA Steroids

www.steroidabuse.org

Information on steroids and their effects

National Institutes of Health

<http://www.nih.gov>

NIH sponsors research to help prevent, detect, diagnose, and treat disease and disability, from the rarest genetic disorder to the common cold.

National Institute of Justice

www.ojp.usdoj.gov/nij

NIJ is the research and development agency of the U.S. Department of Justice and is the only federal agency solely dedicated to researching crime control and justice issues.

National Inhalants Prevention Coalition

www.inhalants.org

NIPC is a public-private effort to promote awareness and recognition of the under publicized problem of inhalant use.

National Judicial College (NJC)

<http://www.judges.org/>

NJC provides educational opportunities for judges on a variety of topics, including substance abuse.

National Library of Medicine (Medline)

www.ncbi.nlm.nih.gov

National Center for Biotechnology Information (NCBI) creates public databases, conducts research in computational biology, develops software tools for analyzing genome data, and disseminates biomedical information.

National Mental Health Association (NMHA)

www.nmha.org

NMHA is the country's oldest and largest nonprofit organization addressing all aspects of mental health and mental illness.

National Organization on Fetal Alcohol Syndrome

<http://www.nofas.org/>

Information on Fetal Alcohol Syndrome

National Youth Anti-Drug Media Campaign

<http://www.theantidrug.com/index.html>

A multi-lingual, prevention website

Neuroscience for Kids

<http://faculty.washington.edu/chudler/neurok.html>

Neuroscience for Kids is for all students and teachers who would like to learn more about the nervous system.

Neurosciences on the Internet

www.neuroguide.com

A searchable and browsable index of neuroscience resources available on the Internet

The Other Bar

www.otherbar.org

The Other Bar is a network of volunteer lawyers and judges who deal with alcoholism and chemical dependency on a personal and absolutely confidential basis by providing on-going assistance and support.

Overeaters Anonymous

www.overeatersanonymous.org

Self help 12 Step site for compulsive overeaters

Pacific Southwest Addiction Technology Transfer Center (PSATTC)

www.attc.ucsd.edu

PSATTC at the University of California, San Diego, (UCSD) assists service systems and institutions develop capacities for addressing substance use disorders within populations they serve.

Pain and Chemical Dependency

<http://www.painandchemicaldependency.org/>

Site for a series of conferences on pain and chemical dependency

Partners for Substance Abuse Prevention

<http://www.samhsa.gov/preventionpartners/>

A virtual meeting place for those involved in substance abuse prevention

Partnership for a Drug-Free America

www.drugfreeamerica.org

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

Physicians' Leadership on National Drug Policy

www.plndp.org

Physicians organization that produced videos "Addiction and Addiction Treatment," and "Health, Addiction Treatment, and the Criminal Justice System."

Quitnet (Stop Smoking)

www.quitnet.org

Information on how to quit smoking.

Research Institute on Addiction (RIA)

www.ria.org

RIA is a research center of the University at Buffalo, The State University of New York, and a national leader in the study of alcohol and substance abuse issues.

Robert Wood Johnson Foundation

www.rwjf.org/main.html

RWJF was established as a national philanthropy in 1972 and today it is the largest US foundation devoted to improving the health and health care of all Americans.

S-Anon International Family Groups

www.sanon.org

Self help 12 step group for people affected by someone's sex addicted behavior

Safe and Drug Free Schools Program

www.ed.gov/offices/OESE/SDFS

Federal government's primary vehicle for reducing drug, alcohol and tobacco use, and violence, through education and prevention activities in our nation's schools.

San Francisco Medical Society

www.sfms.org

The San Francisco Medical Society is a non-profit organization consisting of over 1500 physician members and fifteen staff members that advocate for the interests of San Francisco physicians and their patients in the interest of public health.

Sex Addicts Anonymous

www.saa-recovery.org

Self help 12 Step program for sex addicts

Sex and Love Addicts Anonymous

www.slaafws.org

Self help 12 step program for sex/love addicts

Sexaholics Anonymous

www.sa.org

Self help 12 step program for sexaholics

Sexual Compulsives Anonymous

www.sca-recovery.org

Self help 12 Step program for sex compulsives

Smoke-Free Families

<http://www.smokefreefamilies.org/>

A national program working to identify and disseminate evidence-based approaches to improving smoking cessation rates during pregnancy.

The Smokers Quitline

www.quitnet.org

Information on how to quit smoking.

Sober Dykes

<http://www.soberdykes.org/index.html>

Recovery page for lesbians

Society for Neuroscience

www.sfn.org

World's largest organization of scientists and physicians dedicated to understanding the brain, spinal cord and peripheral nervous system.

Society for Neuroscience Brain Briefings

www.sfn.org/briefings

Information on neuroscience to the lay audience.

Students Against Destructive Decisions (SADD)

www.saddonline.com

To provide students with the best prevention and intervention tools possible to deal with the issues of underage drinking, drunk driving, drug abuse and other destructive decisions.

Substance Abuse and Mental Health Services Administration (SAMHSA)

www.samhsa.gov

SAMHSA is the federal agency charged with improving the quality and availability of prevention, treatment, and rehabilitative services in order to reduce illness, death, disability, and cost to society resulting from substance abuse and mental illnesses.

SAMHSA FAS Prevention

<http://prevention.samhsa.gov/faspartners/>

Fetal Alcohol Syndrome prevention materials

SAMHSA Prevention On Line

<http://www.samhsa.gov/centers/clearinghouse/clearinghouses.html>

SAMHSA information clearinghouses links.

SAMHSA Prevention Pathway

<http://www.samhsa.gov/preventionpathways/>

Information on prevention programs, program implementation, evaluation technical assistance, online courses, and a wealth of other prevention resources.

SAMHSA Substance Abuse and Mental Health Statistics

www.drugabusestatistics.samhsa.gov

Provides the latest national data on alcohol, tobacco, and drug abuse.

SAMHSA Substance Abuse Treatment Locator

<http://findtreatment.samhsa.gov/>

Find the right drug abuse treatment program or alcohol abuse treatment program

Sober Housing

<http://www.soberhouses.com/>

A national directory of sober housing

Substance Abuse and Mental Health Data Archive

www.icpsr.umich.edu/SAMHDA

Access to substance abuse and mental health research data

Treatment Alternatives for Safe Communities (TASC)

www.tasc-il.org

TASC is a not-for-profit Illinois agency that specializes in social service delivery and technology.

United Nations Office for Drug Control and Crime Prevention (UNDCP)

<http://www.undcp.or.at/index.html>

UNDCP educates the world about the dangers of drug abuse.

University of California, Los Angeles Integrated Substance Abuse Program (ISAP)

<http://www.uclaisap.org/>

ISAP coordinates substance abuse research and treatment under authority of the UCLA Neuropsychiatric Institute & Hospital (NPI&H).

Web of Addictions

<http://www.well.com/user/woa>

The Web of Addictions is dedicated to providing accurate information about alcohol and other drug addictions.

Wheeler Center on Neurobiology and Addiction

www.ucsf.edu/cnba/index.html

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

White House Office of National Drug Control Policy (ONDCP)

www.whitehousedrugpolicy.gov

The principal purpose of ONDCP is to establish policies, priorities, and objectives for the Nation's drug control program.

Wisconsin Clearinghouse for Prevention Resources

www.uhs.wisc.edu/wch/

Develops, produces and disseminates educational materials, offers prevention services, and provides information throughout Wisconsin.

Wisconsin/Michigan State Brain Collections

<http://www.neurophys.wisc.edu/www/neurosci.html>

Links to other Neuroscience Resource websites.

Women in Recovery

www.womeninrecovery.com

Home page of a residential recovery home for women

Women for Sobriety, Inc.

www.womenforsobriety.org

A non-profit organization dedicated to helping women overcome alcoholism and other addictions.

Rev. 12/02

MENTAL HEALTH/ALCOHOL AND OTHER DRUGS GLOSSARY¹

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

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

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

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

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

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

Anhedonia The inability to experience pleasure.

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

Antidepressants A group of drugs used in treating depressive disorders.

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

Anxiety Disorders

Panic Disorder (unprovoked panic attacks)

Agoraphobia (generalized irrational fear)

Social Phobia (irrational fear of embarrassment)

Specific Phobia (other specific irrational fears)

Obsessive-Compulsive Disorder (obsessive thoughts and compulsive rituals)

Generalized Anxiety Disorder (nonspecific anxiety)

Post-traumatic Stress Disorder (non-acute psychological consequences of previous trauma) and Acute Stress Disorder (acute psychological consequences of previous trauma)

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

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

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

Crack Slang for a smokable form of cocaine.

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

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

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

Depression A sustained feeling of sadness.

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

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

Mood Disorders

Major Depressive Disorder (major depression without mania)

Bipolar I Disorder (mania with/without major depression)

Bipolar II Disorder (hypomania with major depression)

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

Dysthymic Disorder (prolonged minor depression without mania/hypomania)

Neuron A nerve cell.

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

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

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

Personality Disorders

Paranoid Personality Disorder (suspicious, distrustful)

Schizoid Personality Disorder (socially distant, detached)

Schizotypal Personality Disorder (odd, eccentric)

Antisocial Personality Disorder (impulsive, aggressive, manipulative)

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

Histrionic Personality Disorder (emotional, dramatic, theatrical)

Narcissistic Personality Disorder (boastful, egotistical, “superiority complex”)

Avoidant Personality Disorder (shy, timid, “inferiority complex”)

Dependent Personality Disorder (dependent, submissive, clinging)

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

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

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

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

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

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

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

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

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

Schizophrenia & Psychotic Disorders

Schizophrenia

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

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

Substance-Related Disorders

Alcohol Dependence (alcoholism)

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

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

Cocaine Dependence (coke, crack, coca leaves)

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

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

Nicotine Dependence (tobacco)

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

Phencyclidine Dependence (PCP, angel dust)

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

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

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

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

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

BARRIERS TO TREATMENT FOR WOMEN¹

- Alcoholic women experience significantly higher incidents of domestic violence. “Making the Link: Domestic Violence & Alcohol and Other Drugs,” Center for Substance Abuse Prevention (CSAP) (Spring 1995).
- “Dual diagnosis” (the co-occurrence of a major psychiatric disorder with drug dependency) is more prevalent in women than men (65% vs. 44%). “Practical Approaches in the Treatment of Women Who Abuse Alcohol and Other Drugs,” DHHS Pub.No.(SMA) 94-3006.
- Battered women are at increased risk of attempting suicide, abusing alcohol and other drugs, depression and abusing their own children. “Making the Link...,” *supra*.
- “Cold turkey” withdrawal of a pregnant woman from depressants (alcohol, heroin, Valium, etc.) must be medically supervised to avoid miscarriage and compromising the woman’s health. “Pregnant, Substance-Using Women,” TIP #2 DHHS Pub.No.(SMA) 93-1988; See also: Hora & Becker, “Judicial Considerations in Sentencing Pregnant Substance Users,” *35 Judges’ Journal* 3 (Spring 1996).
- At least 70% of women drug users were sexually abused by the age of 16. “Women & Drug Abuse,” NIDA NIH Pub.No. 94-3732.
- More than 70% of AIDS cases among women are related to IV drug use or sex with a man who uses. “Practical Approaches...” *supra*.
- Drug treatment is the most important element in successful family maintenance or unification. Senate Office of Research, “California’s Drug-Exposed Babies” (1990).
- Most publicly-funded drug treatment centers do not have child care and only 11.5% of all treatment programs provide child care. Congressional Caucus for Women’s Issues, GAO, “Drug Exposed Infants: A Generation at Risk” (1990).
- Women fear loss of dependent children if they seek substance abuse treatment. “Alcohol and Women,” NIAAA (Oct. 1990); “Women and Drug Abuse,” NIDA, NIH Pub.No. 94-3732 (1994).
- 21.5 million women smoke; 4.5 million abuse alcohol/are alcoholic; 3.5 million misuse prescription drugs; 3.1 million use illicit drugs. National Center on Addiction and Substance Abuse, Columbia University (June 1996).
- A predominance of male patients and staff is a barrier. “Men and Women in Drug Abuse Treatment Relapse at Different Rates and for Different Reasons,” *13 NIDA Notes* (1998).
- The social stigma for women addicts is greater. *Id.*
- Women are more likely than men to complete drug treatment. Wallen, Jacqueline, Ph.D., M.S.W., “Researcher/Sex Issues,” in *Drug Addiction Research and the Health of Women*, Executive Summary, Nat’l. Inst. On Drug Abuse, (NIH 98-4289) (May 1998).

¹ Created by Judge Peggy Hora, Alameda County Superior Court, Hayward, CA.

BARRIERS TO TREATMENT FOR WOMEN WITH CHILDREN*

- Loss of income and inability to pay for treatment
- Stigma, particularly for drug dependent mothers
- Lack of child care. Only 12.9% of publicly funded treatment facilities offer child care. When women can take their children to treatment, there is improved retention and treatment success.
- Fear of losing custody. More than half (58% in 1995) of AOD directors and CPS directors report a positive drug test was grounds for reporting a pregnant woman to a state agency compared to 12% in 1992.
- Fear of prosecution. Fewer than ½ (45%) of state AOD and CPS directors reported criminal prosecution of drug using women in their state compared to 71% in 1995.
- Suppression of violence including rape, incest and domestic violence can trigger relapse and is a critical issue that must be addressed in treatment. Recovery can be too painful for some women.

*"Steps to Success. Helping Women with Alcohol and Drug Problems Move from Welfare to Work," Legal Action Center (May 1999) at 14.

JUDICIAL EDUCATION ON SUBSTANCE ABUSE

BENCH CONSIDERATIONS*

The following is a list of issues that judges may want to consider related to parties. (These are some lifestyle traits that may show an inclination toward addiction and may give the judge clues about underlying substance abuse issues.)

A. Introduction/Background

1. What grade did the litigant complete in school?
2. Is the litigant currently employed? When was he/she last employed?
3. Does the litigant own or rent a home? If not, with whom does he/she live?
4. Does the litigant have children? If yes, do they live with the litigant? If no, with whom do they live? Does the litigant have custody?
5. How old are the children? If they are school age, do they attend school?
6. Are his/her children involved with child protective services or the juvenile court system in any way?
7. Does the litigant have any significant debts/owe people money?

B. Substance Abuse

1. Has the litigant, his/her significant other, or child(ren) used alcohol or drugs (including marijuana) during the past six months?
2. Has the litigant, significant other, or child(ren) been treated in an inpatient, outpatient, or other counseling program during the past six months?
3. If yes, is the litigant, significant other, or child(ren) suffering from an addiction to drugs or alcohol?
4. If the litigant has not been involved in treatment, would he/she be amenable to or like a referral to a treatment program?
5. Is the litigant taking any known medications presently?

* *This list of considerations was developed by the National Center for State Courts under a grant from the State Justice Institute (SJI-01-N-210). The points of view expressed do not necessarily represent the official position or policies of the National Center for State Courts, the American Judges Association, or the State Justice Institute.*

JUDICIAL EDUCATION ON SUBSTANCE ABUSE

BENCH RESOURCE LIST

The following is a suggested list of materials that would be helpful to a judge in cases involving substance abuse.

1. **Drug Guide** (including traditional names, slang terms, medical uses, duration of effects, possible effects, effects of overdose, withdrawal symptoms). (Examples provided in materials.)
2. **Information on Drug Testing** (including length of time drugs remain in system, possible adulteration substances and myths). (Example and sources provided in materials.)
3. **List of drug conditions of diversion or probation.** (Example provided in materials.)
4. **Glossary of Mental Health/AOD Terms** (provided in materials).
5. **NIDA Handbook – *Principles of Drug Addiction Treatment*** and other information on the **elements of effective treatment programs** (provided in materials).
6. **Information on 12-step programs**, including the 12 steps (provided in materials), a list of 12-step meetings in neighboring areas of jurisdiction (Findtreatment.org) & attendance verification method (e.g., verification form).
7. **List of useful websites.** (A webliography is provided in materials.)
8. **Personal references found helpful in understanding the recovery process.**

Other handouts (included in materials) that may be useful:

- ◆ Indicators of co-occurring mental health disorders
- ◆ Barriers to treatment for women
- ◆ Barriers to treatment for women with children
- ◆ Child protection issues for using parents
- ◆ Jail considerations for women checklist (including drug-addicted pregnant women)
- ◆ Mental health webliography (list of websites related to mental health issues)
- ◆ Summary of treatment modalities

Commonly Abused Drugs

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

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

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

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

*Schedule I and II drugs have a high potential for abuse. They require greater storage security and have a quota on manufacturing, among other restrictions. Schedule I drugs are available for research only and have no approved medical use; Schedule II drugs are available only by prescription (unrefillable) and require a form for ordering. Schedule III and IV drugs are available by prescription, may have five refills in 6 months, and may be ordered orally. Most Schedule V drugs are available over the counter.

**Taking drugs by injection can increase the risk of infection through needle contamination with staphylococci, HIV, hepatitis, and other organisms.

***Associated with sexual assaults.

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

CPS ISSUES FOR USING PARENTS¹

- Prenatal care is the #1 factor for a healthy birth outcome
- 70% of child abuse/neglect cases based on AOD abuse
- Children in alcohol-abusing families are 3.6 times more likely to be victims of maltreatment
- Children who are abused may be more likely to become AOD abusers as adults
 - #1 barrier to treatment for women is child care (11.5% programs provide child care)
 - Alcohol is present in >50% of DV cases
 - Alcoholic women experience > violence, verbal and physical
 - 1.4 million child abuse/neglect cases in '86;
3.2 million in '97
 - 520,000 children in foster care in '98 vs. 340,000 in '88 at a cost of \$1.2 billion
- In California, 25% of foster children have been in place more than 5 years and 105,000 children are living in out-of-home care
- 80% of welfare agencies report substance abuse and poverty as their top two problems
 - 3% of SAMHSA's budget goes to gender-specific programs
- Federal \$ for AOD treatment targeting pregnant/postpartum women & children is 10% that provided in 1995
 - SAMHSA funding designed for women has dropped 38% since 1994
 - \$1 in treatment saves \$7 in other costs

CSAT study showed after treatment:

2/3 women not using AOD, 86% children with mother,
<10% involved with criminal justice system

¹ Prepared by Judge Peggy Hora, Alameda County Superior Court, Hayward, California.

Resources re: Drug Testing

<http://www.urineluck.com/>

<http://www.cleartest.com/>

<http://www.passyourdrugtest.com/>

<http://www.testclean.com/>

<http://www.thcfree.com/>

<http://www.thewhizzinator.com/>

<http://www.magicvan.com/>

<http://www.wemark.com/zydm.html>

DRUGS OF ABUSE

Class of Drugs	DRUG	Time in Urine
Sedatives- Hypnotics	ALCOHOL BARBITURATES TRANQUILIZERS (Require Detox)	Max. 12 Hours 3 days 3 days
Opiates	HEROIN METHADONE VICADIN PROPOXYPHENE (Darvon) SYNTHETICS (Dilaudid) (Require Detox)	2-3 Days 2-4 Days 3 Days 3-7 Days CANNOT BE DETECTED
Stimulants	COCAINE AMPHETAMINES (Including Meth)	2-3 Days 2-4 Days
Hallucinogens	MARIJUANA PCP LSD MUSHROOMS ECSTACY MDMA	3-27 Days 3-8 Days)) CANNOT BE) DETECTED)

The Implications of Therapeutic Jurisprudence for Judicial Satisfaction

Deborah J. Chase and Peggy Fulton Hora

“Drug court judges get to color outside the lines.”¹

Therapeutic jurisprudence has been posited as the jurisprudential underpinning of the burgeoning drug treatment court movement and drug treatment courts as therapeutic jurisprudence in action.² Therapeutic jurisprudence is the study of the extent to which substantive rules, legal procedures, and the roles of lawyers and judges produce therapeutic or antitherapeutic consequences for individuals involved in the legal process.³

Drug treatment courts are an alternative to traditional case processing in which judges supervise the treatment and recovery of alcoholics/addicts and where the adversarial system is out of place. Drug treatment courts use a team approach among the judge, prosecutor, defense counsel, treatment provider, probation officer, drug treatment court coordinator, and community policing officer where the “focus is on the participant’s recovery and law-abiding behavior—not on the merits of the pending case.”⁴ If, however, a drug treatment court participant is not capable of compliance with the rigors of the drug treatment court program, that individual is returned to the traditional criminal justice system for further processing of his or her case. Drug treatment courts can be either pre- or post-plea and, thus, another court may impose sentence, including jail or prison time, or try the case if there is a program failure.

By shifting the main focus in selected alcohol and other drug cases from legal to therapeutic concerns, the roles of the drug treatment court professionals shift as well. This does not mean that legal concerns, such as due process, are trumped by therapeutic ones. Rather, it means that the therapeutic value of non-adversarial case processing—where the focus is on treatment and recovery—is recognized and utilized. This shift in role appears to benefit staff as well as litigants. Specifically, judges

who work therapeutically seem to experience increased job satisfaction.

For the prosecution, police, and probation, the focus shifts from arrest and conviction to treatment and recovery. Underlying this shift in focus is the belief that it will result in a reduction of criminal behavior, a savings in incarceration costs, and both tangible and intangible benefits to the community, the individual, and the individual’s family.⁵ The defense attorney, after analyzing the legal issues and clarifying all options for the client, shifts focus from minimizing a client’s exposure to criminal sanctions to ensuring that the addicted client stays in treatment and recovery.⁶ Police officers who are involved in drug treatment courts through community policing efforts see their role change from a “You call, we haul, that’s all” role in drug cases to more of a community monitoring and direct participant encouragement role. Many drug treatment court participants have asked that their arresting officer be present at their graduation and they credit the officer with literally saving their lives.

Finally, the judge goes from being a detached, neutral arbiter to the central figure in the team, which is focused on the participants’ sobriety and accountability. Sanctions for program failures are not primarily for punishment; rather, sanctions are tools for program compliance to enhance treatment and recovery. Sanctions provide the external structure needed until participants can develop their own internal structure to be able to maintain sobriety. The judge’s personal knowledge of a participant’s background, reasons for use, living situation, physical and mental health, family, employment, parenting skills, and other matters is unequaled in the criminal system. The judge is both a cheerleader and stern parent, encouraging and rewarding compliance, as well as attending to lapses. Through weekly, fortnightly, then monthly mandatory court appearances, the judge sees the incredible changes a participant makes. The judge watches as the participant gets a GED, gains employment, recovers children from Child Protective Services, gets off wel-

Footnotes

1. Remark overheard at a national drug court conference.
2. Peggy Fulton Hora & William G. Schma, *Therapeutic Jurisprudence*, 82 JUDICATURE 9 (1998); and Peggy Fulton Hora et al., *Therapeutic Jurisprudence and the Drug Treatment Court Movement: Revolutionizing the Criminal Justice System’s Response to Drug Abuse and Crime*, 74 NOTRE DAME L. REV. 439 (1999).
3. See David B. Wexler & Bruce J. Winick, *Therapeutic Jurisprudence as a New Approach to Mental Health Law Policy Analysis and Research*, 45 U. MIAMI L. REV. 979 (1991).
4. DRUG COURTS PROGRAM OFFICE, U.S. DEP’T OF JUSTICE, *DEFINING DRUG COURTS: THE KEY COMPONENTS* 6 (1997).
5. DRUG STRATEGIES, *CUTTING CRIME: DRUG COURTS IN ACTION* (1997); See generally, Steven Belenko, *Research on Drug Courts: A Critical Review*, 1 NAT’L DRUG CT. INST. REV. 1 (1998).
6. See Videotape: *Drug Treatment Courts: The Defense Perspective* (The Rutter Group, 1994), in which Michael Judge, Public Defender of Los Angeles, explains the defense role.

fare, kicks out an abusive boyfriend, gains independence and confidence, and, finally, graduates from the program.

The judge cannot help but be changed by this process. Consequently, the hypothesis for this article stemmed from two judges known to the judicial co-author, who discovered their own alcoholism after becoming drug treatment court judges. She also noticed her own attitudes, job satisfaction, and happiness in court being affected by her assignment as a drug treatment court judge. Personal observation makes it clear that the drug treatment court not only can have a therapeutic effect on the recovering participant but also on the other criminal justice players in the courtroom as well.

THE JUDICIARY

The positive effect of a particular judicial assignment on the judge is not a topic that has received much research attention. In a 1980 study of American trial judges, the perception of their work environment was not found to be related to whether they were sitting on specialized calendars or master calendars.⁷ However, in a 1981 survey, judges complained of job stress arising from lack of control over what type of cases they were given.⁸ In another 1982 study, 422 juvenile court judges in West Germany were surveyed to assess their attitudes toward social assistance and the administration of justice. The highest job satisfaction was found in the judges who endorsed and practiced with a social science and educational orientation in their work, interacted well with service providers, approved of specialized judicial training, and were involved in community work outside the court.⁹ In the 1980 study of American judges, it was found that judges who work long hours, are involved in community relations, and are involved in bar activities are more likely to be satisfied with their environment.¹⁰

Job stress is the more common focus of research on judicial satisfaction.¹¹ Job stress in judges is commonly associated with social isolation,¹² feeling disliked by others, lack of interest and understanding, and not feeling appreciated.¹³ They also suffer from lack of feedback, a heavy caseload volume, and lack of control over what cases they get.¹⁴ Additionally, frustration with their lack of ability to be helpful to litigants seems to contribute to judicial stress.

Judges express dismay when, due to large caseloads, they have to "process" people, because they have so little time to listen. In such circumstances, there can be a tendency for them

to withdraw empathy and respect for the litigants.¹⁵ The presence of judicial stress is frequently observed in family law court judges, for example. Judicial officers in family law seem to experience high stress, frustration, feelings of helplessness, and burnout.¹⁶

In contrast, however, many of the factors related to job stress are not as commonly observed in drug treatment court judges. It is proposed that the therapeutic effects of drug treatment courts carry over to the judicial officers and other court workers in increased job satisfaction and possibly overall mental health. Drug treatment court judges and others have stopped smoking, stopped drinking alcohol, realized their own alcoholism, gone on diets, and exercised more. Many have expressed a sense of pride in a job well done and a brighter outlook since taking the drug treatment court assignment. These feelings had not heretofore been experienced in their professional careers.

Family law court judicial officers work with a courtroom process that is quite different from that of the drug treatment court. Although originally conceptualized to be therapeutic in orientation,¹⁷ family law courts, due to increased caseloads and fragmentation of issues, have not broadly employed therapeutic principles.¹⁸ The National Center for State Courts has determined that family law is the largest and fastest growing segment of state courts' civil caseloads.¹⁹ Legal issues related to a family enter the court system in many different ways. Cases of child abuse and/or neglect are heard in criminal court and/or juvenile dependency court. Juvenile delinquency matters are heard in the juvenile court. Cases concerning the guardianship of children are heard in probate court. Divorce, paternity, and district attorney child support cases may be heard in family court. Requests for civil domestic violence restraining orders may be heard in civil domestic violence courts. If there have been criminal charges, those cases are heard in criminal court. While there is movement toward court reform for family law, to date only eleven states have implemented unified family law systems to address these issues.²⁰

California has not implemented a therapeutic unified family law system. Cases related to families are still fragmented into multiple departments in the overwhelming majority of California counties. According to California Superior Court Judge Donna Petre, "Each of these departments has minimal knowledge of the decisions of the other, even if the decisions

7. JOHN PAUL RYAN, ET AL., AMERICAN TRIAL JUDGES 160 (1980).
8. Issiah M. Zimmerman, *Stress—What It Does to Judges and How It Can Be Lessened*, JUDGES J., Summer, 1981, at 4.
9. R. Pommerening, *Self-Image of German Juvenile Judges*, 65 MONATSSCHRIFT FUER KUMINOLOGIE UND STRAFRECHSREFORM 193 (1982).
10. RYAN, ET AL., *supra* note 7.
11. Pommerening, *supra* note 9; Tracy Eells & Robert C. Showalter, *Work Related Stress in American Judges*, 22 BULL. OF AM. ACAD. OF PSYCHIATRY & L. 71 (1994); Joy Rogers, et al., *The Occupational Stress of Judges*, 36 CANADIAN J. OF PSYCHIATRY 317 (1991).
12. Eells & Showalter, *supra* note 11; Rogers et. al., *supra* note 11. See also Issiah M. Zimmerman, *Isolation in the Judicial Career*, COURT REVIEW, Winter 2000 at 4.
13. Eells & Showalter, *supra* note 11.

14. Zimmerman, *supra* note 8.
15. Zimmerman, *supra* note 8.
16. Jeffrey A. Kuhn, *A Seven-Year Lesson on Unified Family Courts: What We Have Learned Since the 1990 National Family Court Symposium*, 32 FAM. L.Q. 67, 75-93 (1998).
17. Herma Hill Kay, *A Family Court: The California Proposal*, 56 CAL. L. REV. 1205, 1205-1248 (1968).
18. Barbara A. Babb, *America's Family Law Adjudicatory Systems*, 32 FAM. L.Q. 31, 37-50 (1998); Catherine Ross, *The Failure of Fragmentation: The Promise of a System of Unified Family Courts*, 32 FAM. L.Q. 3, 6-14 (1998).
19. Ross, *supra* note 18, at 6.
20. The states are Delaware, the District of Columbia, Hawaii, New Jersey, Rhode Island, South Carolina, Florida, Massachusetts, New York, Vermont, and Washington. See Babb, *supra* note 18, at 38.

involve the same family and its children. The larger the court, the more the problem is compounded. In large courts, each of these departments may not be just in separate courts, but in different facilities miles away from one another with no technological contact."²¹ The lack of a holistic approach by the court to the family law litigants sets it in stark contrast to the approach taken by the drug treatment courts.

RESEARCH

The authors conducted an informal opinion survey of court professionals, including judicial officers, to compare the opinions in drug treatment courts to those in family law courts. It was hypothesized that the differences in judicial satisfaction observed between drug treatment court and family law court judicial officers might be related to the differences between the operation of a court when incorporating the principles of therapeutic jurisprudence²² and the operation of a court that functions in a more traditional manner. Such differences were expected to be expressed through significantly different attitudes in the following areas:

- The drug treatment court judicial officers were expected to feel more strongly that the role of the court includes providing help to the litigants in solving the problems that brought them there.
- The drug treatment court judicial officers were expected to hold a more positive view of the individuals who appeared before them.
- The drug treatment court judicial officers were expected to feel more strongly that their assignments had a personally positive emotional effect on them.
- The drug treatment court judicial officers were expected to report a greater increase in personal insights and motivation for healthy change as a result of their assignment.

THE SURVEY

Participants were given a set of 25 questions with answers on a 5-point scale in which the respondent was to rate each answer from (1) "Very Untrue" to (5) "Very True." The questions were identical for both groups. Questionnaires were distributed to attendees at a January 1999 California conference of drug court professionals; through the California Association of Drug Court Professionals' newsletter in the spring of 1999; and at the National Association of Drug Court Professionals' conference in June 1999. Family law professionals were surveyed at the California Family Support Council's annual training conference in February 1999. There were participants from most of California's counties who were asked to take questionnaires back home and distribute them to judges, attorneys, mediators,

family law facilitators, and others, and to return them by mail. In the summer of 1999, judges attending an advanced family law course in California were surveyed and a direct mail campaign to judicial officers in both assignments was completed in the winter of 1999. Responses from the drug treatment court professionals came from across the country. Responses from the family law court professionals came from within California. The California family law court professionals who responded to this survey were selected from the part of California's fragmented system that handles cases of divorce, legal separation, annulment, paternity, child support, and, in some cases, private guardianships and domestic violence restraining orders.²³ These family law court professionals have not had the benefit of a statewide court strategy that applies the principles of therapeutic jurisprudence to the family law courtroom.

THE PARTICIPANTS

There were a total of 194 judicial officers who responded to the survey; 98 from the family law courts and 96 from the drug treatment courts. One hundred twenty-three non-judicial officers responded; 68 from the drug treatment courts and 55 from the family law courts.

Overall, the judicial officers²⁴ responding were 67% male and 33% female. They ranged in age from 35 years to 75 years with a mean age of 52 years. The drug treatment court judicial officers were 72% male and 28% female. The family law court judicial officers were 63% male and 37% female.

The judicial officers' professional tenures ranged from 1 year to 50 years, with an overall average of 14 years. The time in their current assignments ranged from 3 months to 19 years, with an average of 4 years. The female judicial officers were slightly younger, on average, and had been in the profession for less time. This was true for both the drug treatment court and the family law court groups.

THE ROLE OF THE COURT

The judicial officers were asked to respond to several statements meant to reflect their perception of the court's role. A statistical test called an analysis of the variance (ANOVA) was conducted between the responses of drug treatment court and family law court judicial officers.²⁵

The first statement was, "I believe that part of our job is to help the litigants/defendants work to solve the problems that brought them to our courts." Although the drug treatment court group was slightly stronger in this belief (average=4.57) than the family law court group (average=4.53), this difference was not statistically significant. Both groups, however, were strong in their positive responses to this inquiry. Overall, the

21. Hon. Donna Petre, *Unified Family Court: A California Proposal*, 1 J. OF THE CENTER FOR CHILDREN & THE CTS. 161 (1999).

22. Hora & Schma, *supra* note 2.

23. This survey did not seek respondents from the juvenile court or criminal courts, which deal with cases of child abuse or neglect, delinquency, or domestic violence.

24. Both judges and subordinate judicial officers, such as commissioners and referees, responded to this survey.

25. The statistical size of these differences is represented by the F-val-

ues, which are set out in the footnotes. These differences are considered statistically significant if they are not likely to have occurred by chance. In social science research, the point at which the results are considered not to have occurred by chance is referred to as the probability value or p-value, and is commonly set at a minimum level of p=.05. The p=.05 value indicates that there is only a 5% probability that the observed effect has occurred by chance. Likewise, a value of p=.01 indicates probability of 1% that the effect occurred by chance and a value of p=.001 indicates

judicial officers answered this question in the affirmative 88% of the time.²⁶

The second statement was, "I feel like the court I work in is helpful to the litigants/defendants who appear there." Both groups of judges also felt that their courts were helpful to the people who appeared there before them; however, the drug treatment court judicial officers scored significantly higher (average=4.35) than the family law court judicial officers (average =4.09) on this question.²⁷

In response to the statement "I have seen the litigants/defendants make significant improvement in their lives," there was also a significant difference between the drug treatment court group (average=4.58) and the family law court group (average=3.71).²⁸ While 92% of the drug treatment court judicial officers reported seeing improvement in those appearing before them, only 56% of the family law court judicial officers responded similarly. The non-judicial personnel from the drug treatment court also responded significantly more often that they believe their courts are helpful and witness improvement in the litigants.

A drug treatment courtroom clerk had this to say:

I am part of the solution. Before Drug Court there was a feeling that there were a lot more probation violations and offenders and I would feel, 'Here they are again. They're back.' I feel confident that I won't see graduates [from the Drug Treatment Court] again and the caseload will be less. I am in touch with the community with Drug Court and I know the faces and names of the defendants who are actually smiling and happy.

TABLE NO. 1 WITNESS OF LITIGANT IMPROVEMENT (N=183*)			
	No	Sometimes	Yes
(answers)	(1,2)	(3)	(4,5)
Drug Treatment Court (n=87)	0	8%	92%
Family Law Court (n=96)	4%	40%	56%

* 11 missing responses

Working relationships among the personnel in the courtroom were also addressed. Both the drug treatment court and family law court judicial officers perceived that their courtrooms worked in a teamlike fashion. However, there is a difference in the way the non-judicial professionals view their

.1% probability of a chance occurrence. Statistically, a significant difference is important because it allows a mathematical inference that the differences found between these particular drug treatment court and family law court respondents would be present in a larger population of similar participants.

26. The percentage figures for survey responses were calculated as follows: responses of 1 and 2 were coded as "NO"; responses of 3

courtroom relationships. The drug treatment court professionals indicated that there was more teamwork in their courtrooms than did the family law court professionals.²⁹

Both the drug treatment court and family law court judicial officers felt respected by their co-workers. There was, however, a difference between the responses of each court's non-judicial professionals: the drug treatment court group felt significantly more respect from their co-workers than the family law court group.³⁰

ATTITUDE TOWARD LITIGANTS/DEFENDANTS

The next set of statements dealt with the respondents' attitudes toward the litigants. There were significant differences between the drug treatment court judicial officers and the family law court judicial officers in every question about their attitudes toward those appearing in their courtrooms.

The first statement was, "I believe that the litigants/defendants are really trying hard to solve their problems and improve their lives." The drug treatment court judicial officers seemed more convinced that the individuals in their courts were working hard to solve their problems, while the family law court judicial officers did not express this view. Neither group of judicial officers ranked remarkably high in their view of litigant motivation; however, the drug treatment court responses were significantly higher (average=3.79) than the family law court responses (average=3.08) in this respect.³¹ Fifty-seven percent of the drug treatment court group believed that the litigants were genuinely working to solve their problems. Another 43% of this group expressed the belief that the litigants are making an effort at least some of the time. No drug treatment court respondents thought that the litigants completely lacked motivation to address their problems. Comparatively, only 18% of the family law court respondents felt that the litigants were trying to make progress; 74% reported that they saw this motivation in litigants at least some of the time; and 8% reported that litigants were simply not trying at all.

TABLE NO. 2 LITIGANT MOTIVATION (N=184*)			
	No	Sometimes	Yes
(answers)	(1,2)	(3)	(4,5)
Drug Treatment Court (n=89)	0	43%	57%
Family Law Court (n=95)	8%	74%	18%

* 10 missing responses

were coded as "SOMETIMES"; responses of 4 and 5 were coded as "YES."

- 27. F= 4.94 p=.03
- 28. F= 64.69 p=.0001
- 29. F= 4.85 p=.03
- 30. F= 3.84 p=.05
- 31. F= 51.98 p=.0001

The second statement was, "I believe that the litigants/defendants have a good chance for improvement if they are given some help by the court." The drug treatment court judicial officers were significantly more hopeful (average=4.27) than the family law court judges (average=3.68) that the litigants in their courtrooms could make significant improvements if provided with some help from the court.³² The drug treatment court group expressed hope for the litigants' prospects for improvement 84% of the time while the family law court group reported such hopefulness only 54% of the time. All of the drug treatment court judicial officers had at least some hope for the litigants; however, 3% of family law court judicial officers saw no hope at all for improvement in their litigants.

**TABLE NO. 3
HOPE FOR LITIGANT
(N=185*)**

(answers)	No (1,2)	Sometimes (3)	Yes (4,5)
Drug Treatment Court (n=89)	0	16%	84%
Family Law Court (n=96)	3%	43%	54%

* 9 missing responses

The next statement was, "I feel I am respected by the litigants/defendants." The drug treatment court judicial officers (average=4.45) felt significantly more respected by the individuals who appear in front of them than the family law court judicial officers (average=3.89).³³ Ninety-two percent of the drug treatment court group reported that they felt respected by the litigants while only 72% of the family law court group felt respected by litigants.

**TABLE NO. 4
RESPECTED BY LITIGANTS
(N=184*)**

(answers)	No (1,2)	Sometimes (3)	Yes (4,5)
Drug Treatment Court (n=88)	0	8%	92%
Family Law Court (n=96)	1%	27%	72%

* 10 missing responses

The most significant difference between the two groups was in their responses to the statement, "I feel that the litigants/defendants are grateful for the help our court is providing to them." The drug treatment court group perceived gratitude from the litigants far more frequently (average=4.21)

32. F= 28.12 p=.0001
 33. F= 33.68 p=.0001
 34. F= 70.57 p=.0001

than did the family court group (average=3.34).³⁴ The drug treatment court judicial officers perceived the litigants as grateful for the help that they had received from the court 81% of the time. In the family law court group, only 33% felt that the litigants were grateful for help received from the court.

**TABLE NO. 5
LITIGANT GRATITUDE
(N=184*)**

(answers)	No (1,2)	Sometimes (3)	Yes (4,5)
Drug Treatment Court (n=88)	1%	18%	81%
Family Law Court (n=96)	4%	63%	33%

* 10 missing responses

Additional differences were found in the responses to the statement, "I admire the litigant/defendants for their efforts in trying to change their lives for the better." The drug treatment court judicial officers were significantly more admiring (average=4.37) than the family law court judicial officers (average=3.69) of efforts made by the litigant/defendants to change their lives for the better.³⁵ Of the drug treatment court group, 86% expressed admiration for the litigants. In the family law court group, only 55% reported that they admired the litigants for their efforts. The non-judicial drug treatment court professionals were also significantly more likely than those in the family law court group to admire the litigant/defendants for their efforts to change their lives for the better.³⁶ One drug treatment court judge added the comment: "I have a great respect for what our participants accomplish; I don't even have the ability to stay on a diet."

**TABLE NO. 6
ADMIRE LITIGANTS' EFFORTS
(N=178*)**

(answers)	No (1,2)	Sometimes (3)	Yes (4,5)
Drug Treatment Court (n=83)	0	14%	86%
Family Law Court (n=95)	7%	38%	55%

* 16 missing responses

POSITIVE EFFECT OF JUDICIAL ASSIGNMENT

Other statements were included to elicit responses pertaining to personal beliefs about being influenced by one's court assignment. Significantly more drug treatment court judicial officers enjoyed talking with family and friends about their work,³⁷ were

35. F= 30.46 p=.0001
 36. F= 11.9 p=.001
 37. F= 40.66 p=.0001

happier in their assignments,³⁸ and felt more pride in their work³⁹ than those from the family law court. Drug treatment court judicial officers were slightly less likely than family law court judicial officers to think they might want to transfer to another assignment; however, neither group exhibited much motivation to change assignments. Nevertheless, drug treatment court judicial officers were significantly more likely (average=4.48) than family law court judicial officers (average=3.76) to feel that they had been positively affected by their judicial assignments.⁴⁰ Ninety-one percent of judicial officers in the drug treatment court group reported feeling that their assignment had affected them in a positive way emotionally. Family law court judicial officers felt this way only 64% of the time.

A California drug treatment court judge said:

[I]t's a passion and working with passion is more energizing and worthwhile. . . . I have become more honest and direct in my dealings with others and myself which is a tremendous growth. One reason is that you cannot ask others to be honest without being honest yourself. . . .

[W]orking with a team has increased my skills in that area. My leadership skills have sharpened. Best of all, I am a happier person because I believe that what we are doing in our DTC is making a difference.

Another California drug treatment court judge said she would have left the bench had it not been for Drug Treatment Court:

My involvement with drug court is the most meaningful contribution I have made in my life other than raising my children. . . . I would have quit this job without drug court. I love my job because of drug court. Drug court gives meaning in my life; I am part of a solution rather than part of the problem

FACTORS MOST ASSOCIATED WITH POSITIVE AFFECT OF JUDICIAL ASSIGNMENT

In drug treatment courts the three answers most highly correlated to the feeling that the "judicial assignment was beneficial" were: (1) "litigants are grateful for the help they received";⁴¹ (2) "witnessing the litigants improve";⁴² and (3) "hope for litigant improvement."⁴³ For the family court judicial officers, the order was: (1) "belief that the court is helpful";⁴⁴ (2) "feeling admiration for the efforts of the litigants";⁴⁵ and (3) "feeling that the litigants were grateful for the help they received."⁴⁶ Overall, it was found that the most common predictor of positive emotional effect was the perception by the judicial officers that the "litigants are grateful for the help they are given by the court."⁴⁷

INCREASED INSIGHT AND MOTIVATION FOR HEALTHY CHANGE

The final set of statements were designed to measure insight and motivation for healthy change. Thirty-seven percent of the drug treatment court judicial officers indicated that they had learned a lot about domestic violence from working in their assignment and 95% had reported learning about alcoholism/addiction. Of the family law court judicial officers, 70% reported learning a lot about domestic violence and 57% reported learning about substance abuse. Given the correlation between substance abuse by both the perpetrator and the victim in domestic violence cases, it appears that more training needs to be done in this area.⁴⁸

Twenty percent of both family law court and drug treatment court judicial officers responded that they had gained some insight into their own personal problems. Overall, the drug treatment court professionals (both judicial and non-judicial) far more frequently than the family law court professionals (both judicial and non-judicial) have discovered their own addiction during their court assignments,⁴⁹ have stopped drinking or using other substances,⁵⁰ or have stopped smoking.⁵¹ These differences were more pronounced in the non-judicial professionals than in the judicial officers. However, the drug treatment court judicial officers were still significantly more likely to have stopped drinking or using other substances than the family law court judicial officers.⁵² There was no significant difference between the drug treatment court and family law court groups with regard to diet and exercise.

DISCUSSION

All groups of judicial officers agreed that part of their job is to help those appearing before them solve the problems that brought them to court. Likewise, both groups felt that their

TABLE NO. 7
AFFECTED POSITIVELY BY ASSIGNMENT
(N=177*)

(answers)	No (1,2)	Sometimes (3)	Yes (4,5)
Drug Treatment Court (n=82)	1%	8%	91%
Family Law Court (n=95)	11%	25%	64%

* 17 missing responses

- 38. F= 10.01 p=.002
- 39. F= 6.1 p=.01
- 40. F= 31.70 p=.0001
- 41. r = .56 p=.0001
- 42. r = .49 p=.0001
- 43. r = .44 p=.0001
- 44. r = .34 p=.0007
- 45. r = .33 p=.0009
- 46. r = .30 p=.003
- 47. r = .52 p=.0001

- 48. Using self-reports of substance abuse from assailants and victims, one study found that nearly all of the assailants (94%) and almost half of the victims (43%) used alcohol or other drugs in the six hours prior to the assault. See Daniel Brookoff, Drug Use and Domestic Violence (unpublished National Institute of Justice Research in Progress Seminar Series) (1996).
- 49. F= 7.21 p=.008
- 50. F= 10.96 p=.001
- 51. F=4.53 p=.04
- 52. F= 3.97 p=.05

courts were helpful to the litigants. However, the drug treatment court group was far more likely to report actually getting to witness changes for the better in their litigants. For this group, seeing the litigants improve was highly correlated with viewing their judicial assignment as positive. The drug treatment courts commonly use frequent reviews as part of the therapeutic strategy. This allows the judicial officers to see the litigants on an ordered, routine basis and view their progress. Such is not the case in most family law courts. For the most part, the only time the family law court judicial officers have contact with their litigants is when something has gone wrong. The opportunity to see the effect of the court on the litigants provides the drug treatment court judicial officers with positive feedback about their work and may serve to relieve stress.⁵³

The greatest difference between the drug treatment court and the family law court judicial officers was in their attitude toward the litigants. The drug treatment court judicial officers expressed a far more positive attitude toward those appearing before them. They were more likely to believe that the litigants were actually trying to solve their problems and had a good chance for improvement if given some help from the court. They felt more respected by the litigants, were more likely to feel that the litigants were grateful for the help they received from the court, and were more likely to admire the litigants for their efforts.

Perception of litigant gratitude was the most important overall predictor of feeling positively about the judicial assignment. This suggests that recognition by the litigants of the help they have received is an important part of the helping process and that the effect on both judicial officer and litigant is dependent on the relationship between them. It has been a principle in the drug treatment court literature that the therapeutic effect on the litigant is dependent on the relationship that develops with the judicial officer. Interestingly, this survey suggests that the judicial officers' satisfaction in their work also is a product of the relationship with the litigant. The greatest difference between these two groups of judicial officers is in the perception of litigant gratitude. The family law court group scored remarkably low in this category. Perhaps predictably, the drug treatment court respondents were far more likely than those in the family law court group to report that their assignments had affected them positively.

CONCLUSION

As a final observation, it must be stated that the enthusiasm of drug treatment court professionals for their work is not only infectious but is almost unheard of in a profession which experiences a high degree of "burnout" and job dissatisfaction.⁵⁴ Still, therapeutic jurisprudence is a relatively young field, and much research remains to be done.⁵⁵

For example, there are other factors affecting judicial satisfac-

tion that differentiate drug treatment courts and family law courts and seem to exist independently from the application of therapeutic jurisprudence. The family law court is a civil court in which the two parties are emotionally involved in an inability to resolve their differences. The emotional dynamics of the adversarial system in a criminal court is different when one of the parties is the state. Another difference is that litigants are entitled to attorneys in the criminal court; in family law court, however, the litigants frequently appear pro se. It has also been suggested that family law litigants appear less sympathetic because their actions are often harmful to others, such as in domestic violence or contested custody cases. Of course, drug treatment court defendants, while being basically harmful to themselves, do inflict injury on others as well. Another difference is that the drug treatment court assignment is usually self-selected by judicial officers. For the most part, this is not true for the family law judicial officers. Family law courts are routinely understaffed, underfunded, and are not high-ranking in the judicial status hierarchy. Consequently, family law judicial assignments are frequently entry-level positions of short duration, usually held by those who are younger and have less experience.⁵⁶

Future research is needed to assess the significance of these and other factors in relation to the questions we have posed herein. It would be helpful, for example, to survey a group of family law court judicial officers who are actually working in therapeutic courts, either in the increasing number of therapeutic civil domestic violence courts or from a jurisdiction that employs a unified family court system. Likewise, it would be informative to survey a group of criminal court judicial officers that work in a traditional criminal justice setting.

The study of judicial satisfaction is important because it can be used as an indicator of the efficacy of the court. This research suggests that if, indeed, the work of the court is beneficial to the litigants, this success will express itself in the attitudes of judges and other court professionals with regard to their own job satisfaction. If the work of the court results in fewer criminal cases or fewer protracted family law litigations, both litigants and the court benefit. If stress reduction and job satisfaction result in improved mental and physical health for judges, such benefits are both personal and systemic. Moreover, the ambiance in a courtroom where the judge is happy and satisfied provides an atmosphere in which the litigants are more likely to be comfortable and perform at their maximum. Recognition of the relationship between a judge's perception of litigant gratitude and his or her own job satisfaction shows that judges, too, remain social and human, even while on the bench. It is also believed that the therapeutic effects of these new types of courts, which employ the social sciences and are orientated to problem solving, not only will continue to have beneficial effects on the litigants and court personnel, but also will result in an increased quality of justice for all.

53. Zimmerman, *supra* note 8.

54. See generally, the work of Susan Daicoff, Associate Professor of Law, Capital University Law School, Columbus, Ohio, on lawyer job satisfaction, mental health, and alcoholism/addiction at <http://users.law.capital.edu/sdaicoff> (last visited April 1, 2000). See also, Isaiah Zimmerman, *supra* notes 8 and 12; and Isaiah

Zimmerman, *Dealing With Professional Stress: Insights for Judges*, 31 THE BOSTON B.J. Nov./Dec. 1987, at 39.

55. Professor David Wexler first used the term in 1987 in a paper delivered to the National Institute of Mental Health. The concept began to appear frequently in law literature only in the early 1990s. Hora et al., *supra* note 2.

56. Ross, *supra* note 18.



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Peggy Fulton Hora was elected to the Municipal Court of Alameda County, California, in 1984 and has served as that Court's presiding judge, president of the California-Nevada Women Judges, on numerous planning committees, and as a faculty member for California Judicial Education and Research (CJER). She was dean of the B.E. Witkin Judicial College of California in 1997 and 1998. When the courts consolidated in 1998, Judge Hora became a member of the Alameda County Superior Court. She has taught courses concerning alcohol and other drugs and courts for both the California Judicial College and the National Judicial College; has presented at national alcohol and other drug conferences; and has lectured all over the United States and internationally. She has published a number of articles on substance abuse, with a particular emphasis on pregnant and parenting women, drug treatment courts, and therapeutic jurisprudence.

Editor's note: The survey instrument used in the research reported in this article is reprinted in its entirety at page 20.

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APPENDIX DRUG COURT PROFESSIONALS SURVEY

JOB TITLE: _____ ___ MALE ___ FEMALE AGE: _____

Total years spent in your profession _____ Time in your current assignment _____

This is part of a study about working in the court. Your answers to the following items are anonymous; please do not put your name on this questionnaire. Please answer each question using the 1 to 5 response scale indicated below.

	Very untrue of me OR strongly disagree	Not true of me OR disagree	Sometimes true and sometimes not true OR undecided	True of me OR agree	Very true of me OR strongly agree
1) I believe that part of our job is to help the litigants/defendants work to solve the problems that brought them to our court.	1	2	3	4	5
2) I feel like the court I work in is helpful to the litigants/defendants who appear there.	1	2	3	4	5
3) I have seen litigants/defendants make significant improvement in their lives.	1	2	3	4	5
4) I believe that the litigants/defendants are really trying to solve their problems and improve their lives.	1	2	3	4	5
5) I believe that the litigants/defendants have a good chance for improvement if they are given some help from the court.	1	2	3	4	5
6) I feel that the judge and other members of our court staff work together as a team.	1	2	3	4	5
7) The judge in our court often talks to staff about the cases.	1	2	3	4	5
8) I feel respected by the other members of my court's staff, including the judge.	1	2	3	4	5
9) I feel that I am respected by the litigants/defendants.	1	2	3	4	5
10) I feel that the litigants/defendants are grateful for the help our court is providing to them.	1	2	3	4	5
11) I admire the litigants/defendants for their efforts in trying to change their lives for the better.	1	2	3	4	5
12) I feel I have been affected in a positive way emotionally by my work in this assignment.	1	2	3	4	5
13) I enjoy discussing my work with family and friends.	1	2	3	4	5
14) I feel proud of what I am doing at work.	1	2	3	4	5
15) I feel happier in this assignment than I have in others I have had.	1	2	3	4	5
16) I think I would rather go to another assignment or job.	1	2	3	4	5
17) As a result of this assignment I have learned a lot about domestic violence.	1	2	3	4	5
18) As a result of this assignment I have learned a lot about alcoholism and drug addiction.	1	2	3	4	5
19) As a result of this assignment I feel I have gained some insight into personal problems I have been struggling with.	1	2	3	4	5
20) Since I have been working in this court:					
a. my relationship with my significant other has improved.	1	2	3	4	5
b. I have discovered I was an alcoholic/addict.	1	2	3	4	5
c. I have stopped drinking or using other substances.	1	2	3	4	5
d. I have stopped smoking.	1	2	3	4	5
e. I have been trying to eat a healthier diet.	1	2	3	4	5
f. I have been trying to exercise more.	1	2	3	4	5

INDICATORS OF CO-OCCURRING MENTAL HEALTH DISORDERS

- A history of unstable relationships, divorce, and/or cutoffs.
- A history of being underemployed or consistently unemployed in spite of talent, education, and ability, and often an inexplicable but consistent difficulty in finishing things no matter how enthusiastically started.
- Frequent changes of residence, sometimes across the country, with the hope of “starting over.”
- A past with many unresolved and profound resentments about how unfairly one has been treated, a “victim” stance with a lack of accountability or responsibility for one's own actions, creating the undesired result.
- Inability to succeed at a task or goal in spite of repeated efforts and adequate information.
- A habit of resistance and questioning when an authority figure – manager, supervisor, spouse, parent, judge, police or probation officer gives directions to be followed.
- Periods of having “the blues” without an obvious medical or emotional reason.
- Self-destructive thoughts and/or actions like starving, overeating, overspending, causing meaningless but repetitive and harmful arguments with loved ones, cutting or hurting oneself, or drinking or using drug or sex to damaging excess.
- Frequent trips to emergency rooms, arrests for driving under the influence or for other drug-related charges or any ongoing pattern of painful drama in one's life is often indicative of the negative consequences of an untreated dual disorder.
- Difficulty falling asleep or staying asleep accompanied by frequent insomnia in the early morning hours.
- Fatigue and exhaustion in the morning and unwillingness to face the day.
- Troubling and seemingly unresolvable problems returning again and again to one's thoughts, as if they had a life of their own.
- Periods of euphoria, feeling powerful and capable of anything imaginable, any grand scheme, no matter how unrealistic, along with high energy and little need for sleep.
- A joylessness to life with little reason for laughter, a sense that things are just “gray” and will always be that way, no matter how hard I try, no matter what I do.
- Inability to feel genuine satisfaction with oneself and one's accomplishments despite praise or adulation from others.
- Saying things one believes are meant to be funny, but which are deeply hurtful or anger producing in others – with accompanying losses and loneliness always.
- Difficulty understanding the impact of one's behavior on others, a sense of nothing “being real.”

Judging for the New Millennium

William Schma

Quickly complete this sentence: "The role of the law in society is _____." If you thought "to heal," close this journal and go to your next. You won't find much here you haven't thought about. Everyone else, read on to explore an emerging role for courts and judges in this new millennium.

The topic of this special issue of *Court Review* is "Therapeutic Jurisprudence," or "TJ" as it is commonly known. No single definition of TJ captures it fully.

One author offers the following definition as best capturing the essence of TJ: "the use of social science to study the extent to which a legal rule or practice promotes the psychological and physical well-being of the people it affects."¹ It is the study of the role of law as a healing agent, and it offers fresh insights into the role of law in society and those who practice it.

TJ can be thought of as a "lens" through which to view regulations and laws as well as the roles and behavior of legal actors—legislators, lawyers, judges, administrators. It may be used to identify the potential effects of proposed legal arrangements on therapeutic outcomes. It is useful to inform and shape policies and procedures in the law and the legal process. TJ posits that, when appropriate, the law apply an "ethic of care" to those affected.

TJ does not "trump" other considerations or override important societal values such as due process or the freedoms of speech and press. It suggests, rather, that mental and physical health aspects of law should be examined to inform us of potential success in achieving proposed goals. It proposes to consider possible negative psychological effects that a proposal may cause unwittingly. TJ doesn't necessarily dominate, but

rather informs and in so doing provides insight and effective results. Such considerations enter into the mix to balance when considering a law, or a legal decision, or course of legal action.

It is important for judges to practice TJ because—like it or not—the law does have therapeutic and anti-therapeutic consequences. This is empirical fact. Consider the following situations; they are familiar to judges.

In busy dockets, it is common for judges to accept "no contest" or *nolo contendere* pleas in sex offense cases in lieu of a guilty plea. TJ will not dictate whether a judge should do this or not. It will, rather, ask the judge to consider the therapeutic effects that may follow as a consequence of such a plea. They may be considerable, because in the case of sex offenders a *nolo* plea may reinforce a process of denial that will frustrate the offender's rehabilitation. If the offender does not have to admit the crime to the judge, he or she may more easily deny it later to a probation officer or sex abuse counselor. Anti-therapeutic consequences such as frustration of rehabilitation and return to abusive behavior may result from the judge's acceptance of the plea. Ironically, this process would be started by the judge—the very person society most expects to promote the rule of law.

The same may be said of criminal cases involving an addiction to alcohol or other drugs. The biggest hurdle that an addict or alcoholic usually must overcome is denial. It is difficult to admit affliction with an uncontrollable disease, especially one to which our society has attached moral overtones. Nevertheless, those experienced with recovery know that this admission is critical. If, for whatever reason, a judge accepts a *nolo* plea in such a case and does not require

the defendant to confront his or her addiction openly, the judge misses a critical "therapeutic moment." Moreover, as in the case with sex offenders, the judge may have set in motion a course of denial that will virtually guarantee the failure of subsequent rehabilitation efforts and the eventual return of the offender to the system.

Consider this final example: the role of apology in tort law. Practitioners familiar with medical malpractice cases know that many plaintiffs only want an apology from their health care provider for the adverse outcome they experienced. A lawsuit is the furthest action on their mind. And for negligent care providers, an apology for a regrettable mistake would be a therapeutic event. Unfortunately, some professional insurance practices prohibit an insured from having any contact with a patient who may file a claim. There is a good reason for this from the standpoint of the insured and the insurer: a non-privileged admission could end up in court as a *coup de grace*. The anti-therapeutic result, however, can be that the patient is deprived of what the patient may want most, and the health care provider cannot take necessary steps to cleanse his or her mind and return to productive work. Moreover, because the provider is forced by the law into a position of denial, the likelihood of reoccurrence increases.

TJ first identifies these anti-therapeutic elements that might otherwise go unexplored. Next, it asks whether an action could be taken to avoid them without "trumping" the established legal principles involved. It proposes such action and methods to evaluate it. TJ is, therefore, not merely a speculative exercise, but rather action-oriented. It seeks tangible results.

Permit me to describe some personal

Footnotes

1. Christopher Slobogin, *Therapeutic Jurisprudence: Five Dilemmas to Ponder*, 1 PSYCHOL., PUB. POL. AND LAW 193, 196 (1995).

experience I have had in each of these areas to demonstrate how TJ applies. For more than five years I have refused to routinely accept *nolo* pleas in felony sexual abuse cases. Once my practice became known among local lawyers, no defendant has refused to go forward with a guilty plea. The attorneys prepare their clients for this in advance if they are in my court. (This suggests, of course, the significant role lawyers play to prepare clients for therapeutic or anti-therapeutic court experiences, but that is a separate topic I leave for another day.) Moreover, since then I have never had a sexual abuser appear at sentence and deny to me that he or she committed the crime. Nor have I received a single letter from a family member denying that the defendant was capable of such an act. These were routine when I accepted *nolo* pleas. As a result, at sentencing, I can confront defendants much more effectively with the reality of their behavior and the wrongfulness of their conduct. This result is also more therapeutic for victims of such crimes.

Beginning in 1992, I presided over a drug treatment court in my community. A drug court diverts certain non-violent, substance-abusing criminal defendants from the traditional adversarial criminal justice system into treatment and rehabilitation. Since then, more than 800 adult felony offenders addicted to alcohol or other drugs have been enrolled in this program. Fifty-five percent of women and 64% of men remain engaged in their recovery while they are in the program. The recidivism rate of participants is less than 15%. For graduates, it is less than 2%. This drug court and more than 400 others across the country apply TJ principles to criminal justice.

Recently in my court, I have experimented in medical malpractice cases

with what I call "good faith conferences." As part of the settlement of two cases, one involving a death, a meeting was held between the interested parties, including the plaintiff or the family of the deceased and the physician-defendant. Attorneys were present at both conferences. One was held in my presence; the other occurred in the office of a neutral, experienced personal injury attorney. All participants agreed that anything said could not be used for any purpose. During these conferences, each side was permitted to speak about the feelings they had experienced because of the perceived malpractice and the lawsuit. The physicians explained why they had done what they had believed to have been medically appropriate in the circumstance, yet apologized to the family or plaintiff. Patients and their families expressed frustration and anger over everything from the physician's attitude to the care administered. The results have been mixed. However, the attorneys involved—all experienced in medical malpractice—and I agree that this method of dispute resolution meets significant litigant needs and is worth further refinement. But for the Therapeutic Jurisprudence movement, this project may never have occurred.

These are not radical concepts; they are mainstream. They do give a fresh perspective on honored principles of the legal profession. Abraham Lincoln advised lawyers (and presumably judges): "Discourage litigation. Persuade your neighbor to compromise wherever you can. . . . As a peace-maker, the lawyer has a superior opportunity of being a good man."² Roscoe Pound spoke of "sociological jurisprudence," arguing that law must look to the relationship between itself and the social effects it creates.³ Oliver Wendell Holmes

said "the life of the law has not been logic: it has been experience," and he noted that the practical necessities of the times have always shaped the rules of law and the legal practices of a given age.⁴

At a presentation to the annual meeting of the National Association for Court Management in 1996, the need to become "more therapeutic" in outcome was described as one of the top ten issues facing the courts in the future.⁵ In 1996, in a cover story in the American Bar Association *Journal* entitled, "The Lawyer Turns Peacemaker," the author noted public dissatisfaction with the justice system and argued for the need to apply a more therapeutic approach to litigation so that the parties' feelings of anger, resentment, or rejection could give way to a healing process.⁶

Recently, David Rottman and Pamela Casey, staff members of the National Center for State Courts and frequent authors on this topic, observed that courts are moving towards a "problem-solving" orientation to their responsibilities and forming problem-solving partnerships to address more effectively the complex social problems that have come to dominate their dockets in recent years.⁷ The Commission on Trial Court Performance Standards also raised the level of court consciousness on these matters through its Trial Court Performance Standards. Standard 3.5 is: "The trial court takes appropriate responsibility for the enforcement of its orders. No court should be unaware of or unresponsive to realities that cause its orders to be ignored."⁸ And Standard 4.5 states:

The trial court anticipates new conditions and emergent events and adjusts its operations as necessary. Effective trial courts are responsive to emergent public

2. Abraham Lincoln, in QUOTE IT! MEMORABLE LEGAL QUOTATIONS, 429-430 (Eugene Gerhart, ed. 1987).

3. Roscoe Pound, *The Scope and Purpose of Sociological Jurisprudence*, 25 HARV. L. REV. 140 (1912).

4. Oliver Wendell Holmes, in THE SOCIOLOGY OF LAW 4 (James Simon, ed. 1968).

5. Francis Gavin and James Thomas, *The Top Ten Issues Facing State Courts in 1996 and What You Can Do About Them*, Workshop at Eleventh Annual Conference, National Association for Court Management, Albuquerque, New Mexico, July 18, 1996.

6. Richard Reuben, *The Lawyer Turns Peacemaker*, 82 A.B.A. J.,

August 1996 at 54.

7. David Rottman & Pamela Casey, *A New Role for Courts?*, NAT'L INST. JUST. J., July 1999 at 12.

8. TRIAL COURT PERFORMANCE STANDARDS WITH COMMENTARY 16 (Bureau of Justice Assistance, 1997). For more information about the Trial Court Performance Standards, see Pamela Casey, *Defining Optimal Court Performance: The Trial Court Performance Standards*, COURT REVIEW, Winter 1998 at 24 [available on the Web at <http://aja.ncsc.dni.us/courtrv/cr35-4/CR35-4Casey.pdf> (last visited March 26, 2000)].

issues such as drug abuse, child and spousal abuse, AIDS, drunken driving, child support enforcement, crime and public safety, consumer rights, gender bias, and the more efficient use of fewer resources. A trial court that moves deliberately in response to emergent issues is a stabilizing force in society and acts consistently with its role of maintaining the rule of law.⁹

There is already significant judicial leadership in this movement. Judith S. Kaye, Chief Judge of New York, wrote recently about the emergence of what she called “hands-on courts.” She made these useful observations:

In these new courts, judges are active participants in a problem-solving process What’s so different about this approach? First is the court’s belief that we can and should play a role in trying to solve the problems that are fueling our caseloads. Second is the belief that outcomes—not just process and precedents—matter.¹⁰

In a speech at the Holocaust Museum in 1997, Justice Richard J. Goldstone of the Constitutional Court in South Africa described this same role this way: “One thinks of justice in the context of deterrents, of retribution. But too infrequently is justice looked at as a form of heal-

ing.”¹¹ That healing role is at the heart of TJ, as noted by Michael D. Zimmerman, a member of the Utah Supreme Court and its former chief justice.¹² He called for “involved judging” in which “judges and courts assume a stronger administrative, protective, or rehabilitative role toward those appearing before them, that they become more involved in what some have termed ‘therapeutic jurisprudence.’”¹³ He recognized that this was a “new cultural reality” for most judges.¹⁴ Yet he pointed out that it will not go away, and, unless we craft our own response, it will be thrust upon us by society.¹⁵

TJ acknowledges that the healing roots of the legal profession can be in tension with our highly developed adversarial system and with our emphasis on process. As David Wexler, co-founder with Bruce Winick of the school of TJ, has pointed out, the adversarial nature of our system has legitimate and crucial value for critical thinking. However, the legal system suffers from a culture of adversarial representation and relationships, in which argument rises to the level of a privileged status.¹⁶ This can obscure many important societal values that the legal system need not and should not ignore, such as outcome, social harmony, and the ethic of care. TJ is receiving attention precisely because it requires that we recognize such values, balance them with others, and make choices. Practitioners are discovering

that TJ strikes a resonant chord in the legal system and community for beneficial and sensible outcomes of problems that come to light in legal trappings.

Judges must take the lead and assume appropriate responsibility for these issues. If we do not, as Justice Zimmerman observed, they may be resolved without us.¹⁷ More important, we will have failed in our responsibility as leaders. We will reap the resulting public disaffection with us and the system we supervise. We’ll deserve it.



William G. Schma was appointed as a Kalamazoo County (Mich.) Circuit Court Judge in 1987. He was elected in 1988 and re-elected in 1990 and 1996. He has lectured, published articles and law reviews, and made presentations on substance abuse and criminal justice, drug treatment courts, and Therapeutic Jurisprudence. Judge Schma has presided over the Kalamazoo County Substance Abuse Diversion Program, a diversion program for felony substance abusers. He is a founding member of the National Association of Drug Court Professionals, and he is past president of the Michigan Association of Drug Court Professionals.

9. TRIAL COURT PERFORMANCE STANDARDS WITH COMMENTARY, *supra* note 8, at 20.
10. Judith S. Kaye, *Making the Case for Hands On Courts*, NEWSWEEK, Oct. 11, 1999, at 13 [available on the Web at http://www.newsweek.com/nw-srv/printed/us/dept/my/my0115_1.htm (last visited March 26, 2000)].
11. Richard Goldston, speech given at the Holocaust Museum, Washington, D.C. (Jan. 27, 1997).
12. Michael Zimmerman, *A New Approach to Court Reform*, 82

- JUDICATURE 108 (1998).
13. *Id.* at 109.
14. *Id.* at 109-10.
15. *Id.* at 110.
16. David Wexler, *Therapeutic Jurisprudence and the Culture of Critique*, 10 J. CONTEMP. LEGAL ISSUES 263 (1999).
17. Zimmerman, *supra* note 12, at 110 (“We can choose to be the agents of innovation, or the subjects of innovation.”).

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Mental Health Webliography

Prepared by Hon. Peggy Fulton Hora, Alameda County Superior Court, Hayward, CA

American Academy of Child and Adolescent Psychiatry

www.aacap.org

A public service offering information about developmental, behavioral, and mental disorders which affect children and adolescents.

American Psychiatric Association

www.psych.org

Home page of the American Psychiatric Association, a medical society specializing in the diagnosis and treatment of mental and emotional illnesses and substance abuse disorders.

American Psychological Association

<http://helping.apa.org>

A comprehensive help center designed to help psychologists, students, and the general public access mental health information and services.

Anxiety Disorders Association of America

www.adaa.org

Home page of the Anxiety Disorders Association of America, a non-profit organization that promotes the prevention and cure of anxiety disorders.

Centre for Addiction and Mental Health

www.camh.net

The Centre for Addiction and Mental Health is a public hospital providing direct patient care for people with mental health and addiction problems.

Consumer Organization and Networking Technical Assistance Center

www.contac.org

A national technical assistance center which serves as a resource center promoting self-help, recovery, and empowerment.

Depression and Related Affective Disorders Association (DRADA)

www.med.jhu.edu/drada/index.html

A web site offering information on depressive illness and manic-depressive illness.

Dual Diagnosis Website

<http://users.erols.com/ksciacca/>

This site is designed to provide information and resources for service providers, consumers, and family members who are seeking assistance and/or education in the field of dual diagnosis.

Freedom From Fear (Anxiety disorders)

www.freedomfromfear.org

A national not-for-profit mental health association offering aid and counsel to those who suffer from anxiety and depressive illness.

Internet Mental Health Diagnosis

www.mentalhealth.com/fr.71.html

Online diagnosis of the 37 most common mental disorders.

Mental Health Infsource

www.mhsource.com

Home page of Mental Health Infsource, offering information and educational resources for primary care and mental health professionals.

Mental Help Net

www.mentalhelp.net

Home page of Mental Help Net, a non-profit company offering a comprehensive source of online mental health information, news, and resources.

National Alliance for the Mentally Ill

www.nami.org

A grassroots organization of consumers, families, and friends of people with severe mental illnesses.

National Empowerment Center, Inc.

www.power2u.org

This web site is filled with practical information for those who have been labeled with a mental illness.

National Mental Health Association

www.nmha.org

Home page of the National Mental Health Association, a nonprofit organization addressing all aspects of mental health and mental illness.

National Mental Health Consumers' Self-Help Clearinghouse

www.mhselfhelp.org

A consumer-run national technical assistance center serving the mental health consumer movement.

National Mental Health Services Knowledge Exchange Network (KEN)

www.mentalhealth.org

The Center for Mental Health Services (CMHS) Knowledge Exchange Network (KEN) provides information about mental health.

Obsessive Compulsive Foundation

<http://ocfoundation.org/>

Home page of the Obsessive-Compulsive Foundation, a not-for-profit organization of people with obsessive compulsive disorders and related disorders.

Practitioner Resources in Substance Abuse & Co-Occurring Disorders

www.athealth.com/Practitioner/

Provides information and services for mental health practitioners and those they serve

Schizophrenia Wellness Center

[http://www.medscape.com/pages/editorial/resourcecenters/public/schizophrenia/r
c-schizophrenia.ov](http://www.medscape.com/pages/editorial/resourcecenters/public/schizophrenia/rc-schizophrenia.ov)

The latest psychiatric and medical news on Schizophrenia

Judicial Education on Substance Abuse

PARTICIPANT MATERIALS

A project of the American Judges Association and the National Center for State Courts with funding from the State Justice Institute.



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POSSIBLE ALCOHOL AND OTHER DRUG PROBATION CONDITIONS¹

Formal/court probation Supervised OR release

Jail/prison time Work furlough, electronic leash, home detention, SWAP (Sheriff's Work Alternative Program) volunteer work

Mental health Evaluation, counseling, battered women/PTSD, sexual abuse, grief, parenting classes, take all psychiatric medicine

Treatment In-/Out-Patient, clean & sober living, 12-Step (AA, NA, ACOA, Alanon, Alateen, Alatot)

AOD No Alcohol or Other Drugs or association with users/abusers or places where it's the primary business

Ed./Employment GED/Diploma, employment, job skills training (check TANF resources)

Search and Seizure clause (home, person, personal effects, automobile)

AIDS education is mandatory. Offer confidential testing for HIV, TB, and/or Hepatitis C

Registration as narcotics offender, fines, fees, alcohol assessment, AOD assessment for non-DUI violations

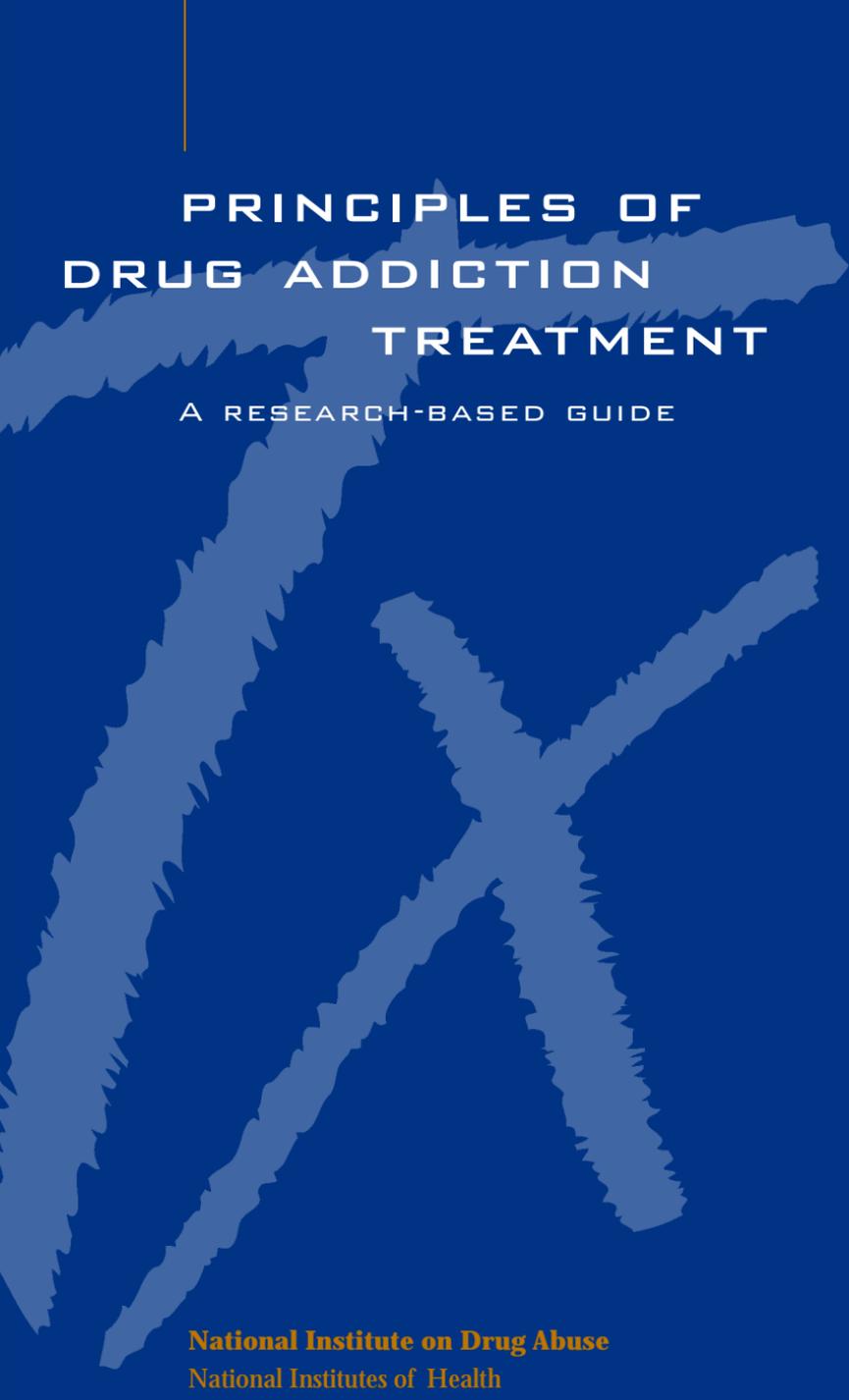
Medications Methadone, Wellbutrin, Naltrexone (Revia™), Acamprosate, Nalmefene, Antabuse, Mecamylamine, baclofen

Urine tests Determine frequency. No poppy seeds, over-the-counter medications (especially containing ephedra), Vitamin B, health food store "remedies" like Goldenseal or water loading. "Provide a clean, fresh, undiluted, unadulterated, personal urine sample upon request."

Prenatal care, Women, Infants and Children (WIC) and Early and Periodic Screening, Diagnostic, and Treatment (EPSDT)

Civil Addict Program

¹ This list was created by Judge Peggy Hora, Judge, Alameda County Superior Court, Hayward, CA.



**PRINCIPLES OF
DRUG ADDICTION
TREATMENT**

A RESEARCH-BASED GUIDE

National Institute on Drug Abuse
National Institutes of Health

PRINCIPLES OF EFFECTIVE TREATMENT

- 1. NO SINGLE TREATMENT IS APPROPRIATE FOR ALL INDIVIDUALS.** Matching treatment settings, interventions, and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.
- 2. TREATMENT NEEDS TO BE READILY AVAILABLE.** Because individuals who are addicted to drugs may be uncertain about entering treatment, taking advantage of opportunities when they are ready for treatment is crucial. Potential treatment applicants can be lost if treatment is not immediately available or is not readily accessible.
- 3. EFFECTIVE TREATMENT ATTENDS TO MULTIPLE NEEDS OF THE INDIVIDUAL, NOT JUST HIS OR HER DRUG USE.** To be effective, treatment must address the individual's drug use and any associated medical, psychological, social, vocational, and legal problems.
- 4. AN INDIVIDUAL'S TREATMENT AND SERVICES PLAN MUST BE ASSESSED CONTINUALLY AND MODIFIED AS NECESSARY TO ENSURE THAT THE PLAN MEETS THE PERSON'S CHANGING NEEDS.** A patient may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, a patient at times may require medication, other medical services, family therapy, parenting instruction, vocational rehabilitation, and social and legal services. It is critical that the treatment approach be appropriate to the individual's age, gender, ethnicity, and culture.
- 5. REMAINING IN TREATMENT FOR AN ADEQUATE PERIOD OF TIME IS CRITICAL FOR TREATMENT EFFECTIVENESS.** The appropriate duration for an individual depends on his or her problems and needs (see pages 13-51). Research indicates that for most patients, the threshold of significant improvement is reached at about 3 months in treatment. After this threshold is reached, additional treatment can produce further progress toward recovery. Because people often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment.

- 4
- C**OUNSELING (INDIVIDUAL AND/OR GROUP) AND OTHER BEHAVIORAL THERAPIES ARE CRITICAL COMPONENTS OF EFFECTIVE TREATMENT FOR ADDICTION. In therapy, patients address issues of motivation, build skills to resist drug use, replace drug-using activities with constructive and rewarding nondrug-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships and the individual's ability to function in the family and community. (Pages 37-51 discuss details of different treatment components to accomplish these goals.)
 - M**EDICATIONS ARE AN IMPORTANT ELEMENT OF TREATMENT FOR MANY PATIENTS, ESPECIALLY WHEN COMBINED WITH COUNSELING AND OTHER BEHAVIORAL THERAPIES. Methadone and levo-alpha-acetylmethadol (LAAM) are very effective in helping individuals addicted to heroin or other opiates stabilize their lives and reduce their illicit drug use. Naltrexone is also an effective medication for some opiate addicts and some patients with co-occurring alcohol dependence. For persons addicted to nicotine, a nicotine replacement product (such as patches or gum) or an oral medication (such as bupropion) can be an effective component of treatment. For patients with mental disorders, both behavioral treatments and medications can be critically important.
 - A**DDICTED OR DRUG-ABUSING INDIVIDUALS WITH COEXISTING MENTAL DISORDERS SHOULD HAVE BOTH DISORDERS TREATED IN AN INTEGRATED WAY. Because addictive disorders and mental disorders often occur in the same individual, patients presenting for either condition should be assessed and treated for the co-occurrence of the other type of disorder.
 - M**EDICAL DETOXIFICATION IS ONLY THE FIRST STAGE OF ADDICTION TREATMENT AND BY ITSELF DOES LITTLE TO CHANGE LONG-TERM DRUG USE. Medical detoxification safely manages the acute physical symptoms of withdrawal associated with stopping drug use. While detoxification alone is rarely sufficient to help addicts

achieve long-term abstinence, for some individuals it is a strongly indicated precursor to effective drug addiction treatment (see pages 25-35).

10. **T**REATMENT DOES NOT NEED TO BE VOLUNTARY TO BE EFFECTIVE. Strong motivation can facilitate the treatment process. Sanctions or enticements in the family, employment setting, or criminal justice system can increase significantly both treatment entry and retention rates and the success of drug treatment interventions.
11. **P**ossible drug use during treatment must be monitored continuously. Lapses to drug use can occur during treatment. The objective monitoring of a patient's drug and alcohol use during treatment, such as through urinalysis or other tests, can help the patient withstand urges to use drugs. Such monitoring also can provide early evidence of drug use so that the individual's treatment plan can be adjusted. Feedback to patients who test positive for illicit drug use is an important element of monitoring.
12. **T**REATMENT PROGRAMS SHOULD PROVIDE ASSESSMENT FOR HIV/AIDS, HEPATITIS B AND C, TUBERCULOSIS AND OTHER INFECTIOUS DISEASES, AND COUNSELING TO HELP PATIENTS MODIFY OR CHANGE BEHAVIORS THAT PLACE THEMSELVES OR OTHERS AT RISK OF INFECTION. Counseling can help patients avoid high-risk behavior. Counseling also can help people who are already infected manage their illness.
13. **R**ECOVERY FROM DRUG ADDICTION CAN BE A LONG-TERM PROCESS AND FREQUENTLY REQUIRES MULTIPLE EPISODES OF TREATMENT. As with other chronic illnesses, relapses to drug use can occur during or after successful treatment episodes. Addicted individuals may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning. Participation in self-help support programs during and following treatment often is helpful in maintaining abstinence.

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14	Why can't drug addicts quit on their own?
15	How effective is drug addiction treatment?
16	How long does drug addiction treatment usually last?
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17	Is the use of medications like methadone simply replacing one drug addiction with another?
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*Three decades of scientific
research and clinical practice
have yielded a variety of
effective approaches to
drug addiction treatment.*



DRUG ADDICTION IS A COMPLEX ILLNESS. It is characterized by compulsive, at times uncontrollable drug craving, seeking, and use that persist even in the face of extremely negative consequences. For many people, drug addiction becomes chronic, with relapses possible even after long periods of abstinence.

The path to drug addiction begins with the act of taking drugs. Over time, a person's ability to choose not to take drugs can be compromised. Drug seeking becomes compulsive, in large part as a result of the effects of prolonged drug use on brain functioning and, thus, on behavior.

The compulsion to use drugs can take over the individual's life. Addiction often involves not only compulsive drug taking but also a wide range of dysfunctional behaviors that can interfere with normal functioning in the family, the workplace, and the broader community. Addiction also can place people at increased risk for a wide variety of other illnesses. These illnesses can be brought on by behaviors, such as poor living and health habits, that often accompany life as an addict, or because of toxic effects of the drugs themselves.

Because addiction has so many dimensions and disrupts so many aspects of an individual's life, treatment for this illness is never simple. Drug treatment must help the individual stop using drugs and maintain a drug-free lifestyle, while achieving productive functioning in the family, at work, and in society. Effective drug abuse and addiction treatment programs typically incorporate many components, each directed to a particular aspect of the illness and its consequences.

Three decades of scientific research and clinical practice have yielded a variety of effective approaches to drug addiction treatment. Extensive data document that drug addiction treatment is as effective as are treatments for most other similarly chronic medical conditions. In spite

of scientific evidence that establishes the effectiveness of drug abuse treatment, many people believe that treatment is ineffective. In part, this is because of unrealistic expectations. Many people equate addiction with simply using drugs and therefore expect that addiction should be cured quickly, and if it is not, treatment is a failure. In reality, because addiction is a chronic disorder, the ultimate goal of long-term abstinence often requires sustained and repeated treatment episodes.

Of course, not all drug abuse treatment is equally effective. Research also has revealed a set of overarching principles that characterize the most effective drug abuse and addiction treatments and their implementation.

To share the results of this extensive body of research and foster more widespread use of scientifically based treatment components, the National Institute on Drug Abuse held the National Conference on Drug Addiction Treatment: From Research to Practice in April 1998 and prepared this guide. Pages 3-5 of the guide summarize basic overarching principles that characterize effective treatment. Pages 13-21 elaborate on these principles by providing answers to frequently raised questions, as supported by the available scientific literature. Pages 23-33 describe the types of treatment, and pages 35-47 present examples of scientifically based and tested treatment components.

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Treatment varies depending on the type of drug and the characteristics of the patient... The best programs provide a combination of therapies and other services.



FREQUENTLY ASKED QUESTIONS

1. WHAT IS DRUG ADDICTION TREATMENT?

There are many addictive drugs, and treatments for specific drugs can differ. Treatment also varies depending on the characteristics of the patient.

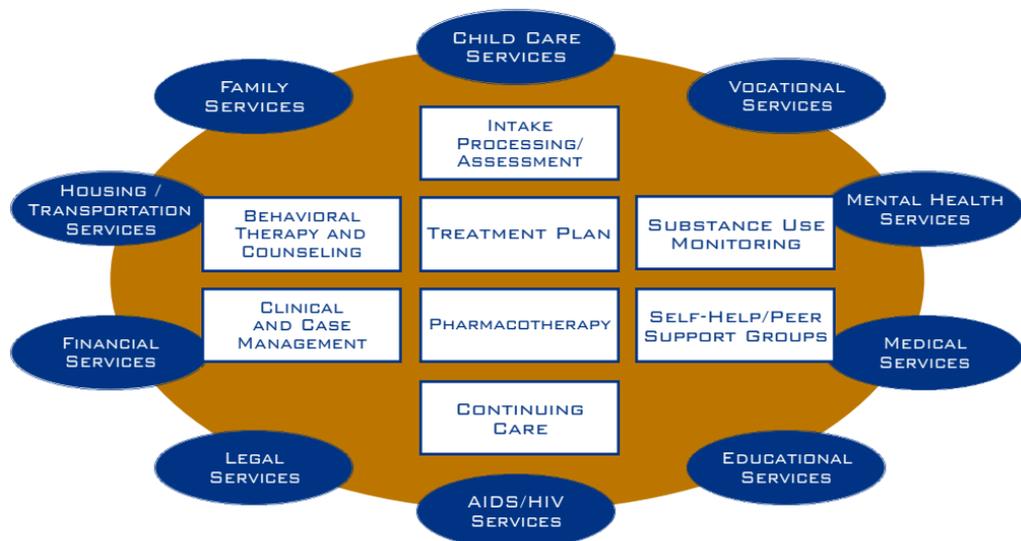
Problems associated with an individual's drug addiction can vary significantly. People who are addicted to drugs come from all walks of life. Many suffer from mental health, occupational, health, or social problems that make their addictive disorders much more difficult to treat. Even if there are few associated problems, the severity of addiction itself ranges widely among people.

A variety of scientifically based approaches to drug addiction treatment exists. Drug addiction treatment can include behavioral therapy (such as counseling, cognitive therapy, or psychotherapy), medications, or their combination. Behavioral therapies offer people strategies for coping with their drug cravings, teach them ways to avoid drugs and prevent relapse, and help them deal with relapse if it occurs. When a person's drug-related behavior places him or her at higher risk for AIDS or other infectious diseases, behavioral therapies can help to reduce the risk of disease transmission. Case management and referral to other medical, psychological, and social services are crucial components of treatment for many patients. (See pages 23-47 for more detail on types of treatment and treatment components.) The best programs provide a combination of therapies and other services to meet the needs of the individual patient, which are shaped by such issues as age, race, culture, sexual orientation, gender, pregnancy, parenting, housing, and employment, as well as physical and sexual abuse.

DRUG ADDICTION TREATMENT CAN INCLUDE BEHAVIORAL THERAPY, MEDICATIONS, OR THEIR COMBINATION.

Treatment medications, such as methadone, LAAM, and naltrexone, are available for individuals addicted to opiates. Nicotine preparations (patches, gum, nasal spray) and bupropion are available for individuals addicted to nicotine.

Components of Comprehensive Drug Abuse Treatment



The best treatment programs provide a combination of therapies and other services to meet the needs of the individual patient.

Medications, such as antidepressants, mood stabilizers, or neuroleptics, may be critical for treatment success when patients have co-occurring mental disorders, such as depression, anxiety disorder, bipolar disorder, or psychosis.

Treatment can occur in a variety of settings, in many different forms, and for different lengths of time. Because drug addiction is typically a chronic disorder characterized by occasional relapses, a short-term, one-time treatment often is not sufficient. For many, treatment is a long-term process that involves multiple interventions and attempts at abstinence.

2. WHY CAN'T DRUG ADDICTS QUIT ON THEIR OWN?

Nearly all addicted individuals believe in the beginning that they can stop using drugs on their own, and most try to stop without treatment. However, most of these attempts result in failure to achieve long-term abstinence. Research has shown that long-term drug use results in significant changes in brain function that persist long after the individual stops using drugs. These drug-

induced changes in brain function may have many behavioral consequences, including the compulsion to use drugs despite adverse consequences—the defining characteristic of addiction.

LONG-TERM DRUG USE RESULTS IN SIGNIFICANT CHANGES IN BRAIN FUNCTION THAT PERSIST LONG AFTER THE INDIVIDUAL STOPS USING DRUGS.

Understanding that addiction has such an important biological component may help explain an individual's difficulty in achieving and maintaining abstinence without treatment. Psychological stress from work or family problems, social cues (such as meeting individuals from one's drug-using past), or the environment (such as encountering streets, objects, or even smells associated with drug use) can interact with biological factors to hinder attainment of sustained abstinence and make relapse more likely. Research studies indicate that even the most severely addicted individuals can participate actively in treatment and that active participation is essential to good outcomes.

3. HOW EFFECTIVE IS DRUG ADDICTION TREATMENT?

In addition to stopping drug use, the goal of treatment is to return the individual to productive functioning in the family, workplace, and community. Measures of effectiveness typically include levels of criminal behavior, family functioning, employability, and medical condition. Overall, treatment of addiction is as successful as treatment of other chronic diseases, such as diabetes, hypertension, and asthma.

TREATMENT OF ADDICTION IS AS SUCCESSFUL AS TREATMENT OF OTHER CHRONIC DISEASES SUCH AS DIABETES, HYPERTENSION, AND ASTHMA.

According to several studies, drug treatment reduces drug use by 40 to 60 percent and significantly decreases criminal activity during and after treatment. For example, a study

of therapeutic community treatment for drug offenders (see pages 23-33) demonstrated that arrests for violent and nonviolent criminal acts were reduced by 40 percent or more. Methadone treatment has been shown to decrease criminal behavior by as much as 50 percent. Research shows that drug addiction treatment reduces the risk of HIV infection and that interventions to prevent HIV are much less costly than treating HIV-related illnesses. Treatment can improve the prospects for employment, with gains of up to 40 percent after treatment.

Although these effectiveness rates hold in general, individual treatment outcomes depend on the extent and nature of the patient's presenting problems, the appropriateness of the treatment components and related services used to address those problems, and the degree of active engagement of the patient in the treatment process.

4. HOW LONG DOES DRUG ADDICTION TREATMENT USUALLY LAST?

Individuals progress through drug addiction treatment at various speeds, so there is no predetermined length of treatment. However, research has shown unequivocally that good outcomes are contingent on adequate lengths of treatment. Generally, for residential or outpatient treatment, participation for less than 90 days is of limited or no effectiveness, and treatments lasting significantly longer often are indicated. For methadone maintenance, 12 months of treatment is the minimum, and some opiate-addicted individuals will continue to benefit from methadone maintenance treatment over a period of years.

GOOD OUTCOMES ARE CONTINGENT ON ADEQUATE LENGTHS OF TREATMENT.

Many people who enter treatment drop out before receiving all the benefits that treatment can provide. Successful outcomes may require more than one treatment experience. Many addicted individuals have multiple episodes of treatment, often with a cumulative impact.

5. WHAT HELPS PEOPLE STAY IN TREATMENT?

Since successful outcomes often depend upon retaining the person long enough to gain the full benefits of treatment, strategies for keeping an individual in the program are critical. Whether a patient stays in treatment depends on factors associated with both the individual and the program. Individual factors related to engagement and retention include motivation to change drug-using behavior, degree of support from family and friends, and whether there is pressure to stay in treatment from the criminal justice system, child protection services, employers, or the family. Within the program, successful counselors are able to establish a positive, therapeutic relationship with the patient. The counselor should ensure that a treatment plan is established and followed so that the individual knows what to expect during treatment. Medical, psychiatric, and social services should be available.

WHETHER A PATIENT STAYS IN TREATMENT DEPENDS ON FACTORS ASSOCIATED WITH BOTH THE INDIVIDUAL AND THE PROGRAM.

Since some individual problems (such as serious mental illness, severe cocaine or crack use, and criminal involvement) increase the likelihood of a patient dropping out, intensive treatment with a range of components may be required to retain patients who have these problems. The provider then should ensure a transition to continuing care or “aftercare” following the patient’s completion of formal treatment.

6. IS THE USE OF MEDICATIONS LIKE METHADONE SIMPLY REPLACING ONE DRUG ADDICTION WITH ANOTHER?

No. As used in maintenance treatment, methadone and LAAM are not heroin substitutes. They are safe and effective medications for opiate addiction that are administered by mouth in regular, fixed doses. Their pharmacological effects are markedly different from those of heroin.

AS USED IN MAINTENANCE TREATMENT, METHADONE AND LAAM ARE NOT HEROIN SUBSTITUTES.

Injected, snorted, or smoked heroin causes an almost immediate “rush” or brief period of euphoria that wears off very quickly, terminating in a “crash.” The individual then experiences an intense craving to use more heroin to stop the crash and reinstate the euphoria. The cycle of euphoria, crash, and craving—repeated several times a day—leads to a cycle of addiction and behavioral disruption. These characteristics of heroin use result from the drug’s rapid onset of action and its short duration of action in the brain. An individual who uses heroin multiple times per day subjects his or her brain and body to marked, rapid fluctuations as the opiate effects come and go. These fluctuations can disrupt a number of important bodily functions. Because heroin is illegal, addicted persons often become part of a volatile drug-using street culture characterized by hustling and crimes for profit.

Methadone and LAAM have far more gradual onsets of action than heroin, and as a result, patients stabilized on these medications do not experience any rush. In addition, both medications wear off much more slowly than heroin, so there is no sudden crash, and the brain and body are not exposed to the marked fluctuations seen with heroin use. Maintenance treatment with methadone or LAAM markedly reduces the desire for heroin. If an individual maintained on adequate, regular doses of methadone (once a day) or LAAM (several times per week) tries to take heroin, the euphoric effects of heroin will be significantly blocked. According to research, patients undergoing maintenance treatment do not suffer the medical abnormalities and behavioral destabilization that rapid fluctuations in drug levels cause in heroin addicts.

7. WHAT ROLE CAN THE CRIMINAL JUSTICE SYSTEM PLAY IN THE TREATMENT OF DRUG ADDICTION?

Increasingly, research is demonstrating that treatment for drug-addicted offenders during and after incar-

ceration can have a significant beneficial effect upon future drug use, criminal behavior, and social functioning. The case for integrating drug addiction treatment approaches with the criminal justice system is compelling. Combining prison- and community-based treatment for drug-addicted offenders reduces the risk of both recidivism to drug-related criminal behavior and relapse to drug use. For example, a recent study found that prisoners who participated in a therapeutic treatment program in the Delaware State Prison and continued to receive treatment in a work-release program after prison were 70 percent less likely than nonparticipants to return to drug use and incur rearrest (see pages 23-33).

INDIVIDUALS WHO ENTER TREATMENT UNDER LEGAL PRESSURE HAVE OUTCOMES AS FAVORABLE AS THOSE WHO ENTER TREATMENT VOLUNTARILY.

The majority of offenders involved with the criminal justice system are not in prison but are under community supervision. For those with known drug problems, drug addiction treatment may be recommended or mandated as a condition of probation. Research has demonstrated that individuals who enter treatment under legal pressure have outcomes as favorable as those who enter treatment voluntarily.

The criminal justice system refers drug offenders into treatment through a variety of mechanisms, such as diverting nonviolent offenders to treatment, stipulating treatment as a condition of probation or pretrial release, and convening specialized courts that handle cases for offenses involving drugs. Drug courts, another model, are dedicated to drug offender cases. They mandate and arrange for treatment as an alternative to incarceration, actively monitor progress in treatment, and arrange for other services to drug-involved offenders.

The most effective models integrate criminal justice and drug treatment systems and services. Treatment and criminal justice personnel work together on plans and implementation of screening, placement, testing, monitoring, and super-

vision, as well as on the systematic use of sanctions and rewards for drug abusers in the criminal justice system. Treatment for incarcerated drug abusers must include continuing care, monitoring, and supervision after release and during parole.

8. HOW DOES DRUG ADDICTION TREATMENT HELP REDUCE THE SPREAD OF HIV/AIDS AND OTHER INFECTIOUS DISEASES?

Many drug addicts, such as heroin or cocaine addicts and particularly injection drug users, are at increased risk for HIV/AIDS as well as other infectious diseases like hepatitis, tuberculosis, and sexually transmitted infections. For these individuals and the community at large, drug addiction treatment is disease prevention.

DRUG ADDICTION TREATMENT IS DISEASE PREVENTION.

Drug injectors who do not enter treatment are up to six times more likely to become infected with HIV than injectors who enter and remain in treatment. Drug users who enter and continue in treatment reduce activities that can spread disease, such as sharing injection equipment and engaging in unprotected sexual activity. Participation in treatment also presents opportunities for screening, counseling, and referral for additional services. The best drug abuse treatment programs provide HIV counseling and offer HIV testing to their patients.

9. WHERE DO 12-STEP OR SELF-HELP PROGRAMS FIT INTO DRUG ADDICTION TREATMENT?

Self-help groups can complement and extend the effects of professional treatment. The most prominent self-help groups are those affiliated with Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and Cocaine Anonymous (CA), all of which are based on the 12-step

model, and Smart Recovery. Most drug addiction treatment programs encourage patients to participate in a self-help group during and after formal treatment.

10. HOW CAN FAMILIES AND FRIENDS MAKE A DIFFERENCE IN THE LIFE OF SOMEONE NEEDING TREATMENT?

Family and friends can play critical roles in motivating individuals with drug problems to enter and stay in treatment. Family therapy is important, especially for adolescents (see pages 35-47). Involvement of a family member in an individual's treatment program can strengthen and extend the benefits of the program.

11. IS DRUG ADDICTION TREATMENT WORTH ITS COST?

Drug addiction treatment is cost-effective in reducing drug use and its associated health and social costs. Treatment is less expensive than alternatives, such as not treating addicts or simply incarcerating addicts. For example, the average cost for 1 full year of methadone maintenance treatment is approximately \$4,700 per patient, whereas 1 full year of imprisonment costs approximately \$18,400 per person.

DRUG ADDICTION TREATMENT IS COST-EFFECTIVE IN REDUCING DRUG USE AND ITS ASSOCIATED HEALTH AND SOCIAL COSTS.

According to several conservative estimates, every \$1 invested in addiction treatment programs yields a return of between \$4 and \$7 in reduced drug-related crime, criminal justice costs, and theft alone. When savings related to health care are included, total savings can exceed costs by a ratio of 12 to 1. Major savings to the individual and society also come from significant drops in interpersonal conflicts, improvements in workplace productivity, and reductions in drug-related accidents.

Treatment for drug abuse and addiction is delivered in many different settings, using a variety of behavioral and pharmacological approaches.



DRUG ADDICTION TREATMENT IN THE UNITED STATES

Drug addiction is a complex disorder that can involve virtually every aspect of an individual's functioning—in the family, at work, and in the community. Because of addiction's complexity and pervasive consequences, drug addiction treatment typically must involve many components. Some of those components focus directly on the individual's drug use. Others, like employment training, focus on restoring the addicted individual to productive membership in the family and society (see diagram on page 14).

Treatment for drug abuse and addiction is delivered in many different settings, using a variety of behavioral and pharmacological approaches. In the United States, more than 11,000 specialized drug treatment facilities provide rehabilitation, counseling, behavioral therapy, medication, case management, and other types of services to persons with drug use disorders.

Because drug abuse and addiction are major public health problems, a large portion of drug treatment is funded by local, State, and Federal governments. Private and employer-subsidized health plans also may provide coverage for treatment of drug addiction and its medical consequences.

Drug abuse and addiction are treated in specialized treatment facilities and mental health clinics by a variety of providers, including certified drug abuse counselors, physicians, psychologists, nurses, and social workers. Treatment is delivered in outpatient, inpatient, and residential settings. Although specific treatment approaches often are associated with particular treatment settings, a variety of therapeutic interventions or services can be included in any given setting.

GENERAL CATEGORIES OF TREATMENT PROGRAMS

Research studies on drug addiction treatment have typically classified treatment programs into several general types or modalities, which are described in the following text. Treatment approaches and individual programs continue to evolve, and many programs in existence today do not fit neatly into traditional drug

addiction treatment classifications. Examples of specific research-based treatment components are described on pages 35-47.

AGONIST MAINTENANCE TREATMENT

for opiate addicts usually is conducted in outpatient settings, often called methadone treatment programs. These programs use a long-acting synthetic opiate medication, usually methadone or LAAM, administered orally for a sustained period at a dosage sufficient to prevent opiate withdrawal, block the effects of illicit opiate use, and decrease opiate craving. Patients stabilized on adequate, sustained dosages of methadone or LAAM can function normally. They can hold jobs, avoid the crime and violence of the street culture, and reduce their exposure to HIV by stopping or decreasing injection drug use and drug-related high-risk sexual behavior.

Patients stabilized on opiate agonists can engage more readily in counseling and other behavioral interventions essential to recovery and rehabilitation. The best, most effective opiate agonist maintenance programs include individual and/or group counseling, as well as provision of, or referral to, other needed medical, psychological, and social services.

PATIENTS STABILIZED ON ADEQUATE
SUSTAINED DOSAGES OF METHADONE
OR LAAM CAN FUNCTION NORMALLY.

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NARCOTIC ANTAGONIST TREATMENT USING NALTREXONE for opiate addicts usually is conducted in outpatient settings although initiation of the medication often begins after medical detoxification in a residential setting. Naltrexone is a long-acting synthetic opiate antagonist with few side effects that is taken orally either daily or three times a week for a sustained period of time. Individuals must be medically detoxified and opiate-free for several days before naltrexone can be taken to prevent precipitating an opiate abstinence syndrome. When used this way, all the effects of self-administered opiates, including euphoria, are completely blocked. The theory behind this treatment is that the repeated lack of the desired opiate effects, as well as the perceived futility of using the opiate, will gradually over time result in breaking the habit of opiate addiction. Naltrexone itself has no subjective effects or potential for abuse and is not addicting. Patient noncompliance is a common problem. Therefore,

a favorable treatment outcome requires that there also be a positive therapeutic relationship, effective counseling or therapy, and careful monitoring of medication compliance.

PATIENTS STABILIZED ON NALTREXONE CAN HOLD JOBS, AVOID CRIME AND VIOLENCE, AND REDUCE THEIR EXPOSURE TO HIV.

Many experienced clinicians have found naltrexone most useful for highly motivated, recently detoxified patients who desire total abstinence because of external circumstances, including impaired professionals, parolees, probationers, and prisoners in work-release status. Patients stabilized on naltrexone can function normally. They can hold jobs, avoid the crime and violence of the street culture, and reduce their exposure to HIV by stopping injection drug use and drug-related high-risk sexual behavior.

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OUTPATIENT DRUG-FREE TREATMENT

varies in the types and intensity of services offered. Such treatment costs less than residential or inpatient treatment and often is more suitable for individuals who are employed or who have extensive social supports. Low-intensity programs may offer little more than drug education and admonition. Other outpatient models, such as intensive day treatment, can be comparable to residential programs in services and effectiveness, depending on the individual patient's characteristics and needs. In many outpatient programs, group counseling is emphasized. Some outpatient programs are designed to treat patients who have medical or mental health problems in addition to their drug disorder.

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LONG-TERM RESIDENTIAL TREATMENT

provides care 24 hours per day, generally in nonhospital settings. The best-known residential treatment model is the therapeutic community (TC), but residential treatment may also employ other models, such as cognitive-behavioral therapy.

TCs are residential programs with planned lengths of stay of 6 to 12 months. TCs focus on the “resocialization” of the individual and use the program’s entire “community,” including other residents, staff, and the social context, as active components of treatment. Addiction is viewed in the context of an individual’s social and psychological deficits, and treatment focuses on developing personal accountability and responsibility and socially productive lives. Treatment is highly structured and can at times be confrontational, with activities designed to help residents examine damaging beliefs, self-concepts, and patterns of behavior and to adopt new, more harmonious and constructive ways to interact with others. Many TCs are quite comprehensive and can include employment training and other support services on site.

THERAPEUTIC COMMUNITIES FOCUS ON THE “RESOCIALIZATION” OF THE INDIVIDUAL AND USE THE PROGRAM’S ENTIRE “COMMUNITY” AS ACTIVE COMPONENTS OF TREATMENT.

Compared with patients in other forms of drug treatment, the typical TC resident has more severe problems, with more co-occurring mental health problems and more criminal involvement. Research shows that TCs can be modified to treat individuals with special needs, including adolescents, women, those with severe mental disorders, and individuals in the criminal justice system (see page 31).

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SHORT-TERM RESIDENTIAL PROGRAMS

provide intensive but relatively brief residential treatment based on a modified 12-step approach. These programs were originally designed to treat alcohol problems, but during the cocaine epidemic of the mid-1980's, many began to treat illicit drug abuse and addiction. The original

residential treatment model consisted of a 3 to 6 week hospital-based inpatient treatment phase followed by extended outpatient therapy and participation in a self-help group, such as Alcoholics Anonymous. Reduced health care coverage for substance abuse treatment has resulted in a diminished number of these programs, and the average length of stay under managed care review is much shorter than in early programs.

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MEDICAL DETOXIFICATION is a process whereby individuals are systematically withdrawn from addicting drugs in an inpatient or outpatient setting, typically under the care of a physician. Detoxification is sometimes called a distinct treatment modality but is more appropriately considered a precursor of treatment, because it is designed to treat the acute physiological effects of stopping drug use. Medications are available for detoxification from opiates, nicotine, benzodiazepines, alcohol, barbiturates, and other sedatives. In some cases, particularly for the last three types of drugs, detoxification may be a medical necessity, and untreated withdrawal may be medically dangerous or even fatal.

DETOXIFICATION IS A PRECURSOR OF TREATMENT.

Detoxification is not designed to address the psychological, social, and behavioral problems associated with addiction

and therefore does not typically produce lasting behavioral changes necessary for recovery. Detoxification is most useful when it incorporates formal processes of assessment and referral to subsequent drug addiction treatment.

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TREATING CRIMINAL JUSTICE-INVOLVED DRUG ABUSERS AND ADDICTS

Research has shown that combining criminal justice sanctions with drug treatment can be effective in decreasing drug use and related crime. Individuals under legal coercion tend to stay in treatment for a longer period of time and do as well as or better than others not under legal pressure. Often, drug abusers come into contact with the criminal justice system earlier than other health or social systems, and intervention by the criminal justice system to engage the individual in treatment may help interrupt and shorten a career of drug use. Treatment for the criminal justice-involved drug abuser or drug addict may be delivered prior to, during, after, or in lieu of incarceration.

COMBINING CRIMINAL JUSTICE SANCTIONS WITH DRUG TREATMENT CAN BE EFFECTIVE IN DECREASING DRUG USE AND RELATED CRIME.

PRISON-BASED TREATMENT PROGRAMS.

Offenders with drug disorders may encounter a number of treatment options while incarcerated, including didactic drug education classes, self-help programs, and treatment based on therapeutic community or residential milieu therapy models. The TC model has been studied extensively and can be quite effective in reducing drug use and recidivism to criminal behavior. Those in treatment should be segregated from the general prison population, so that

the “prison culture” does not overwhelm progress toward recovery. As might be expected, treatment gains can be lost if inmates are returned to the general prison population after treatment. Research shows that relapse to drug use and recidivism to crime are significantly lower if the drug offender continues treatment after returning to the community.

COMMUNITY-BASED TREATMENT FOR CRIMINAL JUSTICE POPULATIONS. A number of criminal justice alternatives to incarceration have been tried with offenders who have drug disorders, including limited diversion programs, pretrial release conditional on entry into treatment, and conditional probation with sanctions. The drug court is a promising approach. Drug courts mandate and arrange for drug addiction treatment, actively monitor progress in treatment, and arrange for other services to drug-involved offenders. Federal support for planning, implementation, and enhancement of drug courts is provided under the U.S. Department of Justice Drug Courts Program Office.

As a well-studied example, the Treatment Accountability and Safer Communities (TASC) program provides an alternative to incarceration by addressing the multiple needs of drug-addicted offenders in a community-based setting. TASC programs typically include counseling, medical care, parenting instruction, family counseling, school and job training, and legal and employment services. The key features of TASC include (1) coordination of criminal justice and drug treatment; (2) early identification, assessment, and referral of drug-involved offenders; (3) monitoring offenders through drug testing; and (4) use of legal sanctions as inducements to remain in treatment.

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Each approach to drug treatment is designed to address certain aspects of drug addiction and its consequences for the individual, family, and society.



SCIENTIFICALLY BASED APPROACHES TO DRUG ADDICTION TREATMENT

This section presents several examples of treatment approaches and components that have been developed and tested for efficacy through research supported by the National Institute on Drug Abuse (NIDA). Each approach is designed to address certain aspects of drug addiction and its consequences for the individual, family, and society. The approaches are to be used to supplement or enhance—not replace—existing treatment programs.

This section is not a complete list of efficacious, scientifically based treatment approaches. Additional approaches are under development as part of NIDA's continuing support of treatment research.

RELAPSE PREVENTION, a cognitive-behavioral therapy, was developed for the treatment of problem drinking and adapted later for cocaine addicts. Cognitive-behavioral strategies are based on the theory that learning processes play a critical role in the development of maladaptive behavioral patterns. Individuals learn to identify and correct problematic behaviors. Relapse prevention encompasses several cognitive-behavioral strategies that facilitate abstinence as well as provide help for people who experience relapse.

The relapse prevention approach to the treatment of cocaine addiction consists of a collection of strategies intended to enhance self-control. Specific techniques include exploring the positive and negative consequences of continued use, self-monitoring to recognize drug cravings early on and to identify high-risk situations for use, and developing strategies for coping with and avoiding high-risk situations and the desire to use. A central element of this treatment is anticipating the problems patients are likely to meet and helping them develop effective coping strategies.

Research indicates that the skills individuals learn through relapse prevention therapy remain after the completion of treatment. In one study, most people receiving this cognitive-behavioral approach maintained the gains they made in treatment throughout the year following treatment.

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SUPPORTIVE-EXPRESSIVE PSYCHOTHERAPY is a time-limited, focused psychotherapy that has been adapted for heroin- and cocaine-addicted individuals. The therapy has two main components:

- Supportive techniques to help patients feel comfortable in discussing their personal experiences.
- Expressive techniques to help patients identify and work through interpersonal relationship issues.

Special attention is paid to the role of drugs in relation to problem feelings and behaviors, and how problems may be solved without recourse to drugs.

The efficacy of individual supportive-expressive psychotherapy has been tested with patients in methadone maintenance treatment who had psychiatric problems. In a comparison with patients receiving only drug counseling, both groups fared similarly with regard to opiate use, but the supportive-expressive psychotherapy group had lower cocaine use and required less methadone. Also, the patients who received supportive-expressive psychotherapy maintained many of the gains they had made. In an earlier study, supportive-expressive psychotherapy, when added to drug counseling, improved outcomes for opiate addicts in methadone treatment with moderately severe psychiatric problems.

References:

Luborsky, L. *Principles of Psychoanalytic Psychotherapy: A Manual for Supportive-Expressive (SE) Treatment*. New York: Basic Books, 1984.

Woody, G.E.; McLellan, A.T.; Luborsky, L.; and O'Brien, C.P. Psychotherapy in community methadone programs: a validation study. *American Journal of Psychiatry* 152(9): 1302-1308, 1995.

Woody, G.E.; McLellan, A.T.; Luborsky, L.; and O'Brien, C.P. Twelve month follow-up of psychotherapy for opiate dependence. *American Journal of Psychiatry* 144: 590-596, 1987.

INDIVIDUALIZED DRUG COUNSELING

focuses directly on reducing or stopping the addict's illicit drug use. It also addresses related areas of impaired functioning—such as employment status, illegal activity, family/social relations—as well as the content and structure of the patient's recovery program. Through its emphasis on short-term behavioral goals, individualized drug counseling helps the patient develop coping strategies and tools for abstaining from drug use and then maintaining abstinence. The addiction counselor encourages 12-step participation and makes referrals for needed supplemental medical, psychiatric, employment, and other services. Individuals are encouraged to attend sessions one or two times per week.

In a study that compared opiate addicts receiving only methadone to those receiving methadone coupled with counseling, individuals who received only methadone showed minimal improvement in reducing opiate use. The addition of counseling produced significantly more improvement. The addition of onsite medical/psychiatric, employment, and family services further improved outcomes.

In another study with cocaine addicts, individualized drug counseling, together with group drug counseling, was quite effective in reducing cocaine use. Thus, it appears that this approach has great utility with both heroin and cocaine addicts in outpatient treatment.

References:

McLellan, A.T.; Arndt, I.; Metzger, D.S.; Woody, G.E.; and O'Brien, C.P. The effects of psychosocial services in substance abuse treatment. *Journal of the American Medical Association* 269(15): 1953-1959, 1993.

McLellan, A.T.; Woody, G.E.; Luborsky, L.; and O'Brien, C.P. Is the counselor an 'active ingredient' in substance abuse treatment? *Journal of Nervous and Mental Disease* 176: 423-430, 1988.

Woody, G.E.; Luborsky, L.; McLellan, A.T.; O'Brien, C.P.; Beck, A.T.; Blaine, J.; Herman, I.; and Hole, A. Psychotherapy for opiate addicts: Does it help? *Archives of General Psychiatry* 40: 639-645, 1983.

Crits-Cristoph, P.; Siqueland, L.; Blaine, J.; Frank, A.; Luborsky, L.; Onken, L.S.; Muenz, L.; Thase, M.E.; Weiss, R.D.; Gastfriend, D.R.; Woody, G.; Barber, J.P.; Butler, S.F.; Daley, D.; Bishop, S.; Najavits, L.M.; Lis, J.; Mercer, D.; Griffin, M.L.; Moras, K.; and Beck, A. Psychosocial treatments for cocaine dependence: Results of the NIDA Cocaine Collaborative Study. *Archives of General Psychiatry* (in press).

MOTIVATIONAL ENHANCEMENT

THE THERAPY is a client-centered counseling approach for initiating behavior change by helping clients to resolve ambivalence about engaging in treatment and stopping drug use. This approach employs strategies to evoke rapid and internally motivated change in the client, rather than guiding the client stepwise through the recovery process. This therapy consists of an initial assessment battery session, followed by two to four individual treatment sessions with a therapist. The first treatment session focuses on providing feedback generated from the initial assessment battery to stimulate discussion regarding personal substance use and to elicit self-motivational statements. Motivational interviewing principles are used to strengthen motivation and build a plan for change. Coping strategies for high-risk

situations are suggested and discussed with the client. In subsequent sessions, the therapist monitors change, reviews cessation strategies being used, and continues to encourage commitment to change or sustained abstinence. Clients are sometimes encouraged to bring a significant other to sessions. This approach has been used successfully with alcoholics and with marijuana-dependent individuals.

References:

Budney, A.J.; Kandel, D.B.; Cherek, D.R.; Martin, B.R.; Stephens, R.S.; and Roffman, R. College on problems of drug dependence meeting, Puerto Rico (June 1996). Marijuana use and dependence. *Drug and Alcohol Dependence* 45: 1-11, 1997.

Miller, W.R. Motivational interviewing: research, practice and puzzles. *Addictive Behaviors* 61(6): 835-842, 1996.

Stephens, R.S.; Roffman, R.A.; and Simpson, E.E. Treating adult marijuana dependence: a test of the relapse prevention model. *Journal of Consulting & Clinical Psychology*, 62: 92-99, 1994.

BEHAVIORAL THERAPY FOR ADOLESCENTS incorporates the principle that unwanted behavior can be changed by clear demonstration of the desired behavior and consistent reward of incremental steps toward achieving it. Therapeutic activities include fulfilling specific assignments, rehearsing desired behaviors, and recording and reviewing progress, with praise and privileges given for meeting assigned goals. Urine samples are collected regularly to monitor drug use. The therapy aims to equip the patient to gain three types of control:

Stimulus Control helps patients avoid situations associated with drug use and learn to spend more time in activities incompatible with drug use.

Urge Control helps patients recognize and change thoughts, feelings, and plans that lead to drug use.

Social Control involves family members and other people important in helping patients avoid drugs. A parent or significant other attends treatment sessions when possible and assists with therapy assignments and reinforcing desired behavior.

According to research studies, this therapy helps adolescents become drug free and increases their ability to remain drug free after treatment ends. Adolescents also show improvement in several other areas—employment/school attendance, family relationships, depression, institutionalization, and alcohol use. Such favorable results are attributed largely to including family members in therapy and rewarding drug abstinence as verified by urinalysis.

References:

Azrin, N.H.; Acierno, R.; Kogan, E.; Donahue, B.; Besalel, V.; and McMahon, P.T. Follow-up results of supportive versus behavioral therapy for illicit drug abuse. *Behavioral Research & Therapy* 34(1): 41-46, 1996.

Azrin, N.H.; McMahon, P.T.; Donahue, B.; Besalel, V.; Lapinski, K.J.; Kogan, E.; Acierno, R.; and Galloway, E. Behavioral therapy for drug abuse: a controlled treatment outcome study. *Behavioral Research & Therapy* 32(8): 857-866, 1994.

Azrin, N.H.; Donohue, B.; Besalel, V.A.; Kogan, E.S.; and Acierno, R. Youth drug abuse treatment: A controlled outcome study. *Journal of Child & Adolescent Substance Abuse* 3(3): 1-16, 1994.

MULTIDIMENSIONAL FAMILY THERAPY (MDFT) FOR ADOLESCENTS is an outpatient family-based drug abuse treatment for teenagers. MDFT views adolescent drug use in terms of a network of influences (that is, individual, family, peer, community) and suggests that reducing unwanted behavior and increasing desirable behavior occur in multiple ways in different settings. Treatment includes individual and family sessions held

in the clinic, in the home, or with family members at the family court, school, or other community locations.

During individual sessions, the therapist and adolescent work on important developmental tasks, such as developing decisionmaking, negotiation, and problem-solving skills. Teenagers acquire skills in communicating their thoughts and feelings to deal better with life stressors, and vocational skills. Parallel sessions are held with family members. Parents examine their particular parenting style, learning to distinguish influence from control and to have a positive and developmentally appropriate influence on their child.

References:

Diamond, G.S., and Liddle, H.A. Resolving a therapeutic impasse between parents and adolescents in Multi-dimensional Family Therapy. *Journal of Consulting and Clinical Psychology* 64(3): 481-488, 1996.

Schmidt, S.E.; Liddle, H.A.; and Dakof, G.A. Effects of multidimensional family therapy: Relationship of changes in parenting practices to symptom reduction in adolescent substance abuse. *Journal of Family Psychology* 10(1): 1-16, 1996.

MULTISYSTEMIC THERAPY (MST)

addresses the factors associated with serious antisocial behavior in children and adolescents who abuse drugs. These factors include characteristics of the adolescent (for example, favorable attitudes toward drug use), the family (poor discipline, family conflict, parental drug abuse), peers (positive attitudes toward drug use), school (dropout, poor performance), and neighborhood (criminal subculture). By participating in intense treatment in natural environments (homes, schools, and neighborhood settings) most youths and families complete a full course of treatment. MST significantly reduces adolescent drug use during treatment and for at least 6 months after treatment. Reduced numbers of incarcerations and out-of-home placements of

juveniles offset the cost of providing this intensive service and maintaining the clinicians' low caseloads.

References:

Henggeler, S.W.; Pickrel, S.G.; Brondino, M.J.; and Crouch, J.L. Eliminating (almost) treatment dropout of substance abusing or dependent delinquents through home-based multisystemic therapy. *American Journal of Psychiatry* 153: 427-428, 1996.

Henggeler, S.W.; Schoenwald, S.K.; Borduin, C.M.; Rowland, M.D.; and Cunningham, P. B. *Multisystemic treatment of antisocial behavior in children and adolescents*. New York: Guilford Press, 1998.

Schoenwald, S.K.; Ward, D.M.; Henggeler, S.W.; Pickrel, S.G.; and Patel, H. MST treatment of substance abusing or dependent adolescent offenders: Costs of reducing incarceration, inpatient, and residential placement. *Journal of Child and Family Studies* 5: 431-444, 1996.

COMBINED BEHAVIORAL AND NICOTINE REPLACEMENT THERAPY FOR NICOTINE ADDICTION consists of two main components:

- The transdermal nicotine patch or nicotine gum reduces symptoms of withdrawal, producing better initial abstinence.
- The behavioral component concurrently provides support and reinforcement of coping skills, yielding better long-term outcomes.

Through behavioral skills training, patients learn to avoid high-risk situations for smoking relapse early on and later to plan strategies to cope with such situations. Patients practice skills in treatment, social, and work settings. They learn other coping techniques, such as cigarette refusal skills, assertiveness, and time management. The combined treatment is based on the rationale that behavioral and

pharmacological treatments operate by different yet complementary mechanisms that produce potentially additive effects.

References:

Fiore, M.C.; Kenford, S.L.; Jorenby, D.E.; Wetter, D.W.; Smith, S.S.; and Baker, T.B. Two studies of the clinical effectiveness of the nicotine patch with different counseling treatments. *Chest* 105: 524-533, 1994.

Hughes, J.R. Combined psychological and nicotine gum treatment for smoking: a critical review. *Journal of Substance Abuse* 3: 337-350, 1991.

American Psychiatric Association: Practice Guideline for the Treatment of Patients with Nicotine Dependence. American Psychiatric Association, 1996.

COMMUNITY REINFORCEMENT APPROACH (CRA) PLUS VOUCHERS is an intensive 24-week outpatient therapy for treatment of cocaine addiction. The treatment goals are twofold:

- To achieve cocaine abstinence long enough for patients to learn new life skills that will help sustain abstinence.
- To reduce alcohol consumption for patients whose drinking is associated with cocaine use.

Patients attend one or two individual counseling sessions per week, where they focus on improving family relations, learning a variety of skills to minimize drug use, receiving vocational counseling, and developing new recreational activities and social networks. Those who also abuse alcohol receive clinic-monitored disulfiram (Antabuse) therapy. Patients submit urine samples two or three times each week and receive vouchers for cocaine-negative samples. The value of the vouchers increases with consecutive clean samples. Patients may exchange vouchers for retail goods that are consistent with a cocaine-free lifestyle.

This approach facilitates patients' engagement in treatment and systematically aids them in gaining substantial periods of cocaine abstinence. The approach has been tested in urban and rural areas and used successfully in outpatient detoxification of opiate-addicted adults and with inner-city methadone maintenance patients who have high rates of intravenous cocaine abuse.

References:

Higgins, S.T.; Budney, A.J.; Bickel, H.K.; Badger, G.; Foerg, F.; and Ogden, D. Outpatient behavioral treatment for cocaine dependence: one-year outcome. *Experimental & Clinical Psychopharmacology* 3(2): 205-212, 1995.

Higgins, S.T.; Budney, A.J.; Bickel, W.K.; Foerg, F.; Donham, R.; and Badger, G. Incentives improve outcome in outpatient behavioral treatment of cocaine dependence. *Archives of General Psychiatry* 51: 568-576, 1994.

Silverman, K.; Higgins, S.T.; Brooner, R.K.; Montoya, I.D.; Cone, E.J.; Schuster, C.R.; and Preston, K.L. Sustained cocaine abstinence in methadone maintenance patients through voucher-based reinforcement therapy. *Archives of General Psychiatry* 53: 409-415, 1996.

VOUCHER-BASED REINFORCEMENT THERAPY IN METHADONE MAINTENANCE TREATMENT helps patients achieve and maintain abstinence from illegal drugs by providing them with a voucher each time they provide a drug-free urine sample. The voucher has monetary value and can be exchanged for goods and services consistent with the goals of treatment. Initially, the voucher values are low, but their value increases with the number of consecutive drug-free urine specimens the individual provides. Cocaine- or heroin-positive urine specimens reset the value of the vouchers to the initial low value. The contingency of escalating incentives is designed specifically to reinforce periods of sustained drug abstinence.

Studies show that patients receiving vouchers for drug-free urine samples achieved significantly more weeks of abstinence and significantly more weeks of sustained abstinence than patients who were given vouchers independent of urinalysis results. In another study, urinalyses positive for heroin decreased significantly when the voucher program was started and increased significantly when the program was stopped.

References:

Silverman, K.; Higgins, S.; Brooner, R.; Montoya, I.; Cone, E.; Schuster, C.; and Preston, K. Sustained cocaine abstinence in methadone maintenance patients through voucher-based reinforcement therapy. *Archives of General Psychiatry* 53: 409-415, 1996.

Silverman, K.; Wong, C.; Higgins, S.; Brooner, R.; Montoya, I.; Contoreggi, C.; Umbricht-Schneiter, A.; Schuster, C.; and Preston, K. Increasing opiate abstinence through voucher-based reinforcement therapy. *Drug and Alcohol Dependence* 41: 157-165, 1996.

DAY TREATMENT WITH ABSTINENCE CONTINGENCIES AND VOUCHERS was developed to treat homeless crack addicts. For the first 2 months, participants must spend 5.5 hours daily in the program, which provides lunch and transportation to and from shelters. Interventions include individual assessment and goal setting, individual and group counseling, multiple psychoeducational groups (for example, didactic groups on community resources, housing, cocaine, and HIV/AIDS prevention; establishing and reviewing personal rehabilitation goals; relapse prevention; weekend planning), and patient-governed community meetings during which patients review contract goals and provide support and encouragement to each other. Individual counseling occurs once a week, and group therapy sessions are held three times a week. After 2 months of day treatment and at least 2 weeks of abstinence, participants graduate to a 4-month

work component that pays wages that can be used to rent inexpensive, drug-free housing. A voucher system also rewards drug-free related social and recreational activities.

This innovative day treatment was compared with treatment consisting of twice-weekly individual counseling and 12-step groups, medical examinations and treatment, and referral to community resources for housing and vocational services. Innovative day treatment followed by work and housing dependent upon drug abstinence had a more positive effect on alcohol use, cocaine use, and days homeless.

References:

Milby, J.B.; Schumacher, J.E.; Raczynski, J.M.; Caldwell, E.; Engle, M.; Michael, M.; and Carr, J. Sufficient conditions for effective treatment of substance abusing homeless. *Drug & Alcohol Dependence* 43: 39-47, 1996.

Milby, J.B.; Schumacher, J.E.; McNamara, C.; Wallace, D.; McGill, T.; Stange, D.; and Michael, M. Abstinence contingent housing enhances day treatment for homeless cocaine abusers. *National Institute on Drug Abuse Research Monograph Series 174, Problems of Drug Dependence: Proceedings of the 58th Annual Scientific Meeting. The College on Problems of Drug Dependence, Inc., 1996.*

THE MATRIX MODEL provides a framework for engaging stimulant abusers in treatment and helping them achieve abstinence. Patients learn about issues critical to addiction and relapse, receive direction and support from a trained therapist, become familiar with self-help programs, and are monitored for drug use by urine testing. The program includes education for family members affected by the addiction.

The therapist functions simultaneously as teacher and coach, fostering a positive, encouraging relationship with the patient and using that relationship to reinforce positive behavior change. The interaction between the therapist and

the patient is realistic and direct but not confrontational or parental. Therapists are trained to conduct treatment sessions in a way that promotes the patient's self-esteem, dignity, and self-worth. A positive relationship between patient and therapist is a critical element for patient retention.

Treatment materials draw heavily on other tested treatment approaches. Thus, this approach includes elements pertaining to the areas of relapse prevention, family and group therapies, drug education, and self-help participation. Detailed treatment manuals contain work sheets for individual sessions; other components include family educational groups, early recovery skills groups, relapse prevention groups, conjoint sessions, urine tests, 12-step programs, relapse analysis, and social support groups.

A number of projects have demonstrated that participants treated with the Matrix model demonstrate statistically significant reductions in drug and alcohol use, improvements in psychological indicators, and reduced risky sexual behaviors associated with HIV transmission. These reports, along with evidence suggesting comparable treatment response for methamphetamine users and cocaine users and demonstrated efficacy in enhancing naltrexone treatment of opiate addicts, provide a body of empirical support for the use of the model.

References:

Huber, A.; Ling, W.; Shoptaw, S.; Gulati, V.; Brethen, P.; and Rawson, R. Integrating treatments for methamphetamine abuse: A psychosocial perspective. *Journal of Addictive Diseases* 16: 41-50, 1997.

Rawson, R.; Shoptaw, S.; Obert, J.L.; McCann, M.; Hasson, A.; Marinelli-Casey, P.; Brethen, P.; and Ling, W. An intensive outpatient approach for cocaine abuse: The Matrix model. *Journal of Substance Abuse Treatment* 12(2): 117-127, 1995.



**GENERAL INQUIRIES: NIDA PUBLIC INFORMATION OFFICE,
301-443-1124**

Inquiries about NIDA's treatment research activities: Division of Clinical and Services Research, 301-443-0107 (for questions regarding behavioral therapies) or 301-443-4060 (for questions regarding access to treatment, organization and management, and cost effectiveness); and, Medications Development Division, 301-443-6173 (for questions regarding medications development).

WEBSITE: <http://www.nida.nih.gov>

CENTER FOR SUBSTANCE ABUSE TREATMENT (CSAT)

CSAT, a part of the Substance Abuse and Mental Health Services Administration, is responsible for supporting treatment services through block grants and developing knowledge about effective drug treatment, disseminating the findings to the field, and promoting their adoption. CSAT also operates the National Treatment Referral 24-hour Hotline (1-800-662-HELP) which offers information and referral to people seeking treatment programs and other assistance. CSAT publications are available through the National Clearinghouse on Alcohol and Drug Information (1-800-729-6686). Additional information about CSAT can be found on their website at www.samhsa.gov/csat.

SELECTED NIDA EDUCATIONAL RESOURCES ON DRUG ADDICTION TREATMENT

The following are available from the National Clearinghouse on Alcohol and Drug Information (NCADI), the National Technical Information Service (NTIS), or the Government Printing Office (GPO). To order, refer to the NCADI (1-800-729-6686), NTIS (1-800-553-6847), or GPO (202-512-1800) number provided with the resource description.

MANUALS AND CLINICAL REPORTS

Measuring and Improving Cost, Cost-Effectiveness, and Cost-Benefit for Substance Abuse Treatment Programs (1999). Offers substance abuse treatment program managers tools with which to calculate the costs of their programs and investigate the relationship between those costs and treatment outcomes. NCADI # BKD340. Available online at <http://www.nida.nih.gov>.

An Overview of Prison and Community-Based Drug Abuse Treatment (1999). Summarizes substantive research on prison and community-based drug abuse treatment from the last 25 years and highlights how public health research can help inform public policies across systems. In press.

A Cognitive-Behavioral Approach: Treating Cocaine Addiction (1998). This is the first in NIDA's "Therapy Manuals for Drug Addiction" series. Describes cognitive-behavioral therapy, a short-term focused approach to helping cocaine-addicted individuals become abstinent from cocaine and other drugs. NCADI # BKD254. Available online at <http://www.nida.nih.gov>.

A Community Reinforcement Plus Vouchers Approach: Treating Cocaine Addiction (1998). This is the second in NIDA's "Therapy Manuals for Drug Addiction" series. This treatment integrates a community reinforcement approach with an incentive program that uses vouchers. NCADI # BKD255. Available online at <http://www.nida.nih.gov>.

An Individual Drug Counseling Approach to Treat Cocaine Addiction: The Collaborative Cocaine Treatment Study Model (1999). This is the third in NIDA's "Therapy Manuals for Drug Addiction" series. Describes specific cognitive-behavioral models that can be implemented in a wide range of differing drug abuse treatment settings. NCADI # BKD337. Available online at <http://www.nida.nih.gov>.

Mental Health Assessment and Diagnosis of Substance Abusers: Clinical Report Series (1994). Provides detailed descriptions of psychiatric disorders that can occur among drug-abusing clients. NCADI # BKD148.

Relapse Prevention: Clinical Report Series (1994). Discusses several major issues to relapse prevention. Provides an overview of factors and experiences that can lead to relapse. Reviews general strategies for preventing relapses, and describes four specific approaches in detail. Outlines administrative issues related to implementing a relapse prevention program. NCADI # BKD147.

Addiction Severity Index Package (1993). Provides a structured clinical interview designed to collect information about substance use and functioning in life areas from adult clients seeking drug abuse treatment. Includes a handbook for program administrators, a resource manual, two videotapes, and a training facilitator's manual. NTIS # AVA19615VNB2KUS. \$52.95.

Program Evaluation Package (1993). A practical resource for treatment program administrators and key staff. Includes an overview and case study manual, a guide for evaluation, a resource guide, and a pamphlet. NTIS # 95-167268. \$44.00.

Relapse Prevention Package (1993). Examines two effective relapse prevention models, the Recovery Training and Self-Help (RTSH) program and the Cue Extinction model. NTIS # 95-167250. \$62.00.

RESEARCH MONOGRAPHS

Beyond the Therapeutic Alliance: Keeping the Drug-Dependent Individual in Treatment (Research Monograph 165) (1997). Reviews current treatment research on the best ways to retain patients in drug abuse treatment. NTIS # 97-181606. \$47; GPO # 017-024-01608-0. \$17. Available online at <http://www.nida.nih.gov>.

Treatment of Drug-Exposed Women and Children: Advances in Research Methodology (Research Monograph 166) (1997). Presents experiences, products, and procedures of NIDA-supported Treatment Research Demonstration Program projects. NCADI # M166; NTIS # 96-179106. \$49; GPO # 017-01592-0. \$13. Available online at <http://www.nida.nih.gov>.

Treatment of Drug-Dependent Individuals With Comorbid Mental Disorders (Research Monograph 172) (1997). Promotes effective treatment by reporting state-of-the-art treatment research on individuals with comorbid mental and addictive disorders and research on HIV-related issues among people with comorbid conditions. NCADI # M172; NTIS # 97-181580. \$38; GPO # 017-024-01605. \$9.

Medications Development for the Treatment of Cocaine Dependence: Issues in Clinical Efficacy Trials (Research Monograph 175) (1998). A state-of-the-art handbook for clinical investigators, pharmaceutical scientists, and treatment researchers. NCADI # M175.

VIDEOS

Adolescent Treatment Approaches (1991). Emphasizes the importance of pinpointing and addressing individual problem areas, such as sexual abuse, peer pressure, and family involvement in treatment. Running time: 25 min. NCADI # VHS40. \$12.50.

NIDA Technology Transfer Series: Assessment (1991). Shows how to use a number of diagnostic instruments as well as how to assess the implementation and effectiveness of the plan during various phases of the patient's treatment. Running time: 22 min. NCADI # VHS38. \$12.50.

Drug Abuse Treatment in Prison: A New Way Out (1995). Portrays two comprehensive drug abuse treatment approaches that have been effective with men and women in State and Federal Prisons. Running time: 23 min. NCADI # VHS72. \$12.50.

Dual Diagnosis (1993). Focuses on the problem of mental illness in drug-abusing and drug-addicted populations, and examines various approaches useful for treating dual-diagnosed clients. Running time: 27 min. NCADI # VHS58. \$12.50.

LAAM: Another Option for Maintenance Treatment of Opiate Addiction (1995). Shows how LAAM can be used to meet the opiate treatment needs of individual clients from the provider and patient perspectives. Running time: 16 min. NCADI # VHS73. \$12.50.

Methadone: Where We Are (1993). Examines issues such as the use and effectiveness of methadone as a treatment, biological effects of methadone, the role of the counselor in treatment, and societal attitudes toward methadone treatment and patients. Running time: 24 min. NCADI # VHS59. \$12.50.

Relapse Prevention (1991). Helps practitioners understand the common phenomenon of relapse to drug use among patients in treatment. Running time: 24 min. NCADI # VHS37. \$12.50.

Treatment Issues for Women (1991). Assists treatment counselors help female patients to explore relationships with their children, with men, and with other women. Running time: 22 min. NCADI # VHS39. \$12.50.

Treatment Solutions (1999). Describes the latest developments in treatment research and emphasizes the benefits of drug abuse treatment, not only to the patient, but also to the greater community. Running time: 19 min. NCADI # DD110. \$12.50.

Program Evaluation Package (1993). A practical resource for treatment program administrators and key staff. Includes an overview and case study manual, a guide for evaluation, a resource guide, and a pamphlet. NTIS # 95-167268. \$44.

Relapse Prevention Package (1993). Examines two effective relapse prevention models, the Recovery Training and Self-Help (RTSH) program and the Cue Extinction model. NTIS # 95-167250. \$62.

OTHER FEDERAL RESOURCES

THE NATIONAL CLEARINGHOUSE FOR ALCOHOL AND DRUG INFORMATION (NCADI). NIDA publications and treatment materials along with publications from other Federal agencies are available from this information source. Staff provide assistance in English and Spanish, and have TDD capability. Phone: 1-800-729-6686. Website: <http://www.health.org>

THE NATIONAL INSTITUTE OF JUSTICE (NIJ). As the research agency of the Department of Justice, NIJ supports research, evaluation, and demonstration programs relating to drug abuse in the contexts of crime and the criminal justice system. For information, including a wealth of publications, contact the National Criminal Justice Reference Service by telephone (1-800-851-3420 or 1-301-519-5500) or on the World Wide Web (<http://www.ojp.usdoj.gov/nij>).



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TOXICOLOGY DRUG TESTING TID BITS

Drug testing is becoming increasingly sophisticated; however, abusers can still find ways to stay a step ahead of modern technology. There are chemical agents which are known to cause a false positive or false negative drug test result, depending on the type of detection system used. Some foods we consume or common over-the-counter drug remedies used for minor ailments may cause a positive test, which may have adverse employment consequences. If the drug testing results are not reviewed with care, they can result in troublesome situations. Following are some examples we encounter on a routine basis.

	Agent	Test Method	Results*	Cause
1.	Muffins or bagels containing poppy seed fillings (ingested)	EMIT, TLC, FPIA	Positive for Opiates	Contains Morphine
2.	Pseudoephedrine & Ephedrine (ingested)	EMIT assays	False Positive Amphetamines	Cross reactivity
3.	Dexromethorphan (ingested)	EMIT assays	False Positive	Dextrophan metabolite
4.	Tolmetin (Tolectin ingested)	EMIT assays	Invalid results	Interference (high absorb)
5.	Metronidazole (ingested)	EMIT assays	Invalid results	Interference (high absorb)
6.	Glutraldehyde (UrinAid Added)	EMIT II assays	Negative	Interference
7.	Trimethobenzamide (Tigan Ingested)	EMIT, FPIA, RIA	Amphetamines False Positive	Cross reactivity
8.	Fluconazole (ingested)	GC/MS	False Negative Cocaine	Interference
9.	Diuretics (ingested)	EMIT, FPIA	False Negative	Dilution due to over-hydration
10.	Salicylates (ingested)	EMIT	False Negative	Interference
11.	Bleach (added)	EMIT, FPIA, RIA	False Negative	Interference
12.	Vanish (added)	RIA	False Negative – Amph, THC, OP, Cocaine	
13.	Vinegar (added)	EMIT, FPIA	False Negative – THC, Opiates, Cocaine	Interference
14.	Visine Drops (added)	EMIT, FPIA	False Negative – THC	Interference
15.	Golden Seal Tea (ingested)	EMIT, FPIA, RIA	False Negative – THC	Interference
16.	Coca-leaf Tea (ingested)	EMIT, FPIA	Positive Cocaine	Contains Cocaine
17.	Peroxide (added)	EMIT	False Negative Benzodiazepines	Interference
18.	Salt (added)	EMIT	False Negative	Interference
19.	Detergent	FPIA, RIA	False Negative – THC, PCP, Benzo	Interference
20.	Gallon of Water (drinking before test)	All assays	False Negative – Cocaine	Dilution
21.	Miscellaneous Additives: Jamaica Me Clean, System Flush, Test Free, Detox, Test Clean, Naturally Clean, Urine Luck, Zydol, Mary Janes' Super Clean 13	Immunoassays	False Negative False Negative - THC	Interference

Some of these additives can be detected by measuring pH, specific gravity, and by odor, but it is difficult to catch through simple detection.

EMIT = Enzyme Multiplied Immunoassay

THC = Thin Layer Chromatography

THC = Cannabinoids

FPIA = Fluorescence Polarized Immunoassay

GC/MS = Gas Chromatography/Mass Spectroscopy

THIS INFORMATION IS PROVIDED BY GATEWAY RECOVERY SERVICES AND THE PATHOLOGY DEPARTMENT OF BORGESS HOSPITAL, KALAMAZOO, MI

DRUGS OF ABUSE INFORMATION SHEET

DRUG OF ABUSE	RESULT	DRUGS CAUSING POSITIVE REACTION	DETECTIONS LIMIT	DETECTION TIME AFTER DOSE	COMMENTS
Amine Group	Positive or Negative	Amphetamine, Methamphetamine, Ephedrine, Phentermine, Mephentermine, Phenylpropanolamine, Pseudoephedrine (decongestant), Phenmetrazine, Isoxsuprine, Diethylpropion, Lebetatol, Isometheptene, Phenelzine, Tranylcypromine, Nyldrine	300 ng/ml	Within 2 hours and up to 48 hours	
Amphetamine/Methamphetamine (Speed/Uppers)	Positive or Negative	Amphetamine, Methamphetamine	1000 ng/ml	Within 2 hours and up to 48 hours	
Barbiturates (Downers/Sedatives)	Positive or Negative	Amobarbital, Aprobarbital, Barbitol, Butabarbital, Butalbital, Cyclopentobarbital, Pentobarbital, Phenobarbital, Secobarbital, Talbutal	200 ng/ml	Within 8 hours and up to 10 days	
Benzodiazepines (Anti-anxiety)	Positive or Negative	Alprazolam (Xanax), Bromazepam, Chloridiazeposide (Librium), Cholorazepat, Clobazam, Clonazepam, Delorazepam, Demoxepam, Desalkylflurazepam, Diazepam (Valium), Estazolam, Flurazepam, Flunitrazepam, Halazepam, Lorazepam, Lormetazepam, Medazepam, Nitrazepam, Nordiazepam, Oxazepam, Oxaprozin, Prazepam, Temazepam, Triazolam	200 ng/ml	Within 24 hours and up to 72 hours	
Cocaine (Coke/Crack/Rock/Snow)	Positive or Negative	Cocaine, Benzoyl Ecgonine, Cocaethylene, Ecgonine, Ecgonine Methyl Ester (Benzoyl Ecgonine is the major matabolite of Cocaine)	300 ng/ml	Within 4 hours and up to 72 hours	
Ethanol (Alcohol/Booze/Liquor/Spirits)	Less than 10 mg/dl = Neg. Between 10 and 500 mg/dl = Num. Value		10 mg/dl		
Opiates (Narcotics: Opium/Heroin/Morphine)	Positive or Negative	Codeine, Diacetylmorphine, Dihydrocodeine, Hydromorphone, Hydrocodone, Levorphanol, Meperidine (Demerol), Oxycodone (Percodan)	300 ng/dl	Within 8 hours and up to 72 hours	
Phencyclidine (Angel Dust)	Positive or Negative	Phencyclidine and its metabolites (also PCP analog TCP)	25 ng/ml	Within 48 hours and up to 6 days	
Cannabinoids – THC (Marijuana/Pot/Weed/Grass/Mary Jane)	Less than 50 ng/ml = Neg. Between 50 and 100 ng/ml = Detected Between 100 and 400 ng/ml = Num. Value	Detects major metabolites of Marijuana	50 ng/ml	Within 48 hours and up to 14 days (may be detected for longer periods of time after chronic usage.)	
Propoxyphene (Darvon/Darbocel)	Positive or Negative	Propoxyphene and its metabolite Norproxyphene	300 ng/ml	Within 6 hours and up to 48 hours	

NOTE: CONFIRMATION OF A POSITIVE RESULT BY GC/MS WILL BE SENT TO SKBL LABORATORY UPON REQUEST.

Treatment Protocol Effectiveness Study: Summary of Treatment Modalities

TREATMENT MODALITIES

1. Therapeutic Communities (TC)

Therapeutic communities (TCs) are intensive, long-term, residential treatment facilities. They attempt to provide an environment that allows clients to develop both socially and psychologically through a combination of personal counseling and life skills courses. As clients progress through the program they are given more responsibilities as well as more freedom, the ultimate goal being complete self-sufficiency and a drug free lifestyle. TCs are recommended for hardcore drug users who have failed other forms of drug abuse treatment.

2. Pharmacological Treatment

Pharmacological treatment is typically a long-term treatment in which the addict is maintained with medications. Dependencies are treated with medication that either replaces the illicit drug or blocks its actions. **Methadone**, for example, is an effective substitute for heroin, morphine, codeine, and other opiate derivatives. It does not produce euphoria or sedation, but it does effectively suppress the withdrawal symptoms such as agitation, sleep disturbance and mild depression. **Naltrexone** blocks the effects of opioids such as heroin and is also effective with alcohol. It is more effective among highly motivated patients who have greater social supports.

Other pharmacological treatments include **Buprenorphine**, which is designed to reduce craving, enhance treatment retention, and block the effect of illicit opioids, and **LAAM** (a long-acting opioid maintenance compound), which also suppresses withdrawal symptoms and requires weekly, rather than daily maintenance are showing increasing popularity and significant success rates.

3. Outpatient Drug Free Treatment

Outpatient drug free treatment includes a range of protocols, from highly professional psychotherapy to informal peer discussions. Counseling services vary considerably and include individual, group, or family counseling, peer group support; vocational therapy; marital therapy; and cognitive therapy. The ideal goal of outpatient drug free treatment is abstinence from drug use, but reduced drug use is commonly viewed as more realistic.

4. Inpatient Treatment

Inpatient treatment refers to the treatment of drug dependence in a hospital and includes medical supervision of detoxification. The primary goal of inpatient drug-free treatment is to help the patient achieve and maintain a drug-free lifestyle. There are various inpatient treatment programs that are proven to have encouraging success rates, including therapy based programs, 12-step programs, and multimodality programs. Finding the right programs for the client's individual circumstances is critical for the long-term effectiveness.

Treatment Protocol Effectiveness Study: Summary of Treatment Modalities

Therapy based programs tend to serve older or middle-class patients rather than adolescents whose drug use has not yet developed or patients who have a specific psychiatric problem in addition to drug use. These psychiatric programs typically require a 4 to 12 week stay. It usually begins with detoxification and is followed by a variety of services including individual, group, and family therapy, education, and training in behavioral techniques such as relaxation and exercise.

Twelve-step programs are based on a model of total abstinence. Patients work on at least the first four steps of the AA model while in the treatment program, with progression through the remaining eight steps expected through subsequent involvement with AA or NA. Twelve-step treatment is reportedly more effective for middle-age participants than for those in other age groups.

Multimodality programs offer a variety of services including inpatient treatment, medical care, outpatient brief treatment, vocational training, educational enhancement for adolescents, family therapy, adult or adolescent TCs, methadone maintenance, group psychotherapy, individual psychotherapy, drug education, and stress-coping techniques. In-patient treatment is generally required at some point in the multimodal treatment process, and because few programs provide childcare services, foster care may be the only option for who require inpatient treatment. Many women avoid treatment for fear they will be unable to regain custody of their children after completing treatment. Pregnant women may risk criminal charges for drug use during pregnancy and also often refrain from seeking treatment

Treatment Protocol Effectiveness Study, Executive Office of the President, Office of National Drug Control Policy, Barry R. McCaffrey, Director, March 1996.
<http://www.whitehousedrugpolicy.gov/treat/trmtprot.html>

WHY A “NO ALCOHOL” CLAUSE NEEDS TO BE IN ALL DRUG TREATMENT COURT CONTRACTS

Hon. Peggy Fulton Hora, Alameda County Superior Court

Understanding that not all defendants who are eligible for a drug treatment court are addicts or alcoholics, drug treatment courts use the medical model for their treatment modality. In fact, some eligible defendants would never be arrested again even without a diversion program. They are either experimenters or thrill-seekers for whom the arrest experience alone will have been enough to stop the drug-using behavior. Since we don't have a system that distinguishes between those persons and alcoholics/addicts, they will all be treated as if they have the disease of addiction.

Assuming that is the case, the hallmark of addiction is a loss of control and continued use despite adverse consequences. It, therefore, makes no sense to tell an addict to use alcohol (or any other drug) in *moderation*; they cannot do anything relating to brain chemistry in moderation. The brain makes no distinction between alcohol and other drugs which may be illegal. All drugs, including alcohol, work on the biochemistry of the brain. Moreover, the incidence of polydrug use (including different illicit drugs as well as alcohol) is rampant. For instance, the 1996 Drug Use Forecasting (DUF) report shows in Los Angeles, 20% of men and 24% of women who tested positive for any drug other than alcohol at the time of arrest tested positive for two or more illicit drugs of abuse. In San Diego it was 31% of males and 25% of females and in San Jose the figures were 15% and 23%, respectively. In another study, 19% of male alcoholics and 31% of female alcoholics were polydrug users. Sixty-six percent of drug treatment courts in a recent survey reported their participants having moderate to severe alcoholism and approximately 60% of programs test for alcohol as well as other drugs.¹

People who are addicted to drugs of abuse, including alcohol, have markedly changed the biochemistry of the brains so that if they do not use, they experience a feeling of dysphoria (the exact opposite of euphoria). They feel really, really bad. It takes up to a year to begin to cope with this feeling that is present when the addict/alcoholic is free from drugs of abuse. Alcoholics never regain a level of dopamine equal to that of “normal” persons. Cocaine addicts may have physical reactions such as a rise in pulse rate, respiration, blood pressure and pupil dilation for as long as ten years after sobriety when they see paraphernalia such as a crack pipe. In short, alcohol and other drugs **injure sobriety**.

The reason it is important to prohibit the use of any drugs, including alcohol, during the recovery process is so that alcoholics/addicts can learn to deal with their normal, sober state – to have “uninjured sobriety.” Any chemical alteration of the brain, including “drinking in moderation” (although there is no such thing for an alcoholic/addict), further injures his or her sobriety. Whether a person started using drugs because they were genetically predisposed, because of a childhood trauma such as sexual abuse, or because of a dual diagnosis (the co-occurrence of a major mental disorder with addiction), they must work through those issues to stay clean and sober. So, for instance, a woman who was repeatedly sexually abused by her father and started using drugs of abuse to mask the pain of being an incest survivor, will start to experience the trauma again when she becomes sober. She needs to be counseled through this issue so that she will not begin using again. Alcohol will not benefit this process.. Recognizing that a “no alcohol” ban is overly inclusive, it is nonetheless necessary in contracts with a drug treatment population so that they may regain their sobriety and continue their recovery.

¹ Cooper, Caroline S., *1997 Drug court Survey report: Executive Summary*, American University Drug court Clearinghouse and Technical Assistance Project (1997) at 4-5.