DRUG TREATMENT COURTS IN THE TWENTY-FIRST CENTURY: THE EVOLUTION OF THE REVOLUTION IN PROBLEM-SOLVING COURTS

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* Judge Hora retired in 2006 from the Alameda County (California) Superior Court after twenty-one years as a judge. She had a criminal assignment that included presiding over the drug treatment court. She has lectured nationally and internationally on therapeutic jurisprudence, cultural competence, domestic violence, and alcohol and other drugs. The appellate court and over one hundred journals and articles have cited her work. She would like to dedicate this Article to tens of thousands of drug treatment court graduates around the world.

** Mr. Stalcup, a California criminal defense attorney, wishes to thank Judge Hora for the opportunity to coauthor this work; Professors Mary Berkheiser and Katherine Kruse of the William S. Boyd School of Law, University of Nevada, Las Vegas, for their invaluable editorial, philosophical, and critical input towards the writing of this Article; and Drs. Alex Stalcup, M.D., and Janice Stalcup, Dr.P.H., for their tutelage in the field of substance abuse treatment.

I. INTRODUCTION

Almost no one minds when an inexpensive trinket breaks, wears out, or rapidly requires replacement. But when something costs hundreds of thousands of dollars, greater assurance is needed that it serves its intended purpose and will continue to do so over a lengthy period of time. The traditional criminal justice system consumes vast economic and human resources in the processing of drug abusers,[1] and yet, historically, it has been willing to arrest, adjudicate, and incarcerate drug abusers without regard to the incredibly high rates of recidivism in this population. Nearly seven in ten convicted drug offenders reoffends within three years of release from incarceration.[2] Resources expended on rearresting, retrying, and reincarcerating drug abusers on similar charges again and again over the years constitutes another kind of abuse; it is an abuse of scant criminal justice resources. Happily, the public as well as innovative members of the criminal justice system have come to see that this exercise in futility is no longer desirable or necessary.[3]

A. THE TRADITIONAL CRIMINAL JUSTICE SYSTEM AND AMERICA'S DRUG PROBLEM

The number of persons incarcerated in federal, state, and local correctional facilities across the nation has risen dramatically in the last decade.[4] As of 2005, more than 2.1 million Americans were incarcerated, 4.1 million Americans were on probation, and

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[1] *See* OFFICE OF NAT'L DRUG CONTROL POLICY, NATIONAL DRUG CONTROL STRATEGY: FY 2008 BUDGET SUMMARY 1 (2007) (listing drug budget total as nearly $13 billion).

[2] *See* PATRICK A. LANGAN & DAVID J. LEVIN, BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, RECIDIVISM OF PRISONERS RELEASED IN 1994, at 8 (2002), *available at* http://www.ojp.usdoj.gov/bjs/pub/pdf/rpr94.pdf (reporting that 66.7% of those released after serving time in state prisons for drug offenses were rearrested within three years).

[3] *See* PEW RESEARCH CTR. FOR THE PEOPLE & THE PRESS, THE 2004 POLITICAL LANDSCAPE: EVENLY DIVIDED AND INCREASINGLY POLARIZED, at T-49 (2003) (noting seventy-two percent of those surveyed believe criminal justice system should try to rehabilitate criminals, not just punish them).

[4] PAIGE M. HARRISON & ALLEN J. BECK, BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, PRISON AND JAIL INMATES AT MIDYEAR 2005 (2006), *available at* http://www.ojp.usdoj.gov/bjs/pub/pdf/pjim05.pdf.

over 700,000 were on parole.[5] In all, nearly seven million people are under the control of the criminal justice system.[6] If they were residents of a single U.S. state, the population would be larger than thirty-eight existing states in the United States.[7]

Of these seven million or so people, eighty percent of adults incarcerated for felonies[8] could be categorized in one or more of the following ways:

1. were regular alcohol or other drug abusers;
2. had been convicted of an alcohol or other drug violation;
3. were under the influence of alcohol or other drugs at the time of their crime;
4. committed a crime to support their drug use; or,
5. exhibited one or more elements of any of these categories.[9]

Additionally, twenty-nine percent of state prisoners and twenty-five percent of federal prisoners have committed violent offenses, including homicides and sexual assaults, while under the influence of drugs.[10] When alcohol is added to the mix, studies suggest that as many as thirty-seven percent of assault offenders and sixty

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[5] LAUREN E. GLAZE & SERI PALLA, BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, PROBATION AND PAROLE IN THE UNITED STATES, 2004 (2005), *available at* http://www.ojp.usdoj.gov/bjs/pub/pdf/ppus04.pdf. "The United States has less than 5 percent of the world's population. But it has almost a quarter of the world's prisoners." Adam Liptak, *Inmate Count in U.S. Dwarfs Other Nations'*, N.Y. TIMES, Apr. 23, 2008, at A1.

[6] *Id.*

[7] *See* U.S. Census Bureau, Annual Population Estimates 2000 to 2007, http://www.census.gov/popest/states/NST-ann-est.html (last visited Apr. 8, 2008) (providing 2007 state population estimates).

[8] Statistics for those incarcerated for misdemeanors were not available, perhaps due to state differences in sentencing.

[9] NAT'L CTR. ON ADDICTION & SUBSTANCE ABUSE AT COLUMBIA UNIV., CROSSING THE BRIDGE: AN EVALUATION OF THE DRUG TREATMENT ALTERNATIVE-TO-PRISON (DTAP) PROGRAM, at i (2003), *available at* http://www.casacolumbia.org/Absolutenm/articlefiles/Crossing_the_bridge_March2003.pdf.

[10] CHRISTOPHER J. MUMOLA, BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, SUBSTANCE ABUSE AND TREATMENT, STATE AND FEDERAL PRISONERS, 1997, at 3 (1999), *available at* http://www.ojp.usdoj.gov/bjs/pub/pdf/satsfp97.pdf.

percent of sexual offenders were drinking alcohol at the time of the offense.[11]

Incarceration does little to change substance use patterns. Subsequent to release, ex-offenders continue to use alcohol or other drugs at alarming rates.[12] In 2004, 19.1 million Americans, nearly eight percent of the total population, were users of an illicit drug.[13] Among persons on probation, however, the rate was over twenty-six percent.[14]

As previously stated, research shows that nearly seventy percent of all drug offenders are rearrested within three years of release from incarceration.[15] Roughly forty-one percent are rearrested for a specific drug offense.[16]

The costs associated with alcohol- or other drug-abusing offenders are staggering. The U.S. government is now spending upwards of $12.9 billion per year on illicit drug control, including police protection, the judiciary, corrections, and related costs.[17] In 2003, alcohol and other drugs were responsible for roughly 628,000 emergency room visits in the United States.[18] Moreover, the total impact on society of alcohol and other drug use is estimated to have cost the United States in excess of $180 billion in 2002, a 5.34% increase over the prior decade.[19] Using U.S. Census data,[20] this figure represents a burden of $642 for every resident of the country during 2002.

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[11] Richard B. Felson et al., *The Impact of Alcohol on Different Types of Violent Incidents*, 34 CRIM. JUST. & BEHAV. 1057, 1059 (2007).

[12] GLAZE & PALLA, *supra* note 5, at 6.

[13] SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., RESULTS FROM THE 2004 NATIONAL SURVEY ON DRUG USE AND HEALTH: NATIONAL FINDINGS 1 (2005), *available at* http://www.oas.samhsa.gov/nsduh/2k4nsduh/2k4results/2k4results.pdf.

[14] *Id.* at 21.

[15] LANGAN & LEVIN, *supra* note 2, at 8; *see also supra* note 2 and accompanying text.

[16] LANGAN & LEVIN, *supra* note 2, at 9 tbl.10.

[17] OFFICE OF NAT'L DRUG CONTROL POLICY, *supra* note 1, at 1.

[18] SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., DRUG ABUSE WARNING NETWORK, 2003: INTERIM NATIONAL ESTIMATES OF DRUG-RELATED EMERGENCY DEPARTMENT VISITS 29 (2004).

[19] OFFICE OF NAT'L DRUG CONTROL POLICY, THE ECONOMIC COSTS OF DRUG ABUSE IN THE UNITED STATES, 1992–2002, at vi (2004).

[20] *See* U.S. Census Bureau, Annual Projections of the Total Resident Population, http://www.census.gov/population/projections/nation/summary/np-t1.txt (last visited Apr. 8, 2008) (indicating projection of U.S. population in 2002 of 280,306,000 residents).

Striking disparities exist across ethnic lines between rates of drug use, rates of incarceration for drug-related crimes, and access to substance abuse treatment. Despite the fact that seventy-two percent of regular drug users are white, fifteen-percent are African American, and ten percent are Latino, of those incarcerated in state prisons on drug charges, forty-five percent are African American, twenty-one percent are Latino, and twenty-six percent are white.[21] Not only are arrest rates higher for people of color, but access to treatment in this population is even more restricted than in the white population, and their treatment outcomes are poorer.[22]

The impact of substance abuse on women and families also is profound. The number of women incarcerated continues to rise at a rate one-third higher than that of men.[23] Nearly one-third of women report being victims of domestic violence and over 1,400 are killed by their partners each year, an average of three women each day.[24] Between 1993 and 1998, nearly three out of every four victims who suffered violence by an intimate partner, such as a spouse, boyfriend, or girlfriend, reported that alcohol or other drug use had been a factor.[25] More than half of men in treatment for alcohol dependence or abuse have inflicted violence on their intimate partners.[26]

The cost of intimate partner violence exceeds $5.8 billion each year, with $4.1 billion in direct medical costs and mental health services.[27] Intimate partner violence also leaves a legacy. Children who witness domestic violence are more likely to become users of

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[21] Drug War Facts: Race, Prison, and the Drug Laws, http://www.drugwarfacts.org/racepris.htm (last visited Apr. 8, 2008).

[22] PHILLIP BEATTY ET AL., JUSTICE POLICY INST., THE VORTEX: THE CONCENTRATED RACIAL IMPACT OF DRUG IMPRISONMENT AND THE CHARACTERISTICS OF PUNITIVE COUNTIES 8 (2007), *available at* http://www.justicepolicy.org/images/upload/07-12_REP_Vortex_AC-DP.pdf.

[23] HARRISON & BECK, *supra* note 4, at 5.

[24] LAWRENCE A. GREENFELD ET AL., BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, VIOLENCE BY INTIMATES: ANALYSIS OF DATA ON CRIMES BY CURRENT OR FORMER SPOUSES, BOYFRIENDS, AND GIRLFRIENDS 5 (1998), *available at* http://www.ojp.usdoj.gov/bjs/pub/pdf/vi.pdf.

[25] GREENFELD ET AL., *supra* note 24, at 26–27.

[26] Robert Walker & TK Logan, *Treating Substance Abuse Clients with Co-occurring Intimate Partner Violence*, IV OFFENDER SUBSTANCE ABUSE REPORT 33, 33 (2004).

[27] Family Violence Prevention Fund, The Facts on Health Care and Domestic Violence, http://www.endabuse.org/resources/facts/HealthCare.pdf (last visited Apr. 8, 2008).

alcohol and other drugs; experience educational, mental health, and behavioral problems; and perpetuate a generational tradition of violence by becoming perpetrators themselves.[28]

With such sobering statistics, the important question to ask is how the criminal justice system handles this troubled population. Despite some innovative efforts, historically, the problem of substance abuse has been addressed by the criminal justice system with a combination of punishment and indifference. In 1997, only ten percent of drug abusers were given treatment while they were incarcerated in state prisons, a fall from twenty-five percent just six years earlier.[29] The numbers are only slightly better when other resources such as self-help programs—with typically voluntary twelve-step attendance—are included as options in the custody setting.[30] Intervention while in custody can be effective when it incorporates not only substance abuse treatment during physical detention but also a transitional program for reentry into society that integrates an aftercare component.[31] Prisoners receiving comprehensive treatment, transitional care, and aftercare have recidivism rates half that of untreated control groups.[32] However, treatment in custody without the structured follow-up offered by the successful programs is only marginally effective.[33] For those on probation, only seventeen percent of drug abusers receive treatment once sentenced.[34]

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[28] *See* David A. Wolfe et al., *Strategies to Address Violence in the Lives of High-Risk Youth*, *in* ENDING THE CYCLE OF VIOLENCE: COMMUNITY RESPONSES TO CHILDREN OF BATTERED WOMEN 255, 256 (Einat Peled et al. eds., 1995) (discussing effects of domestic violence on children).

[29] MUMOLA, *supra* note 10, at 1.

[30] *Id.*

[31] *See, e.g.*, State of Delaware - Substance Abuse Treatment Programs - Department of Correction, http://doc.delaware.gov/Programs/treatmentprograms.shtml (last visited Apr. 13, 2008) [hereinafter State of Delaware] (explaining KEY, Crest, Aftercare treatment program).

[32] *Id.*

[33] *See* Steven S. Martin et al., *Three-Year Outcomes of Therapeutic Community Treatment for Drug-Involved Offenders in Delaware: From Prison to Work Release to Aftercare*, 79 PRISON J. 304, 306 (1999) ("The KEY-CREST group, with both primary and secondary [therapeutic community] treatment, emerges as the group doing by far the best in terms of avoiding relapse and recidivism.").

[34] CHRISTOPHER J. MUMOLA, BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, SUBSTANCE ABUSE AND TREATMENT OF ADULTS ON PROBATION, 1995, at 1 (1998), *available at* http://www.ojp.usdoj.gov/bjs/pub/pdf/satap95.pdf.

Because addiction is a disease that most medical professionals agree cannot be overcome by self-will alone,[35] merely incarcerating substance abusers or placing them on probation without treatment fails to treat the disease and invites the inevitability of recidivism. Perversely, lengthy incarceration is not only the most expensive response to drug crimes but also the option most likely to result in recidivism.[36] While there are multiple, sometimes conflicting, theories of punishment in our criminal justice system—retribution, deterrence, rehabilitation, and incapacitation—it is naïve to believe that merely incarcerating a substance abuser, that is, physically incapacitating them, will lead to recovery from addiction or cessation of alcohol or other drug use. Although prisons and jails, ostensibly, have procedures in place to prevent drugs from entering facilities, they are still readily available behind bars.[37] As a result, drug use by individuals may continue while they are incarcerated, despite the best efforts of law enforcement to prevent it.

The correctional system consumes billions of dollars annually[38] with few positive results.[39] California, for example, spends $900 million annually to incarcerate parole violators.[40] Although three quarters of California inmates have alcohol or other drug problems, only six percent receive treatment while in custody, and a positive drug test is often the sole reason these inmates are returned to prison while paroled.[41] Because of overwhelming statistics like these, multiple jurisdictions across the nation have instituted

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[35] *See* A. Thomas McLellan et al., *Drug Dependence, a Chronic Medical Illness: Implications for Treatment, Insurance, and Outcomes Evaluation*, 284 JAMA 1689, 1693 (2000) (discussing "uncontrolled, involuntary dependence").

[36] *Cf.* LANGAN & LEVIN, *supra* note 2, at 8 (reporting that two-thirds of those released after serving time in state prisons for drug offenses were rearrested within three years).

[37] *See* Chase Riveland, *Prison Management Trends, 1975–2025*, 26 CRIME & JUST. 163, 185 (1999) (describing drug use in prison).

[38] *See* VINCENT SCHIRALDI ET AL., JUSTICE POLICY INST., POOR PRESCRIPTION: THE COSTS OF IMPRISONING DRUG OFFENDERS IN THE UNITED STATES 2 (2000), *available at* http://www.drugpolicy.org/docUploads/PoorPrescription.pdf ("Americans will spend nearly $40 billion on prisons and jails in the year 2000.").

[39] *See* Douglas B. Marlowe, *Effective Strategies for Intervening with Drug Abusing Offenders*, 47 VILL. L. REV. 989, 997 (2002) (reviewing disappointing results of imprisonment strategy).

[40] Fox Butterfield, *Study Calls California Parole System a $1 Billion Failure*, N.Y. TIMES, Nov. 14, 2003, at A24.

[41] *See id.* (discussing large numbers of parolees sent back to prison for minor violations).

problem-solving courts, specifically drug treatment courts, as a pragmatic yet innovative way to address the root cause of many recidivistic offenses: addictive disease.[42]

B. DRUG TREATMENT COURTS AND AMERICA'S DRUG PROBLEM

In 1989, the first adult drug treatment court was established in Miami, Dade County, Florida.[43] Since then, the number of drug courts has grown steadily.[44] As of 2004, there were 1,621 operational drug treatment courts in the United States and 215 jurisdictions were formally involved in the process of planning such a court.[45]

Drug treatment courts enable the criminal justice system to more effectively tackle the problem of addiction and the issues presented by substance abusers.[46] Drug treatment courts are organized around a set of unifying principles called the "key components."[47] These principles of drug treatment courts integrate the need to address addictive disease by enabling the traditional criminal justice system to use a non-adversarial approach.[48] Participants are identified early in the criminal court process,[49] placed quickly into a treatment program,[50] and monitored frequently by the court and by the treatment provider with drug tests.[51] Drug treatment courts

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[42] *See* C. WEST HUDDLESTON III ET AL., NAT'L DRUG COURT INST., PAINTING THE CURRENT PICTURE: A NATIONAL REPORT CARD ON DRUG COURTS AND OTHER PROBLEM SOLVING COURT PROGRAMS IN THE UNITED STATES 3 tbls.I & II, 4 tbl.III, 5 fig.II, 6 fig.III (2005) (displaying tables and figures showing growth in number of drug courts).

[43] Peggy Fulton Hora et al., *Therapeutic Jurisprudence and the Drug Court Movement: Revolutionizing the Criminal Justice System's Response to Drug Abuse and Crime in America*, 74 NOTRE DAME L. REV. 439, 454–55 (citing PETER FINN & ANDREA K. NEWLYN, U.S. DEP'T OF JUSTICE, PUBL'N NO. NCJ-142412, MIAMI'S "DRUG COURT": A DIFFERENT APPROACH 3 (1993)).

[44] *See* HUDDLESTON ET AL., *supra* note 42, at 3 (listing increases in years since 1989).

[45] *Id.* at 2 (citing Personal Communication with E. Pierre, Bureau of Justice Statistics, U.S. Dep't of Justice (Apr. 14, 2005)).

[46] *Id.*

[47] *See generally* BUREAU OF JUSTICE ASSISTANCE, U.S. DEP'T OF JUSTICE, DEFINING DRUG COURTS: THE KEY COMPONENTS (1997), *available at* http://www.ojp.usdoj.gov/BJA/grant/DrugCourts/DefiningDC.pdf (listing components and goals for drug courts).

[48] *Id.* at 3.

[49] *Id.* at 5.

[50] *Id.* at 7.

[51] *Id.* at 11.

may use a pre- or post-adjudication model. Pre-plea drug treatment courts operate as diversion programs in which the defendant is given the opportunity to participate without entering a plea of guilty or going through the trial process.[52] The end result of successful participation is dismissal of the criminal charges.[53] Post-plea courts require a finding of guilt, often by way of a guilty plea.[54] In the post-plea model, the program is imposed as a condition of probation, and any sentence is suspended pending completion of the program.[55]

Drug treatment court participants routinely interact directly with the judge and other members of the drug court team rather than speaking exclusively through counsel as in traditional court proceedings.[56] The drug treatment court team generally is comprised of the judge, defense counsel, prosecutor, treatment providers, and community corrections personnel.[57] Some courts also have team members who are probation officers, substance abuse counselors, or other helping professionals.[58] In addition, some jurisdictions involve community policing representatives and concerned members of the public as part of the team.[59] All team members work cooperatively with the drug treatment court participants to reduce their propensity to commit further crimes by treating their addictive disease.[60] Team members focus on

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[52] *See, e.g.*, CAL. PENAL CODE § 1000.5 (West Supp. 2008) ("The presiding judge of the superior court . . . together with the district attorney and the public defender, may agree in writing to establish and conduct a preguilty plea drug court program pursuant to the provisions of this chapter, wherein criminal proceedings are suspended without a plea of guilty for designated defendants.").

[53] *Id.* § 1000.5(b).

[54] *See, e.g.*, CAL. PENAL CODE § 1000.1(a)(3) (West Supp. 2008) (providing that court shall dismiss charges against defendant upon motion if defendant pleads guilty, completes program, and receives positive recommendation of program authority).

[55] *Id.*

[56] *See* BUREAU OF JUSTICE ASSISTANCE, *supra* note 47, at 14–15 (describing judge's relationship with participant as "active" and "supervising" and stating that "judicial interaction with each participant is essential").

[57] *See id.* at 1 (identifying members of drug court team).

[58] *See* Gregory Baker, *Do You Hear the Knocking at the Door? A "Therapeutic" Approach to Enriching Clinical Legal Education Comes Calling*, 28 WHITTIER L. REV. 379, 400 (2006) (listing Virginia drug court team members).

[59] *See* Anthony Alfieri, *Community Prosecutors*, 90 CAL. L. REV. 1465, 1491 (2002) (describing community component of same systems).

[60] *See* BUREAU OF JUSTICE ASSISTANCE, *supra* note 47, at 14 (emphasizing cooperative nature of treatment plan among team members).

returning drug treatment court participants to productive, sober membership in society.[61] The primary goal of the drug treatment court is finding solutions that will be "mutually beneficial to the defendant, the larger community, and . . . [the] victims."[62]

This Article addresses and rebuts the criticisms of drug treatment courts and the assumptions their authors rely on in formulating their arguments against the courts. It is not enough to merely reject the arguments of critics. It also is necessary to address their issues and make recommendations based on those concerns for the improvement of drug treatment courts. In doing so, it is hoped that an open discourse will allay critics' fears and contribute to the dialectic on the now proven and innovative therapeutic alternative to incarceration: drug treatment courts. Part II of this Article addresses critics' concerns about the disease model of addiction and the effectiveness of treatment for substance abusers, especially in a drug court setting. For instance, some articles that express a dislike for drug treatment courts question whether treatment may, or should, be coerced.[63] Part III of this Article discusses the legal issues surrounding the right to refuse treatment and the distinctions between cases where this issue has traditionally arisen and treatment in the drug court context. Concern over the potential for unchecked judicial discretion and the variety of safeguards in place to protect drug treatment court participants is discussed in Part IV. Ethical issues are the focus of some criticism about drug treatment courts.[64] Part V reconciles the role of defense in drug treatment courts with the requirement of diligent advocacy. It also discusses the prosecutor's duty to promote public safety, even in a non-adversarial context focused on a

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[61] *See id.* at 13–14 (naming abstinence and public safety as drug court's goals and claiming team's strategy encourages compliance).

[62] William H. Simon, *Criminal Defenders and Community Justice: The Drug Court Example*, 40 AM. CRIM. L. REV. 1595, 1596 (2003).

[63] *See* Kevin W. Whiteacre, *Strange Bedfellows: The Tensions of Coerced Treatment*, 18 CRIM. JUST. POL'Y REV. 260, 261–62 (2007) (summarizing articles criticizing drug treatment courts and coercing treatment).

[64] *See* Tamar M. Meekins, *Risky Business: Criminal Specialty Courts and the Ethical Obligations of the Zealous Criminal Defender,* 12 BERKELEY J. CRIM. L. 75, 79–82 (2007) (arguing that detailed ethical guidelines are needed to assist defenders in protecting clients' interests in drug courts and other specialty courts).

therapeutic goal. Economic concerns and whether drug treatment courts represent an adequate return on investment is discussed in Part VI. Part VII provides future recommendations, such as standardization and accreditation, for the continuing success of drug treatment courts. Lastly, Part VIII concludes that drug treatment courts are a strong alternative to incarceration as well as an effective mechanism in dealing with America's drug problem.

II. THE DISEASE MODEL OF ADDICTION AND TREATMENT EFFICACY

The widely accepted and evidence-based disease model of drug addiction is attacked by a few with the claim that drug addiction is not a disease; these critics see drug addiction as a poor moral choice made by an addict.[65] Some "neo-retributionists" such as Morris Hoffman, a district court judge in Denver, Colorado, have argued that drug treatment courts rest on the critical assumptions that drugs are an epidemic about which something has to be done and that drug addiction is a disease that can be successfully treated.[66] In support of the claim that the disease model lacks scientific credibility, Judge Hoffman cites himself as an authority.[67] Other judicial bodies, including the Supreme Court of the United States, disagree with this moralistic view and have for decades considered addiction to be a disease. As Justice Stewart wrote in the majority opinion in *Robinson v. California*, wherein the court found it unconstitutional to criminalize the status of addiction, "[Drug addition] is apparently an illness which may be contracted innocently or involuntarily."[68] Justice Douglas, in his concurrence in *Robinson,* wrote that treating a person who is a drug addict as a

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[65] *See* Morris B. Hoffman, *A Neo-Retributionist Concurs with Professor Nolan*, 40 AM. CRIM. L. REV. 1567, 1571 (2003) (claiming that "regular people" consider drug addiction to be "complex mix of compulsion and free will").

[66] *See id.* at 1567 (referring to author as "neo-retributionist"); Morris B. Hoffman, Commentary, *The Drug Court Scandal*, 78 N.C. L. REV. 1437, 1464–65 (2000) [hereinafter Hoffman, *Scandal*] (naming two assumptions on which drug courts are grounded).

[67] *See* Hoffman, *supra* note 65, at 1567 n.1 (citing Morris B. Hoffman, *Therapeutic Jurisprudence, Neo-Rehabilitationism and Judicial Collectivism: The Least Dangerous Branch Becomes the Most Dangerous*, 29 FORDHAM URB. L.J. 2063 (2002)).

[68] Robinson v. California, 370 U.S. 660, 667 (1962) (Douglas, J., concurring).

criminal amounts to "cruel and unusual punishment" under the Eighth Amendment.[69]

Critics have contended that addiction is not a disease because there is no identifiable disease mechanism.[70] This argument is decades out of date; a diagnosis of "dependence" or "addiction" has been included in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM) since the third edition in 1987.[71] Also, some scholars have classified addiction as a disease for centuries.[72] While a definition is not determinative, it can be illuminating. The fourth edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-IV-TR) defines substance dependence as "[a] maladaptive pattern of substance abuse, leading to clinically significant impairment or distress . . . occurring at any time in the same 12-month period."[73] In order to diagnose substance dependence, a "pattern" of at least three manifestations of the disease must be present.[74] These manifestations are defined as: "tolerance; withdrawal; larger consumed amounts or a longer periods of substance use; unsuccessful attempt to reduce use; much given to obtaining, using, and recovering from the effect of a substance; reduced social, occupational, and/or recreational activities; or continued use despite physical or psychological problems."[75] The most modern view of addiction is that it is a disease of the pleasure-producing chemistry of the brain.[76] One current scientific view

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[69] *Id.* at 668.

[70] Hoffman, *Scandal*, *supra* note 66, at 1470.

[71] AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 169 (3d ed. 1987).

[72] *See generally* William L. White, *Addiction As a Disease: Birth of a Concept*, COUNSELOR, Oct. 2000, at 46, *available at* http://www.counselormagazine.com/content/view/213/63/ (discussing early view of addiction as disease).

[73] AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 197 (4th ed., text rev. 2000) [hereinafter DSM-IV-TR].

[74] *Id.*

[75] Celia C. Lo & Richard C. Stephens, *Drugs and Prisoners: Treatment Needs on Entering Prison*, 26 AM. J. DRUG & ALCOHOL ABUSE 229, 235 (2000) (citing DSM-IV-TR, *supra* note 73).

[76] *See* Alan I. Leshner, *Science-Based Views of Drug Addiction and Its Treatment*, 282 JAMA 1314, 1314–15 (1999) (describing brain function changes resulting from prolonged drug use).

describes drug dependence as "less a failure of will than a miscarriage of brain chemistry."[77]

Addiction begins with substance use that leads to the occasional loss of control over that substance and a gradual exposure to increasingly adverse consequences.[78] With the continued use of alcohol, other drugs, or both, the disease progresses to more frequent and profound loss of control, development of tolerance caused by adaptive changes in the brain, craving or drug hunger, and denial.[79] Use of the word "denial" in the treatment of addiction refers not to the lay meaning of the word, but instead to a medical term indicating distorted and irrational thinking focused on obtaining and using the drug.[80] A diagnosis of addiction signifies that the individual is unable to control the use of substances in the face of adverse consequences, including penal and judicial consequences, caused by a pattern of irrational behaviors driven by tolerance, craving, and denial.[81]

All substance users are unique, but a combination of predisposing factors coupled with social factors can lead to an individual's diagnosis of addiction. There are three major risk factors that predispose an individual for the disease of addiction: genetics, childhood trauma, and mental illness, including learning disabilities.[82] Compounding the preexisting factors, the circumstances of first use and the properties of the drug or drugs

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[77] Geoffrey Cowley, *New Ways to Stay Clean*, NEWSWEEK, Feb. 12, 2001, at 44.

[78] *See* Peter W. Kalivas & Nora D. Volkow, *The Neural Basis of Addiction: A Pathology of Motivation and Choice*, 162 AM. J. PSYCHIATRY 1403, 1403 (2005) (detailing inability to suppress drug seeking response even when faced with incarceration or other adverse consequences).

[79] *See generally* Norman S. Miller et al., *The Relationship of Addiction, Tolerance, and Dependence to Alcohol and Drugs: A Neurochemical Approach*, 4 J. SUBSTANCE ABUSE TREATMENT 197 (1987) (providing neurochemical basis for tolerance, dependence, and craving of drugs and alcohol).

[80] *See* Barbara C. Wallace, *Psychological and Environmental Determinants of Relapse in Crack Cocaine Smokers*, 6 J. SUBSTANCE ABUSE TREATMENT 95, 101 (1989) (discussing "narcissistic denial" and distortion of reality).

[81] *See* DSM-IV-TR, *supra* note 73, at 194–95 (describing increased use of substance despite desire to regulate use and recurring substance-related legal problems).

[82] Michael P. Marshal et al., *Attention-Deficit Hyperactivity Disorder Moderates the Life Stress Pathway to Alcohol Problems in Children of Alcoholics*, 31 ALCOHOLISM: CLINICAL & EXPERIMENTAL RES. 564, 564 (2007) (asserting that life stress, genetics, and attention deficit hyperactivity disorder serve as "pathways" to substance use problems in children).

used are predictive of further use.[83] A person who uses a drug for the first time and has an extremely pleasurable experience will be more likely to continue to use that drug in the future as compared to a person who has a neutral or negative experience with the same drug.[84] The presence of an enabling system, which protects the user from the consequences of drug-using behavior, also is predictive of uncontrolled drug use.[85] Additionally, women and girls "become addicted to alcohol, nicotine, and illegal and prescription drugs at lower levels of use and in shorter periods of time . . . [and] suffer more severe brain damage from alcohol and drugs like Ecstacy . . . ."[86] While pre-disposing factors do not *cause* addictive disease, the presence of one or more of these factors in an individual's history increases the propensity of that person to use alcohol and other drugs in a manner that results in the loss of control over his or her behavior, making the person more likely to have contact with the criminal justice system.[87]

There is little argument that drug users exist; some critics, however, believe that the disease model of addiction and drug treatment courts fail to recognize the real factors that lead to addiction.[88] These critics claim social, cultural, and economic forces are the actual culprits that lead to addiction.[89] That assertion, however, is only partially correct. Drug treatment courts employing a bio-psycho-social model are by definition alert to contributory

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[83] *See* NAT'L INST. ON ALCOHOL ABUSE & ALCOHOLISM, U.S. DEP'T OF HEALTH & HUMAN SERVS., ASSESSING ALCOHOL PROBLEMS: A GUIDE FOR CLINICIANS AND RESEARCHERS 143 (John P. Allen & Veronica B. Wilson eds., 2d ed. 2003) (relating positive, alcohol-related experiences of user to maintenance of problematic drinking behavior).

[84] *See* McLellan et al., *supra* note 35, at 1690 (discussing interplay between initial, involuntary response to drug and voluntary choice to take drug and how this interplay affects dependence).

[85] *See id.* at 161 (noting that understanding social support is important in predicting relapse).

[86] Joseph A. Califano Jr., *Foreword* to NAT'L CTR. ON ADDICTION & SUBSTANCE ABUSE AT COLUMBIA UNIV., WOMEN UNDER THE INFLUENCE, at vii (2006).

[87] *See* Lo & Stephens, *supra* note 75, at 238–42 (correlating personal background factors of inmates with substance use).

[88] *See, e.g.*, Hoffman, *Scandal*, *supra* note 66, at 1471 (contending disease model ignores complex social and economic forces); Eric J. Miller, *Embracing Addiction: Drug Courts and the False Promise of Judicial Interventionism*, 65 OHIO ST. L.J. 1479, 1524 (2004) (emphasizing social factors relating to addiction).

[89] Hoffman, *Scandal*, *supra* note 66, at 1471.

factors. They recognize and target a variety of the environmental and societal influences that contribute to addiction. Specifically, drug treatment courts address social, cultural, and economic factors by offering ancillary services[90] that often include education, job training and placement, domestic relationship counseling, parenting classes, anger management, and literacy programs.[91] These programs work in conjunction with addiction treatment to mitigate the social pressures that can factor into substance abuse.

Critics not familiar with the recent decades of medical and pharmaceutical advancements argue addiction is not a disease because there is no effective treatment.[92] There is overwhelming evidence that drug treatment is effective,[93] but even were it not, this argument is specious because there are many diseases for which there are no known or effective treatments. These include common afflictions like the ubiquitous cold or more severe conditions such as Alzheimer's, Huntington's, and Parkinson's disease.[94] AIDS might not have been classified as a disease until decades after its discovery because, although treatments now can extend the lives of those infected, the disease cannot be "cured."[95] Likewise, although addictive disease cannot be cured at this juncture,[96] treatment models utilizing theories from several disciplines have shown remarkable potential to help substance abusers manage their disease and have been incorporated with success into the drug

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[90] BUREAU OF JUSTICE ASSISTANCE, *supra* note 47, at 23 (discussing partnerships between drug courts, public agencies, and community based organizations).

[91] HUDDLESTON ET AL., *supra* note 42, at 2 (noting capacity of drug court to provide job training, family counseling, and other services).

[92] Hoffman, *Scandal*, *supra* note 66, at 1470.

[93] *See* NAT'L INST. ON DRUG ABUSE, U.S. DEP'T OF HEALTH & HUMAN SERVS., PRINCIPLES OF DRUG ABUSE TREATMENT FOR CRIMINAL JUSTICE POPULATIONS 16 (2006), *available at* http://www.nida.nih.gov/PDF/PODAT_CJ/PODAT_CJ.pdf ("Treatment is an effective intervention for drug abusers . . . .").

[94] *See, e.g.*, *Huntington's Disease Findings Pave Way for Potential Cure*, SCIENCEDAILY, Aug. 11, 1997, http://www.sciencedaily.com/releases/1997/08/970811003504.htm (last visited Apr. 13, 2008) (noting that Huntington's disease is incurable).

[95] *See* What Is AIDS?, http://www.avert.org/aids.htm (last visited Apr. 13, 2008) (stating there is no cure for AIDS but antiretroviral medication can slow progression of HIV to AIDS).

[96] *See* Pat Wingert, *Nora Volkow*, NEWSWEEK, Dec. 25, 2006, at 78 (indicating currently there is no cure for addiction). In a recent interview, Dr. Nora Volkow, director of the National Institute of Drug Abuse, said that the future may bring a cocaine vaccine, drugs designed to disrupt and weaken an individual's memory of how good an addictive substance feels, and drugs to increase dopamine receptors. *Id.*

treatment court model. Such scientifically designed models include cognitive-behavioral therapy,[97] motivational enhancement,[98] contingency management,[99] and "hybrid" models that combine aspects of several models, such as the Matrix model.[100] These treatment modalities have been proven effective:[101]

> The ultimate goal of drug addiction treatment is to enable an individual to achieve lasting abstinence, but the immediate goals are to reduce drug abuse, improve the patient's ability to function, and minimize the medical and social complications of drug abuse and addiction. Like people with diabetes or heart disease, people in treatment for drug addiction will need to change behavior to adopt a more healthful lifestyle.[102]

Another goal of treatment programs employed by drug treatment courts is to produce law-abiding individuals who maintain control over their behavior, thus eliminating the need to commit collateral crimes to sustain their supply of the drug.[103]

Oftentimes, the effectiveness of treatment for a chronic illness relies on compliance with a treatment regimen.[104] Generally, drug

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[97] *See generally* AARON T. BECK ET AL., COGNITIVE THERAPY OF SUBSTANCE ABUSE (1993) (discussing cognitive-behavioral therapy).

[98] *See generally* WILLIAM R. MILLER & STEPHEN ROLLNICK, MOTIVATIONAL INTERVIEWING: PREPARING PEOPLE TO CHANGE ADDICTIVE BEHAVIOR (1991) (discussing motivational therapy).

[99] *See generally* Nancy M. Petry, *Contingency Management in Addiction Treatment*, PSYCHIATRIC TIMES, Feb. 2002, http://www.psychiatrictimes.com/display/article/10168/53961 (discussing contingency management technique).

[100] *See generally* Richard A. Rawson et al., *An Intensive Outpatient Approach for Cocaine Abuse Treatment: The Matrix Model*, 12 J. SUBSTANCE ABUSE TREATMENT 117 (1995) (discussing Matrix model).

[101] *See, e.g.*, Richard A. Rawson et al., *A Multi-Site Comparison of Psychosocial Approaches for the Treatment of Methamphetamine Dependence*, 99 ADDICTION 708, 716 (2004) (comparing Matrix results to those of conventional treatment).

[102] NAT'L INST. ON DRUG ABUSE, U.S. DEP'T OF HEALTH & HUMAN SERVS., NIDA INFOFACTS: TREATMENT APPROACHES FOR DRUG ADDICTION 1 (2006), *available at* http://www.nida.nih.gov/PDF/Infofacts/Treatment06.pdf.

[103] *See, e.g.*, William D. Bales et al., *Substance Abuse Treatment in Prison and Community Reentry: Breaking the Cycle of Drugs, Crime, Incarceration, and Recidivism?*, 13 GEO. J. ON POVERTY L. & POL'Y 383, 401 (2006) (finding prison-based drug treatment to be effective in increasing likelihood of successful community reintegration).

[104] *See* McLellan et al., *supra* note 35, at 1693 (connecting compliance with treatment

abusers who work to overcome their disease and comply with the regimen of education, counseling, and medication needed for recovery will have more favorable outcomes.[105] Success rates decline significantly when factors such as low socioeconomic status, co-occurring mental health disorders, and lack of family and social support block the road to recovery.[106] Hypertension, diabetes, and asthma all are related to lifestyle choices like exercise, weight control, and smoking.[107] Persons with these diseases may have the same difficulties adhering to treatment regimens as those addicted to alcohol or other drugs.[108] Studies have shown that although effective treatment exists, only sixty percent of adults with Type I diabetes adhere to their medication schedule and treatment regime, and seventy percent of adults with hypertension fail to follow prescribed regimens even though failure to do so may be fatal.[109] Similar statistics exist for persons with asthma or hypertension, who also must be retreated within a year at the same rate as people with substance abuse disorders.[110] The success rate of treating chronic illnesses, including substance dependence, is negatively impacted when there is not compliance with treatment protocols and maintenance regimens.[111] Substance dependence, similar to other chronic illnesses, should not escape classification as a disease because outcomes are altered when one person adheres to a treatment regimen and another person does not. Ultimately, however, it is not necessary to accept the disease model to be effective advocates for drug treatment courts.

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regimens to favorable outcomes).

[105] *Id.*

[106] *Id.*

[107] *See, e.g.*, Tommi Sulander et al., *Association of Smoking Status with Obesity and Diabetes Among Elderly People*, 45 ARCHIVES GERONTOLOGY & GERIATRICS 159, 164 (2007) (finding links between diabetes, obesity, and high levels of smoking).

[108] *See* McLellan et al., *supra* note 35, at 1693 (stating that treatment is heavily dependent on adherence to medical regimen).

[109] *Id.*

[110] *See id.* (finding fifty to seventy percent of adult patients with hypertension or asthma experience recurrence of systems each year and require additional medical care).

[111] *See id.* (linking treatment adherence to relapse rates).

A. THE ROLE OF GENETICS

While people vary greatly with respect to their propensity for addictive disease, studies of twins demonstrate empirically that there is a genetic component to addiction that makes some individuals more vulnerable to becoming addicts than others.[112] For example, research shows the sons of alcohol-dependent fathers inherit more tolerance to the effects of alcohol than the sons of non-alcohol-dependent fathers.[113] Additionally, persons found in select demographic groups like those from mainland China or male Israelis, who have the inherited presence of an aldehyde dehydrogenase genotype, experience an "involuntary skin 'flushing'" response to alcohol administration.[114] Alcoholism long has been associated with Native Americans, both stereotypically and empirically.[115] One study compared Finnish natives to southwestern Native Americans and located a shared genetic susceptibility to alcoholism.[116] All of these examples demonstrate the disparate effects that certain addictive substances have on different individuals under different circumstances.

Throughout the span of recorded human experience, it has been understood that intoxicants make people behave oddly and that some people use intoxicants to excess. What has not been understood, however, is why different people or groups react in different ways to the same substances. Changes in technology have

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[112] *See* Kenneth S. Kendler & Carol A. Prescott, *Cocaine Use, Abuse, and Dependence in a Population-Based Sample of Female Twins*, 173 BRIT. J. PSYCHIATRY 345, 345 (1998) (finding vulnerability to cocaine use and abuse substantially influenced by genetic factors); Marianne B.M. Van den Bree et al., *Genetic and Environmental Influences on Drug Use and Abuse/Dependence in Male and Female Twins*, 52 DRUG & ALCOHOL DEPENDENCE 231, 231 (1998) (finding influence from genetics and environment).

[113] McLellan et al., *supra* note 35, at 1690.

[114] *Id.* at 1690–91.

[115] Kirk C. Wilhelmsen & Cindy Ehlers, *Heritability of Substance Dependence in a Native American Population*, 15 PSYCHIATRIC GENETICS 101, 101–07 (2005); *see also* Everett R. Rhoades et al., *The Indian Burden of Illness and Future Health Interventions*, 102 PUB. HEALTH REP. 361, 365 (1987) (describing alcohol as leading risk factor among Native Americans).

[116] Marta Radel et al., *Haplotype-Based Localization of an Alcohol Dependence Gene to the 5q34 [γ]-Aminobutyric Acid Type A Gene Cluster*, 62 ARCHIVES GEN. PSYCHIATRY 47, 47 (2005). The Finnish population served as a control group not subject to the stresses of Native American life. *Id.*

made it possible to demonstrate genetic reasons for these differences. Genetic inheritance of substance dependence is significant in that, like all of us, defendants are unable to select their families and DNA. Genetic inheritance may be a factor that causes certain people to get in trouble with alcohol or other drugs, thus bringing them under the scrutiny of the criminal justice system.

In several recent studies of twins published in the field of addiction medicine, higher rates of substance dependence were found among twins than among non-twin siblings, and higher rates also were noted among monozygotic (identical or maternal) twins than among dizygotic (fraternal) twins.[117] In addition, published heritability studies indicate an empirically demonstrable genetic contribution to substance dependence, noting that the descendants of alcoholics or addicts are prone to addiction themselves.[118] Young teens who experiment with alcohol may experience different effects depending on whether there is a genetic history of addictive disease.[119] Teens from alcoholic families may not experience intoxication at low levels that affect other teens without the genetic background.[120] The genetically susceptible teens therefore tend to drink more to achieve the same desired level of inebriation.[121] This behavior can be observed in both genders, and the "daughters of alcoholics tend to have a greater physiological tolerance for alcohol, increasing their risk of heavy drinking and the development of subsequent alcohol problems."[122]

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[117] McLellan et al., *supra* note 35, at 1690.

[118] *See id.* (noting heritability estimates for male dependence on heroin and alcohol and female dependence on marijuana).

[119] *See* Marcia Russell, *Prevalence of Alcoholism Among Children of Alcoholics*, *in* CHILDREN OF ALCOHOLICS: CRITICAL PERSPECTIVES 9, 9–35 (Michael Windle & John S. Searles eds., 1990) (describing scientific tests showing influence of factors including genetics on children's alcoholism); *see also* McLellan et al., *supra* note 35, at 1690 (describing research showing sons of alcohol-dependent fathers inherit higher tolerance to alcohol than sons of non-alcohol-dependent fathers).

[120] *See* NAT'L INST. ON ALCOHOL ABUSE & ALCOHOLISM, U.S. DEP'T OF HEALTH & HUMAN SERVS., ALCOHOL ALERT NO. 67, UNDERAGE DRINKING 1–3 (2006) (showing alcohol tolerance might directly link to genetics).

[121] *See* Marc A. Schuckit et al., *Performance of a Self-Report Measure of the Level of Response to Alcohol in 12- to 13-Year-Old Adolescents*, 66 J. STUD. ON ALCOHOL 452 (2005) (describing impact of low level of response on consumption of alcohol).

[122] NAT'L CTR. ON ADDICTION & SUBSTANCE ABUSE AT COLUMBIA UNIV., WOMEN UNDER THE

Going deeper into the foundations of addiction and complementing the survey research, molecular geneticists have shown in recent studies that inheritance of the M2 muscarinic acetylcholine receptor predisposes humans to alcoholism, drug dependence, and depression.[123] Researchers conducted DNA analysis of 2,310 people from 262 biological families having at least three members suffering from alcoholism.[124] Some individuals in the families were both addicts and diagnosed as having major depressive disorder.[125] Both addicts and depressed addicts had distinguishable similarities in their DNA in a region on chromosome seven.[126] Individuals who were both addicted and depressed were the most likely to have the chromosomal marking.[127]

Looking closer at the specific region of the number seven chromosome, the researchers isolated the CHRM2 gene.[128] This gene has been identified as relevant to attention, learning, memory, and cognition.[129] The research found the gene was strongly associated with alcoholism and depression.[130] The correlation between presence of the gene and the disorders was strongest in those with both alcoholism and depression, suggesting the gene increases risk for developing both diseases.[131] The results were subsequently confirmed in a case-controlled study at Yale University.[132]

Studies on mice with a key brain receptor blocked—a receptor keyed to cannabinoid molecules found not only in marijuana but

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INFLUENCE 5 (2006) (citing Toni Lapp, *ACOG Addresses Psychosocial Screening in Pregnant Women*, 62 AM. FAMILY PHYSICIAN 23, 2701 (2000)).

[123] Jen C. Wang et al., *Evidence of Common and Specific Genetic Effects: Association of the Muscarinic Acetylcholine Receptor M2 (CHRM2) Gene with Alcohol Dependence and Major Depressive Syndrome*, 13 HUM. MOLECULAR GENETICS 1903, 1908 (2004).

[124] *Id.*

[125] *Id.*

[126] *Id.* at 1906.

[127] *Id.*

[128] *See id.* at 1904 (describing single nucleotide polymorphism analysis of CHRM2).

[129] *See id.* (detailing function of muscarinic receptors).

[130] *See id.* at 1908 (summarizing relationship between CHRM2 gene and disorders).

[131] *Id.* at 1905.

[132] *See generally* Xingguang Luo et al., *CHRM2 Gene Predisposes to Alcohol Dependence, Drug Dependence and Affective Disorders: Results from an Extended Case–Control Structured Association Study*, 14 HUM. MOLECULAR GENETICS 2421 (2005) (presenting results of study on CHRM2 gene).

naturally occurring in the brain—show a genetic basis for susceptibility to acquiring an addiction.[133] Mice with the cannabinoid receptor present in their genetic code preferred drinking alcohol when offered either alcohol or water and also, regardless of what they were offered, preferred the cage where alcohol was available.[134] When the molecular receptor was blocked, the mice drank less alcohol and stopped preferring the cage with alcohol.[135] Switching a section of genetic code around to modify addictive behavior indicates a strong causal connection between heredity and the predisposition to addictive disease. Men are not mice, but, by combining statistical and empirical studies of human behavior with research involving the genetic manipulation and dissection of animals, a formidable case is made for a link between the propensity for addiction and ancestry.

B. CHILDHOOD ABUSE

Children who grow up in chaotic homes where alcohol and other drugs are abused and who experience abuse and neglect by their parents or others are more likely to have problems as adults.[136] More than one in five high school girls report having experienced sexual or physical abuse, and those who suffered abuse are twice as likely to smoke, drink alcohol, or use illicit drugs as those who were not abused.[137]

Childhood sexual abuse is even more devastating. Nearly twice as many girls as boys in substance treatment report prior sexual abuse, and more than twice as many girls with a history of abuse

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[133] Panayotis K. Thanos et al., *Ethanol Self-Administration and Ethanol Conditioned Place Preference Are Reduced in Mice Lacking Cannabinoid CB1 Receptors*, 164 BEHAV. BRAIN RES. 206 (2005) (demonstrating effects of cannabinoid CB1 receptor on alcohol consumption in mice).

[134] *Id.* at 210.

[135] *Id.*

[136] *See* Cathy Spatz Widom & Susanne Hiller-Sturmhöfel, *Alcohol Abuse As a Risk Factor for and Consequence of Child Abuse*, 25 ALCOHOL RES. & HEALTH 52, 52–57 (2001) (discussing links between parental alcohol abuse and child abuse as predictive factor for later abusive and antisocial behavior).

[137] NAT'L CTR. ON ADDICTION & SUBSTANCE ABUSE AT COLUMBIA UNIV., *supra* note 122, at 53.

begin using alcohol before the age of eleven than girls who were not abused.[138]

C. CO-OCCURRING MENTAL HEALTH ISSUES

The National Mental Health Association has addressed the relationship between mental health disorders and substance abuse:

> Co-occurring mental health and substance abuse disorders are common. More than half (52 percent) of the people surveyed who had ever been diagnosed with *alcohol* abuse or dependence had also experienced a mental disorder at some time in their lives. An even larger proportion (59 percent) of people with a history of *other drug* abuse or dependence also had experienced a mental disorder. Mental health problems often predate substance abuse problems by 4/6 years; alcohol or other drugs may be used as a form of self-medication to alleviate the symptoms of the mental disorder. In some cases, substance abuse precedes the development of mental health problems. For instance, anxiety and depression may be brought on as a response to stressors from broken relationships, lost employment, and other situations directly related to a drug-using lifestyle.[139]

D. THE NATURE OF ADDICTIVE DRUGS

One myth asserted by drug treatment court critics is that addiction is not a disease since many people use drugs without becoming addicted. In support of this assertion, some, such as Judge Hoffman, cite the fact that many people use marijuana daily without becoming addicted.[140] Of course, it could be argued that daily use of an intoxicant is demonstrative of addictive behavior, but

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[138] *Id.* at 133.

[139] Alcohol and Drug Abuse, Addiction and Co-occurring Disorders: Factsheet, http://www1.nmha.org/substance/factsheet.cfm (last visited Apr. 13, 2008).

[140] Hoffman, *Scandal*, *supra* note 66, at 1471 n.136.

this point is ignored. Judge Hoffman writes, "[M]ost people exposed to even the most allegedly addictive of substances do not develop dependencies."[141] This claim is difficult to respond to because the article offers no citation for the proposition and declines to quantify the level of exposure or list the addictive substances to which he is referring.

The substance used by the defendant—alcohol, marijuana, methamphetamine, heroin, cocaine, or any other drug—may contribute to the progression and severity of addictive disease. Some drugs are more potent than others. Compared to heroin, cocaine, or nicotine, marijuana has a relatively lower propensity to be addictive to users.[142] High potency drugs, such as methamphetamine, cocaine, and heroin, tend to promote the rapid acquisition of tolerance.[143] Tolerance to a drug forces the user to escalate the dose to maintain the drug's effect.[144] Symptoms of withdrawal may occur if the amount used is less than the tolerance level.[145] Therefore it may be reasonably inferred that the potency of a given drug predicts the risk of developing physical dependence.[146]

The route by which a substance user administers a drug also is important in evaluating the effects.[147] For example, the use of a drug by nasal insufflation, known colloquially as "snorting," may lead to addiction slowly because of the rate at which the drug enters the body and the amount of the drug entering the defendant's system at any one time.[148] Compare this to the intravenous, injected use of a drug, which leads to physical dependence faster than

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[141] *Id.* at 1471.

[142] *See* Sandra P. Welch & Billy R. Martin, *The Pharmacology of Marijuana*, *in* PRINCIPLES OF ADDICTION MEDICINE 543, 547 (Allan W. Graham et al. eds., 3d ed. 2003) (noting risk of dependence on cannabis is more like that of alcohol than of nicotine or opioids).

[143] *See* Carlton K. Erickson & Richard E. Wilcox, *Neurobiological Causes of Addictions*, 1 J. SOC. WORK PRAC. ADDICTIONS 7, 11 (2001) (discussing brain chemistry in drug use).

[144] *See* MILLER & ROLLNICK, *supra* note 98, at 39 (explaining physical effects of tolerance).

[145] *See id.* (explaining withdrawal effects of drugs).

[146] *See, e.g.*, DRUG ENFORCEMENT ADMIN., U.S. DEP'T OF JUSTICE, DRUGS OF ABUSE 32 (2005), *available at* http://www.usdoj.gov/dea/pubs/abuse/doa-p.pdf (noting relation of dose to psychological effect).

[147] *See id.* (noting relation of rate of entry to psychological effect).

[148] *See* NIDA - Publications - Teaching Packets - The Neurobiology of Drug Addiction, http://www.nida.nih.gov/pubs/Teaching/Teaching2/Teaching5.html (last visited Apr. 13, 2008) (noting likelihood of abuse linked to speed with which drug reaches brain and relative slowness of snorting).

snorting because the route of administration is far more efficient.[149] Intravenous use, like inhalation or smoking, produces an immediate, intense euphoria called a "rush" that prompts the user to try to recapture the euphoric feeling with subsequent uses.[150] Although those injecting drugs show higher dependencies, smoking or inhalation are becoming the more common routes of administration for drug addiction.[151] This may be because many people are needle averse, so the offer of a pipe or a line of powder may seem more palatable than the proffer of a needle-tipped syringe and tourniquet, despite the relative effectiveness of administering drugs in these ways.

There has been extensive research on the neurochemical, neuroendocrine, and cellular changes observed during substance dependence.[152] Addictive drugs, in addition to any other physical effects that might be unique to a particular drug, have a specific effect on the brain structure involved in control of motivation and learned behaviors.[153] When the areas of the brain responsible for decisionmaking and weighing consequences in terms of pleasure and punishment are impaired or damaged, the brain becomes more stimulus-driven; addicts no longer consider the consequences of their actions but instead respond almost instinctively to the drive to remain stimulated and artificially rewarded.[154]

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[149] *See* DRUG ENFORCEMENT ADMIN., *supra* note 146, at 32 (listing times for cocaine to reach brain when taken intravenously and through snorting).

[150] *See* Reese T. Jones, *The Pharmacology of Cocaine Smoking in Humans*, *in* RESEARCH FINDINGS ON SMOKING OF ABUSED SUBSTANCES 30, 35 & fig.3 (C. Nora Chiang & Richard L. Hawks eds., 1990) (noting that peak concentrations occur early for smoking or intravenous administration).

[151] *See* Benedikt Fischer et al., *Comparing Injecting and Non-Injecting Illicit Opioid Users in a Multisite Canadian Sample (OPICAN Cohort)*, 12 EUROPEAN ADDICTION RES. 230, 230–31 (2006) (noting that injectors show more intense patterns of use and that increasing number of users are moving to non-injection routes of administration); Michael Gossop et al., *Cocaine: Patterns of Use, Route of Administration, and Severity of Dependence*, 164 BRIT. J. PSYCHIATRY 660, 661–63 (1994) (noting that cocaine injectors showed highest dependency and that route of first use was trending away from injection and toward smoking).

[152] McLellan et al., *supra* note 35, at 1691.

[153] *Id.*

[154] *See* Rita Z. Goldstein & Nora D. Volkow, *Drug Addiction and Its Underlying Neurobiological Basis: Neuroimaging Evidence for the Involvement of the Frontal Cortex*, 159 AM. J. PSYCHIATRY 1642, 1643 (2002) (proposing that "the behaviors and associated motivational states that are at the core of drug addiction are distinctly the processes of loss of self-directed/willed behaviors to automatic sensory-driven formulas and attribution of

The area of the brain involved in many of the actions of addictive drugs is the ventral tegmental area connecting the limbic cortex through the midbrain to the nucleus accumbens.[155] This area of the brain typically is associated with cue-induced craving, which occurs when addicts are in the "presence of people, places, or things that they have previously associated with their drug taking."[156] "Brain imaging studies have shown that cue-induced craving is accompanied by heightened activity in the forebrain, the anterior cingulate, and the prefrontal cortex[, all of which are]key brain areas for mood and memory."[157] Remarkably, addicted persons who are no longer using drugs can experience a demonstrable neurological reaction when they encounter a person, place, or thing connected to their previous drug usage, even years after last use.[158] Imaging studies likewise have demonstrated that mentioning an addict's preferred drug in conversation produces an abnormal reaction in the frontal and prefrontal cortex, the executive, decisionmaking part of the human brain, a reaction that is not present during a neutrally themed conversation.[159]

Drugs like alcohol, opiates, cocaine, and nicotine also have marked effects on the brain's dopamine system.[160] Both the ventral tegmental region and the dopamine system have been connected to feelings of euphoria, a sense of well-being, and contentment.[161] Addictive substances such as cocaine, opiates, and methamphetamine have been shown to stimulate the reward circuitry of the brain far in excess of what naturally pleasurable activity would produce, leading to an urgent and intense desire to

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primary salience to the drug of abuse at the expense of other rewarding stimuli").

[155] *See id.* at 1647 (illustrating interactions of mesocortical and mesolimbic circuits in drug addiction).

[156] Alan J. Leshner, *Treating the Brain in Drug Abuse*, NIDA NOTES (Nat'l Inst. on Drug Abuse, Rockville, Md.), Sept. 2000, http://www.drugabuse.gov/NIDA_Notes/NNVol15N4/DirRepVol15N4.html.

[157] *Id.*

[158] *See* Goldstein & Volkow, *supra* note 154, at 1644 (explaining that drug craving alone is possibly sufficient to activate frontolimbic circuits).

[159] *Id.* at 1645.

[160] *See id.* at 1646 (illustrating lower striatal dopamine receptor binding in drug users during withdrawal).

[161] McLellan et al., *supra* note 35, at 1691.

continue drug use.[162] This process, in which drug produced pleasure overrides natural sources of reward like food, sex, and parenting, results in physical changes to brain structure, which helps to explain the unnatural behaviors of addicted defendants.[163]

Studies also have shown that, depending on the dose administered, the frequency of use, and the chronicity of the condition, permanent pathophysiologic changes in the brain's reward circuitry, baseline levels of many neurotransmitters, and stress response system may persist.[164] In one study, such brain alterations persisted for ten years after sobriety.[165] Thus, medical findings support the disease model of addiction by illustrating the direct link between genetic variables, pathophysiology, and substance dependence.[166] There can be no reasonable doubt that addiction is a brain disease with observable symptoms and courses of treatment, just like any other disease.[167]

E. THE DISEASE MODEL OF ADDICTION IN DRUG TREATMENT COURTS

Some authors incorrectly believe that in relying on the disease model of addiction, and specifically the role of genetics and other predisposing factors, drug treatment courts deny that drug abusers are exercising a choice to use drugs.[168] This is supposedly problematic because this denial occurs in a criminal justice context wherein people can be terminated from the program for failing to control their behavior.[169] Critics believe this is an inconsistency in ideology and argue that part of the underlying foundation of drug

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[162] *See* Goldstein & Volkow, *supra* note 154, at 1647 (stating that adaptation responses to repeated dopamine enhancement in reward circuits render them less responsive to natural reinforcement).

[163] *See id.* (suggesting that lower sensitivity in reward circuits represent generalized impairment in ability to derive pleasure from non-drug-related stimuli).

[164] *See id.* at 1642 (stating that "dopamine involvement in drug addiction is likely to be mediated by means of functional and structural changes in the circuits that are modulated by dopamine").

[165] *Id.*

[166] *See generally supra* notes 112–38 and accompanying text.

[167] *See* Leshner, *supra* note 156 (describing methamphetamine users exhibiting symptoms similar to those seen in Parkinson's disease).

[168] *See, e.g.*, Miller, *supra* note 88, at 1519 (suggesting that disease model in part negates responsibility of addict for addictive behavior).

[169] Hoffman, *Scandal*, *supra* note 66, at 1475.

treatment courts is that drug abuse is involuntary.[170] This assertion is incorrect in two respects. First, regardless of whether or not a drug treatment court subscribes to the disease model of addiction, drug treatment courts do not consider defendants to be without volition. Second, while initial drug use may be a choice, subsequent addiction to those drugs is not. Such factors as behavioral control or willpower may play a powerful role at the onset of drug use,[171] and drug court participants will differ as to the extent of the control they have over their addictions.[172] Personal responsibility and choice work in conjunction with, and not to the exclusion of, genetic and cultural factors.[173]

Decades of scientific evidence on the nature of drug addiction supports the disease model of addiction.[174] The disease model of addiction is an empirically verifiable and evidence-based way of looking at substance dependence. There are many factors in addition, including: the first choice to use alcohol or other drugs that may contribute to addiction, genetics, socioeconomics, co-occurring mental health disorders, an abuse history, the age at which the drug was first used, and family and social relationships.[175] These factors should be considered together when determining and exploring the function that addictive disease has played in a defendant's behavior and in crafting a judicial response.

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[170] *See id.* ("If drug addition is truly a disease that manifests itself in uncontrollable behavior until treated, why is the criminal law involved at all . . . ?"); Miller, *supra* note 88, at 1520 ("[T]he disease model may, on occasion, be compatible with the administrative or due process models of crime control, although these models may also operate to limit its operation in certain circumstances.").

[171] *See* Alan I. Leshner, *Understanding Drug Addiction: Insights from the Research*, *in* PRINCIPLES OF ADDICTION MEDICINE, *supra* note 142, at 47, 48 ("Initial drug use is a voluntary behavior.").

[172] *See* McLellan et al., *supra* note 35, at 1690–91 (describing involuntary components embedded within seemingly volitional choices).

[173] *Id.*

[174] *See, e.g.*, Carol P. Waldhauser, *Identifying Addiction*, GPSOLO, July/Aug. 2001, at 22, 24 ("The disease model has dominated addiction studies for well over 20 years.").

[175] *See supra* notes 82–91, 112–41 and accompanying text.

III. THE ROLE OF COERCION

According to *Black's Law Dictionary*, to coerce is to "compel by force or threat."[176] In the drug treatment court context, it is more accurate to say that a bench officer, using "judicial leverage," "offers" or "suggests" the treatment option rather than "coerces" its selection. The drug court judge offers the defendant a choice of penal consequences where historically the available options were exceedingly narrow.[177] As outlined above, these options without treatment are largely ineffective, while the less onerous option, drug treatment court, offers a program wherein the individual has the opportunity for rehabilitation and often the possibility of less onerous penal consequences.[178]

Plea bargaining, which requires the defendant to waive many of his or her rights in exchange for conviction on a lesser charge and a diminished punishment, is the status quo for the overwhelming majority of criminal drug defendants in the United States.[179] The drug treatment court model, which asks defendants to waive some of their rights in exchange for the opportunity to receive treatment and possibly avoid a criminal conviction, should be embraced as a natural extension of the plea bargaining process.

A. COERCED VERSUS "VOLUNTARY" TREATMENT

Detractors of the treatment proffered by drug courts argue that the treatment is forced, and question whether courts should be in the business of coercing people accused or convicted of crimes into medical treatment.[180] The implication is that by offering defendants

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[176] BLACK'S LAW DICTIONARY 275 (8th ed. 2004).

[177] *See generally* Dan Kahan, *What Do Alternative Sanctions Mean?*, 63 U. CHI. L. REV. 591, 591 (1996) (discussing hesitancy in imposing punishments other than imprisonment).

[178] *See supra* notes 11–14 and accompanying text.

[179] K. JACK RILEY ET AL., RAND CORP., JUST CAUSE OR JUST BECAUSE? PROSECUTION AND PLEA-BARGAINING RESULTING IN PRISON SENTENCES ON LOW-LEVEL DRUG CHARGES IN CALIFORNIA AND ARIZONA 3 (2005), *available at* http://www.rand.org/pubs/monographs/2005/RAND_MG288.pdf.

[180] *See, e.g.*, Tamar M. Meekins, *"Specialized Justice": The Over-Emergence of Specialty Courts and the Threat of a New Criminal Defense Paradigm*, 40 SUFFOLK U. L. REV. 1, 19–20 (2006) (contending specialty drug courts coerce behavior through sanctions rather than

a subjectively favorable sentence in exchange for their agreement to enter the drug treatment court program, the defendants' right to refuse treatment somehow has been violated.[181]

Contrary to this assertion, drug treatment courts are voluntary programs that do not diminish the right to refuse treatment.[182] In many models, a determination of eligibility to participate in treatment is made at the time of charging.[183] In a drug treatment court context, an arrest is viewed as an "opportunity for intervention."[184] Initially, the defendant is offered the choice of whether to participate in the drug treatment program or to receive traditional case processing, whether or not that commonly includes incarceration.[185] In some models, post-conviction defendants are referred after sentencing to the drug treatment court for supervised probation.[186] In any case, a full explanation is given to the offender by defense counsel or, if the person is unrepresented, by a court coordinator.[187] The explanation must include a description of the program and the consequences that may result from each possible choice.[188] This counseling represents an opportunity for the defense both to practice advocacy and to ensure the client understands the rights being extended or waived.[189]

Although defendants often hope to avoid incarceration by voluntarily enrolling in drug treatment court programs, they must be, and are, informed that violation of the drug treatment court contract may result in short terms of confinement, sometimes called "smart punishment."[190] Some programs allow participants to choose

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rewards).

[181] *Id.* at 16–17.

[182] *Developments in the Law: Alternatives to Incarceration*, 111 HARV. L. REV. 1863, 1914–15 (1998).

[183] *Id.* at 1915.

[184] Peggy F. Hora, *A Dozen Years of Drug Treatment Courts: Uncovering Our Theoretical Foundation and the Construction of a Mainstream Paradigm*, 37 SUBSTANCE USE & MISUSE 1469, 1473 (2002).

[185] *Id.*

[186] *See, e.g.*, *Developments in the Law: Alternatives to Incarceration*, *supra* note 182, at 1915 (discussing how cases arrive in drug courts).

[187] *See* Simon, *supra* note 62, at 1600 (describing role of defense counsel in holding drug court programs to commitments and providing information to their clients).

[188] *Id.*

[189] *Id.* at 1600–01.

[190] *See* JEFFREY S. TAUBER, DRUG COURTS: A JUDICIAL MANUAL 9–10 (1994) (discussing

between jail time and a community work alternative program when there has been a breach of the drug treatment court contract.[191]

If the defendant chooses the drug treatment program alternative, he may still, at any point in the process, decide to leave the program and enter the traditional criminal justice case processing system, with all the attendant rights, remedies, burdens, and consequences of that system.[192]

The treatment option provided by drug treatment courts is synonymous with the practice of plea bargaining. Nationally over ninety-five percent of drug offenses are settled with a plea bargain; less than one in twenty is adjudicated by trial.[193] Every day in courts across the nation defendants waive certain constitutional rights in order to receive a more favorable outcome, such as a reduced sentence or charge.[194] In a plea bargaining situation, defendants who receive probation may be required to waive their right to be free from unreasonable search and seizure under the Fourth Amendment of the U.S. Constitution by accepting what is known as a "search clause," which may include their person, personal effects, automobile, and home.[195] Defendants in drug treatment courts, like most criminal defendants, also relinquish the right to a speedy trial guaranteed by the Sixth Amendment.[196] Similarly, drug court participants surrender various rights when agreeing to enter drug treatment court (for example, substance

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"smart punishment").

[191] *See* Hora, *supra* note 184, at 1479–80 (discussing "contingency contracting").

[192] H. Blair Carlson et al., *Special Issues in Treatment: Drug Courts*, *in* PRINCIPLES OF ADDICTION MEDICINE, *supra* note 142, at 543, 548.

[193] OFFICE OF NAT'L DRUG CONTROL POLICY, DRUG DATA SUMMARY 4 (2003), *available at* http://www.whitehousedrugpolicy.gov/pdf/drug_datasum.pdf.

[194] *See Developments in the Law: Alternatives to Incarceration*, *supra* note 182, at 1912 (stating that plea bargaining "requires defendants to waive significant constitutional protections").

[195] *See* Griffin v. Wisconsin, 483 U.S. 868, 872–73 (1987) (holding warrantless search of probationer's home did not violate Fourth Amendment).

[196] U.S. CONST. amend. VI; *see, e.g.*, CAL. PENAL CODE § 1000.5 (West Supp. 2008) (providing that "criminal proceedings are suspended" for drug court participants); Nelson v. Hargett, 989 F.2d 847, 850 (5th Cir. 1993) (holding defendant waives all nonjurisdictional defects, including speedy trial claims, upon entering guilty plea); Smith v. United States, 677 F.2d 39, 40–41 (8th Cir. 1982) (per curiam) (noting that defendant waives speedy trial right unless "plea of guilty was not based upon reasonably competent advice of counsel").

abuse treatment confidentiality), but also gain the benefits that go along with successful treatment.

Because many defendants brought under the authority of the criminal justice system for substance abuse related offenses also have co-occurring mental health disorders,[197] the issue of coerced psychiatric treatment ought to be addressed to preserve the rights of participants.[198] Defendants may have had their mental illness mistaken for recalcitrance or noncompliance during earlier interactions with the criminal justice system.[199] For instance, a defendant with agoraphobia or clinical depression who misses court dates or treatment contacts may be seen as malingering. Treatment for defendants with co-occurring disorders must address the underlying mental health issues or risk certain failure. Ample evidence in the literature supports the notion that inadequately treated psychiatric symptoms interfere with addiction treatment.[200] Many persons who become addicted to some drugs began their use of those drugs in an attempt to self-medicate their underlying mental health disorder.[201] Treatment that serves only to remove what, for them, has been a functional, if illegal, method of psychiatric symptom management will leave them with the

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[197] *See* George Winokur et al., *Alcoholism and Drug Abuse in Three Groups: Bipolar I, Unipolars and Their Acquaintances*, 50 J. AFFECTIVE DISORDERS 81, 82 (1998) (noting co-occurrence of substance abuse and affective disorders "has been well-documented in both clinic- and population-based studies"); *see also* Melissa Reuland & Gary J. Margolis, *Police Approaches That Improve the Response to People with Mental Illnesses: A Focus on Victims*, POLICE CHIEF, Nov. 2003, at 35 ("Nearly three-quarters of inmates with mental illness have a co-occurring substance abuse problem.").

[198] *See* Washington v. Harper, 494 U.S. 210, 227 (1990) (holding "Due Process Clause permits the State to treat a prison inmate who has a serious mental illness with antipsychotic drugs against his will").

[199] *See* THE SENTENCING PROJECT, MENTALLY ILL OFFENDERS IN THE CRIMINAL JUSTICE SYSTEM: AN ANALYSIS AND PRESCRIPTION 7 (2002), *available at* http://www.soros.org/initiatives/justice/articles_publications/publications/mi_offenders_20020101/mentallyill.pdf ("People with mental illness are more likely to exhibit the kinds of behaviors that will bring them into conflict with the criminal justice system . . . .").

[200] *See* Alan S. Bellack & Carlo C. DiClemente, *Treating Substance Abuse Among Patients with Schizophrenia*, 50 PSYCHIATRIC SERVICES 75, 80 (1999) (claiming "broad agreement" among researchers that "dually diagnosed patients need a special program that integrates and coordinates elements of both psychiatric and substance abuse treatment").

[201] *See* Henry David Abraham & Maurizio Fava, *Order of Onset of Substance Abuse and Depression in a Sample of Depressed Outpatients,* 40 COMPREHENSIVE PSYCHIATRY 44, 44 (1999) (noting drug use may be form of self-medication).

problems that began their drug use in the first place. The Supreme Court in *Sell v. United States*, most recent of the *Cruzan*[202] line of cases defining the limitations of state control over medical decisions, held that defendants may be forcibly medicated.[203] At issue in *Sell* was an attempt to reduce the dangerous propensities of the defendant through forced medication.[204] While such forced medication was disallowed, the Court suggested that a coerced pharmaceutical regime is permissible where it serves an "important" government interest.[205] The forcible medication must be necessary to further the government's important interest and must be medically appropriate.[206] The level of coercion employed in a drug treatment court context does not rise to the level of forced, in-custody medication found in cases like *Sell* because the defendant retains the right to withdraw from the program and return to traditional criminal case processing.[207] Because defendants with co-occurring mental health disorders may have been self-medicating with illegal substances, they may be amenable to the substitution of more effective, legal, psychotropic medication as an aspect of their treatment plan.

Like any criminal defendant, drug treatment court participants unable to give informed and knowledgeable consent due to a mental disability are not able to enroll in court-ordered treatment because competency "must be established as a matter of fairness to the defendant before any other procedures may take place."[208] Ultimately, the decision to participate in a drug treatment court program is, and must be, an intelligent, informed, and voluntary one made by persons that meet the legal standards of competency.[209]

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[202] Cruzan v. Dir., Mo. Dep't of Health, 497 U.S. 261 (1990).

[203] Sell v. United States, 539 U.S. 166, 179 (2003).

[204] *Id.* at 169–71.

[205] *Id.* at 180.

[206] *Id.* at 182.

[207] *See, e.g.*, SARAH E. PARKER & RALPH A. WALKER, SUPREME COURT OF N.C. ANNUAL REPORT ON NORTH CAROLINA'S DRUG TREATMENT COURTS 5 (2007), *available at* http://www.nccourts.org/Citizens/CPrograms/DTC/Documents/NDlegRp2007.pdf (noting that seventeen percent of discharges from drug treatment came from voluntary withdrawal).

[208] Thomas G. Gutheil, *A Confusion of Tongues: Competence, Insanity, Psychiatry, and the Law*, 50 PSYCHIATRIC SERVICES 767, 769 (1999).

[209] *See, e.g.*, William D. McColl, *Theory and Practice in the Baltimore City Drug Treatment Court*, *in* DRUG COURTS IN THEORY AND IN PRACTICE 3, 6–8 (James L. Nolan Jr. ed., 2002)

Finally, although a defendant's participation in a pre-plea drug court is based on an informed decision to accept treatment, the defendant retains the right to subsequently refuse treatment, withdraw from the program, and face resumption of traditional criminal proceedings. The defendant's drug treatment court participation cannot be used adversely if he withdraws from the program and returns to traditional criminal proceedings.[210] Those who elect to leave the program and have their case tried in a traditional court have all of their constitutional rights reinstated.[211] Post-plea participants also are able to leave the program, although they may have to accept any conviction and its subsequent penal consequences based on the plea entered prior to beginning the program.[212]

B. A HOBSON'S CHOICE?

The "Hobson's choice" is another focus of drug treatment court detractors who claim defendants are asked to choose between two undesirable alternatives: treatment or incarceration.[213] Hobson's choice is an allegorical reference to the option of choosing between taking what is offered, despite its undesirability, or taking nothing at all.[214] Unlike the original Hobson, however, defendants offered drug treatment court placement are given a true choice between therapeutic court enrollment and regular case processing.[215]

People with addictions have the right to make their own decisions except when their choices interfere with the rights of others or the

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(describing process judges go through to ensure participants make informed decisions before entering program).

[210] Hora et al., *supra* note 43, at 470.

[211] Carlson, *supra* note 192, at 548.

[212] *See* JAMES L. NOLAN JR., REINVENTING JUSTICE: THE AMERICAN DRUG COURT MOVEMENT 41 (2001) (describing different points in judicial process when participants enter program).

[213] *See* Meekins, *supra* note 180, at 5–6 (illustrating hypothetical conversation between attorney and client faced with option of entering drug treatment court).

[214] Posting of David Wilton to Wordorigins.org, Hobson's Choice, http://www.wordorigins.org/index.php/site/comments/hobsons_choice (July 3, 2006). The aphorism "a Hobson's choice" is said to come from the name of Tobias Hobson (c. 1544–1631) of Cambridge, England, who kept a livery stable and required every customer to take either the horse at the stall closest to the door or no horse at all. *Id.*

[215] *See* McColl, *supra* note 209, at 8 (describing choices arrestee can make).

law.[216] In *McKune v. Lile*, the U.S. Supreme Court upheld the Sexual Abuse Treatment Program (SATP) offered by the Kansas Department of Corrections for incarcerated sexual abuse offenders.[217] SATP required participants to disclose all prior instances of sexual abuse that they had committed.[218] SATP was geared toward protecting public health[219] and reducing recidivism.[220] The Court discussed the voluntariness of participation in the treatment program and the alternatives to non-participation such as staying in less comfortable conditions.[221] A refusal to participate in the program meant that the inmate would suffer a significant reduction in visitation rights, earnings, work opportunities, the ability to send money to family, the ability to purchase items in the prison canteen, and access to personal television, as well as the denial of other sundry privileges.[222] The inmate also would be moved to a maximum-security unit, ostensibly a more restrictive, and thus less desirable, environment.[223] The Court held that the incentives that were provided to those in need of treatment were not an unconstitutional compulsion.[224] Thus, the Supreme Court recognized that offering treatment is within a state's police powers, even when the consequences to the incarcerated person of foregoing the treatment are quite onerous. Because the sanctions in drug courts are notably less severe than those imposed by SATP, by inference they do not rise to an unconstitutional level of compulsion, let alone a Hobson's choice.

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[216] JACKIE MASSARO, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., OVERVIEW OF THE MENTAL HEALTH SERVICE SYSTEM FOR CRIMINAL JUSTICE PROFESSIONALS 2 (2005), *available at* http://gainscenter.samhsa.gov/pdfs/jail_diversion/MassaroII.pdf.

[217] McKune v. Lile, 536 U.S. 24, 48 (2002).

[218] *Id.* at 30.

[219] *Id.* at 48.

[220] *Id.* at 33.

[221] *Id.* at 36.

[222] *Id.* at 30–31.

[223] *Id.*

[224] *Id.* at 48.

C. TREATMENT COMPONENTS

1. Compulsory Treatment in General. States are allowed to create compulsory treatment programs with the possibility of penal sanctions for noncompliance.[225] Even if some participants feel the treatment program is the only alternative to imprisonment and they otherwise would refuse treatment, the state has the authority to compel enrollment.[226] A few states even allow for the civil commitment of pregnant drug users where no criminal charges are pending.[227] Because all criminal defendants must enter a plea of guilty, *nolo contendere*, or not guilty and accept the consequences thereof, and because defendants may not opt out of the system, the decisionmaking process almost always will have a certain amount of coercion since penal consequences may follow.[228] In a therapeutic context, "coercion," or "compulsory treatment," describes an "array of strategies that shape behavior by responding to specific actions with external pressure and predictable consequences."[229] Evidence indicates that substance abusers mandated to receive treatment benefit as much as, and sometimes more than, substance abusers who spontaneously elect to enter treatment.[230] Some coercive pressures involved in compulsory treatment include the "avoidance of harsh conditions associated with confinement, . . . promised reductions in periods of confinement, . . . [and] forced exposure to the initial stages of the treatment process."[231] A wide array of inducements or methods of persuasion may be used in settings other

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[225] Robinson v. California, 370 U.S. 660, 664–65 (1962) (dictum) (stating that state could establish program for involuntary treatment of drug addicts involving penal sanctions for noncompliance).

[226] *Id.*

[227] *E.g.*, MINN. STAT. ANN. § 253B.065(5)(c) (West Supp. 2008); S.D. CODIFIED LAWS § 34-20A-70(3) (2004); WIS. STAT. ANN. § 48.193 (West 2003). These statutes provide variously for early intervention treatment, commitment by behest of a responsible person, and forced custody of pregnant drug users.

[228] NAT'L DRUG COURT INST., CRITICAL ISSUES FOR DEFENSE ATTORNEYS IN DRUG COURT 41 (2003).

[229] HUDDLESTON ET AL., *supra* note 42, at 4.

[230] John F. Kelly et al., *Substance Use Disorder Patients Who Are Mandated to Treatment: Characteristics, Treatment Process, and 1- and 5-year Outcomes*, 28 J. SUBSTANCE ABUSE TREATMENT 213, 213 (2005).

[231] Franklin E. Zimring, *Drug Treatment As a Criminal Sanction*, 64 U. COLO. L. REV. 809, 820 (1993).

than the criminal justice system to encourage or compel treatment when decisionmaking may be hindered by the problems associated with addiction.[232] Pressure to seek treatment from addicts' families, employers, or communities often is present when persuading addicts to submit to a treatment program.[233] Besides being a benevolent form of coercion, this process also can be an informed and intelligent decisionmaking tool, where the individual weighs the benefits and costs of successfully completing drug treatment court against the difficulties of proceeding through the array of unpleasant alternatives the criminal justice system has to offer.

When coercion is employed in the drug treatment court system, it does not involve forcing the defendant to receive treatment against his or her will. In this context, it is the careful leverage of judicial authority to encourage the offender to choose the most statistically probable opportunity for rehabilitation and a better life. The court could use pure compulsion and require an addict to enroll in treatment,[234] but if defendants are not convinced of the value of participation in that treatment, they almost certainly will fail.

The drug treatment court team must take into account the resistance to treatment that the defendant may present in the early stages of recovery. Many defendants may have only limited recollections of what normal, everyday life feels like or how to act in sober society.[235] For defendants in early recovery, the lure of a return to their customary, but socially unacceptable, patterns of behavior may be overwhelming.[236] For instance, their friends and associates all may use alcohol or other drugs. The defendants themselves may live in an environment full of drug paraphernalia and other triggering stimuli; they may be used to staying up all night and sleeping all day; and some might not remember how to perform mundane tasks like grocery shopping that most people take for granted. The court must exert its authority to encourage

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[232] *Id.* at 812.

[233] *Id.*

[234] *Cf.* Yih-Ing Hser et al., *Predicting Drug Treatment Entry Among Treatment-Seeking Individuals*, 15 J. SUBSTANCE ABUSE TREATMENT 213, 213 (1998) (finding legal coercion to be "effective factor" in promoting drug treatment entry).

[235] *See supra* notes 162–64 and accompanying text.

[236] *See supra* notes 156–58 and accompanying text.

defendants to tackle these challenges and must maintain that pressure in the face of inevitable setbacks.

Some behaviors exhibited by a person in early recovery may be the result of withdrawal from the drug itself. Defendants may experience not only painful physical withdrawal but also symptoms in reverse of the drug's effects.[237] Abusers of stimulants may need weeks of rest to alleviate long-term deprivation;[238] methamphetamine abusers may in fact sleep for more than a full day when first initiating sobriety.[239] Depressant abusers will experience stimulation and may be unable to sleep at all, requiring careful medication to allow them some rest.[240] Heroin abusers especially will experience an extremely unpleasant resurgence in their metabolism as it returns to normal after years of suppression.[241] Abusers who experienced feelings of euphoria and pleasure and received a "high" from their drug will suffer through an extended period of dysphoria, discomfort, and a "low," known medically as anhedonia, describing a complete, pathological inability to experience pleasure.[242] Defendants with co-occurring mental illness may need to have medications to address the underlying co-occurring disorder.[243] A medical school professor described the value of judicial leverage for these individuals: "Judges should coerce treatment until sobriety becomes tolerable."[244]

Studies cited by the National Institutes of Health found that drug abuse is reduced by up to sixty percent with treatment.[245] Likewise,

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[237] Hugh Myrick et al., *Management of Intoxication and Withdrawal: General Principles*, *in* PRINCIPLES OF ADDICTION MEDICINE, *supra* note 142, at 611, 612.

[238] *See* Sanford Auerbach, *Sleep Disorders Related to Alcohol and Other Drug Use*, *in* PRINCIPLES OF ADDICTION MEDICINE, *supra* note 142, at 1179, 1187 (stating hypersomnia is consequence of episodic stimulant use).

[239] B.K. Logan, *Methamphetamine: Effects on Human Performance and Behavior*, 14 FORENSIC SCI. REV. 133, 138 (2002).

[240] *See* Auerbach, *supra* note 238, at 1188 (noting opioid users often experience insomnia during withdrawal).

[241] *See* Patrick G. O'Connor et al., *Management of Opioid Intoxication and Withdrawal*, *in* PRINCIPLES OF ADDICTION MEDICINE, *supra* note 142, at 651, 654–55 (discussing opioid withdrawal).

[242] *See* Myrick et al., *supra* note 237, at 612–13 (discussing withdrawal states).

[243] *Id.* at 616.

[244] John Chappel, Professor of Med., Univ. of Nev., Reno, Address at the National Judicial College (Sept. 25, 2007).

[245] NAT'L INST. ON DRUG ABUSE, U.S. DEP'T OF HEALTH & HUMAN SERVS., PRINCIPLES OF

there is evidence that treatment works in the context of drug treatment courts, where the rate of retention is vital to the success of a person seeking drug treatment.[246] Compared to traditional "voluntary"[247] treatment, drug treatment courts increase retention rates.[248] The Drug Abuse Treatment Outcome Study found that half of those who checked into an outpatient drug treatment program stayed less than three months.[249] However, studies show that sixty percent of those who participate in outpatient drug treatment as part of a drug treatment court program are still in treatment after one year.[250] Moreover, the longer a participant is in treatment, the lower the recidivism rate.[251] Overall, addicts referred to treatment by the criminal justice system are more likely to complete treatment and less likely to leave treatment against medical advice than those patients who are not mandated to treatment.[252] Employing the authority of the drug treatment court to extend time in treatment appears to be a positive factor for increasing program retention and reducing recidivism.[253]

Given the existing methods used to encourage defendants to make particular decisions with respect to drug treatment in both the criminal justice system and society at large, using drug treatment courts to initiate treatment is not only a legally permissible option but also an effective option for reducing criminal behavior and helping defendants achieve sobriety and a productive life.

2. Urine Testing. Testing urine for indicia of alcohol and other drugs has been upheld by courts as a valid condition of drug

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DRUG ADDICTION TREATMENT: A RESEARCH-BASED GUIDE 15 (1999), *available at* http://www.nida.nih.gov/PDF/PODAT/PODAT.pdf.

[246] Steven Belenko, *Research on Drug Courts: A Critical Review*, NAT'L DRUG CT. INST. REV., Winter 1999, at 1, 26.

[247] Voluntary treatment is that in which the individual decides to enter the program without the intervention of the court system.

[248] Belenko, *supra* note 246, at 26–27.

[249] *Id.* (citing D.D. Simpson et al., *Treatment Retention and Follow-Up Outcomes in the Drug Abuse Treatment Outcome Study*, 11 PSYCHOLOGY OF ADDICTIVE BEHAVIORS 294 (1997)).

[250] *Id.* at 26.

[251] *Id.*

[252] Substance Abuse & Mental Health Servs. Admin., U.S. Dep't Health & Human Servs., *Discharges Who Left Against Professional Advice: 2003*, DASIS REP., 2006, http://oas.samhsa.gov/2k6/leftTX/leftTX.htm.

[253] *Id.*

diversion programs.[254] Urine testing has not been limited to drug treatment programs; it also is employed in the penal system, in educational settings like high school and college athletics, and in government and private sector hiring programs.[255] In a treatment context, frequent urine testing is used "to monitor a participant's alcohol or other drug use, not for the purpose of 'catching' [the client in non-compliance], but to measure treatment effectiveness and make adjustments in the treatment plan in a timely fashion."[256] Moreover, urine testing is therapeutic in the sense that it provides motivation for the individual to stay free from alcohol and other drugs by creating an incentive to continue with good behavior.[257] Frequent testing promotes candor and honesty between the participant and the entire treatment team, including the judge.[258]

If voluntarily agreed to, urine testing is a valid condition of probation or diversion, not unlike the ubiquitous search clauses common in traditional criminal case processing. One of the criticisms of drug testing has been that drug testing violates an individual's right to be free from unreasonable searches and seizures granted under the Constitution. Urine testing, which is considered a search within the meaning of the Fourth Amendment, violates the Fourth Amendment when conducted without probable cause and patient consent.[259] For example, a program that tested pregnant women without their consent or knowledge and referred positive tests to law enforcement was held to be an unconstitutional intrusion into protected rights.[260] However, this line of reasoning does not apply to the drug treatment court context because drug

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[254] *See* Terry v. Superior Court, 86 Cal. Rptr. 2d 653, 654 (Cal. Ct. App. 1999) (holding that trial court could impose drug testing conditions); *see also* Oliver v. United States, 682 A.2d 186, 194 (D.C. 1996) (holding that requiring criminal defendant to submit to drug testing as condition to pretrial release was lawful).

[255] *See, e.g.*, Michael J. Hudock III, Comment, *Behind the Hysteria of Compulsory Drug Screening in Employment: Urinalysis Can Be a Legitimate Tool for Helping Resolve the Nation's Drug Problem If Competing Interests of Employer and Employee Are Equitably Balanced*, 25 DUQ. L. REV. 597, 608–09 (1987) (discussing situations in which urinalysis has been used).

[256] Hora, *supra* note 184, at 1476.

[257] *Id.*

[258] *Id.*

[259] Ferguson v. City of Charleston, 532 U.S. 67, 76–77 (2001).

[260] *Id.* at 85–86.

court participants knowingly agree to be drug tested.[261] Additionally, all drug treatment court team members stipulate ahead of time that results of the tests will not be used against the participant, either to file a new case or to prosecute the current case in the event the participant elects to leave the program.[262] A disputed drug test result may be challenged by the participant by requesting a retest or providing an explanation for a false positive.[263] Defendants may produce evidence to challenge the scientific accuracy of the results, assert their right to confront and cross examine government witnesses regarding any chain of custody issues, or call expert witnesses with regard to the testing mechanisms.[264] The benefits of urine testing outweigh any criticisms, and there is certainly no legal bar to using them. Utilizing urine testing as part of a drug treatment court contract does not violate the rights of the participant and is an effective form of monitoring throughout the drug treatment process.

3. Counseling. Counseling is a key aspect of drug treatment and the drug treatment court process. Counseling helps participants resolve underlying issues that may contribute to their addiction and hinder recovery.[265] The concern has been raised that participants must choose between therapy and jail time.[266] Therapy, however, is only one component of drug treatment court in a set of valid options the state may offer to criminal defendants.[267] In addition, drug treatment counseling is similar to other interventions that are routinely imposed in plea-bargaining situations for similar types of criminal offenses. For example, when defendants are convicted of a domestic violence charge in California, they are required to participate in a mandatory, fifty-two-session domestic violence

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[261] For a description of some constitutional rights waived by criminal defendants in plea bargaining situations, see *supra* notes 193–95 and accompanying text.

[262] BUREAU OF JUSTICE ASSISTANCE, *supra* note 47, at 3–4.

[263] NAT'L DRUG COURT INST., *supra* note 228, at 34–35.

[264] *Id.* at 35.

[265] CTR. FOR SUBSTANCE ABUSE TREATMENT, SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., SUBSTANCE ABUSE TREATMENT FOR PERSONS WITH CO-OCCURRING DISORDERS (2005), *available at* http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.chapter.74073.

[266] *See* Meekins, *supra* note 180, at 18 (noting defendant's "untenable position").

[267] CENTER FOR SUBSTANCE ABUSE TREATMENT, U.S. DEP'T OF HEALTH & HUMAN SERVS., PUBL'N NO. (SMA) 05 - 4056, SUBSTANCE ABUSE TREATMENT FOR ADULTS IN THE CRIMINAL JUSTICE SYSTEM (2005), http://www.ncbi.nlm.nih.gov/books/bv.fcgi?rid=hstat5.chapter.80017.

intervention program.[268] Failure to participate in the mandatory counseling may be charged as a probation violation just like the violation of any other condition and could subject the defendant to incarceration.[269] A similar burden is placed on a fundamental constitutional right, that of familial integrity.[270] California mandates that any motion for custody or visitation with a minor, or to change a previous order for custody or visitation, automatically results in assignment to mediation with a family court services worker who encourages conciliation.[271] The counsel for parties may even be prohibited from attending this session.[272] Thus, drug treatment is but one legal scenario in which defendants may find themselves ordered into counseling, and there is no legal bar to doing so.

4. Residential Treatment. Residential treatment facilities are far less onerous than incarceration and are rarely required of drug treatment court participants because of the cost savings realized in an outpatient setting. During residential stays, however, which are similar to outpatient treatment, participants are required to participate in counseling sessions.[273] Also similarly to outpatient treatment, residential patients are given medical treatment designed to mitigate the physical pain of withdrawal, as well as other medications to blunt the compulsion and craving that create pressure to return to drug use. The key difference is that the participant in residential treatment lives in the facility for a time.[274] This valuable treatment option is not for every participant and is

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[268] CAL. PENAL CODE § 1203.097(a)(6) (West Supp. 2008).

[269] *See, e.g.*, 18 U.S.C.S. § 3563(a)(4) (Lexis 2006) (requiring defendant to attend "public, private, or private nonprofit offender rehabilitation program that has been approved by the court" after first-time domestic violence conviction).

[270] *See* Troxel v. Granville, 530 U.S. 57, 65 (2000) (plurality opinion) (recognizing fundamental liberty interest of parents to care for and control their children).

[271] *See* CAL. FAM. CODE §§ 3161, 3170 (West 2004) (requiring court to set contested issues for mediation to "reduce alimony," "develop an agreement," and "effect a settlement").

[272] *See* CAL. FAM. CODE § 3182 (West 2004) (conferring authority on mediator to exclude counsel if appropriate or necessary).

[273] *See* Martin Adler et al., *The Treatment of Drug Addiction: A Review*, *in* PRINCIPLES OF ADDICTION MEDICINE, *supra* note 142, at 419, 422 (discussing residential treatment).

[274] *Id.*

most helpful for those who live in a cue-rich environment that induces craving.[275]

Research has shown that for years after the cessation of use, even the sight of the drug can set off a neurochemical chain reaction in the recovering person that may lead to relapse.[276] For some drug treatment court defendants, placement into their habitual environments, rich in the sights, sounds, and experiences with which they associate drug use, reliably leads to failure of the treatment program.[277] Residential treatment, which focuses on transitioning the defendant from a using lifestyle to a sober one, thereby provides relapse prevention, and prepares the resident for handling the results of cuing.[278] Residential treatment programs are a less onerous judicial imposition than placing participants into situations where they are likely to fail and then be punished for that failure.[279] Residential treatment is permissible as a valid exercise of the state police power[280] and may serve as a critical solution to participants in need of more closely supervised care.

5. Twelve-Step Meetings. One of the more controversial components of many, if not most, drug treatment courts is the requirement that participants attend twelve-step meetings.[281] While Alcoholics Anonymous (AA) and other twelve-step programs may be incorporated by drug treatment courts into treatment

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[275] *See* Leshner, *supra* note 171, at 52 (noting persistence of drug-related memory and its ability to evoke past drug experiences).

[276] *See* Eric J. Nestler & Robert C. Malenka, *The Addicted Brain*, SCI. AM., Mar. 2004, at 78, 83 ("A mere taste or a memory can draw the addict back . . . even after long periods of abstention.").

[277] *See* John W. Finney & Rudolf H. Moos, *Effects of Setting, Duration, and Amount on Treatment Outcomes*, *in* PRINCIPLES OF ADDICTION MEDICINE, *supra* note 142, at 443, 444 (noting superiority of inpatient detoxification).

[278] *Id.*

[279] *See, e.g.*, *Developments in the Law: Alternatives to Incarceration*, *supra* note 182, at 1906–07 (discussing poor outcomes for drug monitoring while on probation).

[280] People v. Elmore, 77 Cal. Rptr. 721, 724 (Cal. Ct. App. 1969); *see also* Robinson v. California, 370 U.S. 660, 665 (1962) (noting potential establishment of compulsory treatment effectuated by involuntary confinement).

[281] *See* Erwin Chemerinsky, *Why Separate Church and State?*, 85 OR. L. REV. 351, 365–66 (2006) (discussing coercive effects of drug court incentives for defendants to participate in twelve-step programs).

plans,[282] there is no requirement in the key components that define drug treatment courts, that this be so.[283]

The most prominent twelve-step groups are based on a belief in the existence of some higher power.[284] In AA, the eleventh step involves "prayer and meditation to improve our conscious contact with God, as we [understand God]."[285] "God" may be considered any "higher power" and is not necessarily the Judeo-Christian God.[286] The references to a higher power may prove problematic for the nonreligious drug court participant. Since the concept of a higher power has constitutional implications, it would be improper for a drug treatment court to require AA and not offer nonreligious alternatives; mandating attendance at a faith-based program has been found to run afoul of the First Amendment's Establishment Clause.[287] However, not all twelve-step programs are faith-based. There is a long history of secular or non-faith based, alternative self-help groups such as SMART Recovery, Moderation Management, LifeRing Secular Recovery, Secular Organization for Sobriety, and

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[282] Emily M. Gallas, Comment, *Endorsing Religion: Drug Courts and the 12-Step Recovery Support Program*, 53 AM. U. L. REV. 1063, 1065 (2004) (reviewing use of various twelve-step programs such as Alcoholics Anonymous by drug treatment courts).

[283] *See* BUREAU OF JUSTICE ASSISTANCE, *supra* note 47, at 8 ("Treatment services may include . . . 12-step self-help groups . . . ."); *see also supra* notes 47–51 and accompanying text.

[284] *See* Alcoholics Anonymous: Service Material, http://www.alcoholics-anonymous.org/en_services_for_members.cfm?PageID=98&SubPage=117 (last visited Apr. 16, 2008) (referring to a higher power in several steps).

[285] *Id.*

[286] *See* Alcoholics Anonymous, http://www.alcoholics-anonymous.org/en_is_aa_for_you.cfm?PageID=16&SubPage=86 (last visited Apr. 18, 2008) (sharing testimony of AA participant holding atheistic beliefs).

[287] *See, e.g.*, Inouye v. Kemna, 504 F.3d 705, 714 (9th Cir. 2007) (holding coercion into faith-based drug treatment programs unconstitutional); Warner v. Orange County Dep't of Prob., 115 F.3d 1068, 1077 (2d Cir. 1996) (holding probation department liable for nominal damages for establishment of religion by requiring AA); Griffin v. Coughlin, 673 N.E.2d 98, 108 (N.Y. 1996) (holding mandated AA participation unconstitutional); *see also* Michael G. Honeymar Jr., *Alcoholics Anonymous As a Condition of Drunk Driving Probation: When Does It Amount to Establishment of Religion?*, 97 COLUM. L. REV. 437, 437 (1997) (contending mandates requiring AA participation are unconstitutional); Christopher M. Meissner, Note, *Prayer Or Prison: The Unconstitutionality of Mandatory Faith-Based Substance Abuse Treatment*, 54 CLEV. ST. L. REV. 671, 674–75 (2006) (contending mandatory participation in faith-based substance abuse programs is unconstitutional under Establishment Clause); *cf.* Cox v. Miller, 154 F. Supp. 2d 787, 792 (S.D.N.Y. 2001) (rejecting argument that statements made at AA meeting are confidential religious communications); O'Connor v. California, 855 F. Supp. 303, 308 (C.D. Cal. 1994) (finding no First Amendment violation where individual is given choice between AA and secular program).

Women for Sobriety.[288] The federal courts have held that when participants are given the option of attending secular self-help programs there is no violation of the First Amendment Establishment Clause.[289] As a result, a general requirement to attend support group meetings does not create an unconstitutional condition for participation in drug treatment court programs.

There is ample evidence that twelve-step programs work.[290] Despite some methodological flaws, outcome studies have found that AA members report greater abstinence than nonmembers and that the longer the duration of the AA membership, the greater the length of sobriety.[291] On the downside, waiting for people to intervene on their own behalf leads to more deaths despite the improved outcomes among those who seek help.[292]

6. Abstinence. Abstinence from alcohol and other drugs is both a key element of treatment and an ultimate goal of most treatment programs.[293] Therefore, although the state may legalize some types of behavior, the courts still have the fairly broad authority to limit that same behavior in certain circumstances. For example, although alcohol use by adults is legal, courts routinely prohibit convicted drunk drivers from drinking during the period of their probation and may even prohibit alcohol use by someone who was arrested for another drug charge.[294] It has become standard procedure in drug

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[288] Martin Nicolaus & William White, *Styles of Secular Recovery*, COUNSELOR, Aug. 2005, at 58, *available at* http://www.counselormagazine.com/content/view/67/63.

[289] *See O'Connor*, 855 F. Supp. at 308 (holding availability of secular alternatives defeats claims of unconstitutionality); *see also* NAT'L DRUG COURT INST., *supra* note 228, at 25 (discussing cases holding coerced participation in faith-based programs is unconstitutional).

[290] *See* John F. Kelly et al., *A 3-Year Study of Addiction Mutual-Help Group Participation Following Intensive Outpatient Treatment*, 30 ALCOHOLISM: CLINICAL AND EXPERIMENTAL RES. 1381, 1382 (2006) (reviewing various studies aimed at measuring success of AA and similar programs).

[291] Christine Lê et al., *Alcoholics Anonymous and the Counseling Profession: Philosophies in Conflict*, 73 J. COUNSELING & DEV. 603, 603 (1995).

[292] *See* Deborah A. Dawson et al., *Estimating the Effect of Help-Seeking on Achieving Recovery from Alcohol Dependence*, 101 ADDICTION 824, 831 (2006) (discussing positive outcomes for help-seekers).

[293] *See* NAT'L INST. ON DRUG ABUSE, *supra* note 102, at 1 (reviewing goals of drug treatment programs).

[294] *See* People v. Beal, 70 Cal. Rptr. 2d 80, 82 (Cal. Ct. App. 1997) (upholding prohibition against all alcohol consumption in drug case); *see also* People v. Smith, 193 Cal. Rptr. 825, 826 (Cal. Ct. App. 1983) (prohibiting individual from visiting bars).

treatment court contracts to include an explicit no-alcohol clause.[295] Furthermore, since the illicit drugs are, by definition, illegal, the court will impose the condition that participants abstain from any drug use. However, because relapse is a common occurrence during the addiction recovery process, participants are not usually expelled from the program upon a single finding of drug use.[296]

D. DRUG TREATMENT COURT COMPONENTS

1. Short Jail Terms. Brief periods of incarceration for noncompliance with the terms of the treatment program are an integral part of drug treatment courts.[297] The sanctions usually involve one or two days but no more than one week of jail time.[298] "Smart punishment," as the short jail stays are sometimes called,[299] is primarily criticized because of concerns about potential due process violations.[300] When the drug court team determines that a remedial period of incarceration is necessary to facilitate recovery, there may be no formal hearing. A formal adversarial hearing is not required because the drug treatment court team has agreed in advance to the availability of this sanction, and the client has knowingly and voluntarily consented to this process upon enrollment in the program.[301] A hearing may be granted, however, if specifically requested by the participant or defense attorney. In any court setting, constitutional principles are paramount, therefore the outcome goals of drug courts never trump a defendant's fundamental constitutional rights.[302] It is the defendant, and never

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[295] *See* JOHN N. MARR, U.S. DEP'T OF JUSTICE, THE INTERRELATIONSHIP BETWEEN THE USE OF ALCOHOL AND OTHER DRUGS: SUMMARY OVERVIEW FOR DRUG COURT PRACTITIONERS 1 (1999) (discussing no-alcohol clauses and their underlying presumptions).

[296] *See* Hora et al., *supra* note 43, at 509 (discussing therapeutic attitudes towards relapse).

[297] *See* TAUBER, *supra* note 190, at 9–10 (describing incarceration as part of drug court judges' "tool box").

[298] Carlson et al., *supra* note 192, at 547.

[299] TAUBER, *supra* note 190, at 9.

[300] *See* Mae C. Quinn, *Whose Team Am I on Anyway? Musings of a Public Defender About Drug Treatment Court Practice*, 26 N.Y.U. REV. L. & SOC. CHANGE 37, 50 (2000) (asking how drug treatment court principles can be squared with constitutional and other mandates).

[301] *Cf. id.* at 55 (emphasizing importance of drug treatment court clients' "truly knowing, voluntary, and intelligent choice [to participate]").

[302] *Cf.* State v. Rogers, 170 P.3d 881 (Idaho 2007) (discussing liberty interests retained by

the court, who exercises the right to waive constitutional safeguards, and such waiver must be voluntary, knowing, and intelligent.[303] Additionally, participants are forewarned of the consequences for failing to comply with the program's terms and are advised that the punishments may include short jail stays.[304] Only after being advised of the terms can a defendant voluntarily and knowingly consent to such conditions and become a drug court participant.

2. Frequent Court Appearances. Frequent appearances before the same judge are a crucial component of drug treatment court.[305] A survey conducted by the Drug Court Clearinghouse at American University found that "eighty percent of participants . . . would not have remained if they did not appear before a judge as part of the process."[306] Involving the same bench officer in each of the defendant's appearances lessens the chance that inconsistent rulings and ignorance of a particular defendant's circumstances will interfere with the treatment program. The Criminal Justice Research Institute reported that drug treatment court participants hailed close supervision and encouragement by judges as among the top three factors that led to their success in drug court programs.[307]

The direct involvement of the bench officer may be one of the reasons that drug treatment court programs are more successful than other methods employed by the criminal justice system in dealing with addicts. One study of high-risk drug addicts (those with previous treatment failures or mental disorders) found that eighty percent of participants who had frequent mandatory contact

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defendants that enter diversionary programs after pleading guilty); Quinn, *supra* note 300, at 56 ("The ostensibly voluntary nature of treatment court participation does not . . . absolve drug treatment courts from their obligation to operate in an appropriate and impartial manner." (citations omitted)).

[303] Brady v. United States, 397 U.S. 742, 748 (1970).

[304] *See* Carlson et al., *supra* note 192, at 545 (discussing written contracts with participants).

[305] BUREAU OF JUSTICE ASSISTANCE, *supra* note 47, at 15 (noting ongoing relationship with judge increases chances for success).

[306] Sally L. Satel, *Observational Study of Courtroom Dynamics in Selected Drug Courts*, NAT'L DRUG CT. INST. REV., Summer 1998, at 56, 60.

[307] *See* JOHN S. GOLDKAMP ET AL., U.S. DEP'T OF JUSTICE, AN HONEST CHANCE: PERSPECTIVES ON DRUG COURTS (2002), http://www.ncjrs.gov/html/bja/honestchance (listing judge, threat of incarceration, and positive incentives as factors in drug court success).

with the judge successfully graduated from the program.[308] A comparison group that saw the judge only when requested by the treatment provider, much like California's Proposition 36 program,[309] suffered from a completion rate of only twenty percent.[310]

3. Public Policy Considerations. One symptom of drug abuse and addiction is the denial that the drug abuse and addiction exists.[311] This state of denial is more than mere refusal to accept reality as it is, but is instead a pathological inability to do so. Defendants in the grasp of drug addiction are unable to see the magnitude of their problem.[312] Nevertheless, eighty-five percent of drug court participants will later acknowledge that they entered the program in order to treat their drug problem.[313] In addition, even individuals who have been "coerced" acknowledge their sickness and are grateful to their treatment providers.[314]

Some overly simplistic arguments are made that drug treatment courts are inappropriate from a policy standpoint because the criminal law is not a means to an end, but rather the end itself and should not be used for other social goals.[315] This argument borders on the inexplicable because criminal law exists for the sole purpose of advancing social ends. Criminal law does not spring from some abstract desire to have courthouses, judges, and trials. Criminal courts seek the social goals of punishment, rehabilitation, and the

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[308] Douglas B. Marlowe et al., *The Judge Is a Key Component of Drug Court*, *in* DRUG COURT REVIEW 1, 18 (Nat'l Drug Court Inst., 2004).

[309] *See infra* notes 331–46 and accompanying text.

[310] Marlowe et al., *supra* note 308, at 18.

[311] *Cf.* Adam Lamparello, Comment & Note, *Reaching Across Legal Boundaries: How Mediation Can Help the Criminal Law in Adjudicating "Crimes of Addiction,"* 16 OHIO ST. J. ON DISP. RESOL. 335, 372 (2001) (stating success at rehabilitation of drug offenders depends on recognition that treatment is necessary).

[312] H. Westley Clark & Margaret K. Brooks, *Ethical Issues in Addiction Treatment*, *in* PRINCIPLES OF ADDICTION MEDICINE, *supra* note 142, at 487, 488.

[313] CAROLINE S. COOPER ET AL., U.S. DEP'T OF JUSTICE, 2000 DRUG COURT SURVEY REPORT: PROGRAM OPERATIONS, SERVICES, AND PARTICIPANT PERSPECTIVES 10 (draft 2001), *available at* http://spa.american.edu/justice/documents/128.pdf.

[314] Robert D. Miller, *The Continuum of Coercion: Constitutional and Clinical Considerations in the Treatment of Mentally Disordered Persons*, 74 DENV. U. L. REV. 1169, 1174 (1997) (citing generally ALAN A. STONE, MENTAL HEALTH AND LAW: A SYSTEM IN TRANSITION (1975)).

[315] Hoffman, *Scandal*, *supra* note 66, at 1478.

maintenance of peace, safety, and order for the community. Drug treatment courts are no different in this regard.[316] Drug treatment courts specifically—and problem-solving courts generally—seek to achieve tangible outcomes for victims, offenders, and society. These goals include reduced recidivism, reduced stays in foster care for children, reduced criminal justice costs, increased sobriety for addicts, and healthier, safer communities.[317]

Lastly, drug treatment courts make excellent sense from a policy standpoint because they are successful at turning addicts into drug free, productive citizens.[318] The White House has endorsed drug courts as an important part of our national drug control policy.[319] President George W. Bush has touted drug courts as "effective and cost-efficient tools that enable non-violent drug offenders to enter into drug treatment programs, rather than prison," and as a result "individuals are abstaining from continued drug use and crime is being reduced."[320] In 2002, the President's budget included fifty million dollars to support local drug courts and additional funding for the National Drug Court Institute.[321] In February 2005, the White House proposed increasing funding for drug courts by thirty million dollars.[322] In announcing the President's proposal, National Drug Policy Director John Walters described drug courts as "where miracles happen"[323] and the "most significant criminal justice

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[316] *See* Zimring, *supra* note 231, at 810–11 (contending goals of drug treatment are permissible objectives of criminal law).

[317] *See* Aubrey Fox & Greg Berman, *Going to Scale: A Conversation About the Future of Drug Courts*, COURT REV., Fall 2002, at 4, 4 (noting drug courts are "using the authority of the judicial branch in new ways—in an effort to improve outcomes for victims, communities, and defendants").

[318] *See* Carlson et al., *supra* note 192, at 548 (arguing "Why Drug Treatment Courts Work").

[319] Letter from President George W. Bush to attendees of the National Association of Drug Court Professionals Annual Training Conference "Changing the Face of Criminal Justice" (May 31, 2001) (on file with authors).

[320] *Id.*

[321] *Id.*

[322] *White House Wants More Drug Courts*, S.F. DAILY J., Feb. 24, 2005, at 4. In fiscal year 2008, the funding was only ten million dollars, but the fiscal year 2009 budget increases that amount to forty million dollars. U.S. DEP'T OF HEALTH & HUMAN SERVS., BUDGET IN BRIEF: FISCAL YEAR 2009, at 5 (2008), *available at* http://www.hhs.gov/budget/09budget/2009BudgetInBrief.pdf.

[323] Linda Hughes, *Where Miracles Can Happen: The Promise of Drug Court Programs*, HUM. RTS., Winter 2004, at 5, *available at* http://www.abanet.org/irr/hr/winter04/miracles.

initiative in the last 20 years."[324] Given the success of drug treatment courts in rehabilitating substance abusers and reducing criminal behavior, expansion of drug courts, rather than their reduction, is sound public policy.

The involvement of the legislatures of forty-nine states in providing funding, statutory guidelines, or both to drug treatment courts refutes the argument that drug treatment courts represent a violation of the separation of powers doctrine.[325] If legislatures wanted to exercise their check on the powers of drug courts, they would only have to throttle the courts at the funding stage. Instead, drug courts have increased from the lone Miami court in 1989[326] to over 1,600 operational drug courts as of January 2005 with another 478 drug courts in the planning stages.[327] Legislatures have funded an additional 937 problem-solving courts that address issues other than adult criminal substance abuse, e.g., domestic violence, mental health, and juvenile dependency and delinquency, for a total legislative approval of 2,558 operational courts.[328] Finally, contrary to any appearances of unrestrained legislative exuberance, the legislature is keeping the size of drug courts precisely in balance with demand through their appropriation and spending powers. The average court is operating at a healthy eighty-seven percent of capacity, and seventy-two percent of drug courts cite funding as the limiting factor in expanding that capacity.[329] The legislatures of the states, territories, and the federal government seem to have struck a careful balance. Therefore, in no way do drug treatment courts usurp the domains of the other branches. If they were to encroach on reserved powers, the legislatures would have only to reach for their budgeting pens.

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[324] Press Release, Executive Office of the President of the U.S., White House Drug Czar Calls for Dramatic Increase in Number of Drug Treatment Courts Nationwide (Feb. 23, 2005), *available at* http://www.whitehousedrugpolicy.gov/pda/022305.html.

[325] *See* HUDDLESTON ET AL., *supra* note 42, at 15 tbl.V (listing states' drug court legislation and budget appropriations).

[326] *See supra* note 43 and accompanying text.

[327] HUDDLESTON ET AL., *supra* note 42, at 2.

[328] *Id.* at 10.

[329] *Id.* at 8.

Drug treatment courts are not the only option available for the treatment of the drug-abusing offender. Models other than drug treatment courts, however, have been tried and found lacking. The first option drug abusers have is the voluntary initiation of abstinence. While some offenders may be able to "just say no," most will require more than willpower and platitudes to address their addiction.[330] When faced with the option of maintaining the status quo or making a drastic change in lifestyle, many people find the status quo, no matter how currently painful, more familiar and comfortable.

Alternative options include programs like the California voter-approved Substance Abuse and Crime Prevention Act of 2000, known colloquially as "Proposition 36."[331] In the Procrustean, rather arbitrary setting of Proposition 36 programs, the court plays an inactive role and instead asks the addict to overcome the incredible forces of addiction, both medical and social, with little outside help. This program offers a powerful incentive: the dismissal of criminal charges upon successful completion of the treatment program.[332] Few, however, have been able to complete the task. Of nonviolent drug offenders sent to community based treatment programs under Proposition 36, between one-third and one-fourth (depending on the year studied), did not even bother to show up.[333] Of the two-thirds who did show up, only one in three completed treatment.[334] Furthermore, Proposition 36 is ineffective in combating addiction in those substance abusing offenders who manage to arrive at their intake appointments. Although some offenders have been able to complete treatment while participating in the Proposition 36 programs, rearrest rates are actually forty-eight percent higher for

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[330] *See* McLellan et al., *supra* note 35, at 1694 (suggesting that drug addiction is chronic illness requiring continuing care and treatment).

[331] CAL. PENAL CODE § 1210.1 (West 2004). Proposition 36 was passed in 2000 and implemented in July 2001, illustrating the will of the voters that those arrested for nonviolent drug offenses be given treatment rather than incarceration. *Id.*

[332] *Id.* § 1210.1(d).

[333] INTEGRATED SUBSTANCE ABUSE PROGRAMS, UCLA EVALUATION OF THE SUBSTANCE ABUSE AND CRIME PREVENTION ACT: FINAL REPORT 16 (2007).

[334] *Id.* at 4; *see also* Editorial, *Finding Better Ways to Handle Drug Offenders*, SAN JOSE MERCURY NEWS, July 22, 2005, at A1, *available at* 2005 WLNR 11488650 (stating that Proposition 36 "has given drug abusers too much freedom to fail").

Proposition 36 "graduates" than the rates for offenders left in the traditional criminal justice system.[335] Some Proposition 36 candidates even report a preference for incarceration over an enrollment in that program.[336] Because the promise of empty jails has not materialized in some counties, a jail sentence functionally means an early release.[337]

Proposition 36 provides little oversight as to the quality or quantity of treatment that the offender receives, requiring only that the program be "certified," a status carrying only vague requirements that do not include a standard of efficacy.[338] Actual sanctions, including short bursts of incarceration—a standard drug treatment court response—are specifically forbidden by Proposition 36.[339] Instead, Proposition 36 employs "strikes" that are without actual consequence until three of them accrue.[340] When offenders commit the third strike, they are then sentenced under the regular penal scheme, which often will not include further treatment.[341]

Proposition 36 has saved California money in terms of prison costs,[342] but judging by how few defendants complete the program, this represents a tacit decriminalization of drug offenses. California saves money because Proposition 36 puts drug offenders back on the street without either punishment or treatment. Perhaps this stealth legalization of illicit drugs explains the rabid defense of the law by pro-drug organizations like the Drug Policy Alliance, which have opposed every attempt to modify Proposition 36 into the proven drug treatment court model.[343]

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[335] Cicero A. Estrella, *Drug Treatment Grads More Likely to Reoffend*, S.F. CHRON., Nov. 26, 2004, at B1, *available at* 2004 WLNR 12244110.

[336] Chris Nichols, *More Opting for Jail over Treatment*, UNION DEMOCRAT.COM, May 23, 2006, http://www.uniondemocrat.com/news/results.cfm?story_no=20519.

[337] *Id.*

[338] CAL. PENAL CODE § 1210(b) (West 2004 & Supp. 2008) (defining "drug treatment program").

[339] *See id.* § 1210.1(a) ("A court may not impose incarceration as an additional condition of probation.").

[340] *Id.* § 1210.1(e)(3)(C).

[341] *Id.*

[342] *See* DOUGLAS LONGSHORE ET AL., UCLA INTEGRATED SUBSTANCE ABUSE PROGRAMS, EVALUATION OF THE SUBSTANCE ABUSE AND CRIME PREVENTION ACT: SACPA COST-ANALYSIS REPORT 5 (2006) (finding Proposition 36 substantially reduced incarceration costs).

[343] *See* Reform in California, http://www.drugpolicy.org/statebystate/california (last visited

The Proposition 36 protocol is both more restrictive and less discretionary than the drug treatment courts in that many drug treatment court participants are given more than three chances (depending on the nature of the violation) to "get it" before they are terminated.[344] While Proposition 36 ties the judges' hands and mandates termination after three violations,[345] a drug treatment court judge preserves the option of retaining someone who may not yet be clean and sober but who seems engaged in the program and is making adequate, albeit imperfect, progress.[346] Although this discretion can be abused, standardization and accreditation of drug treatment court programs would avoid opportunities for abuse.[347]

In-custody treatment is another traditional option offered to a few drug-abusing offenders.[348] However, hundreds of studies have revealed very small reductions in recidivism for offenders participating in prison rehabilitation programs unless aftercare in a controlled environment also is provided.[349] The State of Delaware's KEY-Crest program, for example, maintains parolees in transitional housing for months after the ends of their prison stays.[350] In-custody treatment also is among the most expensive of the options available for substance abuse treatment, with incarceration alone costing as much as $35,212 annually per offender.[351] The slight reduction in recidivism from in-custody treatment combined with aftercare is a costly, inadequate, and incomplete solution to the problem of addiction in substance abusing

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Apr. 16, 2008) (criticizing attempts to strengthen Proposition 36); *see also County Judge Delays Drug Treatment Law Change*, OAKLAND TRIB., Sept. 15, 2006, at Metro 5, *available at* 2006 WLNR 16696798 (reporting success of Drug Policy Alliance in obtaining preliminary injunction against amendment to drug treatment law adding incarceration option).

[344] *See* BUREAU OF JUSTICE ASSISTANCE, *supra* note 47, at 14 (listing several responses for noncompliance other than termination from program).

[345] CAL. PENAL CODE § 1210.1(e)(3) (West 2004 & Supp. 2008).

[346] *See* BUREAU OF JUSTICE ASSISTANCE, *supra* note 47, at 13 (noting cessation of use is ultimate goal, but seeing value in incremental progress).

[347] For a discussing of efforts to standardize drug treatment courts see Part VII.

[348] *See, e.g.*, State of Delaware, *supra* note 31 (explaining one in-custody treatment program).

[349] *See, e.g.*, Prison Substance Abuse with Aftercare Reduces Recidivison, http://www.psychologymatters.org/prison_drugabuse.html (last visited Apr. 16, 2008) (citing several studies on topic).

[350] State of Delaware, *supra* note 31.

[351] Editorial, *supra* note 334.

offenders unless the gravity of their current crime warrants incarceration.

The campaign of one critic, Judge Hoffman, against drug courts[352] ironically provides the best demonstration of what occurs in the absence of drug treatment court programs. In 2002, the Denver drug treatment court was dismantled due to a number of factors, including a lack of judicial leadership.[353] The Denver presiding judge, with the urging of Judge Hoffman, disbanded the drug court and spread drug cases amongst all bench officers.[354] A mere three years later, many of Judge Hoffman's predictions have become a reality, but the irony is that negative results came from the *elimination* of the Denver drug court, not its continuance.

The rationales for ending the Denver drug treatment court were those that Judge Hoffman created in his articles: flooding the jails with addicts, increasing costs, and improperly expanding the judicial role.[355] Three years after the demise of its drug court, Denver now has defendants "stacking up" in jail awaiting adjudication of their cases.[356] Under the drug court system, cases were assigned in an average of seventy-two hours, whereas absent a drug court, defendants now sit in a jail cell, at taxpayer expense, for forty-five to ninety days.[357] More drug defendants are going to state prison than they were during drug court, despite a Colorado law that makes probation the preferred resolution of drug use cases.[358]

Judge Hoffman claimed that drug treatment courts decriminalize drugs by judicial fiat.[359] However, the number of drug cases in

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[352] *See supra* notes 65–67, 70, 88–92, 140–41, 169–71, 315 and accompanying text.

[353] Christopher N. Osher, *Drug Court May Stage Comeback*, DENVER POST, Nov. 13, 2005, at A1, *available at* 2005 WLNR 18402963.

[354] *Id.*

[355] *See* Hoffman, *supra* note 65, at 1567 (noting that Denver drug court increased imprisonment of drug defendants and costs); Morris B. Hoffman, *Therapeutic Jurisprudence, Neo-Rehabilitationism and Judicial Collectivism: The Least Dangerous Branch Becomes the Most Dangerous*, 29 FORDHAM URB. L.J. 2063, 2072 (2002) (criticizing drug courts for impinging on legislative and executive functions and forcing judges to act as therapists).

[356] Osher, *supra* note 353.

[357] *Id.*

[358] *Id.*; *see also* COLO. REV. STAT. ANN. § 18-18-404(3) (West 2004 & Supp. 2007) (authorizing judges to suspend proceedings and order treatment for substance abuse).

[359] *See* Hoffman, *Scandal*, *supra* note 66, at 1523–24 (contending drug court judges exercise legislative function).

Denver has plummeted.[360] Instead of greater charges and more trials, Denver is putting people back out on the street without so much as a slap on the wrist.[361] Ironically, it is the enforcement arm of the criminal justice system that has been the most voracious in calling for the return of the Denver drug court. It is the Denver police chief and District Attorney who lament the demise of the system that Judge Hoffman helped destroy.[362]

IV. JUDICIAL DISCRETION

The charge that drug treatment courts deny participants the right to refuse treatment is discussed above, but there are also critics who argue that drug court participants are at risk of being harmed by unchecked judicial discretion. One author, in a moment of unrestrained hyperbole, wrote: "[Working therapeutically] cheapens the judicial office, placing the judge at the level of a ringmaster in a judicial circus."[363] This view is not shared, however, by the highest policy-making body of judges in the United States, the Conference of Chief Justices (CCJ). In a resolution that passed in 2000 and was reaffirmed in 2004, the CCJ and the Conference of State Court Administrators (COSCA) recognized that traditional case processing did not adequately address complex social issues like substance abuse.[364] "Well-functioning drug courts represent the

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[360] Osher, *supra* note 353.

[361] *See id.* (noting sharp increase in probations).

[362] *Id.*

[363] Philip Bean, *Drug Courts, the Judge, and the Rehabilitative Ideal*, *in* DRUG COURTS IN THEORY AND IN PRACTICE, *supra* note 209, at 235, 237–38. Other critics have expressed concerns over ethical issues and professional responsibility rules and whether they conflict with the collaborative nature of the relationship between the defense counsel and prosecution in drug treatment courts. *See* Quinn, *supra* note 300, at 50 (discussing need to examine defense counsel's role); *see also* Martin Reisig, *The Difficult Role of the Defense Lawyer in a Post-adjudication Drug Treatment Court: Accommodating Therapeutic Jurisprudence and Due Process*, 38 CRIM. L. BULL. 216, 216 (2002) (noting challenge of defense lawyer in balancing need for treatment with due process rights).

[364] Conference of Chief Justices & Conference of State Court Administrators, Resolution 22 in Support of Problem-Solving Court Principles and Methods 1 (July 29, 2004), *available at* http://cosca.ncsc.dni.us/Resolutions/CourtAdmin/Problem-SolvingCourtPrinciplesMethods.pdf.

best practice of these principles and methods," according to CCJ and COSCA.[365]

Hands-on involvement by the judge is an essential element of drug treatment courts. Judges actively supervise and coordinate treatment,[366] improving oversight and using judicial authority to encourage compliance with the dictates of the treatment program. The role of the detached and neutral arbiter is only part of taking the lead role in the drug treatment court team.[367] This role involves awarding incentives and imposing sanctions on participants as they continue on the path to law-abiding and productive sobriety.[368] Participants appear frequently before the judge for status reports, the exact frequency of which depends on the participant's stage in the program and his or her compliance with conditions.[369] More than three-fourths of participants cite the judge's supervision as instrumental to their continuing progress in the program.[370]

One easily countered claim of drug treatment court critics is that state prisons are being filled with drug treatment court participants because of the judge's ability to impose incarceration as a sanction.[371] Generally a defendant will be sent to state prison only if sentenced to a year or more in custody.[372] Flooding the prisons with inmates is simply not an accurate assessment in the vast

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[365] Conference of Chief Justices & Conference of State Court Administrators, CCJ Resolution 22, COSCA Resolution IV, In Support of Problem-Solving Courts, *available at* http://cosca.ncsc.dni.us/Resolutions/CourtAdmin/resolutionproblemsolvingcts.html.

[366] BUREAU OF JUSTICE ASSISTANCE, *supra* note 47, at 15.

[367] *See id.* (noting that judges must go beyond role of arbiter).

[368] *Id.*

[369] *See id.* (noting that frequent status hearings are used to monitor participant performance).

[370] *See* COOPER ET AL., *supra* note 313, at 12 (noting that four-fifths of participants reported that judicial oversight was "very important"); *see also* GOLDKAMP ET AL., *supra* note 307, at 371 (noting that many participants developed close connections with their judge).

[371] *See* Hoffman, *Scandal*, *supra* note 66, at 1439 (discussing negative effects of drug courts, including filling state prisons with drug users).

[372] *See, e.g.*, CAL. PENAL CODE § 17(a)–(b) (Deering 2008) (defining misdemeanor and felony offenses and indicating misdemeanor offenses generally are not punishable by imprisonment in state prison); CAL. BUS. & PROF. CODE § 1700 (Deering 2008) (identifying certain misdemeanors as punishable "by imprisonment in the county jail not . . . more than one year"); *see also* AMANDA PETTERUTI & NASTASSIA WALSH, JUSTICE POLICY INST., JAILING COMMUNITIES 5 (2008), *available at* http://www.justicepolicy.org/images/upload/08-04_REP_JailingCommunities_AC.pdf ("Prisons are meant to hold people who are generally sentenced to more than one year, and jails are intended to hold people . . . sentenced to a year or less.").

majority of drug treatment courts because incarceration is usually no more than a few days when applied by the drug court judge as a sanction.[373] Judges and other practitioners may receive specific training from the National Drug Court Institute on the imposition of sanctions and incentives.[374] Moreover, although the judge tends to be the final arbiter concerning issues involving the participants, he or she may receive input from the entire treatment team, including the participant.[375] In some instances, such as a relapse episode of alcohol or other drug use, a participant may have already self-disclosed the problem to the treatment provider, probation officer, or court coordinator.[376] The participant may present his or her own sanction recommendation such as jail time or increased attendance at drug counseling or self-help meetings.[377] Drug court judges report that when participants suggest their own punishment, they are more likely to comply and not feel coerced by the judge or the criminal justice system.[378]

As discussed previously, short periods of incarceration help to improve performance in treatment and are instrumental to the success of drug treatment courts.[379] In fact, while individuals are in the program, drug use is markedly reduced.[380] One study based on urine test results reveals that on average only ten percent of drug court participants test positive for drug use as opposed to their counterparts in probation department-managed programs who tested positive thirty-one percent of the time.[381] The ability of the

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[373] *See* James L. Nolan Jr., *Redefining Criminal Courts: Problem-Solving and the Meaning of Justice*, 40 AM. CRIM. L. REV. 1541, 1557 (2003) (referring to short-term incarceration as "shock therapy," "motivational jail," and "my motel").

[374] *See* Marlowe, *supra* note 39, at 1010 (noting that National Association of Drug Court Professionals lists progressive sanctions and rewards as core components of drug court).

[375] Hora, *supra* note 184, at 1476.

[376] *Id.* at 1476–77.

[377] *Id.* at 1477.

[378] *Id.*

[379] *See* Hora et al., *supra* note 43, at 474 ("[T]he court may use jail time as a form of 'smart punishment' to get the defendant to conform to treatment protocol."); *see also* Adele Harrell & John Roman, *Reducing Drug Use and Crime Among Offenders: The Impact of Graduated Sanctions*, 31 J. DRUG ISSUES 207, 209 (2001) (describing program in which consistent legal penalties result in reduction of drug use).

[380] *See* Belenko, *supra* note 246, at 24–25 (noting that proportion of positive urine tests is low for drug court participants).

[381] *See id*. at 25 (describing results of drug court survey). Regular urine testing is not

judge to impose short jail sentences for noncompliance with the program may motivate the participants to avoid drug use while receiving treatment for the underlying issues that contribute to their addiction.

The regular and immediate delivery of sanctions and incentives is vital to the effectiveness of any program.[382] This type of immediate response is impossible in probation-based systems because it may take weeks to discover the infraction, give notice of it, schedule a hearing, and sanction the defendant if found in violation.[383] In contrast, and in keeping with drug court key components, drug treatment court participants appear on a scheduled basis before the judge, as often as once a week, and are given urine tests regularly.[384] The judge and the rest of the treatment team are usually informed of the test results prior to each appearance and then are able to discuss any infraction with the participant.[385] Thus, the judge may impose a suitable sanction "on the spot."[386] The timing is critical because studies show that the best predictor of whether there will be behavior change in response to sanctions is the immediacy of those sanctions.[387] In studies, substance abusers choose heavy future punishment over smaller immediate punishment because it is common among this population

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unlike diet programs that require participants to be weighed once a week. People think twice before eating a donut when they know they have to face a scale on Saturday. Likewise, urine testing abets an addicted person in staying on course in treatment, recovery, and abstinence.

[382] *See* Marlowe, *supra* note 39, at 1019–20 (stating that delay in administering sanctions and rewards makes intervention less effective). *But cf.* Greg Berman & Anne Gulick, *Just the (Unwieldy, Hard to Gather But Nonetheless Essential) Facts, Ma'am: What We Know and Don't Know About Problem-Solving Courts*, 30 FORDHAM URB. L.J. 1027, 1032 & n.27 (2003) (noting that effect of punishment is based on certainty, severity, and celerity of sanction, but finding that celerity (how quickly punishment is imposed is less important than other factors) (citing Daniel S. Nagin & Greg Pogarsky, *Integrating Celerity Impulsivity and Extralegal Sanction Threats into a Model of General Deterrence: Theory and Evidence*, 39 CRIMINOLOGY 1, 3 (2000)).

[383] *See id.* at 1020 (describing how procedural due process can delay sanctions).

[384] *See* BUREAU OF JUSTICE ASSISTANCE, *supra* note 47, at 11–12, 15 (highlighting importance of ongoing judicial interaction and frequent drug and alcohol testing).

[385] *See id.* at 11–12 (noting that test results should be communicated to court within one day to allow for immediate response).

[386] *See id.* (including prompt response to positive tests in coordinated strategy).

[387] *See* James G. Murphy et al., *Delayed Reward and Cost Discounting*, 51 PSYCHOL. REC. 571, 571 (2001) (describing how value of rewards and costs varies as function of delay).

to discount future consequences.[388] One participant in the Portland, Oregon, drug court said, "I think the worst part [of drug court] is if you go into court and you know that you've screwed up and that you've got to be sanctioned. I think it's the fear that something is going to happen to you."[389] Drug treatment courts are in a truly unique position to leverage compliance with the program, largely due to the immediacy of the sanctions and the constant opportunity for incentives during the program.

Any program that imposes months or years of incarceration for a relapse during treatment is misguided in its approach and would not be working within the established methodology of drug courts. Longer periods of incarceration are inconsistent with the goals intended by the imposition of sanctions.[390] Although to the casual observer jail time would seem to be the strongest sanction in the judicial arsenal, defendants may not agree with that perception.[391] In one study, inmates preferred one year of jail to residency in a halfway house (6.7%); probation (12.4%); or day fines (24%).[392] Those with more connection to their communities, including ties like employment, domicile, or children, chose alternatives to jail.[393] Therefore broader judicial discretion in the imposition of sanctions, including incarceration, is important to drug treatment court success.

When an individual is given a sanction without the ability to demonstrate behavior modification, the sanction has little effect on

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[388] *See id.* at 585 (providing example of smoker who weighs cost of immediate discomfort of quitting smoking more heavily than long-term costs of poor health).

[389] GOLDKAMP ET AL., *supra* note 307, at http://www.ncjrs.gov/html/bja/honestchance/chp4c.html.

[390] *See* Marlowe, *supra* note 39, at 1016 (pointing to negative consequences of removing individuals from their support systems and jobs while exposing them to antisocial peer influences).

[391] *See generally* Joan Petersilia & Elizabeth Piper Deschenes, *What Punishes? Inmates Rank the Severity of Prison vs. Intermediate Sanctions*, FED. PROBATION, Mar. 1994, at 3 (showing that certain community based sanctions are "quite punitive"); Peter B. Wood & Harold G. Grasmick, *Inmates Rank the Severity of Ten Alternative Sanctions Compared to Prison*, 2 J. OKLA. CRIM. JUST. RES. CONSORTIUM 30 (1995), *available at* http://www.doc.state.ok.us/offenders/ocjrc/95/950725J.HTM (challenging conventional wisdom that incarceration is more punitive than alternative sanctions).

[392] Wood & Grasmick, *supra* note 391, at tbl.2.

[393] *See id.* at tbl.4 (summarizing reasons inmates chose to participate in alternative sanctions).

changing their behavior to the desired norm.[394] As discussed above, most jails do not provide in-custody treatment as an option and what is provided is inadequate.[395] Consequently, a drug treatment court that imposes excessive jail time would be ineffective because participants would be absent from treatment and therefore would not have an opportunity to address the behavior for which they are being punished. In addition, drug treatment courts recognize that "structure without support feels punitive and support without structure is enabling."[396] Therefore, measured responses and incentives are awarded to participants to encourage program compliance.[397] These incentives range from small prizes such as movie tickets, baseball game passes, or certificates of program completion to praise and encouragement from the bench.[398] Research on graduated rewards demonstrates participants receiving graduated reinforcement achieve greater mean levels of abstinence than participants receiving fixed reinforcement.[399]

The amount of discretion held by drug treatment court judges concerns some because it may open the door to inconsistency in judgments.[400] One frequent criticism is that drug treatment courts will encounter many of the same problems early juvenile courts did with regard to the imposition of punishment without the traditional due process protections of the criminal justice system.[401] The deterioration of the juvenile courts was perhaps best demonstrated

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[394] D.B. Marlowe, *Strategies for Administering Rewards and Sanctions*, *in* DRUG COURTS: A NEW APPROACH TO TREATMENT AND REHABILITATION 317 (James E. Lessenger & Glade F. Roper eds., 2007).

[395] *See supra* notes 29–34 and accompanying text.

[396] Hora, *supra* note 184, at 1476.

[397] *Id.*

[398] *See id.* (listing incentives used by court to encourage compliance).

[399] *See* John M. Roll et al., *An Experimental Comparison of Three Different Schedules of Reinforcement of Drug Abstinence Using Cigarette Smoking As an Exemplar*, 29 J. APPLIED BEHAV. ANALYSIS 495, 499–500 (1996) (finding smoking cessation study participants who were paid more for each consecutive week they refrained from smoking resumed smoking less often than smokers who were paid fixed rate).

[400] *See* Richard C. Boldt, *Rehabilitative Punishment and the Drug Treatment Court Movement,* 76 WASH. U. L.Q. 1205, 1230 (1998) (citing judicial discretion as one of critics' concerns).

[401] *See id.* at 1269 (suggesting comparison between juvenile courts and drug courts would be helpful); *see also* Marygold S. Melli, *Juvenile Justice Reform in Context*, 1996 WIS. L. REV. 375, 375 (describing lack of due process in juvenile courts of mid-twentieth century).

in the Supreme Court case of *In re Gault*.[402] In that case, a juvenile suspect was convicted and incarcerated for allegedly making lewd phone calls, without the benefit of counsel, the right of confrontation, the right against self incrimination, or even the support available from his parents.[403] The Supreme Court, in overruling the Arizona courts, looked to its earlier decision in *Kent v. United States* involving the waiver of juvenile jurisdiction without due process.[404] In *Kent*, the Court ruled, "[T]here is no place in our system of law for reaching a result of such tremendous consequences without ceremony—without hearing, without effective assistance of counsel, without a statement of reasons."[405] Examining drug treatment courts in light of the litany of errors in *Gault* and *Kent*, one can see that those framing drug treatment courts have assiduously developed safeguards to avoid repetition of the old abuses in a new context.

Drug court key components require the assistance of counsel, hearings for placement in and removal from the program, hearings for sanctions resulting from program violations, the opportunity for appeal, the opportunity to reject treatment and enroll in traditional case processing, and all of the notice requirements attendant to modern criminal cases.[406] Each safeguard put in place to avoid a denial of due process works effectively to protect participants from judicial or procedural missteps. However, potential for abuses of judicial discretion is not unique to drug treatment courts. Many of the criticisms leveled at drug treatment court judges could be directed with equal accuracy at any other member of the bench. A trial judge is in a powerful position in both the legal process and society at large. The same oversight that works to hold other judges in check operates with equal efficacy to constrain drug treatment court judges. If an individual drug court judge abused her discretion, it would be no different from judicial misconduct in any other post-*Gault* case. Responses would include appropriate

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[402] *In re* Gault, 387 U.S. 1 (1967).
[403] *Id.* at 4, 56–57.
[404] *Id.* at 12 (citing Kent v. United States, 383 U.S. 541 (1966)).
[405] *Kent*, 383 U.S. at 554.
[406] *See* BUREAU OF JUSTICE ASSISTANCE, *supra* note 47, at 3–4, 15 (describing measures protecting drug court participants' due process rights).

reporting mechanisms to judicial oversight bodies and sanctions for the member of the bench.[407]

One of the first considerations in monitoring the role of judicial discretion is the tenet that drug treatment courts are not punitive in nature. On the contrary, drug treatment courts focus on attacking the root of the problem—addiction—through treatment compliance and program retention.[408] Drug treatment courts were created in response to the failure of the traditional penal system to rehabilitate drug-abusing offenders.[409] As part of the drug treatment court program, judges are required to become familiar with the elements of substance abuse and addiction.[410] Appropriate education provides them with the knowledge that addiction is a medical and not merely a moral or behavioral issue and that incarceration is not a solution for a medical problem. With this understanding, judicial officers are less inclined to act in a morally judgmental way or abuse their discretion.[411]

The claim that drug court judges inappropriately act as "amateur psychiatrists"[412] is specious. All judges gain a measure of expertise in the subject matter of the cases coming before them, and drug treatment court judges are no different in that regard. Although drug treatment court judges gain expertise in issues relating to drug addiction,[413] they do not have responsibility for the formulation of each participant's treatment program; that is left to treatment professionals.[414] Instead, the judge acts as the lead member of a team that includes treatment providers and takes an active role in

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[407] *See* Cynthia Gray, *The Line Between Legal Error and Judicial Misconduct: Balancing Judicial Independence and Accountability*, 32 HOFSTRA L. REV. 1245, 1245–46 (2004) (discussing when state judicial conduct commissions impose sanctions).

[408] Carlson et al., *supra* note 192, at 547.

[409] Richard S. Gebelein, *The Rebirth of Rehabilitation: Promise and Perils of Drug Court*, SENT'G & CORRECTIONS ISSUES FOR 21ST CENTURY, May 2000, at 1, 3 (describing drug court formation as response to high number of drug cases and solution to "revolving door" problem).

[410] BUREAU OF JUSTICE ASSISTANCE, *supra* note 47, at 15.

[411] *See* Boldt, *supra* note 400, at 1230–33 (identifying lack of specialized training as one source of judges' sentencing bias).

[412] *See* Hoffman, *Scandal*, *supra* note 66, at 1479 (referring to potential dangers of "judiciary full of amateur psychiatrists").

[413] *See* BUREAU OF JUSTICE ASSISTANCE, *supra* note 47, at 15 ("Drug courts require judges to . . . develop new expertise.").

[414] *See id.* at 7–10 (describing policies on treatment and rehabilitation services for drug courts).

supervising the participant's progress.[415] One treatment team member is a clinician who has more extensive training in addiction and who provides or oversees the formal therapy in the form of psychological substance abuse counseling.[416] Therefore, judges do not act as psychiatrists—amateur or otherwise—but act instead as the team captain and boundary spanner.[417] Moreover, through drug treatment courts, physicians and judges have begun a whole new dialogue about alcohol and other drug addiction.[418] Physician Leadership on National Drug Policy, based at Brown University, has joined with the American Judges Association to develop an interdisciplinary curriculum for the joint training of judges and physicians.[419] At a session in Pennsylvania, sixteen local physicians and psychologists joined with criminal and family law judges for specialized training.[420] In addition, judges and law professors conversant with drug treatment courts and therapeutic jurisprudence presented, for the first time, a panel at the 2000 annual meeting of the American Society of Addiction Medicine.[421] The California Society of Addiction Medicine specifically endorses drug treatment courts because they "blend Public Health and Public Safety perspectives – treatment and monitoring – as exemplified by the therapeutic jurisprudence model guiding our Drug Courts."[422] One medical school professor, an addiction psychiatrist, joins judicial faculty members in three National Judicial College courses on basic substance abuse issues, a mental health course, and another course addressing co-occurring mental and substance abuse disorders.[423] This type of collaboration between the legal and

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[415] *See id.* at 15 ("The judge is the leader of the drug court team.").

[416] *See id.* at 7–10 (discussing various members of treatment team).

[417] *See* MASSARO, *supra* note 216, at 35 ("Individuals who can work across systems to facilitate communication and coordinate policies or services are referred to as 'boundary spanners.' ").

[418] *See* PHYSICIAN LEADERSHIP ON NAT'L DRUG POLICY, BROWN UNIV., POSITION PAPER ON DRUG POLICY 32 (2000), *available at* http://www.plndp.org/Physician_Leadership/Resources/researchrpt.pdf (discussing "many opportunities for collaboration" between medical profession and criminal justice system).

[419] Carlson et al., *supra* note 192, at 548.

[420] *Id.*

[421] *Id.*

[422] California Society of Addiction Medicine, Methamphetamine Policy Fact Sheet, http://www.csam-asam.org/pdf/misc/Meth_Summary.pdf (last visited Apr. 16, 2008).

[423] The National Judicial College is located on the campus of the University of Nevada,

medical communities is essential to the team-oriented approach to the adjudication of drug-related offenses by drug treatment courts across the nation.

Professional peer review is another important safeguard put in place to protect drug court participants from indiscretion by court officers and treatment program staff. The National Association of Drug Court Professionals (NADCP) is the premier drug court-related association and is a strong force nationally in both the legal community and among drug court proponents.[424] The NADCP has developed a booklet on ethical considerations for judges and attorneys in drug courts,[425] and it has offered workshops on ethical issues at many of its trainings.[426]

In the event a judge does abuse her discretion, the powerful drug court community is poised to speak in protest, as is her local judicial misconduct organization.[427] Pressure from the drug court community could potentially result in the judge being removed from a drug treatment court assignment.[428] The commission on judicial performance, or other judicial oversight body, of each state serves to check any abuses as well. As with any other judicial action, those taken in drug treatment court cases are subject to appellate or performance review.[429] If judges abuse discretion, they may be disciplined or, in extreme cases, removed from the bench. Unchecked abuses of discretion are not a problem for drug courts, but rather a problem that should be addressed by state judicial

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Reno. A full course offering may be found at http://www.judges.org.

[424] *See* Letter from C. West Huddleston III, Chief Executive Officer & Executive Dir., Nat'l Ass'n of Drug Court Prof'ls to Friend of Drug Court, http://www.nadcp.org/about/ (last visited Apr. 16, 2008) ("NADCP has become the premier national membership and advocacy organization for over 2,100 drug courts . . . .").

[425] NAT'L DRUG COURT INST., ETHICAL CONSIDERATIONS FOR JUDGES AND ATTORNEYS IN DRUG COURT 1 (2001), *available at* http://www.ndci.org/publications/ethicalconsiderations.pdf.

[426] *See, e.g.*, *Conference At-A-Glance*, NADCP NEWS (Nat'l Ass'n of Drug Court Prof'ls, Alexandria, Va.), Spring 2006, at 5, 6, *available at* http://www.nadcp.org/ppt/11454_NADCP_News_Spr06_v4.pdf (referencing workshop on ethics).

[427] *See* NAT'L DRUG COURT INST., *supra* note 425, at 13 (describing judge removed from office for improper relationships and citing *In re* Complaint Against Jones, 581 N.W.2d 876 (Neb. 1998)).

[428] *See id.* (discussing standards of drug court community).

[429] For a discussion of contemporary trends in judicial discipline, see generally Gray, *supra* note 407. Research by the authors reveals no statute or rule of court in any jurisdiction insulating drug court judges from performance or appellate review.

discipline boards. In a recent case a judge was disciplined for allowing a drug treatment court defendant to escape through her chambers to avoid being served with an arrest warrant.[430] Another judge, although not in a drug court, was removed from office for imposing conditions of probation that required an addicted female defendant to "not get pregnant" during the five year probation period.[431] Where discipline is weak in state oversight bodies, it will be weak for all judges, and where discipline is strong, drug treatment court judges will be subject to the same stringent oversight as for any other judge.

Appellate courts have exercised their oversight on drug court judges as well. In one case, a judge refused entry to an entire class of defendants, undocumented aliens.[432] The appellate court reversed his decision and exclusion of aliens was no longer allowed.[433] Appellate courts' exercise of their supervisory authority is indistinguishable from the oversight process that binds all judges. A trial court judge who acts beyond the scope of her authority receives uproar and increased scrutiny,[434] whether in a drug treatment court or not.

The team nature of drug treatment courts often also helps in preventing judicial missteps. Treatment providers and counsel, both for the state and for the defendant, have varying perspectives regarding the participant's situation. Where the judge takes a more punitive posture, the treatment providers and defense counsel can remind the judge of the nature of the disease and the objective of the program.[435] Where the judge appears too lenient, prosecutors assigned to drug court cases must voice their concerns should justice go undone and the public go unprotected.[436] One attorney, upon her

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[430] *See* Joseph Goldstein, *Judge Is Removed for Helping Felon Escape Police*, N.Y. SUN, June 14, 2006, at 1 (reporting judge removed from office for allowing "wanted man [to] elude capture").

[431] Broadman v. Comm'n on Judicial Performance, 959 P.2d 715, 725 (Cal. 1998).

[432] People v. Cisneros, 100 Cal. Rptr. 2d 784, 785 (Cal. Ct. App. 2000).

[433] *Id.* at 788–89.

[434] *See, e.g.*, Mary Alice Robbins, *Lawyers Allege Judge Steps on Individuals' Rights*, TEX. LAW., Oct. 31, 2005, at 6, 6–7 (discussing lawyers' outrage at judge's "heavy-handed methods and unorthodox decisions").

[435] *See* NAT'L DRUG COURT INST., *supra* note 425, at 24 (discussing roles of defense counsel and prosecution).

[436] As attorneys for the public, prosecutors owe the public the same duties of competence

first visit to a drug treatment court, said, "The judge was scrupulous about the rights of the defendants. I practiced criminal law in Vermont for 14 years and I often served as acting judge. I know innovating, competent, respectful jurisprudence when I see it, and I saw it in Judge Anderson's drug court."[437] Where a judge continues to impose inappropriate sanctions, the attorneys always retain the option to appeal or move to disqualify the judge from hearing drug treatment court cases, just as they may challenge any other judge.[438]

Drug treatment court participants can appeal excessive sanctions imposed upon them, and defendants also can appeal outright denial of entry into a drug treatment court program.[439] If a person is not technically eligible because he fails to meet the statutory requirements, he will be denied entry into the program.[440] Even at that juncture, a defendant could request a hearing to challenge his ineligibility and have the judge make the ultimate decision.[441] The individual then can appeal that decision in the same fashion the undocumented alien denied entry into the drug court program successfully challenged his placement decision, as discussed above.[442] As in all of American jurisprudence, a healthy and vigorous appellate process is essential in protecting against judicial abuses whether they occur in a therapeutic court or not.

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and diligence that would be due a private client. *See* ABA STANDARDS FOR CRIMINAL JUSTICE § 3-1.3 cmt. (1993) ("The correct role of the prosecutor is to strive . . . for results that best serve the overall interests of justice and that satisfy the prosecutor's fiduciary and statutory duties to the people in a lawful and professional manner.").

[437] Valerie White, *The Wind Beneath My Wings: A Visit to the Drug Court*, SOS INT'L NEWSL. (Secular Orgs. for Sobriety, Hollywood, Cal.), 2000, http://www.cfiwest.org/sos/archives/newsletter/court.htm (last visited Apr. 16, 2008).

[438] *See, e.g.*, CAL. CIV. PROC. CODE § 170 (West 2006) (stating disqualification possibility); Deborah Goldberg et al., *The Best Defense: Why Elected Courts Should Lead Recusal Reform*, 46 WASHBURN L.J. 503, 512–16 (2007) (outlining history of judicial disqualification in America).

[439] *See* People v. Sturiale, 98 Cal. Rptr. 2d 865, 867 (Cal. Ct. App. 2000) (stating appeal is sole remedy for anyone found ineligible for diversion); Butler v. Superior Court, 73 Cal. Rptr. 2d 504, 407 (Cal. Ct. App. 1998) (same).

[440] In some jurisdictions, the prosecution, not the judge, makes the determination of eligibility for drug treatment court. *See* NAT'L DRUG COURT INST., *supra* note 425, at 31 (mentioning impact of prosecutor's initial decision).

[441] *See id.* at 27 (listing appeal decision as belonging to accused).

[442] People v. Cisneros, 100 Cal. Rptr. 2d 784, 788–89 (Cal. Ct. App. 2000).

Another potential issue surrounding judicial discretion rests in determining what constitutes unsuccessful performance in the program. Certainly, urine tests indicating drug use, or "dirty tests," are common at the outset.[443] However, grounds for removal vary from program to program and may even vary within a specific program.[444] No set standards exist regarding how to respond when a participant fails to meet the conditions of the drug court program. In some jurisdictions, a participant may be removed from a drug treatment court program if arrested on new charges, especially if those charges are not drug-related.[445] In others, removal for new arrests only occurs in cases with allegations of violence.[446] Alternatively, the drug court team may notice the participant's hard work in the program and allow him to stay.[447] In the course of treatment, other issues may come to light, such as co-occurring mental health problems, that require other concurrent forms of treatment and referral to additional resource providers.

Repeated noncompliance with the provisions of a treatment plan often may trigger a mental health assessment.[448] Many drug treatment court participants suffer from co-occurring mental health problems such as severe depression, post-traumatic stress disorder, bipolar disorder, or schizophrenia.[449] While no statistics specific to drug treatment courts can be found, "[eighty percent] of probationers sentenced to participate in substance abuse treatment

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[443] *See* Hora et al., *supra* note 43, at 482–83 (describing urine test regimen).

[444] Videotape: Drug Treatment Courts: The Prosecution Perspective (The Rutter Group 1994) (on file with authors).

[445] The Bureau of Justice Assistance offers a list of suggested drug treatment court termination criteria online. *See* Drug Court Planning Initiative (DCPI): Adult Section, http://www.dcpi.ncjrs.gov/dcpi/dcpi_adult.html#gatc (last visited Apr. 16, 2008) (providing links to various jurisdictions' criteria).

[446] *See, e.g.*, ADULT DRUG COURT POLICIES AND PROCEDURES MANUAL MONTGOMERY COUNTY, MARYLAND 10 (2006), *available at* http://hca.montgomerycountymd.gov/mc/judicial/circuit/drugcourt/AdultDrugCourtPoliciesandProceduresManualOct03-2006.pdf (listing commission of violent crime as potential disqualification for enrollment and participation in drug court).

[447] *See* BUREAU OF JUSTICE ASSISTANCE, U.S. DEP'T OF JUSTICE, DRUG COURT DISCRETIONARY GRANT PROGRAM: FY 2005 RESOURCE GUIDE FOR DRUG COURT APPLICANTS 35, *available at* http://www.ojp.usdoj.gov/BJA/grant/05DrugCtResGuide.pdf (mandating written termination criteria for programs receiving federal funding grants).

[448] Carlson et al., *supra* note 192, at 547.

[449] *Id.*

and as many as half of female offenders and juvenile detainees" have a co-occurring mental health and substance use disorder.[450] Furthermore, research shows that seventy-two percent of inmates with a mental illness are also substance abusers.[451] Removal from the program for behavior caused by a mental illness would be an unfair and inappropriate response to the treatable condition that contributed to the participant's entanglement with the criminal justice system. As a result, mental health issues should be assessed throughout the treatment process. According to the Co-Occurring Center for Excellence, a division of the federal Substance Abuse and Mental Health Services Administration: "Providing integrated services [for substance abuse and other mental health issues] is fundamental to providing quality care. Failure to address co-occurring disorders in either substance abuse or mental health programs is tantamount to ignoring the needs of the majority of participants."[452]

The lack of pre-established, hard-line rules that define the standards for "failure" in drug treatment courts keeps the door open for judicial discretion and the tailoring of different judicial responses to the demographics and needs of each individual and jurisdiction.

In certain situations, understandably, terminated participants may feel they have been unfairly treated by the program and deprived of important legal opportunities. Nevertheless, the safeguards discussed above have been implemented and are effective.[453] The collaborative nature of drug treatment courts brings all members of the treatment team together in order to ensure that each participant's specific treatment needs are met.[454]

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[450] Roger H. Peters & Nicole M. Bekman, *Treatment and Reentry Approaches for Offenders with Co-occurring Disorders*, JAIL SUICIDE/MENTAL HEALTH UPDATE, Fall 2007, at 1, 1, *available at* http://www.ncianet.org/suicideprevention/publications/update/Fall%202007.pdf.

[451] Karen M. Abram & Linda A. Teplin, *Co-occurring Disorders Among Mentally Ill Jail Detainees: Implications for Public Policy*, 46 AM. PSYCHOLOGIST 1036, 1044 (1991); *see also* JOAN EPSTEIN ET AL. SUBSTANCE ABUSE & MENTAL HEALTH SERVS. ADMIN., SERIOUS MENTAL ILLNESS AND ITS CO-OCCURRENCE WITH SUBSTANCE USE DISORDERS, 2002, at 21 (2004) (finding high correlation between mental illness and illicit drug or alcohol use).

[452] Erin Bryant, *Co-occurring Disorders: Integrating Services*, SAMHSA NEWS (Substance Abuse & Mental Health Servs. Admin., Rockville, Md.), Sept./Oct. 2007, http://www.samhsa.gov/SAMHSA_NEWS/VolumeXV_5/article13.htm.

[453] *See* BUREAU OF JUSTICE ASSISTANCE, *supra* note 47, at 13 (citing success of program).

[454] *See id.* at 3 (noting teamwork among prosecutor, defense attorney, and judge in drug

The defense attorney, the prosecution, community corrections and the treatment providers advocate for the participant.[455] This collaborative advocacy often protects participants from withdrawing from the program because the drug treatment court team can anticipate potential problems.[456] All of the team members become intimately familiar with participants' individual issues and, using their expertise, advance participants' likelihood to succeed in the program.[457] Individualized information allows each team member to make a knowledgeable, thoughtful decision when choosing whether to advocate for the retention or termination of a participant from the program, a decision ultimately resting with the drug court judge.

Removal from the drug court program is not always the end of the road. In pre-plea programs, the individual retains full trial rights and is scheduled for arraignment.[458] Because perjury is unlawful, a former participant is prevented from denying drug usage due to admissions made in drug treatment court.[459] Conversely, the prosecution is prevented from using those admissions to prosecute the original case.[460] The case starts over from where it left off: after arraignment.[461] Given that the individual has now been exposed to treatment, however, the individual may refer back to this experience in order to gather the strength or experience helpful for completing a future program.[462]

Unfortunately, many drug courts follow the post-plea model, a program more complicated than pre-plea and potentially more onerous for a defendant.[463] Lack of timeliness in post-plea programs

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court program).

[455] *Id.* at 3, 14–15.

[456] *See id.* at 14 (highlighting rapid response element to program).

[457] *See* Carlson et al., *supra* note 192, at 547 (noting team concept "uniquely facilitates an individual's treatment progress").

[458] *See* Boldt, *supra* note 400, at 1255–56 (noting that defendants may still contest guilt at trial if they fail to complete drug court program).

[459] *See* BUREAU OF JUSTICE ASSISTANCE, *supra* note 47, at 4 (noting advice given by defense attorneys).

[460] *See id.* at 3 (providing course of action for prosecutor).

[461] Eric Lane, *Due Process and Problem-Solving Courts*, 30 FORDHAM URB. L.J. 955, 962 (2003).

[462] *See* BUREAU OF JUSTICE ASSISTANCE, *supra* note 47, at 13 (highlighting learning process for defendants).

[463] *See* Nolan, *supra* note 373, at 1561 (citing study that found sixteen percent of drug

is problematic because while the treatment ultimately may be similar, there is a longer gap between the arrest and the treatment. Thus, one of the key components of effective drug treatment, requiring prompt placement into treatment, is abrogated.[464] Also, in a post-adjudication situation, the participant already has been found guilty of the charge. As a result, certain constitutional rights, such as the right to a trial, have been waived or exhausted, and if the participant then fails out of the program, the pending sentence will most likely be imposed.[465] In some jurisdictions, however, there is a provision allowing the defendant to withdraw the plea and proceed with the case in the traditional fashion.[466] Otherwise, the participant has very few legal options. The same due process rights available to all defendants on their acceptance of a plea agreement are afforded to drug treatment court participants even absent the formal trial process.[467] In post-adjudication programs participants are on probation, where successful completion of the treatment program serves as one condition of the probation.[468] Due process requires that a participant be provided with a hearing before probation is terminated.[469]

Drug treatment courts, like all court settings, employ a variety of standards in order to ensure the process will flow smoothly. Judges must be given some leeway to structure the program in a way that works for the jurisdiction, conforms to local legal culture, and allows for the individuality of each participant. The ultimate goals of drug treatment courts are recovery for the defendant and reduced crime in the community.[470] Therefore, judges need to be in the best position to facilitate the process to meet those ends. Drug

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court participants were "post-plea" and twelve percent were "post-conviction").

[464] *See* BUREAU OF JUSTICE ASSISTANCE, *supra* note 47, at 5 (noting "critical window of opportunity" for treatment).

[465] *See* Hora et al., *supra* note 43, at 516 (describing problems with post-adjudication process).

[466] *Id.*

[467] *See* Lane, *supra* note 461, at 964 (describing ethical issues raised by plea bargaining as not unique to drug courts).

[468] *See id.* at 962 (noting consequences if defendant fails treatment).

[469] Gagnon v. Scarpelli, 411 U.S. 778, 782 (1973) (holding that probation revocation results in "loss of liberty").

[470] *See generally* Greg Berman & John Feinblatt, *Problem-Solving Courts: A Brief Primer*, 23 LAW & POL'Y 125 (2001) (discussing rationales for problem-solving courts).

treatment courts are real courts; the defendants face very real consequences, including criminal records and incarceration, and are entitled to the same protections as defendants in more traditional courtrooms. For this reason, drug treatment courts must act fairly towards each participant involved in the process.

The defendant's belief in the fairness of the process is important. The effect that perceived unfairness has on behavior is of greater importance than previously realized. Reactions to perceived unfairness include "punishing" the "unfair" system by ignoring mandates or deliberate misbehavior, even if such actions are detrimental to the participant.[471]

Although standards may be flexible, the drug court team must have a plan in place for handling different situations that may arise, especially with persons who have co-occurring substance abuse and mental health disorders. It is undisputed that an undiagnosed mental health problem can affect the course of substance abuse treatment and outcomes for a drug treatment court participant.[472] Likewise, a substance abuse problem can affect the efficacy of mental health treatment.[473] Both conditions can mask the other, and each can exacerbate the severity of the other illness.[474] Both illnesses must be addressed and treatment of them should be concurrent.[475] Even if planning does limit judicial discretion, it also limits overstepping and allows participants to be treated fairly throughout the process.

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[471] *See* James Andreoni et al., *The Carrot or the Stick: Rewards, Punishments, and Cooperation*, 93 AM. ECON. REV. 893, 898–99 (2003) (providing detailed statistical analysis of outcomes of reward-only systems and reward-and-punishment systems, concluding rewards higher for all participants when no punishment option is available).

[472] *See* Anna M. Johnson, *A Perspective Regarding Treatment for Methamphetamine Addiction*, 82 NOTRE DAME L. REV. 1435, 1436 (2006) (noting cognitive defects inherent in Methamphetamine addiction and treatment consequences).

[473] *See generally* DUAL DIAGNOSIS (Richard N. Rosenthal ed., 1st ed. 2003) (offering collection of articles on diagnosis and treatment of co-occurring substance abuse and mental disorders).

[474] Johnson, *supra* note 472, at 1436.

[475] Alan I. Leshner, *Drug Abuse and Mental Disorders: Comorbidity Is Reality*, NIDA NOTES (Nat'l Inst. on Drug Abuse, Rockville, Md.), Nov. 1999, at 3, 3–4; *see also* T. Howard Stone, *Therapeutic Implications of Incarceration for Persons with Severe Mental Disorders: Searching for Rational Health Policy*, 24 AM. J. CRIM. L. 283, 285 (1997) (describing lack of resources for mental health treatment in prisons).

Concerns over judicial discretion may be warranted to some extent, but such discretion is critical to the success of drug treatment court programs. Safeguards are in place to prevent judges, including drug treatment court judges, from imposing excessive punishments and acting arbitrarily.[476] Drug treatment court judges learn that drug addiction is not a moral failing, but a medical condition that requires clinical treatment. This knowledge helps the drug treatment court judge strike an appropriate balance between sanction and reward and allows revisiting that balance as the addict resumes a more normal profile of responses. Key safeguards such as peer review and collaboration between defense counsel, prosecution, community corrections, and treatment providers also are in place to hinder any judicial overreaching. Moreover, hearings and other due process considerations are provided to those who fail to perform well in the program.

V. ETHICAL ISSUES OF COLLABORATION BETWEEN PROSECUTION AND DEFENSE

Drug treatment courts are founded on a nonadversarial, collaborative approach that is focused on the participant's recovery rather than the minutia of the pending case.[477] This is critical because drug addiction remains a unique and pervasive problem that cannot be adequately addressed by traditional case processing.[478] The adversarial nature of traditional criminal courts may be a roadblock to open communication and thus a hindrance to the goal of recovery.[479] As a result, the adversarial process is suspended in drug treatment courts in order to focus solely on the participant's recovery and law-abiding behavior.[480] "[C]ollaborative undertakings can have a meaningful impact because they can facilitate the process of arriving at a mutually beneficial and

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[476] *See, e.g.*, Mullin v. Jenne, 890 So. 2d 543, 547 (Fla. Dist. Ct. App. 2005) (granting defendant's writ of habeas corpus and release from drug treatment program); Diaz v. State, 884 So. 2d 299, 299 (Fla. Dist. Ct. App. 2004) (same).

[477] BUREAU OF JUSTICE ASSISTANCE, *supra* note 47, at 3.

[478] Lamparello, *supra* note 311, at 335.

[479] *Id.* at 356.

[480] Hora, *supra* note 184, at 1474.

effective resolution, allowing the parties to collaboratively probe an issue in an in-depth, incisive manner."[481] This collaborative framework therefore is essential to a participant's successful recovery from alcohol or other drug addiction.

Emergence of the drug treatment court movement has led to a redefinition of the traditional view of lawyering.[482] Appropriate advocacy, and the twin duties of competence and diligence[483] that require each attorney to do all he can to advance his clients' interests within the given legal framework,[484] can be achieved in a drug treatment court context. Because canons of ethics for judges and rules of professional responsibility for attorneys both are built on the foundation of an adversarial system, at first blush they may appear to be in conflict with drug treatment court practices; but there is no need to blur the ethical parameters of a lawyer's role in advancing the best interests of the client.[485]

In drug treatment courts, practices of the criminal court system that otherwise would hinder recovery are suspended and replaced with less traditional roles for the defense and prosecution.[486] For defense counsel, the drug treatment court process may be viewed as more cumbersome for the defendant. For example, the defendant may be required to spend (initially at least) more time in jail, to attend court more frequently, and to examine and address the root causes for his drug addiction.[487] Additionally, in order to be

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[481] Lamparello, *supra* note 311, at 354.

[482] Simon, *supra* note 62, at 1599.

[483] The expected performance of attorneys under ABA Model Rule 1.3 is "reasonable diligence." MODEL RULES OF PROF'L CONDUCT R. 13 (2002).

[484] Appropriate advocacy is not the "zealous advocacy" often cited as a "duty" by some defense attorneys. The term does not appear in any of the ABA Model Rules. *See generally* MODEL RULES OF PROF'L CONDUCT (2002). The term is instead relegated to the preamble, in section 8, and comment 1 of Rule 1.3. *Id.* pmbl., R. 1.3. The phrase has lost the prominence it had in the 1981 Model Code, Canon 7, requiring zealous advocacy within the bounds of the law. MODEL CODE OF PROF'L RESPONSIBILITY Canon 7 (1981). The ABA Defense Function Guidelines similarly do not impose a requirement of zeal. The guidelines instead encourage devotion and courage in advocacy. *See* AM. BAR ASS'N, ABA STANDARDS FOR CRIMINAL JUSTICE: PROSECUTION FUNCTION AND DEFENSE FUNCTION 4-1.2 (3d ed. 1993), *available at* http://www.abanet.org/crimjust/standards/prosecutionfunction.pdf.

[485] Simon, *supra* note 62, at 1599.

[486] BUREAU OF JUSTICE ASSISTANCE, *supra* note 47, at 3.

[487] *See* Quinn, *supra* note 300, at 63 (noting that defendants often have to provide judge with information about their progress in treatment).

effective, the prosecution must proceed less punitively and more constructively, a stance viewed by some as appearing "soft on crime."[488] On the surface, these goals may raise some ethical questions. However, a closer look shows that the duties inherent to both defense counsel and the prosecution may successfully be carried out in a drug treatment court context.

One concern that may be voiced by drug treatment court detractors is the softening of the traditional focus on an adversarial relationship between the prosecution and defense. In using a problem-solving approach, drug treatment courts do not purport to "trump" traditional and respected doctrines such as due process, equal protection, and judicial independence, which may conflict with therapeutic considerations.[489] On the contrary, the approach suggests how the adversarial process might be "reinvigorated or supplemented" by new psychological and sociological insight.[490] The defining principles of the drug treatment court movement explicitly adhere to the necessity of due process, even when traditional roles are altered.[491] The adversarial system is one of the American criminal justice system's most treasured components and represents our best effort to ensure that people are treated fairly and that the truth is ferreted out. Crimes motivated by the defendant's addictive disease, however, as discussed above in reference to the latest research on the neurobiology of addiction, may have different causes than those crimes around which traditional case handling was designed. As long as society continues to approve the arrest of people who are substance abusers—and we do not in this Article attempt to discuss legalization, decriminalization, or so-called medical uses of illicit drugs—a revised system of adjudication will be required to address their needs.

One important role of the prosecutor is taking the legal steps necessary to protect and promote public safety. This is particularly true with respect to substance abuse because it places community

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[488] Videotape: Drug Treatment Courts: The Prosecution Perspective (The Rutter Group 1994) (on file with authors).

[489] Warren Brookbanks, *Therapeutic Jurisprudence: Implications for Judging*, N.Z. L.J. 463, 464 (2003).

[490] *Id.*

[491] BUREAU OF JUSTICE ASSISTANCE, *supra* note 47, at 3.

members at risk and jeopardizes public safety.[492] As previously discussed, incarceration has proven ineffective in decreasing recidivism among alcohol and other drug users,[493] whereas drug treatment courts are proving to be significantly more successful.[494] Given this set of facts, continuing to pursue incarceration as a complete solution for drug-addicted offenders despite the low success rates may actually decrease public safety. Reducing recidivism by providing effective drug treatment for offenders is a logical and successful strategy, and since we are nowhere near "treatment on demand,"[495] drug treatment courts represent the most effective strategy available.

Prosecutors in drug treatment court settings must redefine what it means to "win" a case. Putting defendants in jail only to have them return again and again protects public safety only during those times when prisoners are incarcerated. Providing treatment for the offender, however, costs less and removes many from an endless cycle of court involvement, thus resulting in a more lasting public benefit.[496] When the criminal court process returns a now sober and productive offender to society, the prosecutor should consider it a positive outcome or win. Because the adversarial system hinders the treatment process by obstructing communication and encouraging denial,[497] pure iterations of the adversarial system fail to effectively promote public safety.

Drug treatment courts also are proper forums for the defense attorney's primary responsibility: ensuring the protection of his

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[492] *See generally* TINA L. DORSEY ET AL., BUREAU OF JUSTICE STATISTICS, U.S. DEP'T OF JUSTICE, DRUGS AND CRIME FACTS (2007), *available at* http://www.ojp.usdoj.gov/bjs/pub/pdf/dcf.pdf (surveying relation between substance abuse and crime).

[493] *See supra* notes 35–37 and accompanying text.

[494] *See supra* notes 43–62 and accompanying text.

[495] *See* Peter D. Friedmann et al., *Accessibility of Addiction Treatment: Results from a National Survey of Outpatient Substance Abuse Treatment Organizations*, 38 HEALTH SERVS. RES. 887, 887 (2003) (finding accessibility problems persist in drug treatment programs for indigent patients).

[496] *See, e.g.*, CTR. FOR FAMILIES, CHILDREN, & THE COURTS, ADMIN. OFFICE OF THE COURTS, CALIFORNIA DRUG COURT COST ANALYSIS STUDY 3–5 (2006), *available at* http://www.courtinfo.ca.gov/programs/collab/documents/cost_study_research_summary.pdf (stating that California would enjoy ninety million dollar net benefit from its operational drug courts, with average net benefit of between three thousand and fifteen thousand dollars per participant, and with each successful participant saving state eleven thousand dollars on average).

[497] *See* Lamparello, *supra* note 311, at 356 (describing adversarial system's failures).

clients' rights. One task of the defense counsel is to inform the client of all rights and available options, allowing the client to make informed decisions given the specific situation. Just as competent defense attorneys will advise their clients of the risks and benefits of accepting a plea,[498] savvy defense counsel will familiarize themselves with at least the fundamentals of addiction, substance abuse treatment, and the options afforded by their jurisdiction's drug treatment court.[499] Defense attorneys who complain that they cannot adequately advise clients because of their own ignorance of the programs being offered in exchange for pleas have to educate themselves,[500] a requirement no different than that imposed by any new court assignment, such as defending domestic violence defendants instead of armed robbery defendants.

Once the client is in a drug treatment program, the concerns change from those found in the traditional court setting to a broader goal. In traditional courts, the defense counsel's main goal is to "beat" the charges or reduce the amount of time the client spends incarcerated.[501] Although there is a possibility that drug court participants could spend more time in jail than they would have in the traditional court setting,[502] participants may spend less time in jail over the course of their lives by becoming sober and not committing new crimes because of their addiction.[503] This requires defense counsel to have a broader lens through which to view their client's "criminal lifetime" and best interests. Traditional recovery

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[498] *See* Cait Clarke, *Problem-Solving Defenders in the Community: Expanding the Conceptual and Institutional Boundaries of Providing Counsel to the Poor*, 14 GEO. J. LEGAL ETHICS 401, 422 (2001) (describing importance of defense counsel's plea bargaining competence).

[499] *See* DAVID D. DICKMANN, THE PUBLIC DEFENDER IN DRUG COURT: ROLES AND SPECIAL ETHICAL CONSIDERATIONS 3 (2004), *available at* http://www.wisspd.org/html/forprac/spddrug.asp (describing what public defenders should do to represent clients potentially eligible for drug court).

[500] *See* Quinn, *supra* note 300, at 55 (describing problems resulting from defense's lack of information about treatment-related pleas); *see also infra* notes 505–08 and accompanying text.

[501] *See* DICKMANN, *supra* note 499, at 3–4 (describing completely new role of defense counsel in drug court).

[502] *See* Hora et al., *supra* note 43, at 516 (noting drug treatment court's more time-consuming adjudication process).

[503] *See id.* at 514 (asserting that treatment increases chance that participant will not return to court).

lore holds that there are but three outcomes for addicts: becoming inmates in prisons or institutions, dying, or becoming clean and sober through treatment.[504] In order to decrease the overall amount of time spent incarcerated and avoid fatal outcomes, defendants must receive treatment at the beginning of their criminal careers.

A. ATTORNEY ETHICS UNDER AMERICAN BAR ASSOCIATION STANDARDS

1. Defense Counsel. Client representation in drug treatment courts is entirely consistent with the rules of professional responsibility. The American Bar Association *Model Rules of Professional Conduct* state, "A lawyer shall provide competent representation to a client . . . [which] requires the legal knowledge, skill, [and] thoroughness . . . necessary for the representation."[505] In a drug treatment court context, "Competence to represent a client who may be eligible for a drug court program requires that the attorney be familiar with the program."[506] The attorney is required to know the types of treatment programs available, the eligibility requirements, the potential sanctions and incentives that may be imposed, and the circumstances surrounding their imposition.[507] The defense attorney also must be familiar with those situations that may lead to termination from the drug treatment court and the confidentiality waivers and restrictions placed on the government's use of information obtained in drug court.[508]

The collaboration between defense counsel and prosecution enhances, rather than hinders, the role of defense counsel in providing competent representation. Defense counsel work collaboratively with the prosecution to find solutions that assure the participant's continued path to recovery.[509] Working hand-in-hand with the prosecution, other team members, and the judge to provide

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[504] *See generally* BEHIND THE WALLS (1990), *available at* http://www.na.org/pdf/litfiles/us_english/Booklet/Behind%20the%20Walls.pdf (describing inevitable results of addiction).

[505] MODEL RULES OF PROF'L CONDUCT R. 1.1 (2002).

[506] NAT'L DRUG COURT INST., *supra* note 228, at 10.

[507] *Id.*

[508] *Id.*

[509] *See Defenders Largely Satisfied with Drug Court Experience*, INDIGENT DEFENSE, Nov./Dec. 1997, at 8, 8 (indicating ninety percent of defenders in drug courts who were surveyed participated in regular drug court team meetings).

the client with an opportunity to fight addiction and address his or her legal problems, requires competence, diligence, and skill. This type of collaborative effort honors defense counsel's ethical duty to provide competent legal services and, overwhelmingly, increases job satisfaction.[510]

Some traditionalist defense attorneys have complained about being placed in a collaborative role.[511] They argue that prosecutors still retain charging authority and may elect to send less worthy cases to drug courts instead of dismissing them, in the hope that the defendants will plea bargain in exchange for treatment.[512] This argument fails because in no way do drug courts deprive defense attorneys of the methods that they have traditionally employed to dissuade the prosecution from bringing weak or flawed cases. Likewise, extensive studies of drug defendants in Arizona and California found no evidence to suggest that district attorneys were increasing the severity of charges to keep defendants out of treatment and in the traditional criminal justice system, unless they were defendants with prior criminal histories or those who were arrested with large amounts of illegal drugs.[513] One study found that even in those cases with more severe charging decisions, there were times when charges were reduced on the prosecution's initiative to enable a previously ineligible defendant to become a candidate for a treatment program.[514]

Defense attorneys representing a drug-addicted client must still perform the duties of their position: they must look at the facts of the case, evaluate applicable law, and counsel that client accordingly, even if that means counseling the client to reject the plea agreement and proceed to trial.[515] Properly conducted, the

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[510] *See id.* (indicating nearly sixty-nine percent of defenders in drug courts who were surveyed indicated they can "satisfy their ethical obligations" and "[ninety] percent reported that their job satisfaction is higher in drug court than in conventional defender practice").

[511] *See* Quinn, *supra* note 300, at 57 (stating that defense attorneys do not have same power as prosecutors during planning stages in treatment courts).

[512] *See id.* at 58 (explaining that drug treatment courts do not give defense attorneys greater ability to have cases dismissed).

[513] RILEY ET AL., *supra* note 179, at xxii.

[514] *See id.* at 51 (stating that serious offenders were more likely to have their charges reduced).

[515] *See* Reisig, *supra* note 363, at 217 (contending that defense lawyers should "make due process a reality" in context of drug treatment courts).

preliminary groundwork provided by diligent defense counsel can actually improve the outcomes for drug treatment court clients.[516] The complaints of defense attorneys that clients might find treatment and probationary release on their own recognizance more palatable than incarceration while awaiting trial[517] fail to differentiate drug treatment courts from the identical allure of traditional plea bargaining. When defense attorneys believe charges to be without merit, their display of readiness to proceed to trial will quickly discourage prosecutors from squandering limited resources on those marginal cases. Likewise, the approbation of the judiciary is a strong disincentive for prosecutors and serves to check any lack of diligence in filtering out those cases not worthy of trial.

Defense attorneys have raised some legitimate concerns about the presence of counsel in drug court proceedings, concerns that may be assuaged by using a two-part solution. If the concern regards hearings at which defense counsel is not present,[518] then the defense bar should strive for strict adherence to the American Bar Association *Model Code of Judicial Conduct*[519] and protest that such hearings represent improper ex parte communication. To avoid the appearance of improper procedure, it is in the best interests of both the parties and the ethical duty of the bench officer to ensure that even the *appearance* of impropriety is avoided.[520]

Concerns that defense attorneys provide only cursory representation at some stages of the drug treatment court process, such as by "checking in" on hearings between other tasks,[521] may be alleviated by changing the customs of the local defense bar, by more careful scheduling of status hearings so that the clients of a given attorney are all heard on the same calendar, and by strict

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[516] *See id.* at 220 (noting that cases are sometimes dismissed at preliminary hearings).

[517] *See id.* (questioning how much due process should be sacrificed for sake of immediate treatment).

[518] *See* Quinn, *supra* note 300, at 56 (expressing concern about programs where court personnel interview clients outside of counsel's presence).

[519] MODEL CODE OF JUDICIAL CONDUCT Canon 3B(7) (2004) ("A judge shall accord to every person who has a legal interest in a proceeding, or that person's lawyer, the right to be heard according to law.").

[520] *Id.* Canon 2 ("A judge shall avoid impropriety and the appearance of impropriety in all of the judge's activities.").

[521] *See* Quinn, *supra* note 300, at 64 (recognizing existence of such concern).

compliance with notice requirements. Where the defense bar is alert and vocal in ensuring that procedures are not merely rubber-stamped, the system will better reflect their concerns and ideals.[522]

Model Rule of Professional Conduct (Model Rule) 2.1 states that when rendering advice, a lawyer may discuss moral, social, and political considerations that may be relevant to the client's situation.[523] Under Model Rule 1.4, "A lawyer shall explain a matter to the extent reasonably necessary to permit the client to make informed decisions regarding the representation."[524] Moreover, American Bar Association Standard of Criminal Justice 4-5.1 directs, "Defense counsel should not intentionally understate or overstate the risks, hazards, or prospects of the case to exert undue influence on the accused's decision as to his or her plea."[525] This information must be imparted so that a client is completely informed and in a manner that allows for genuine choice.[526]

Although each attorney has a different style when communicating with a client, some criteria are critical to ensuring the opportunity for a genuine choice. For example, clients who do not speak English must be afforded an interpreter and forms should be read to clients who are illiterate or cannot read English well. Defense counsel must be aware of the cognitive limitations of their client and alert to possible impairments due to alcohol or other drug use when giving explanations. Explanations should be clear and should contain specific examples of potential consequences—both positive, like sobriety and the possible sealing of records, and negative, such as smart punishments and termination from the program.[527]

Encouraging a client to participate in a program even though the attorney knows it may or may not initially result in more jail time or require more effort from the client does not usurp the ethical duties owed to the client as long as the attorney provides all of the

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[522] *See* Clarke, *supra* note 498, at 457 (stating that defense attorneys must ensure that their presence is not used to rubber-stamp predetermined policies of police and prosecutor).

[523] MODEL RULES OF PROF'L CONDUCT R. 2.1 (2002).

[524] *Id.* at R. 1.4.

[525] AM. BAR ASS'N, *supra* note 484, at 4-5.1(b).

[526] NAT'L DRUG COURT INST., *supra* note 228, at 11 ("There are no 'client decisions,' unless the client has the information and the time to make a genuine choice about how to proceed.").

[527] *Id.*

information needed to make a genuine choice.[528] Presenting the client with an opportunity to lead a clean and sober life gives the client the chance not only of an improved legal outcome in the present case, but also enhances prospects for life in the future. The Marin County, California, Public Defender's Office sees it this way:

> [I]t is in both the State's interest and our client's interest to promote healing rather than hurting the offender. Whether entitled as "Therapeutic Justice" or "Restorative Justice" a balanced justice system must [do the following]: [d]iagnose underlying disorders leading to criminal involvement[;] [c]ontain risk of violence or further criminality[;] [e]nhance the options of the offender to lead a law abiding life[;] [r]estore losses to victims and the community[; and r]estore the offender to the community, with appropriate social, medical, counseling, and other support systems in place.[529]

In contrast to traditional courts, where the defense counsel withdraws after sentencing, the role of the defense counsel in a drug treatment court setting continues when the client enters the drug treatment program.[530] A diligent defense attorney will remain involved throughout the process, attend team meetings in drug treatment courts, and advocate for the client at hearings where program violations are discussed.[531] In drug courts where participation of the defense counsel historically has been minimized, the defense bar must agitate and press for inclusion. Continuing involvement with the defendant may require some novel thinking for the attorney.[532] The defense attorney must be a good listener, be ready to practice conciliation, and be adept at managing all of the information flowing from various players in the drug court

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[528] *See* Reisig, *supra* note 363, at 221 (stressing importance of preserving defendant's due process in drug treatment court).

[529] County of Marin: Public Defender - Problem Solving Courts, http://www.co.marin.ca.us/depts/PD/Main/CADEF01B.cfm (last visited Apr. 20, 2008).

[530] *See* NAT'L DRUG COURT INST., *supra* note 228, at 13 (discussing attorney's role in drug court program).

[531] *Id.*

[532] *Id.*

process.[533] The extension of the attorney-client relationship is crucial in providing effective representation and achieving a successful outcome resulting in recovery. This model of the problem-solving defense attorney is not novel, but rather was the practice for many members of the defense bar long before either therapeutic jurisprudence or problem-solving courts were institutionalized.[534]

Post-adjudication programs present somewhat different challenges for the defense attorney. As in any plea bargain agreement, the protections afforded by the trial process are waived.[535] Some jurisdictions seal the record or enter a judgment of *nolle prosequi*, which formally abandons the prosecution, for those defendants who successfully complete treatment.[536] Counsel and the defendant must always be aware, however, that failure in a post-plea drug court program results in execution of any suspended or pending sentence.[537] Contrast this to pre-plea, diversionary programs where failure of the defendant to comply with treatment results in the opportunity for a trial. Therefore, defense counsel and the defendant must analyze all the facts, applicable law, and possible defenses and consider the option and potential outcome of a trial before deciding whether to enter a post-plea program.[538] The incentives for defense cooperation with a post-plea drug court are not as attractive as those in a pre-plea situation. However, a post-plea drug court still offers a better alternative than traditional case processing, which places the client in the revolving door of recidivism. Either the pre- or post-adjudication type of drug

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[533] County of Marin: Public Defender - Problem Solving Courts, *supra* note 529.

[534] Clarke, *supra* note 498, at 404–05.

[535] United States v. Ruiz, 536 U.S. 622, 623 (2002) ("[A] defendant who pleads guilty forgoes a fair trial as well as various other accompanying constitutional guarantees . . . ."). *See generally* Jacqueline E. Ross, *The Entrenched Position of Plea Bargaining in United States Legal Practice*, 54 AM. J. COMP. L. 717 (2006) (discussing constitutional rights waived during traditional plea bargaining process).

[536] *See, e.g.*, MICH. COMP. LAWS ANN. § 333.7411 (West 2001 & Supp. 2007) (requiring plea of guilty but dismissing charges without adjudication after successful completion of drug court).

[537] *See* Steven Belenko, *The Challenges of Integrating Drug Treatment into the Criminal Justice Process*, 63 ALB. L. REV. 833, 845–46 (2000) (discussing post-plea drug court program sentencing).

[538] Reisig, *supra* note 363, at 221.

treatment court does not conflict with the duty of diligent representation or advocacy and does not trump other important considerations.[539]

Defense attorneys who are willing to participate in the drug treatment court process are overwhelmingly satisfied with the process.[540] Ninety-seven percent of defense counsel in one survey—the only survey available but with a sample size of forty-four—reported that they were glad that their jurisdictions offered the option of a drug court.[541] The surveyed counselors unanimously agreed that their clients were as well off in drug court as they would have been had the cases been adjudicated in the traditional manner.[542] Tellingly, nearly seventy percent of defense attorneys questioned felt that drug treatment courts did not require them to abandon their traditional adversarial duties, and ninety percent reported more job satisfaction when participating in the drug treatment court programs than when assigned to traditional case handling.[543] Although the survey sample is somewhat limited, the survey demonstrates that when defense counsel is willing to participate, drug treatment court is a positive experience for them and their clients.

2. Prosecution. Participation in drug treatment court is consistent with a prosecutor's ethical obligations as well. First and foremost, a prosecutor is charged with protection of public safety.[544] This duty is met by participation in drug treatment court because the prosecutor works to rehabilitate the defendant, thus making the community safe from continued lawlessness by that person. As a member of the drug treatment court team, the prosecutor is uniquely positioned to assess the participant's progress in the program and make recommendations that serve the goals of the

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[539] Hora, *supra* note 184, at 1474.

[540] *See Defenders Largely Satisfied with Drug Court Experience*, *supra* note 509, at 8 (indicating ninety percent satisfaction).

[541] *See id.* (answering affirmatively: "Overall, I'm glad we have a drug court").

[542] *See id.* ("There was unanimity that 'my clients are seldom worse off in drug court[ ]' . . . .").

[543] *Id.*

[544] Videotape: Drug Treatment Courts: The Prosecution Perspective (The Rutter Group 1994) (on file with authors).

community.[545] If the participant has difficulties complying and fails to make sufficient progress towards rehabilitation, the prosecution can advocate for an alternative strategy.[546] The prosecutor also may advance the goal of community safety by recommending that a participant be terminated from the program when it is clear that the client is not amenable to further interventions. Termination from the program would subject the defendant to his or her previously suspended sentence or allow the defendant to be brought to trial.[547]

One concern of defense attorneys is that defendants may end up in drug court unnecessarily because community pressure to arrest drug offenders results in substandard practices by law enforcement.[548] Ethical obligations, however, serve as a prosecutorial check to limit this type of abuse.[549] For example, Model Rule 3.8 states that a "prosecutor in a criminal case shall . . . refrain from prosecuting a charge that the prosecutor knows is not supported by probable cause."[550] Prosecutors have a duty to use their own discretion and dismiss weaker cases.[551] The prosecutor meets this obligation by working in conjunction with defense counsel to discuss the case, determine eligibility for drug treatment court, and sort out strengths and weaknesses before proceeding.[552]

More importantly, even though the prosecutor is but one member of the team, the prosecution in many jurisdictions also is the program's gatekeeper and has discretion to determine who is permitted to participate.[553] The prosecutor determines the defendant's eligibility for a program even in courts where the prosecution is not actively and personally involved throughout the

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[545] *See* Kirk Torgensen et al., *How Drug Courts Reduce Substance Abuse Recidivism*, 32 J.L. MED. & ETHICS 69, 71 (2004) (noting prosecutor's consent is required).

[546] BUREAU OF JUSTICE ASSISTANCE, *supra* note 47, at 3.

[547] *Id.*

[548] *See* Miller, *supra* note 88, at 1553–54 n.395 (noting result of "war on drugs" and drug courts as response); Quinn, *supra* note 300, at 42 (noting criticism of "drug war" tactics).

[549] *See* MODEL RULES OF PROF'L CONDUCT R. 3.8 (2002) (requiring probable cause to charge).

[550] *Id.*

[551] Videotape: Drug Treatment Courts: The Prosecution Perspective (The Rutter Group 1994) (on file with authors).

[552] BUREAU OF JUSTICE ASSISTANCE, *supra* note 47, at 3.

[553] Torgenson et al., *supra* note 545, at 71.

treatment phase.[554] Any reservations about a defendant's entry into the program will be considered by the prosecution before admission to the program. A prosecutor's ethical obligation to prosecute crime and keep the community safe is not compromised by collaborating with defense counsel in determining appropriate resolutions for individual defendants, provided the disposition serves those ends.

In a pre-plea drug treatment court program, the prosecution may be concerned about the passage of time and the ability to prosecute a case in which evidence and the memories of witnesses have gone stale. Realistically, however, major high-profile cases involving serious crimes or violence are not eligible for drug treatment court programs, and no evidence exists to suggest that availability of the drug treatment court option has changed this practice.[555] Furthermore, given some defense counsels' practice of exhausting continuances and stretching out the pre-trial process, prosecutors routinely try cases quite some time after the crime occurred.

VI. RETURN ON INVESTMENT AND OTHER ECONOMIC CONCERNS

The traditional criminal justice approach to dealing with alcohol and other drug addiction is costly to the taxpayer. Incarceration of drug-using offenders costs between twenty thousand dollars and fifty thousand dollars per person per year, depending on the jurisdiction.[556] The cell used to hold a drug-using offender can cost a state more than eighty thousand dollars to construct.[557] Contrast these figures to the costs of a drug court system, which typically range from $2,500 to $4,000 annually for each offender.[558] Even

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[554] In the Hayward, California, and Reno, Nevada, drug treatment courts, for example, no prosecutor is assigned to the drug treatment court, but the district attorney's office still determines whether the participant is eligible and gives a recommendation to the arraigning judge or agrees to drug treatment court supervision of probation. Observation of Hayward, Ca. and Reno, Nev. Drug Treatment Courts by Peggy Fulton Hora, Judge, Superior Court of Cal. (Ret.).

[555] *See* RILEY ET AL., *supra* note 179, at 5 (noting offenders convicted of serious crimes are ineligible for California's drug courts).

[556] NAT'L ASS'N OF DRUG COURT PROF'LS, FACTS ON DRUG COURTS 1 (n.d.), *available at* http://www.nadcp.org/docs/FactsFinal.pdf.

[557] *Id.*

[558] *Id.*

residential treatment, required only in rare cases, is less costly than incarcerating the offender.[559]

The defendant is not the sole beneficiary of the drug treatment court process. A recent California study estimated that drug courts save taxpayers ninety million dollars annually.[560] Additionally, the community experiences a reduction in crime, with an estimated monetary value of as much as twenty-four thousand dollars per drug court participant due to reduced future court costs and victim impact costs.[561] This value may actually *underestimate* the financial benefit to society because it does not take into account the ability of the newly sober drug treatment court graduate to work, effectively parent, pay taxes, participate in commerce, and perhaps lead a healthier lifestyle, all of which would result in savings of future medical costs, including the costs of substance-exposed infants.[562] A study of addicted California Medicaid recipients conducted by the Kaiser Permanente Foundation, found that addicts who underwent outpatient drug treatment reduced their overall medical costs by a third.[563] The study found that the costs were truly reduced, not merely shifted from one area of care to another.[564]

In the first year following graduation from drug treatment court, roughly eighty-five percent of offenders, measured nationally, will have no new arrests.[565] Two years after leaving the drug treatment court program, nearly seventy-three percent of graduates will not

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[559] *See* LEGAL ACTION CENTER, COST SAVINGS THAT WOULD ACCRUE TO NEW YORK UNDER THE ASSEMBLY'S DRUG LAW REFORM BILL (A-7078 OF 2003) 7 (2003), *available at* http://www.drugpolicy.org/docUploads/NYAssemblycostsavingsreport__Pdf_.pdf (noting highest cost estimate for residential treatment is twenty-five thousand dollars per year).

[560] SHANNON CAREY ET AL., CALIFORNIA DRUG COURTS: A METHODOLOGY FOR DETERMINING COSTS AND BENEFITS, at vii (2005), *available at* http://www.courtinfo.ca.gov/programs/collab/documents/drug_court_phase_II.pdf.

[561] U.S. GOV'T ACCOUNTABILITY OFF., ADULT DRUG COURTS: EVIDENCE INDICATES RECIDIVISM REDUCTIONS AND MIXED RESULTS FOR OTHER OUTCOMES 72–73 (2005).

[562] *Id.* at 74.

[563] Lawrence J. Walter et al., *Medicaid Chemical Dependency Patients in a Commercial Health Plan: Do High Medical Costs Come Down over Time?*, J. BEHAV. HEALTH SERVICES & RES., Sept. 2005, at 253.

[564] *Id.*

[565] JOHN ROMAN ET AL., CALIBER ASSOCS. & URBAN INST., RECIDIVISM RATES FOR DRUG COURT GRADUATES: NATIONALLY BASED ESTIMATES, FINAL REPORT 28 (2003), *available at* http://www.ncjrs.gov/pdffiles1/201229.pdf.

have been rearrested.[566] The causes of recidivism among drug-using populations are difficult to determine for a number of reasons. Substance abusers are individuals and will have different arrays of factors that have led to their involvement with drugs. Individual drugs have different effects on the human body; some alter brain chemistry at a molecular level, and others may be addictive because they can produce extreme sensations of pleasure.

Comparisons across drug courts also is difficult; they are as different as the populations they serve and may have different criteria for eligibility.[567] For example, the larger the population a drug court serves, the more graduates that will reoffend.[568] This result can only partially be ascribed to variations in drug court practice. A large part of any disparity may be because large drug courts tend to serve urban populations, which have lengthier histories of criminal behavior and substance abuse.[569] This stands in marked contrast to the accusations of detractors that drug courts are successful because they "cherry pick" only the most promising clientele.[570] When looking at smaller sample sizes—individual drug courts or drug courts within a jurisdiction—drug treatment courts tend to have markedly improved recidivism rates as compared to traditional criminal adjudication in the same jurisdiction.[571]

With their substantial cost savings, described by one study as seven dollars saved for each dollar spent on treatment,[572] and high success rates, demonstrated by much lower recidivism, drug treatment courts offer a win-win solution that cannot be ignored.

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[566] *Id.*

[567] *See id.* at 7 ("[C]omparisons must be interpreted cautiously in light of the differences in sample characteristics . . . .").

[568] *Id.*

[569] *See id.* (noting that large drug courts "tend to be located in the largest metropolitan areas" and "tend to accept populations with the most severe drug problems").

[570] *See* Deborah P. Small, The Lindesmith Center, Panel Discussion at Eleventh Annual Symposium on Contemporary Urban Challenges, *in What Does the Future Hold for Drug Courts?*, 29 FORDHAM URB. L.J. 1858, 1890 (2002) (arguing that prosecutors "cherry-pick" people who they think will be most successful and who may have been successful without drug court intervention).

[571] Belenko, *supra* note 246, at 34.

[572] Neil Swan, *California Study Finds $1 Spent on Treatment Saves Taxpayers $7*, NIDA NOTES (Nat'l Inst. on Drug Abuse, Rockville, Md.), Mar./Apr. 1995, *at* http://www.nida.nih.gov/NIDA_Notes/NNVol10N2/CAStudy.html.

VII. FUTURE DIRECTIONS AND RECOMMENDATIONS

Even the most successful program can be improved, and drug courts are no exception. First and foremost is the need for additional funding. The best programs are unable to work without adequate financial support for treatment programs, education, judges, attorneys, and a competent staff. Federal, state, and county governments should exploit the effective rehabilitation potential and cost efficacy provided by drug treatment courts by stabilizing funding for these courts. Drug treatment courts should not have to raise their own funds to stay open. The drug treatment court component of a criminal justice system should be a regular budget item like any other part of the system.

Second, although the number of drug treatment courts is growing across the country, exceeding 1,600 nationally,[573] many jurisdictions do not currently provide alcohol or other drug-addicted offenders with this option.[574] In addition, except for driving while impaired (DWI)[575] and serial inebriate courts,[576] many adult treatment courts fail to include those crimes primarily related to alcohol or include alcoholics in their program, despite the fact that alcohol is perennially the number one drug problem in the United States with costs of nearly $180 billion annually.[577] This leaves a substantial segment of the addicted population free to continue clogging the criminal justice system and free to create a menace to safe society by driving under the influence and committing other alcohol-related offenses. These crimes endanger the safety of all Americans.

The third recommendation involves an increase in joint interdisciplinary education as required by key component nine.[578] Interdisciplinary education allows all members of the team to participate in a common forum and receive the education necessary

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[573] Huddleston, *supra* note 42, at 1.

[574] *See id.* at 9 (showing chart with number of drug programs per state).

[575] *See id.* at 11–12 (discussing DWI courts).

[576] *See* Pauline Repard, *Graduates of Alcohol Treatment Program Ready to Start New Lives*, SIGNONSANDIEGO.COM, June 5, 2003, http://www.signonsandiego.com/news/metro/20030605-9999_7m5rehab.html (discussing San Diego's serial inebriate program).

[577] *See* Dorothy P. Rice, *Economic Costs of Substance Abuse, 1995*, 111 PROC. OF THE ASS'N OF AM. PHYSICIANS 119, 119 (1999) (showing alcohol abuse cost $175.9 billion in 1995).

[578] BUREAU OF JUSTICE ASSISTANCE, *supra* note 47, at 21.

to pursue effective participant recovery. Attorneys, judges, community corrections personnel, court managers, and treatment providers all should have the opportunity to learn from one another's experience. Participants should be taught from the same materials and given a common vocabulary, a practice that helps prevent future miscommunication. Commonality of experience fosters trust among the members and strengthens the entire team. Distance learning tools and basic primers based on drug treatment court roles should be developed so that the education of new team members can be less dependent on geography and more time efficient. For cash-strapped jurisdictions, online or satellite distance learning is more cost effective than sending the whole team to out-of-town training. We should be implementing new, inexpensive, off-the-shelf technologies, such as podcasts, to discuss up-to-date research and practices, or chat rooms to discuss sticking points.

Changes must occur in the area of mandatory minimum sentencing in order to allow judges to exercise their discretion in sentencing. Many of the obstacles to establishing drug treatment courts and critiques about post-plea programs occur in jurisdictions with mandatory minimums. Defense attorneys in particular express concern that they are "walking a tight rope without a net" when they recommend a client enter a plea in order to take part in a drug treatment court program.[579] In jurisdictions with mandatory minimum sentencing rules, clients who fail out of the drug treatment program are immediately subject to years of incarceration without the benefit of a trial.[580] The risk of this happening, however, has been greatly reduced by the Supreme Court's holding in *United States v. Booker*, which rendered the Federal Sentencing Guidelines advisory as opposed to mandatory,[581] and state actions like the reform of New York's harsh "Rockefeller" drug sentencing laws.[582] Judges should be taught to use addiction as a factor in

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[579] *See, e.g.*, Quinn, *supra* note 300, at 54–55 (discussing uncertain issues defense attorneys face when counseling clients to accept plea to enter drug treatment program).

[580] *See id.* at 49 (noting that court imposes sentence promised under plea agreement for those who fail to meet treatment goals).

[581] United States v. Booker, 543 U.S. 220, 245 (2005).

[582] *See* Michelle O'Donnell, *Pataki Signs Bill Softening Drug Laws,* N.Y. TIMES, Aug. 31, 2005, at B6 (discussing bill that softens Rockefeller drug laws).

departing from mandatory minimums. If the legislature lacks the political courage to alter mandatory minimum sentencing laws in any given state, those having the power of initiative could change the law through the ballot box, a strategy that has been quite successful in places such as California and Arizona.[583] If all else fails, the solution would be to change post-plea drug treatment court programs to pre-plea diversion models. Clients failing out of the program would still have the full range of due process protections and the opportunity to go to trial or enter into a plea bargain that could include treatment as a condition of probation.

Some reforms that have been suggested, such as the publication of the available sanctions,[584] which constrains excessive creativity by the judiciary, already are in practice in some drug courts.[585] Matching participants with the best possible treatment program already is incorporated into the drug court model,[586] but as critics legitimately point out, there often is a paucity of available programs within a specific jurisdiction.[587] By reducing the necessity for correctional placement, newly available resources may be directed towards amelioration of the root causes of criminality, one of which is the limited number of treatment slots available. Savings in a department of corrections budget could be used to fund treatment and drug treatment courts.

Some in the drug treatment court community have already stated that there must be rigorous, national performance standards and firm guidelines for drug court practice.[588] Measures such as

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[583] *See* William D. McColl, Drug Policy Alliance, Federal Sentencing Laws: U.S. Sentencing Commission Testimony (Mar. 19, 2002) (transcript available at http://www.drugpolicy.org/library/mandatorytestimony.cfm) (discussing state ballot measures for drug policy reform).

[584] *See* Miller, *supra* note 88, at 1573 (noting that publishing available sanctions is step in due process model of drug treatment courts).

[585] *See, e.g.*, MINN. JUDICIAL BRANCH, DRUG COURT STANDARDS 6 (2007), *available at* http://www.mncourts.gov/documents/0/Public/Problem_Solving_Courts/MN_SCAO_ADULT_DRUG_STANDARDS-DCI-FINAL-7-20-07.pdf (requiring drug courts to have written eligibility and termination criteria).

[586] *See* BUREAU OF JUSTICE ASSISTANCE, *supra* note 47, at 8 (requiring individuals to be screened and periodically assessed to ensure that treatment services and individuals are matched).

[587] *See* Miller, *supra* note 88, at 1546 (noting that there may not be enough treatment providers for offenders requiring treatment).

[588] *See, e.g.*, JOHN ROMAN, URBAN INST., ACCREDITATION KEY TO CREATING THE NEXT

accreditation criteria can ensure that individual drug court programs meet appropriate standards of professionalism.[589] An excellent first step is the performance benchmarks established in the ten key components.[590] Some jurisdictions that assert they have a drug court show no fidelity to the model and tend to confuse not only the critics but also the evaluators. Peppering studies of drug court efficacy with results from courts that do not adhere to standardized practices makes evaluation difficult at best and provides ammunition to critics who then can point to a given "drug court" and say there is one that does not work and so disproves the model. Standardization and certification would yield improvement on two fronts: (1) to demonstrate the efficacy of drug courts and, therefore, bolster the credibility of drug courts in the broader community and (2) to ensure eligible defendants are being appropriately served in a culturally competent manner.

The drug treatment court community should not dismiss criticisms as unfounded or completely without merit. The response of the drug court movement must be an increased acceptance of standards and guidelines. The buoyant and somewhat evangelical phase of the movement must be gracefully retired and replaced with a willingness to seek improvement continually, while always paying close attention to due process and traditions of ethical jurisprudence.

GENERATION OF DRUG COURTS (2004), *available at* http://www.urban.org/url.cfm?ID=900735 (proposing that "[w]ith a more formalized research process funneled through an objective accreditation process, best practices and future advances can be institutionalized"); Drug Court Efficacy vs. Effectiveness, http://www.jointogether.org/news/yourturn/commentary/2004/drug-court-efficacy-vs.html (last visited Apr. 21, 2008) (providing comment of Douglas B. Marlowe, Director of Law and Ethics Research, Treatment Research Institute, University of Pennsylvania, that "responsibility now falls to the drug-court field to establish performance benchmarks and best practices for drug-court programs").

[589] *See* Drug Court Efficacy vs. Effectiveness, *supra* note 588 ("The responsibility now falls to the drug-court field . . . to develop accreditation procedures . . . to document whether a particular program is in compliance with professionally accepted standards of practice.").

[590] *See generally* BUREAU OF JUSTICE ASSISTANCE, *supra* note 47 (describing Key Components and relevant benchmarks).

VIII. CONCLUSION

Concerns are always raised when a program alters the traditional components of the criminal justice system. But, rather than adhere blindly to tradition, especially when tradition is shown to be ineffective, court systems should strive to improve results, even though that may require some flexibility. Organizations such as the Conference of Chief Justices have clearly placed their imprimatur on drug treatment courts.[591] The judiciary of the fifty states should take note of their leadership and support problem-solving courts. The National Center for State Courts has published the trial court performance standards and measurement system, a "best practices" guideline that may improve procedures not only for drug courts but also for handling traditional criminal cases using a problem-solving lens.[592] In mid-2006, the National Institute of Corrections, a division of the U.S. Department of Justice, published *Getting it Right*, a primer on collaborative problem solving for criminal justice, which sets forth a model for criminal court judges and staff to incorporate problem-solving modalities into their existing practices.[593] Funded by the Bureau of Justice Assistance, the National Judicial College recently published *Effective Judging for Busy Judges*, which advocates treatment and recovery for alcohol and other drug involved offenders.[594]

The entrenched conservatism of the legal community is a difficult hurdle to clear. Drug treatment courts are an excellent example of a successful deviation from established practice. A review of the literature on drug courts reveals that there is a substantial and profound disconnect between the realities of the criminal justice system and the perceptions of that system by authors who

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[591] *See generally* Conference of Chief Justices & Conference of State Court Administrators, *supra* note 365 ("Well functioning drug courts represent the best practice of [therapeutic jurisprudence].").

[592] *See generally* Video: National Center for State Courts, Trial Court Performance Standards & Measurement System (2005) (copy available at http://www.ncsconline.org/D_research/TCPS/index.html).

[593] *See generally* NAT'L INST. OF CORRECTIONS, U.S. DEP'T OF JUSTICE, GETTING IT RIGHT (2006), *available at* http://nicic.org/Downloads/PDF/Library/019834.pdf.

[594] *See generally* NAT'L JUDICIAL COLLEGE, EFFECTIVE JUDGING FOR BUSY JUDGES (2006), *available at* http://www.judges.org/pdf/effectivejudging_book.pdf.

themselves have never participated in a drug treatment court or who criticize from the security of the ivory tower of academia.[595] Again and again, the drug treatment court is described as abrogating or ignoring the classical adversarial conflict between prosecution and defense.[596] The drug treatment court judge is derided as presiding over a circus, while traditional judges are portrayed as neutral and austere.[597] The realities of the criminal justice system bear very little resemblance to the picture painted by some authors. Most cases, over ninety-five percent nationally and over ninety-nine percent in some jurisdictions, are closed by guilty plea, not trial.[598] Judges preside over calendars that resemble not circuses of jugglers and clowns but rather reflect the mayhem of the Roman circus. The average large jurisdiction criminal case is resolved in a crowded courtroom, full of the rumble of voices, the constant entrance and departure of attorneys, and the ceaseless movements of bailiffs and prisoners. A judge hearing minor drug possession cases might see forty or fifty defendants before noon, five days a week, every week.[599] The judge is often reduced to the status of a functionary, dispensing "McJustice" because of the mandatory guidelines for bail, sentencing, and acceptance of pleas that have been imposed by the legislature and negotiated by the attorneys. Some court systems have functionally dispensed with due process, the right to counsel, and the presumption of innocence entirely.[600] Drug treatment courts do not seek to modify the fabled and pristine criminal justice systems of theoretical practice; that system is working perfectly. The system that real clients experience is far from the antiseptic abstraction, and it is this dysfunctional system that drove the innovators of the drug court movement. Drug courts were created by sitting criminal court judges, overwhelmed and somewhat appalled by the real world they saw before them each

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[595] *See supra* notes 315–19 and accompanying text.

[596] *See supra* note 363 and accompanying text.

[597] *See supra* notes 363–64 and accompanying text.

[598] RILEY ET AL., *supra* note 179, at 47 tbl.3.14.

[599] *See supra* notes 353–58 and accompanying text.

[600] *See, e.g.*, NAT'L LEGAL AID & DEFENDER ASS'N, EVALUATION OF THE PUBLIC DEFENDER OFFICE: CLARK COUNTY, NEVADA 25 (2003), *available at* http://www.nlada.org/Defender/Defender_Evaluation/old_index_html (follow hyperlinks to report sections) (finding serious crisis in indigent representation).

day. The distance between abstract conceptualizations of the criminal justice system and reality can be effectively bridged by law school clinical programs.[601] As suggested by the National Center for State Courts Future Trends Project, law schools can use clinical practice to produce attorneys already versed in the lexicon of therapeutic jurisprudence and problem-solving lawyering;[602] even students who do not pursue careers in criminal law may find aspects of the new disciplines to be relevant and applicable to their practice.[603]

Critics and advocates of drug treatment courts should always keep in mind that no court is a panacea for every societal ill. The legislature cannot pass a set of laws to correct every problem, the executive cannot issue a silver bullet order to right every imbalance, and no single judicial program will work in isolation. If society truly wishes to ameliorate the impact of alcohol and other drugs as well as the peripheral effects of substance abuse, then drug treatment courts along with effective prevention, interdiction, and treatment on demand should be parts of an integrated approach to reducing crime. Some problems that contribute to substance abuse are beyond the reach of any one branch of government. A drug treatment court cannot, for example, eliminate poverty in a community. On the other hand, a drug treatment court can mandate that participants obtain a high school general equivalency diploma—providing a pathway out of poverty—while also clearing the way for entry into the job market without the social stigma of a felony conviction. A drug treatment court also cannot make every person a model parent, but the court can require that drug offenders participate in parenting classes and ensure that one of the major causes of poor parenting has been reduced or eliminated; good parenting pays dividends unavailable to courts that rely on

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[601] *See* David B. Wexler, *Therapeutic Jurisprudence and the Rehabilitative Role of the Criminal Defense Lawyer*, 17 ST. THOMAS L. REV. 743, 746 (2005) (advocating law school clinical teaching and scholarship).

[602] *See* NAT'L CTR. FOR STATE COURTS, FUTURE TRENDS IN STATE COURTS 2005, at 21 (Tracy Peters et al. eds., 2005), *available at* http://www.ncsconline.org/WC/Publications/KIS_CtFutu_Trends05.pdf (advocating teaching of problem-solving methods and therapeutic jurisprudence).

[603] *See* Wexler, *supra* note 601, at 767 (discussing application of therapeutic jurisprudence to appellate practice).

incarceration. When viewed as one front in an integrative approach, drug treatment courts are an invaluable and effective tool society can use to address the previously intractable.

Not only do drug treatment courts introduce new concepts and practices to the legal community, but they do so while protecting the defendant's procedural and substantive rights. The right to refuse treatment is intact because drug treatment court participation remains voluntary. Participants are not forced to leap blindly but instead are given a choice between the traditional and time-honored criminal justice system and treatment for their addiction. Although judges may be given significant discretion as heads of drug treatment court teams, there are adequate safeguards in place to prevent abuses of power and deviations from therapeutic practice. Attorneys practicing in drug treatment courts are able to broaden the options available to their clients, while offering improved safety and economy to the community. As long as drug treatment courts are adequately funded, they will continue to serve the ultimate goals of the criminal justice system by taking in intransigent and recidivistic offenders and returning productive and sober members of society.