

The 10 Essential Elements of Opioid Intervention Courts



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This publication is not intended to be the final word on opioid intervention courts. Rather, it represents the first step toward the eventual creation of research-based best practices. As practitioners implement more opioid intervention courts and researchers evaluate the model, the field will learn lessons about what works. Inevitably, these essential elements will be updated to reflect the latest research and practice experience. In the meantime, we hope this publication will help court planners develop opioid intervention courts that incorporate the best knowledge currently available, while following a consistent model that can be evaluated and refined for the benefit of the field as a whole.

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The Opioid Epidemic

Heroin, prescription pain relievers, and synthetic opioids like fentanyl have created a national epidemic. More than 70,200 Americans died from drug overdose in 2017, and more than two-thirds of these deaths involved opioids.¹ Overdose deaths have increased by double-digit percentages each year since 2014. At the present rate, more Americans are dying of overdose every year than were killed in the Vietnam, Iraq, and Afghanistan wars combined. To complicate matters, fentanyl is increasingly contaminating the supply of cocaine, methamphetamine, and other drugs—often without users' knowledge—putting even more people at risk of opioid overdose.²

This epidemic poses special challenges for the justice system. Opioid-related arrests have spiked. Police, probation officers, and court staff are being trained to administer overdose reversal medication. Jails are overseeing the detoxification of incarcerated opioid users. In the face of these pressures, justice officials across the country are working to develop new, more effective responses to opioid-related crime. At the forefront of this effort is a group of pioneering opioid intervention courts—specialized programs designed to save lives by offering immediate linkage to evidence-based treatment and intensive supervision and support.

The First Opioid Courts

The country's first opioid intervention court opened in Buffalo, New York in 2017. Created with the explicit goal of saving lives, the Buffalo Opioid Court relies on day-of-arrest intervention, rapid access to evidence-based treatment, daily judicial supervision, and wrap-around services to prevent overdose death. Prior to arraignment, court staff go to the jail and interview defendants, using a brief survey developed by the court, to identify those at risk of opioid overdose.³ Those at risk for overdose receive a brief bio-psycho-social screening, which is administered immediately following arraignment by an onsite team of treatment professionals and case coordinators. Based on the results, each consenting individual is transported to an appropriate treatment provider, where most begin medication-assisted treatment with buprenorphine,⁴ methadone, or naltrexone.⁵ The process of initial interview, arraignment, bio-psycho-social screening, and transfer to treatment is completed within 24 hours of arrest.

Once connected with a treatment provider, the participant receives a comprehensive clinical assessment and an individualized treatment plan. Opioid intervention court staff provide daily case management for participants, including helping with transportation, conducting curfew checks, and linking participants with a primary medical doctor and a range of recovery support services. Participants must return to the opioid court every business day for 90 days for progress check-ins with the opioid court judge.

The court randomly tests participants for illicit drugs at check-in hearings. Positive drug tests help the court recognize when a participant is in danger and often result in adjustments to the participant's treatment plan, such as increasing treatment intensity or changing medications. Graduated sanctions, ranging from non-jail sanctions up to a maximum of several days in jail, are reserved for behaviors such as tampering with a drug test, refusing to engage in treatment or take medication, failing to attend court hearings, or absconding from the program.

While a defendant is participating in the Buffalo Opioid Court, the prosecutor's office suspends prosecution of the case. The prosecutor and the defense attorney may investigate the case during this period, interview witnesses, engage in discovery, and negotiate a plea agreement to be entered after the 90-day program ends. After completing the program, many participants enter into a plea agreement and are diverted to a formal drug court, mental health court, or veterans treatment court for longer-term treatment and supervision.⁶ Others have their cases dismissed or, in serious felony cases, may be indicted and prosecuted in the traditional manner.

The Buffalo Opioid Court is a groundbreaking model that has shown early promise in achieving its goal of saving lives. The program is currently undergoing a federally-funded evaluation, which will be used to make modifications to the model and will inform the design of future opioid intervention courts around the country. In addition, New York State is in the process of building opioid intervention courts in each of the state's thirteen judicial districts. To support this effort, the New York State Unified Court System and the Center for Court Innovation worked together to produce a guidance document entitled *Essential Elements of Opioid Courts*. Released in December 2018, New York's *Essential Elements* were rooted in the Buffalo court's experience and decades of research related to treatment courts, substance use disorders, and behavior change.

In the meantime, the opioid intervention court concept has already spread to at least four other states and continues to attract attention from justice system practitioners nationwide. Some courts, like the Pennsylvania's Cumberland County Opioid Intervention Court and Arizona's Gila County Opioid Court, were expressly developed as adaptations of the Buffalo model. Other initiatives, including the Recovery Oriented Compliance Strategy (ROCS) Docket in eastern Tennessee and the Brown County Heroin Court in Wisconsin, arose independently and follow somewhat different models.

ROCS, for example, accepts individuals at various stages of the court process, serves many participants whose criminogenic risk is considered too low for a traditional drug court, has a special focus on serving pregnant women, and takes an average of two years to complete. Brown County's Heroin Court, by contrast, is structured as a dedicated track within the drug court, but it accepts lower-risk individuals and aims to transition stabilized participants to community re-entry and probation earlier than in other drug court tracks, typically after 3-4 months. These and other opioid intervention programs are featured in a companion publication released by the Center for Court Innovation, *Happening Now: Court-Based Opioid Intervention Programs*.

Toward National Essential Elements

As opioid intervention courts are launched throughout the country, it is becoming increasingly important to define the model and identify the core practices that these courts should include. A clearly-defined model that is grounded in research and practice experience can help court planners build strong, sustainable programs. Likewise, identifying essential elements—even if those elements are implemented in different ways—will allow researchers to evaluate the opioid intervention court model across sites, assess its effectiveness, and recommend refinements to improve the model over time. Just as the *Ten Key Components* offered a framework for drug court planners during the early years of drug court proliferation, a set of guiding principles are needed today to support the development of new opioid intervention courts.⁷

To this end, the Center for Court Innovation, with support from the Bureau of Justice Assistance, convened 37 multidisciplinary experts and practitioners for a national roundtable discussion at BJA's

office in Washington, DC on March 25-26, 2019. The roundtable was intended to explore different variations on the opioid intervention court model, learn from medical and behavioral health experts about the latest evidence-based approaches for treating opioid use disorders, and begin developing a set of national essential elements for opioid intervention courts.

On the first day, leading medical doctors and treatment experts discussed the science of opioid dependency, the efficacy of different medications for treating opioid use disorders, and best practices in treatment. Two prominent drug court researchers then described how existing research can inform the planning of opioid intervention courts and how courts can lay the groundwork for future evaluation. Next, practitioners from six of the country's first opioid intervention courts described and compared their programs. The assembled judges, prosecutors, defense attorneys, court administrators, researchers, medical experts, and treatment professionals asked questions, offered critiques, and grappled with the challenges of building opioid intervention courts in jurisdictions with different legal systems, resources, and politics. Senior officials from the Bureau of Justice Assistance and the Substance Abuse and Mental Health Services Administration provided a federal perspective and helped explore how federal resources might support these courts.

To kick off the second day, New York's statewide drug court coordinator presented the New York State Unified Court System's *Essential Elements of Opioid Courts*, which served as the foundation for the development of the national essential elements. For the next several hours, the participants discussed, debated, and advocated for adjustments to the New York *Essential Elements* that would balance the need for rigor and consistency with sufficient flexibility to allow jurisdictions to adapt the model to their different circumstances.

Following the two-day roundtable, the Center for Court Innovation convened several follow-up videoconferences, during which the roundtable participants refined the essential elements and reviewed preliminary drafts of this publication. *The 10 Essential Elements of Opioid Intervention Courts* is intended to help urban, suburban, rural, and tribal jurisdictions develop programs that incorporate the practices that experts believe are most likely to prevent overdoses and save lives. These essential elements, however, are only a first step. Although most of the practices described in this document are based on decades of research in drug courts and other settings, targeted research on opioid intervention courts is only beginning. It is hoped that a robust research base will be developed in the coming years and will ultimately lead to a formal set of research-based best practice standards.⁸

The Essential Elements

Opioid intervention courts are rapid response programs that use immediate screening and treatment engagement, intensive judicial monitoring, and recovery support services to prevent opioid overdose and save lives. By helping to stabilize individuals who are at immediate risk of overdose death, opioid courts offer support to individuals in crisis and set participants on the path to long-term recovery and a better quality of life. Opioid intervention courts need not be identical. Each court will inevitably reflect local conditions, resources, and constraints. Nonetheless, all opioid intervention courts should strive to incorporate the following essential elements.

1. Broad legal eligibility

Opioid intervention courts should accept the broadest range of charges possible, ideally including felony and misdemeanor charges. Eligibility for opioid intervention court should rest primarily on the defendant's clinical needs rather than the crime charged. The purpose of these programs is to

prevent overdose deaths through immediate access to evidence-based treatment and enhanced judicial monitoring. Therefore, opioid intervention courts should strive to accept every clinically-appropriate defendant.^{9 10} Courts considering inclusion of domestic violence or family offense cases should create protocols to ensure victim safety and coordinate with available victim advocacy programs.

2. Immediate screening for risk of overdose

Opioid courts should use a specialized screening tool to identify individuals who are at high risk of overdose.¹¹ This screening should be as immediate and universal as possible. Ideally, every defendant should be screened within hours of arrest. Screening can be administered by court staff, pretrial services, or another partner agency. Information obtained through screening must be protected in accordance with federal and state confidentiality laws and professional ethics.¹² This information should be shared only with defense counsel until defense counsel consents to broader release.¹³

3. Informed consent after consultation with defense counsel

Every person who screens positive for risk of opioid overdose and who also meets the jurisdiction's legal eligibility criteria should be offered the opportunity to enter the opioid intervention court after consultation with defense counsel. Defense counsel should be on hand to advise clients as immediately as possible after overdose screening. Defendants who agree to participate in the opioid intervention court should have their cases transferred without delay.

4. Suspension of prosecution or expedited plea

Opioid courts should concentrate on meeting participants' clinical needs rather than on the legal posture of the case. The legal process should not interfere with the participant's rapid engagement in treatment. To facilitate this goal, prosecutors should agree to suspend prosecution of the case for the duration of the program, allowing the participant, the court, and the treatment providers to focus on clinical stabilization.¹⁴ In post-plea models, opioid courts should expedite the plea process and facilitate the rapid resolution of the legal case so that treatment inception is not delayed by legal procedures.

5. Rapid clinical assessment and treatment engagement

Defendants who enter the opioid intervention court should receive a comprehensive clinical assessment¹⁵ administered by a qualified treatment professional and should rapidly engage in individualized, evidence-based treatment services,¹⁶ ideally within 24 hours of arrest.¹⁷ Treatment plans should be developed in partnership with the participant and should consider each participant's unique mental and physical health, trauma, and other needs.¹⁸ Medication-Assisted Treatment should be a core component of the program and should be offered to all participants as medically appropriate, following informed consent, and ideally within 24 hours of arrest.¹⁹ Note, however, that participants cannot be required to engage in Medication-Assisted Treatment. An abstinence-based option should be available for participants who do not wish to use opioid-based medications as part of their treatment plan. Additional treatment modalities, including cognitive behavioral approaches, individual and group counseling, and others, should be utilized to the greatest extent possible. Opioid intervention courts should work proactively with the treatment community and government agencies to identify and fill treatment gaps.²⁰ At all times, information pertaining to a participant's treatment must be protected in accordance with federal and state confidentiality laws and shared only in accordance with properly executed release agreements.²¹

6. Recovery support services

Opioid intervention courts should offer participants a broad range of evidence-based recovery support services. Support groups like Alcoholics Anonymous, Narcotics Anonymous, and similar groups—including secular alternatives—can be important supports to participants.²² Whenever possible, courts should utilize peer recovery advocates to help participants engage in the program and offer them additional guidance and encouragement.²³ In addition, courts should leverage partner agencies and volunteers to assist participants with general medical needs, trauma-related care, housing, transportation, and other supports. Where available, opioid intervention courts should partner with family support navigators, who can help address the impact of opioids on the entire family.

7. Frequent judicial supervision and compliance monitoring

Opioid intervention courts should require participants to return to court frequently for supervision and monitoring—ideally every weekday—for at least 90 days.²⁴ The judge should use evidence-based techniques, like motivational interviewing, to engage participants in strengths-based conversations about their progress.^{25 26} Participants should undergo frequent, random drug testing using evidence-based drug testing protocols.²⁷ During the 90-day stabilization period, however, the court should avoid imposing punitive sanctions for positive drug tests. Rather, the court should work with treatment partners to adjust the participant's treatment plan to achieve clinical stabilization.²⁸ Programs that include a longer-term, post-stabilization component should use sanctions judiciously and in a graduated manner consistent with the national best practices for drug courts.

8. Intensive case management

Case managers employed by the opioid intervention court or a partner agency should help to ensure that participants have necessary support systems during the critical stabilization period.²⁹ Case managers act as liaisons between the court, supervision agencies, and service providers.³⁰ In addition, they help to coordinate the ordering and timing for services.³¹

9. Program completion and continuing care

Opioid courts should require participants to complete a minimum of 90 days of treatment and supervision before leaving the program to achieve stabilization and lay an effective foundation for longer-term treatment.³² After this period, eligible participants should be assessed for possible enrollment in longer-term programs, like a drug court, mental health court, veterans treatment court, or other problem-solving court models, where they can continue to receive evidence-based treatment and achieve long-term recovery. Alternatively, opioid intervention courts can be designed to include a longer-term component that participants transition into after completing the stabilization period. In situations where the participant's legal case will be resolved at the conclusion of the 90-day stabilization period—for example, through dismissal of charges or a plea agreement with no ongoing court involvement—participants should be offered continuing care planning before they leave the program.³³

10. Performance evaluation and program improvement

Opioid courts should collect data around clearly-defined, participant-level performance measures, such as: date of arrest; date of screening for overdose risk; dates and types of assessment conducted; date of program entry; date of treatment inception; dates of overdose events (fatal and non-fatal); participant use of medication-assisted treatment (including type of medication used); participant use of other treatment modalities; dates of attendance at treatment; dates and nature of contacts with peer support specialists, case managers, and others; dates and frequency of drug testing and

test results; dates and frequency of court check-in hearings; dates and nature of contacts between participants and treatment providers; dates of any re-arrests or technical violations; and other measures.³⁴ Courts should collect this data continuously and meet at least annually as a team analyze this data, ideally with the help of a qualified research partner, to identify service gaps and make program improvements.³⁵

Conclusion

Court practitioners throughout the country are responding to the opioid crisis by working diligently to develop new programs that save lives. *The 10 Essential Elements of Opioid Intervention Courts* offer planners a tool for building effective programs that incorporate the best research currently available. These essential elements can help courts achieve the goal of preventing overdose deaths while offering individuals and families impacted by opioid use disorders the support they need to start down the long road to recovery. Practitioners everywhere are urged to put these essential elements into action.

Endnotes

¹ National Institute on Drug Abuse, *Overdose Death Rates* (Revised January 2019), available at: <https://www.drugabuse.gov/related-topics/trends-statistics/overdose-death-rates>

² See, e.g., Christine Vestal, “As the Opioid Crisis Peaks, Meth and Cocaine Deaths Explode,” Pew Charitable Trusts, Stateline (May 13, 2019), available at: <https://www.pewtrusts.org/en/research-and-analysis/blogs/stateline/2019/05/13/as-the-opioid-crisis-peaks-meth-and-cocaine-deaths-explode>

³ The Buffalo court’s survey asks:

1. Are you currently using drugs? If so, what kind, frequency, amount, and time of last use?
2. Are you currently in treatment? If so, with what provider?
3. How many times have you gone to the emergency room for a drug-related illness in the last 6 months?
4. How many treatment attempts have you had in the past 24 months?
5. Are you willing to participate in a treatment program?
6. Have you ever overdosed? If so, what drug, when, and how many times?

⁴ The buprenorphine provider maintains a mobile medical unit funded by the New York State Office of Alcoholism and Substance Abuse Services in front of the courthouse every morning, where participants, and others, can receive medication and other medical services.

⁵ For more information about medication-assisted treatment, see *Medication-Assisted Treatment in Drug Courts: Recommended Strategies*, New York, NY: Center for Court Innovation, 2015, <https://www.courtinnovation.org/sites/default/files/documents/MedicationAssisted%20Treatment%20in%20Drug%20Courts.pdf>; *Adult Drug Courts and Medication-Assisted Treatment for Opioid Dependence*, Washington, DC: Substance Abuse and Mental Health Services Administration, 2014, <https://store.samhsa.gov/system/files/sma14-4852.pdf>.

⁶ Participants who transition from opioid intervention court to drug court enter directly into phase 2 of the drug court program, having completed the stabilization phase in the opioid court.

⁷ *Defining Drug Courts: The Key Components*, Alexandria, VA: National Association of Drug Court Professionals, 1997 (reprinted 2004).

⁸ In 2013, twenty-four years after the country’s first drug court opened, the National Association of Drug Court Professionals released Volume I of the *National Drug Court Best Practice Standards*, drawing upon more than two decades of research. Volume II followed in 2015. Both volumes are available at: <https://www.nadcp.org/standards/>.

⁹ Note, however, that courts operating with federal grant funding are not permitted to use grant funds to serve violent offenders.

“Violent offender,” for purposes of exclusion from federally-funded courts, is defined in 34 U.S.C. § 10613 and includes a person who:

1. is charged with or convicted of an offense that is punishable by a term of imprisonment exceeding one year, during the course of which offense or conduct—
 - (A) the person carried, possessed, or used a firearm or dangerous weapon; or
 - (B) there occurred the death of or serious bodily injury to any person; or
 - (C) there occurred the use of force against the person of another, without regard to whether any of the circumstances described in subparagraph (A) or (B) is an element of the offense or conduct of which or for which the person is charged or convicted; or
2. has 1 or more prior convictions for a felony crime of violence involving the use or attempted use of force against a person with the intent to cause death or serious bodily harm.

¹⁰ Unlike drug courts, opioid intervention courts need not focus on individuals with high criminogenic risk (risk of reoffending). Rather, opioid intervention courts are crisis response programs that seek to stabilize participants in the short term, until their cases can proceed in a longer-term setting like a traditional drug court. Consistent with this goal, the Buffalo Opioid Court accepts participants regardless of criminogenic risk. Similarly, Tennessee’s ROCS docket primarily serves a lower-risk population who would not be eligible for drug court.

¹¹ Research on overdose risk is still emerging, and there are no validated overdose screening tools that are broadly used in the justice system. Until such validated tools are available, opioid courts should see *Assessing Risk for Overdose: Key Questions for Intake*, Waltham, MA: Brandeis University, 2017, https://www.pdmpassist.org/pdf/PDMP_admin/assessing_overdose_risk_intake_20170217.pdf.

¹² The Legal Action Center has published some of the leading resources on federal confidentiality laws. Visit <https://lac.org/addiction-confidentiality-42-cfr-part-2-important/> and <https://lac.org/resources/substance-use-resources/confidentiality-resources/> for more information.

¹³ Screening information may be shared with both defense counsel and prosecuting attorney if there is a written agreement that the information will not be used in any prosecution or other legal action against the defendant.

¹⁴ During the period of suspended prosecution, the parties must meet their obligations to preserve evidence and witnesses. In addition, the parties may move forward with discovery.

¹⁵ Hundreds of clinical assessment tools are available, many of them validated. The most widely used is the Addiction Severity Index, available at: http://adaa.washington.edu/instruments/pdf/addiction_severity_index_baseline_followup_4.pdf. A database of clinical assessment tools is maintained by the Alcohol and Drug Abuse Institute at the University of Washington, available at: <http://lib.adaa.washington.edu/instruments/>. The Substance Abuse and Mental Health Services Administration has also issued a compilation of clinical assessment tools, available at: <https://www.ncbi.nlm.nih.gov/books/NBK64140/>. Opioid courts should work closely with treatment providers and qualified medical professionals to ensure that an appropriate clinical assessment tool is being used to develop individualized treatment plans for program participants.

¹⁶ Evidence-based practices are those for which there is sufficient evidence, established through rigorous research studies, to conclude that the practice is effective. Information about evidence-based approaches to substance abuse treatment can be found on the web site of the National Institute on Drug Abuse, available at: <https://www.drugabuse.gov/publications/principles-drugaddiction-treatment-research-based-guide-thirdedition/evidence-based-approaches-to-drug-addiction-treatment>. Additional resources can be found on the web site of the Substance Abuse and Mental Health Services Administration, available at: <https://www.samhsa.gov/ebpweb-guide/substance-abuse-treatment>.

¹⁷ Research indicates that immediacy of treatment referral is a critical factor that increases the likelihood of program success. See Michael Rempel, et al., *Conclusions: The New York State Adult Drug Court Evaluation*, New York, NY: Center for Court Innovation, 2003, http://www.courtinnovation.org/sites/default/files/ccf-d6-legacy-files/pdf/drug_court_eval_conc.pdf.

¹⁸ A person's history of trauma, mental illness, and other factors can both contribute to their substance abuse and present a barrier to successful treatment. It is critically important that these issues are identified and addressed during treatment. More information about the role of trauma in substance abuse and recovery can be found in Norma Finkelstein, PhD., et al., *Enhancing Substance Abuse Recovery Through Integrated Trauma Treatment*, Sarasota, FL: The National Trauma Consortium, 2004, <https://www.samhsa.gov/sites/default/files/wcdvsarticle.pdf>, and from the web site of the National Institute on Drug Abuse, available at: <https://www.drugabuse.gov/publications/drugfacts/comorbidity-substance-use-disorders-other-mental-illnesses>.

¹⁹ Ideally, all three FDA-approved drugs for treating opioid use disorders should be made available to participants.

²⁰ Note that in opioid intervention courts operated by American Indian or Alaska Native tribes, or in those that serve Native participants, culturally competent treatment services are encouraged. Culturally competent services may include traditional healing methods as well as treatment approaches rooted in western medicine.

²¹ See note 9, above.

²² Note that some support groups take a strictly abstinence-based approach and are opposed to the use of Medication-Assisted Treatment for opioid use disorders. Court participants using Medication-Assisted Treatment should consider the support group's position on this issue and select a group that fits their needs. Often, alternative groups that are open to Medication-Assisted Treatment are available. Likewise, participants who are uncomfortable with the spiritual component of traditional twelve-step programs should be offered secular alternatives.

²³ See *Evidence for Peer Support*, Alexandria, VA: Mental Health America (2018), <http://www.mentalhealthamerica.net/sites/default/files/Evidence%20for%20Peer%20Support%20May%202018.pdf>. For a detailed description of one successful peer support program, see *Peer Support Toolkit*, Philadelphia, PA: City of Philadelphia Department of Behavioral Health and Intellectual disability Services, 2017, https://dbhids.org/wp-content/uploads/1970/01/PCCL_Peer-Support-Toolkit.pdf.

²⁴ The Buffalo opioid court requires participants to appear in court every business day, at least at the beginning of the program. Some participants are permitted to appear less frequently after achieving stabilization and testing clean. A substantial body of research establishes that better outcomes are achieved when status hearings are held frequently. See Carey, S.M., Mackin, J.R., & Finigan, M.W., "What Works? The Ten Key Components of Drug Court: Research-Based Best Practices," *Drug Court Review* Vol. VIII, Issue 1 (2012): 6, https://www.ndci.org/wp-content/uploads/DCR_bestpractices-in-drug-courts.pdf.

²⁵ A presentation about motivational interviewing techniques for treatment court judges is available at <http://www.nadcpconference.org/wp-content/uploads/2017/06/E-16.pdf>.

²⁶ Opioid intervention courts should take care to protect the confidentiality of any documentary records created during court monitoring hearings and should ensure that records are not available for use in any future court proceeding involving the defendant.

²⁷ For a detailed discussion of best practices in drug testing, refer to the *Adult Drug Best Practice Standards*, Volume II, Standard VII: Drug and Alcohol Testing, available at <https://www.nadcp.org/standards/>.

²⁸ Sanctions may be appropriate during the initial 90-day stabilization period for non-relapse behaviors such as tampering with a drug test, refusing to engage in treatment, or missing court appearances.

²⁹ Case management has been shown to increase treatment retention in both inpatient and outpatient settings. See Harvey A. Siegal, et al., "The Role of Case Management in Retaining Clients in Substance Abuse Treatment: An Exploratory Analysis," *Journal of Drug Issues* Vol. 27, No. 4 (1997): 821, <https://doi.org/10.1177/002204269702700410>. The National Drug Court Institute has published a detailed guide to drug court case management. Randy Monchick, Anna Scheyett, Jane Pfeifer, *Drug Court Case Management: Role, Function, and Utility*, Alexandria, VA: National Drug Court Institute, 2006, <http://www.ndci.org/sites/default/files/ndci/Mono7.CaseManagement.pdf>.

³⁰ See *Comprehensive Case Management for Substance Abuse Treatment*, Rockville, MD: Center for Substance Abuse Treatment, Treatment Improvement Protocol (TIP) Series, No. 27, 1998, <https://www.ncbi.nlm.nih.gov/books/NBK64863/>.

³¹ Critical Time Intervention (CTI) case management is a time-limited evidence-based practice that mobilizes support for society's most vulnerable individuals during periods of transition. <https://www.criticaltime.org/cti-model/>

³² A minimum of 90 days of treatment is consistent with National Institute on Drug Abuse recommendations. Research shows that individuals who engage in treatment for at least 90 days have better long-term treatment outcomes. See <https://www.drugabuse.gov/publications/teaching-packets/understanding-drug-abuse-addiction/section-iii/6-duration-treatment>.

³³ Discharge planning and aftercare can be instrumental in helping identify needs and providing important linkages to post-release services and resources, as well as facilitating social supports and coping strategies to buffer the stresses of transitioning into the community. See *Substance Abuse Treatment For Adults in the Criminal Justice System*, Rockville, MD: Substance Abuse and Mental Health Services Administration, Treatment Improvement Protocol [TIP] Series 44, 2014, <https://store.samhsa.gov/shin/content/SMA13-4056/SMA13-4056.pdf>. See also Steven L. Proctor and Philip L. Herschman, "The Continuing Care Model of Substance Use Treatment: What Works, and When Is Enough, 'Enough?'" *Psychiatry Journal* Vol. 2014, <http://dx.doi.org/10.1155/2014/692423>.

³⁴ For more information, see Carey, S.M., Mackin, J.R., & Finigan, M.W., "What Works? The Ten Key Components of Drug Court: Research-Based Best Practices," *Drug Court Review* Vol. VIII, Issue 1 (2012): 6, https://www.ndci.org/wp-content/uploads/DCR_bestpractices-in-drug-courts.pdf.

³⁵ As stated in the Adult Drug Court Best Practice Standards: "Studies have not determined how frequently programs should review performance information and implement and evaluate self-corrective measures. Common practice among successful organizations is to collect performance data continually and meet at least annually as a team to review the information and take self-corrective measures." *Adult Drug Best Practice Standards*, Volume II, Standard X: Monitoring and Evaluation, available at: <https://www.nadcp.org/standards/>.

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