Report of the

Special Commission on Substance Addiction Treatment in the Criminal Justice System

Report to:

House and Senate Committees of Ways and Means
Joint Committee on the Judiciary
Joint Committee on Public Health
Joint Committee on Mental Health and Substance Abuse
Clerk of the House of Representatives
Clerk of the Senate
Office of the Governor

December 31, 2015

COMMISSION ON
SUBSTANCE ADDICTION TREATMENT IN THE CRIMINAL JUSTICE SYSTEM

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Report of the Commission on Substance Addiction Treatment in the Criminal Justice System

Executive Summary

The Commission on Substance Addiction Treatment in the Criminal Justice System (Commission) was established by Section 42 of Chapter 258 of the Acts of 2014, an act to increase opportunities for long-term substance abuse recovery.

In conducting its investigation, the Commission was encouraged by the quality of leadership across all branches of government in the effort to provide the very best treatment to address issues of substance addiction. The Legislature has provided funding for initiatives to address substance addiction through support of specialty courts and funding of other innovative practices. The Trial Court will have a network of 44 specialty courts in operation by the end of FY2016. The Trial Court has also instituted a number of important structures to ensure that the very best practices are used in these specialty courts. The Executive branch has addressed the issue of substance addiction in both public health agencies and those criminal justice agencies that service substance addicted individuals.

The Commission recognizes the impact of substance abuse on the lives and well-being of so many persons in the Commonwealth. The Commission found a need for a broadly based system-wide approach to substance abuse treatment and services that will address the needs of justice-system involved individuals as well as the population of the Commonwealth at large. Drug courts have a unique and important role in this system by addressing the needs of certain targeted defendants in the criminal justice system. The Commission is confident that a structure of well-managed and well-operated drug courts will contribute to public safety and the well-being of the community and the participants. The Commission also recognizes that drug courts are not a solution to the substance abuse issues faced by the Commonwealth – these need to be addressed broadly and there needs to be improved access to and availability of treatment options. The Commission in its inquiry found a large number of promising treatment options and planning initiatives that should be supported to create an efficient and effective substance abuse system with drug courts being one part of the system.

The Commission submits the following recommendations to the Legislature:

RECOMMENDATION 1. CONTINUED FUNDING OF DRUG COURTS TO PROVIDE ACCESS ACROSS THE COMMONWEALTH TO THESE SERVICES FOR EVERY CITIZEN OF THE COMMONWEALTH.

To make drug court services available to all those in need, the Trial Court has requested a total of $3.3 million in FY2017 for continued expansion of drug courts.

RECOMMENDATION 2. FORMALLY ADOPT VOLUMES 1 AND 2 OF THE NATIONAL ASSOCIATION OF DRUG COURT PROFESSIONALS (NADCP) "ADULT DRUG BEST PRACTICE STANDARDS."

These standards are the result of extensive consultation and research on the drug court model and represent the best thinking to date on how best to address the needs of the high risk/high need population.

RECOMMENDATION 3. ENSURE ADHERENCE AND FIDELITY TO THE DRUG COURT BEST PRACTICE STANDARDS THROUGH THE PROCESS OF CERTIFICATION OF DRUG COURTS.

The Trial Court has developed a certification process outlined in the Adult Drug Court Manual and will begin certification of drug courts in 2016 as outlined in Finding II.

RECOMMENDATION 4 USE OBJECTIVE RISK ASSESSMENT TO ASSESS SUBSTANCE ADDICTED OFFENDERS.

The Commission recommends assessments of a substance addicted offender be defined in terms of risk through objective risk assessment.

RECOMMENDATION 5. DEVELOP WRITTEN POLICY ON MEDICATION ASSISTED TREATMENT IN THE COURT SYSTEM.

The Commission recognizes the utility of Medication Assisted Treatment (MAT) as an effective treatment for certain forms of substance addiction as well as the utility of incorporating MAT into drug

courts as a viable treatment option. The Commission recommends the Trial Court develop a court systemwide policy regarding the use of MAT which accounts for these barriers.

Recommendation 6. Recommend SJC Standards on Substance Abuse be updated to incorporate current practices.

The Chief Justice of the Trial Court and Trial Court Administrator are actively engaged in discussions with the SJC about potential updates to these standards. Since the publication of these standards, much of their content has been incorporated into the court system. Further, the Trial Court is engaged with stakeholders, both inside and outside the criminal justice system, on issues surrounding substance use addiction and access to treatment services. The process to update the standards is on-going.

Recommendation 7. Consideration should be given to expanding Diversion Models for pre-adjudicated offenders.

The Commission learned about the effectiveness of diversion programs and recommends their expansion.

Recommendation 8. Study peer support model for possible incorporation into drug courts.

The Commission recommends a study of applying the peer support model to other specialty courts, focusing on drug courts in particular.

Recommendation 9. Further expansion of the recovery coach model into publicly funded substance abuse treatment.

Recovery coaches, another form of peer support, help move those in recovery through the process and provide structure and support. Recovery coach services are a cost-effective way of keeping recovering addicts on track. Accordingly, the Commission recommends this model be further expanded into publicly funded substance abuse treatment.

Recommendation 10. Continued Funding of the Sequential Intercept Model (SIM) Initiative

As the Commonwealth addresses substance addiction, on-going analysis of resources, and identification of gaps in resources need to be systematically identified. The Commission recommends that the Trial Court accomplish this by implementing *Sequential Intercept Model* mapping workshops across the entire state.

Recommendation 11. Support the development of a central navigation system for substance addiction treatment services.

The Commission recommends that the Commonwealth support the development of a central navigation system for substance addiction treatment services. Such a system should provide information that is accessible to consumers and professionals.

Recommendation 12. Conduct study regarding the effectiveness of Drug Courts in the Commonwealth.

The Commission supports the efforts of the Center of Excellence for Specialty Courts (CoE) as the CoE undertakes a comprehensive study regarding the effectiveness of drug courts and their contribution to reducing recidivism.

Recommendation 13. Conduct a thorough independent study of the structure of publicly assisted substance abuse treatment including comparison to other states

The Commission recommends that a comprehensive study of the publicly assisted substance abuse treatment system be conducted with a comparison to the substance abuse delivery system in other states, to determine if there are ways to increase the effectiveness of the system.

Report of the Commission on Substance Addiction Treatment in the Criminal Justice System

Section I. Introduction

The Special Commission on Substance Addiction Treatment in the Criminal Justice System (Commission) was created pursuant to Section 42 of Chapter 258 of the Acts of 2014, "An Act to Increase Opportunities for Long Term Substance Abuse." The Special Commission was charged with conducting an investigation and evaluation of, but not limited to, the following:

> (a) an evaluation of the application and effectiveness of Standards on Substance Abuse, approved by the justices of the supreme judicial court on April 28, 1998, and recommendations to improve and ensure the consistent application of the standards in the courts;
>
> (b) an evaluation and recommendations for improvement of specialty courts that address substance addictions, including current eligibility requirements or practices, availability of such courts and use of best practices in establishing quality of services;
>
> (c) the optimum number and estimated expansion costs associated with the drug courts necessary to meet the needs of the total annual number of nonviolent substance addicted offenders;
>
> (d) an evaluation of the number and type of nonviolent offenses committed by substance addicted defendants adjudicated in the commonwealth;
>
> (e) the development of a definition of nonviolent substance addicted offender;
>
> (f) an examination of best practices relative to specialty courts that deal with substance addicted offenders, both within the commonwealth and in other states;
>
> (g) an assessment of the quantity, quality and availability of effective, evidence-based addiction treatment programs in the commonwealth; and
>
> (h) an assessment of the cost of expanding addiction treatment resources to meet the needs of the total annual number of nonviolent substance addicted offenders.

The Commission shall submit its report and findings, along with any draft of legislation, to the House and Senate Committees on Ways and Means, the Joint Committee on the Judiciary, the Joint Committee on Public Health, the Joint Committee on Mental Health and Substance Abuse and the clerks of the House of Representatives and the Senate, not later than December 31, 2015.

Section II. Commission Activities

In keeping with its statutory charge, the Commission launched an exploratory phase, inviting numerous subject matter experts, both from inside and outside the criminal justice system, to its monthly meetings to present information to Commission members on various aspects of substance use treatment and the courts. The topics of these presentations included:

- An Overview of Specialty Courts in Massachusetts;
- Services and Treatment Available from the Bureau of Substance Abuse Services (BSAS);
- The Hampden County Sheriff's Department Approach to Substance Abuse Treatment and Re-entry;
- The Department of Correction Approach to Substance Use Disorders and Re-entry;
- Veterans Treatment Court and Partnering with the Department of Veterans Services;
- Medication Assisted Treatment for Opiate Addiction;
- Pre-Arraignment Drug Diversion Programs and District Attorney Referrals; and
- The Trial Court's Sequential Intercept Mapping Initiative.

In addition to its monthly meetings, because so much of the Commission's charge involved evaluating the status of the Commonwealth's drug courts, Commission members attended a drug court session. The Commission reviewed data regarding the operations of current drug courts, statistical information on criminal defendants, caseloads, and charges across the Commonwealth, and information from Massachusetts Probation Service risk/needs assessment tools. The Commission also appointed a subcommittee to review data and research materials in more detail and to draft its legislatively mandated report.

Section III. Findings

Finding a) SJC Standards on Substance Abuse

> *. . . an evaluation of the application and effectiveness of Standards on Substance Abuse, approved by the justices of the supreme judicial court on April 28, 1998, and recommendations to improve and ensure the consistent application of the standards in the courts;*

The Special Commission was charged with conducting "an evaluation of the application and effectiveness of Standards on Substance Abuse, approved by the justices of the Supreme Judicial Court on April 28, 1998, and recommendations to improve and ensure the consistent application of the standards in the courts."

As part of its evaluation, the Commission reviewed the Standards and their history. On March 30, 1995, the Supreme Judicial Court adopted the following policy "designed to enhance the judiciary's response to the impact of substance abuse on the courts of the Commonwealth:"

> *Every judge in the Commonwealth should attempt to identify and appropriately respond to the indication of substance abuse by any party appearing before him or her in a court of the Commonwealth, where substance abuse is a factor in behavior related to the case. At every stage of the adjudicatory process, courts should provide access to substance abuse information and to referrals for screening, assessment and treatment for substance abuse.*

In light of the current opioid epidemic, this policy was visionary, representing an early recognition of the impact of substance abuse on the Commonwealth's courts and society at large, as well as a belief in the effectiveness of court-ordered treatment.

The Policy Statement was followed three years later by the adoption of the Standards on Substance Abuse created to provide guidance in the implementation of the Policy.[1] The Standards recommended for the judicial branch a course of engagement and collaboration with multiple internal and external stakeholders, including but not limited to the prosecution and defense bar, corrections and public and private treatment providers. The standards reflected a recognition of the breadth of the effect of substance use, reaching beyond criminal matters and permeating the system, including juvenile and child and custody matters.

At that time, the Court expected that the implementation of these Standards would:

> *. . . promote public safety, provide access to treatment, protect due process, reduce recidivism, ensure offender accountability and maintain a responsible and productive work environment for court personnel. By embracing them the courts will become leaders in the Commonwealth's efforts to stop the abuse of all additive substances-alcohol and other drugs-and to curtail related criminal activities and social dysfunction. Public safety will be enhanced, because offenders who succeed in treatment are much less likely to re-offend. Substance abusers will be directed toward treatment, recovery and more productive lives. Public funds will be saved, since treatment is significantly less expensive than incarceration.*

The Commission also evaluated how these standards have been incorporated into the court system. It is clear that the Trial Court has assumed a leadership position with respect to

[1] http://www.mass.gov/courts/court-info/court-management/pol-reprt/substance-abuse-standards-toc.html

substance abuse in the extended criminal justice system. With unprecedented cooperation among all branches of government, the Trial Court has worked closely with Executive Branch colleagues, particularly the Department of Mental Health, the Department of Public Health, and the Department of Veterans Services, and with financial support from the Legislature, the Trial Court has been able to significantly expand drug court sessions and correspondingly has increased the exchange of current research relative to substance use issues. The Massachusetts Probation Service and its Office of Community Corrections also play a significant role in providing access to drug treatment for offenders with substance use disorders who are on probation.

Since 1998, the Trial Court has engaged in extensive training of employees in issues of substance abuse. All new employees receive information regarding substance use and substance use disorders at mandatory new employee orientation. Judges, as well as probation officers, receive extensive training on all aspects of substance use disorders.

The Commission also recognizes that the SJC standards apply not only to litigants in the court system but to the broader court community, including lawyers who appear before the court. The Trial Court also makes referrals to Lawyers Concerned for Lawyers (LCL) when appropriate.[2]

Additionally, Trial Court Chief Justice Paula Carey and Trial Court Administrator Harry Spence, both Commission members, have been in communication with the Supreme Judicial Court seeking the Court's direction in revising the above referenced policy and substance abuse standards.

Finding b) Status of Specialty Courts in Massachusetts

> *. . . an evaluation and recommendations for improvement of specialty courts that address substance addictions, including current eligibility requirements or practices, availability of such courts and use of best practices in establishing quality of services;*

The Commission, in determining how to evaluate drug courts and make recommendations for improvement, looked to the Trial Court for the history and current status of specialty courts in the Commonwealth.

In accordance with the Trial Court's Strategic Plan adopted in 2013, the Trial Court is expanding specialty courts across Massachusetts. The goal of the Trial Court is to have a drug court accessible to every

[2] http://www.lclma.org/

person in the Commonwealth by the end of its expansion in 2017. To support this initiative, the Legislature appropriated an additional $3 million in FY2015 and $3.2 million in FY2016 to the Trial Court to support the expansion of specialty courts across Massachusetts. Much of that funding has been used to hire Specialty Court Clinicians, hire Peer Support Specialists through the Department of Veterans Services, and to pay for residential treatment beds for specialty court participants.

Current Status of Specialty Courts in the Commonwealth

Specialty courts provide innovative judicial processes, practices and collaborations that improve outcomes for court users. Specialty courts increase public safety by reducing recidivism for targeted populations for whom traditional deterrence methods have not been effective.

By using evidence-based best practices, these court sessions typically target individuals with underlying medical, mental health, substance use disorders and other issues that contribute to these individuals coming before the courts with greater frequency. Specialty court sessions aim to reduce recidivism and to improve public safety by providing innovative court practices in the delivery of justice.

The objective of the Massachusetts Trial Court specialty courts is to operate in accordance with proven evidence-based practices. A hallmark of most specialty court sessions is the integration of treatment and services with judicial case oversight and intensive court supervision. By providing focused case management with consistent accountability to the court, specialty court sessions promote improved outcomes which reduce recidivism and enhance public safety. The Commonwealth is fortunate that peer-reviewed, evidence-based practices necessary for maximum efficacy of specialty court sessions have been adopted in Massachusetts. These sessions are designed to protect all due process, equal protection, and constitutional rights of defendants participating in current specialty court sessions.

Massachusetts has five types of specialty court sessions: adult and juvenile drug courts, mental health courts, veterans' treatment courts, a homeless court, and a new Family Resolutions Specialty Court which will be located at the Hampshire Probate & Family Court. The use of specialty courts continues to expand across the Trial Court through FY2017.

The use of specialty courts (also referred to as "problem-solving courts") has increased significantly in the last few years throughout the country. Specialty courts most often focus on substance use disorders and addiction (drug courts), mental health issues (mental health courts) and veterans' issues (veterans' treatment courts).

Drug Courts

Drug courts are problem-solving courts that operate under a specialized model in which the judiciary, prosecution, defense bar, probation, law enforcement, substance use, mental health, and social service

communities work together to provide treatment to people with substance use challenges, help individuals in the criminal justice system become productive citizens, and reduce recidivism.

Eligible persons with drug-addiction may be sent to drug court in lieu of incarceration or traditional probation. Drug courts endeavor to keep individuals in treatment long enough for it to work, while supervising them closely. For a minimum term of one year, participants are:

- monitored for their engagement in substance use treatment and other services required to get and stay clean and sober;
- held accountable by the drug court judge for meeting their obligations to the court, society, themselves, and their families;
- regularly and randomly tested for drug use;
- required to appear in court frequently so that the judge may review their progress; and
- rewarded for doing well or sanctioned when the probationer does not live up to obligations.[3]

The majority of drug courts in Massachusetts are a post-adjudicative form of probation. Drug court participants are probationers who have been adjudicated, found guilty, or had criminal cases continued without a finding after admitting to sufficient facts, and are placed on supervised probation. Often drug court participants have served committed time for past crimes, or participants enroll in drug court as part of a split sentence in which probation is imposed after committed time. Typically, the court orders drug court as a condition of probation, either at a sentencing hearing, or after finding a violation of probation. Violations of drug court conditions, such as failure to attend treatment or positive drug screens, are violations of probation. If there is probable cause for the violation, the drug court participant can be detained pending the final violation of probation hearing. If a violation of probation is found by the judge, the judge can revoke probation and commit the drug court participant for a period of time or the judge can modify the conditions of probation. Generally, revocation of probation happens only after the court has exhausted all intermediate sanctions and/or the probationer evinces unsuitability by committing a new criminal offense and posing a threat to public safety[4].

Mental Health Courts[5]

Since 2009, the Springfield District Court has had a mental health session designed for individuals who are competent to stand trial, have disposed of their criminal cases by admission to sufficient facts or guilty plea, and have been placed on probation. In 2011, the Plymouth District Court established a mental health session as the first mental health court whose clinical services were funded by the Department of Mental Health, which now funds the service agencies supporting both specialty

[3] http://www.nadcp.org/learn/what-are-drug-courts

[4] Massachusetts Adult Drug Court Manual, available at www.macoe.org

[5] http://www.mass.gov/courts/programs/specialty-courts/

sessions. The mental health court sessions include a court-imposed condition of probation for defendants who have serious mental illness or co-occurring mental health or alcohol/substance abuse issues. The sessions are designed to provide an alternative to incarceration through case management, and by linking to community-based services with probation. The probationers are required to participate in community-based treatment for a minimum of three months in conjunction with regular reviews by the mental health court team.

There are three mental health courts within the Boston Municipal Court Department. Participation in the mental health court is for individuals who have been placed on pre-trial probation or post-disposition probation, and have serious mental health issues or co-occurring mental health and alcohol/substance abuse issues. When competency is an issue, after consultation with an attorney, participation may be available as a term of release.

The first mental health session began in 2007 in the Central Division through the financial assistance of the Sidney Baer Foundation and the efforts of Judge Maurice Richardson (ret.). Since 2014, the Department of Mental Health has provided additional financial support and resources, which has enabled the expansion of the mental health sessions to the West Roxbury Division and Roxbury Division. Working with a mental health clinician from the Boston Medical Center, the probation officer assigned to the mental health session identifies the particular mental health and social needs of each participant, and creates a service plan which includes referrals to mental health treatment, substance abuse treatment when appropriate, as well as housing, educational and employment opportunities. The length of participation in a mental health session is usually between three to twelve months. The Court monitors progress and compliance of the service plan through regular in-court reviews with the Judge, mental health clinician, and probation officer.

The Trial Court now has six mental health court sessions, having opened another session in Quincy in 2015.

Veterans' Treatment Courts

Veterans' treatment courts are designed to handle criminal cases involving defendants who have a history of military service through a coordinated effort among the veterans' services delivery system, community-based providers, and the court, thereby improving public safety while dealing with the underlying issues of posttraumatic stress disorder, traumatic brain injury, and military sexual trauma. Abstinence from drugs and alcohol, mandated treatment, swift accountability, and weekly interaction with the court are requirements of the Veterans Treatment Court. Currently, there are five veterans' treatment courts in Massachusetts, the Norfolk County Veterans Treatment Court, located at the Dedham District Court, the Boston Veterans Court, located in the Central Division of the Boston Municipal Court, the Essex County Veterans Treatment Court at the Lawrence District Court, the Middlesex County Veterans Treatment Court at the Framingham District Court, and the Western Massachusetts Veterans Treatment Court sitting at the Holyoke District Court.

Juvenile Drug Courts

Juvenile drug courts serve youth ages 13 – 17.5 who have a criminal violation and a substance use disorder that is impacting their social, educational and familial functioning. Participants receive case management, access to treatment, probation supervision and weekly interaction with the Court. There are currently three Juvenile drug court sessions operating in Bristol County – New Bedford, Fall River and Taunton, and the Trial Court will open a fourth session in Salem in the spring of 2016.

Family Resolutions Specialty Court

The Family Resolutions Specialty Court, to be operated in Hampshire County, will be based on Australia's Less Adversarial Trial model and will offer litigants in family law matters the opportunity to resolve their family law issues in an alternative manner in which the Judge provides intensive case management and oversight; the rules of evidence can be abrogated; issues are heard and resolved over a series of conferences among the interested parties, rather than in a single trial at the end of the proceedings; the parties may speak directly to the Judge in the conferences, rather than solely through their attorneys; and the child's voice is always heard via appointed counsel for the child. In addition, there will be a Family Consultant who is assigned to advise the parents about ways to improve communication, decrease conflict, and develop age-appropriate parenting plans. The Family Consultant shepherds the family through the process, participating in conferences with the family, lawyers, and the judge.

Current Locations of Specialty Courts in Massachusetts

Massachusetts has five types of specialty court sessions:

- drug courts
- mental health courts
- veterans' treatment courts
- homeless court
- family resolutions court.

Each specialty court is comprised of a multidisciplinary team of dedicated professionals including prosecution and defense counsel, probation, clinicians and treatment providers, law enforcement and a judge. The teams require training and resources to operate a specialty court in accordance with evidence-based practices.

As of November, 2015, the Massachusetts Trial Court operates 37 specialty courts throughout the state. The specialty courts are comprised of:

- 22 drug courts,
- 6 mental health courts,
- 3 juvenile courts,
- 5 veterans' treatment courts, and
- 1 homeless court.

Figure 1 Current Specialty Courts

Drug Courts

Boston Municipal Court
Charlestown
Dorchester
East Boston
South Boston

District Court Department
Ayer
Barnstable
Brockton
Cambridge
Chelsea
Concord
Dudley
Fall River
Greenfield
Lawrence
Lowell
Lynn
Malden
New Bedford
Newton
Orange
Plymouth
Quincy

Juvenile Court Department
Fall River
New Bedford
Taunton

Mental Health Courts

Boston Municipal Court
Central
Roxbury
West Roxbury

District Court Department
Plymouth
Quincy
Springfield

Veterans' Treatment Courts

Boston Municipal Court
Central

District Court Department
Dedham
Lawrence (serving Essex County)
Framingham (serving Middlesex County)
Holyoke (serving Western Massachusetts)

Homeless Court

Boston Municipal Court
West Roxbury

Specialty Courts Planned for FY2016

The Trial Court plans to open seven additional specialty courts in FY2016, which will bring the total to 44. In siting a specialty court, consideration is given to judicial and probation resources, need and commitment of the community, drug arrests and arraignments, property crimes and availability of treatment resources.

Again, the expansion of specialty courts across Massachusetts is due in large part to the support of the Legislature which provided $3 million in funding in FY2015, and $3.2 million in funding in FY2016.

To assist with the expansion of drug courts, the Trial Court created, in collaboration with the Department of Mental Health and the Department of Public Health Bureau of Substance Abuse Services, the Center of Excellence for Specialty Courts, located in the UMass Medical School's Department of Law and Psychiatry. The CoE will assist the Trial Court in monitoring and evaluating its drug courts and ensuring adherence to best practices.

Figure 2 Specialty Courts Planned for FY2016

Drug Courts

District Court Department
Hingham
Pittsfield
Springfield
Taunton
Worcester

Juvenile Court Department
Salem

Mental Health Courts

District Court Department
Cambridge

Effectiveness of Drug Courts

Nationally, studies on drug courts have found them to be effective at reducing recidivism and improving lives.

•Nationwide, 75% of drug court graduates remain arrest-free at least two years after leaving the program.

•Rigorous studies examining long-term outcomes of individual drug courts have found that reductions in crime last at least 3 years and can endure for over 14 years.

•The most rigorous and conservative scientific "meta-analyses" have all concluded that drug courts significantly reduce crime as much as 45 percent more than other sentencing options.[6]

[6] http://www.nadcp.org/learn/drug-courts-work-0

Multisite Adult Drug Court Evaluation

The National Institute of Justice (NIJ) funded an unprecedented drug court evaluation called the Multisite Adult Drug Court Evaluation (MADCE).[7]

Description of the Evaluation

This five-year longitudinal process, impact and cost evaluation of adult treatment drug court programs employed a hierarchical model and sampled nearly 1,800 drug court and non-drug-court probationers from 29 rural, suburban and urban jurisdictions across the United States.

The sample includes 23 drug courts and six comparison groups in eight states: Florida, Georgia, Illinois, New York, Pennsylvania, North Carolina, South Carolina and Washington.

A conceptual framework for this study, similar in layout to a program logic model, conveys how resources are invested or input to generate activities designed to produce program outputs.

The framework proposes that program activities collectively will result in immediate or short-term outcomes for the participants, typically measured while participants are in the program. The expectation then is that program participation will result in long-term outcomes, which include changes in drug use, criminal behavior and other functions.

Research Questions

The MADCE study addresses several research questions:

- What is the impact of adult drug courts on alcohol and other drug use, criminal recidivism, employment and other functional outcomes?
- What community, program and offender characteristics predict these short- and long-term outcomes?
- How do changes in short-term outcomes — such as offender perceptions and attitudes — mediate the impact of programs on long-term outcomes?
- Are there cost savings attributable to drug court programs?

The study found:

• *Substance Use: Drug courts produce significant reductions in drug relapse.*

Drug court participants were significantly less likely than the comparison group to report using any drugs (56 vs. 76 percent) in the year prior to the 18-month interview, and also less likely to report using “serious” drugs (41 vs. 58 percent), which omit marijuana and “light” alcohol use

[7] Shelli B. Rossman, et.al. The Multi-Site Adult Drug Court Evaluation: Executive Summary, The Urban Institute, December 2011.

(fewer than four drinks per day for women or less than five drinks per day for men). On the 18-month oral fluids drug test, significantly fewer drug court participants tested positive for illegal drugs (29 vs. 46 percent). Further, among those who tested positive or self-reported using drugs, drug court participants used drugs *less frequently* than the comparison group.

• *Crime: Drug courts produce significant reductions in criminal behavior.*

Drug court participants were significantly less likely than the comparison group to report committing crimes (40 vs. 53 percent) in the year prior to the 18-month interview. Also, of those who reported criminal activity at the 18-month follow-up, drug court participants reported about half as many criminal acts (43.0 vs. 88.2), on average, in the year prior. Among specific offenses, drug court participation reduced drug possession, drug sales offenses, driving while intoxicated, and property related crime. Finally, drug courts reduced the probability of an official re-arrest over 24 months (52 vs. 62 percent), but this last effect was not statistically significant.

• *Other Psychosocial Outcomes*: *Drug court participants experience select benefits in other areas of their lives besides drug use and criminal behavior.*

At 18 months, drug court participants were significantly less likely than comparison offenders to report a need for employment, educational, and financial services, suggesting that drug court participation addressed those needs. Further, drug court participants reported significantly less family conflict than comparison offenders. However, there were only modest, nonsignificant differences in 18-month employment rates, income, and family emotional support; and the samples did not differ in reported symptoms of depression or in experiencing homelessness.

• *Durability of the Drug Court Impact: Drug courts produced long term benefits for participants.*

With respect to substance use and crime, improved outcomes at the 6-month interviews were nearly identical to improvements reported at the 18-month interviews, which includes at least some post-program time for 72 percent of the drug court sample. For instance, drug court participants were significantly less likely to report drug use in the prior six months (41 percent) than the comparison group (62 percent), a gap that was then largely sustained.

Suffolk County Drug Court Evaluation

While the CoE is currently working on a comprehensive state-wide outcome study of drug courts in Massachusetts, several years ago, a study of drug courts operating in Suffolk County was completed that found results similar to research across the nation.[8] Using standard statistical analysis to examine

[8] William Rhodes, Ryan Kling, Michael Shively, Suffolk County Drug Court Evaluation, Abt Associates, Inc., June 14, 2006.

outcomes, the study found compared with non-drug court matched probationers, drug court participants (graduates and non-graduates):

- Are 13 percent less likely to be arrested (0.46 arrest probability for drug court participants and 0.52 arrest probability for matched probationers);
- Have 34 percent fewer convictions on average (1.45 convictions for drug court participants and 2.20 convictions for matched probationers);
- Remain arrest-free for 15 percent longer on average (410 days for drug court participants and 356 days for matched probationers);
- Are 24 percent less likely to be incarcerated (the probability of incarceration is 0.16 for drug court participants and 0.21 for matched probationers);
- Have 35 percent fewer incidents of incarceration (an average of 0.20 events per drug court participant and 0.31 events for matched probationers); and
- Have 36 percent fewer suspensions and revocations (an average of 0.25 for drug court participants and 0.39 for matched probationers).

Target Population for Drug Courts[9]

The current mainstream drug court model is focused on High Risk/High Need (HR/HN) participants. Risk under this model refers to risk for re-offending or a risk to public safety specifically, and is not to be confused with other types of risk like risk to self. Guidance on HR/HN is provided below.

There are both static (unchanging) and dynamic (changeable) risk factors that affect an individual's offending behavior. The static factors are included in the Risk (R) category and the dynamic risk factors (those that should be the targets of intervention) are included in the Criminogenic Needs (N) category.

A responsivity factor is a characteristic of the individual that affects responsiveness to types of treatment, and should be taken into consideration in making a specific referral.

As noted above, the mainstream drug court model focuses on individuals who are considered high risk/high need as described above. More often than not, if someone is high risk that person also will be high need because criminogenic needs are factors that elevate one's risk for reoffending so the two are strongly correlated. It should be evident from the description above that an offender does not need to be a violent offender (past or present) to be high risk. So violence history is related to, but not synonymous with, risk.

The risk-need-responsivity approach, a widely tested and evidence-based approach for case management, dictates three primary principles.

[9] http://www.macoe.org/

- First, **the Risk principle** states the higher the risk the more intensive the intervention should be in order to reduce one's risk of reoffending. Thus, more resources and intensive supervision should be focused on high risk offenders relative to low risk offenders who are unlikely to reoffend regardless of the intervention received.
- Second, **the Need principle** dictates that only the individual's unique criminogenic needs should be targeted for intervention by the Court. Research has indicated that treatments that target needs that are unrelated to the person's offending behavior or issues will be ineffective in reducing reoffending. Thus, case management planning for high risk offenders will need to address their criminogenic problem areas in addition to substance abuse or mental health concerns in order to be effective.
- Third, **the "Responsivity" principle** indicates that once the needs are identified, the mode of service should be matched to the characteristics of the individual that may affect his/her responsiveness to treatment approaches.

Although the published literature suggests that only a small percentage of offenders charged with a drug offense fall into the low risk/high need category[10], it is unclear if this is currently the case in Massachusetts, given the severity of opiate use among defendants. The CoE is currently studying the actual prevalence in Massachusetts drug courts. In the interim, some courts (e.g., Dudley and Greenfield) believe there is an identified subset of individuals who are low risk (e.g., probationers that do not have an extensive criminal history or many static risk factors) but high need based on the

Figure 3 Risk Factors Used in Assessing Drug Court Participants

Static Risk (R) factors examples:

- Criminal onset before age 16
- History of varied/serious criminal behavior
- Age onset of substance abuse
- History of employment problems
- Ruptured family/marital relations

Need Factors/Dynamic Risk factors (N) examples:

- Current alcohol/drug abuse
- Criminal associations
- Antisocial orientation/criminal thinking
- Antisocial traits/impulsivity
- Current unemployment

Responsivity factors examples:

- Drug/alcohol dependence and severity (e.g., age of onset, frequency of use, level of functional impairment)
- Cultural issues
- Trauma history
- Mental health conditions
- Special education/learning disability

[10] Doug Marlowe, et.al, "Targeting Dispositions for drug involved offenders: A field trial of the Risk and Need Triage (RANT)," Journal of Criminal Justice 39(3), pages 253-260, 2011.

severity of current drug use, primarily opiates. These individuals may be at high risk to themselves, as evidenced by the concerning numbers of opiate-related deaths in Massachusetts. Issues have been raised about how to adapt current models to incorporate this group of individuals. There is some guidance available from the research literature, although further work to clarify some of the findings is still needed. One option would be to place these individuals in a separate "track" from the high-risk offenders, with lower level of supervision and less frequent court appearances. Greenfield Drug Court is planning on adopting this model. The EOTC will work with the CoE to evaluate the various models for incorporating this group of low risk/high need into drug courts.

Adherence to Evidence Based Practices

In addition to delivering services to an appropriate target population, the Commission found that fidelity to the key components of the program model was essential to the successful implementation of the drug court model. The Commission reviewed Trial Court activities with respect to assessments of current drug court operations and management infrastructure to establish an infrastructure consistent with adherence to best practices.

Assessments of Drug Courts

In recognition of the importance of drug courts, the Trial Court has completed two assessments of drug court operations. These assessments continue to guide the development of Trial Court policy and strategy with respect to the management and operation of drug courts.

The first assessment was done as part of the grant received by the Department of Public Health from the Bureau of Justice Assistance in 2012. The Grant Steering Committee conducted site visits of 12 drug courts across Massachusetts. The Committee concluded that "each court adheres to the 10 Key Components of Drug Courts and the Seven Design Features to varying degrees. Although capacity varies, each District drug court is operated by an interdisciplinary team of criminal justice and behavioral health professionals who strive to identify eligible defendants early and motivate them to engage and participate in a program of behavioral change. Drug court participants are required to maintain regular contact with their Drug court case manager, submit to frequent, random and monitored alcohol and drug testing, participate in substance abuse treatment, and comply with the other conditions of drug court participation and probation."

The second assessment was done in 2013 by American University. The assessment team conducted site visits at three Boston Municipal Court sessions in Charlestown, East Boston and Dorchester. The report lauded the courts for their strong associations with both substance abuse and mental health treatment providers, as well as the stability and leadership of the drug court team personnel. The report suggested that the courts address several issues including judicial participation in staffings, increasing the number of program participants through the establishment of clear eligibility criteria, screening and assessment of risk and needs of participants, developing a consistent and systematic framework of sanctions and

incentives, developing policy and procedures manuals, and the creation of an information management system. Many of the recommendations in the report have been addressed with changes in drug court operational procedures and management structure.

Drug Court Management and Operations

To oversee the operation of all drug courts, the Trial Court created the role of specialty courts administrator within the Executive Office of the Trial Court. In addition, the Boston Municipal Court Department and the District Court Department designated a judge to coordinate drug court operations within that court department.

The EOTC, in partnership with the Massachusetts Departments of Public Health and Mental Health, solicited bids for the establishment of the CoE, and the University of Massachusetts Medical School was the successful bidder. The CoE provides assistance to the EOTC in promulgating best practices in juvenile and adult court specialty sessions, and in implementing best practices in addressing the issues of mental health, substance use disorders and trauma.

The CoE seeks to standardize the establishment and operation of drug courts throughout the state—while taking into account that some practices may need to be adapted to fit local circumstances. In fulfilling its mission, the CoE is organized into Cores, which work together, but with each Core taking lead responsibility for specific functions. These Cores include:

- The **Training Core** takes lead responsibility for assisting the Trial Court in promoting best practices/evidence-based drug court operations, treatment, and recovery support services to meet the needs of drug court participants. This Core also provides technical assistance and strategies on trainings to support drug court operations.

- The **Legal Research/Support Core** is responsible for researching case law and new federal and state legislation relevant to drug courts, and providing case law summaries of relevant court cases to inform the operations of Massachusetts drug courts. This core also provides summaries and citations of mental health and social science research that impacts services at drug courts.

- The **Evaluation Core** takes lead responsibility for assisting the EOTC and state agencies via consultation on data analytic and cost-effectiveness projects to guide policy change throughout the Commonwealth as it relates to the Trial Court Drug Court Strategic Plan.

- The **Research Core** leverages CoE funds to apply for additional funding through federal and other grant submissions on behalf of the EOTC. In 2015, the Research Core worked with the EOTC to successfully obtain a grant from SAMSHA to apply the MISSION Model to the Barnstable Drug Court. Two other grants were also submitted, with decisions pending.

- The **Marketing and Outreach Core** collaborates with the EOTC in the development of a marketing and outreach plan. This Core has taken the lead in developing the CoE website, and will assist the EOTC in promoting court and community engagement to support drug court participation.

The Director of each of the Cores reports to the CoE Director who oversees the operations of the CoE and works with the Advisory Committee and the EOTC's Specialty Courts Administrator, to develop priorities for the CoE, ensure that its goals are met, and provide technical assistance and consultation to aid in the enhancement of drug courts in Massachusetts. In addition, the Director will deploy the resources of the CoE to aid the EOTC in developing a certification process for drug courts. The final decision on all matters related to the CoE lies with the Chief Justice of the Trial Court.

Adult Drug Court Manual

The Adult Drug Court Manual, released by the Trial Court in September, 2015 and posted on the internet[11] incorporates the 10 Key Components for drug courts and the Best Practice Standards issued by the NADCP. The Trial Court will ensure adherence to the standards through the process of certification of drug courts. The manual is included in Appendix B.

Trial Court Adult Drug Court Certification Process

The purpose of the Trial Court's drug court certification process is to support adult drug courts throughout Massachusetts in utilizing nationally-recognized best practices for program operation. The certification process goals are 1) to educate drug courts on national best practices, 2) ensure that drug court participants are enrolled in effective drug courts, and 3) ensure that drug court operations are consistent with providing participants with all constitutionally protected rights. The CoE will coordinate and provide trainings, and may act as a liaison for the drug court to enroll in national trainings. The CoE will also serve as a resource to applicant drug courts in the creation of policies and procedures, mission statements, and the development of other documents or procedures specific to that drug court which are necessary for certification. In addition, the certification process will include the varied and innovative approaches to drug courts, and will foster and support drug courts designed to address specific community needs consistent with evidence-based practices.

The adult drug court certification process begins with an application submitted by the drug court team to the CoE. The application must be submitted at the direction of the departmental Chief Justice.

Once the CoE possesses a completed application, the certification process will begin with a document review, conducted by the certification team. The Trial Court will establish a certification team consisting of at least one judge, one probation officer, and a treatment provider or drug court clinician. The

[11] http://www.mass.gov/courts/docs/specialty-courts/adult-drug-court-manual.pdf

document review will include the drug court's policy and procedures manual, its mission statement, the participant handbook, a list of drug court team members, and copies of any team members' drug court training certificates.

After the document review, the certification team will conduct a site visit to see the drug court in operation and to meet the members of the drug court team. The certification team may engage in additional conversations with the presiding justice or other drug court team members after the site visit.

The certification team will then write a report to the departmental Chief Justice. If the report recommends certification, the departmental Chief Justice will review and forward the report to the Chief Justice of the Trial Court. The Chief Justice of the Trial Court will review the report and recommendation of the certification team and make the final certification determination. A copy of the certification issued by the Chief Justice of the Trial Court will be provided to the drug court Presiding Justice and the departmental Chief Justice. Certifications will remain active for 3 years.

If the certification team is unable to recommend certification, it will transmit a report to the departmental Chief Justice. This report will outline the steps recommended to achieve certification. The report will include an action plan for the CoE to assist the drug court in meeting this goal, and a time frame after which the certification team will reconsider the drug court for certification. The departmental Chief Justice will be responsible for monitoring the adoption of the certification recommendations put forth by the certification team.

Finding c) Estimating the Need for Drug Courts

> *. . . the optimum number and estimated expansion costs associated with the drug courts necessary to meet the needs of the total annual number of nonviolent substance addicted offenders;*

The task of the Commission was to estimate the resources required to achieve a goal of universal access to drug courts for all regions and probationers in the Commonwealth. In consideration of this goal, the Commission recognized the need for considering a variety of delivery protocols to efficiently serve remote and rural areas of the state, to create delivery protocols to meet large high-volume courts as well as smaller community based courts. The Trial Court is fortunate in having a variety of experienced operating drug court models in a variety of settings to draw upon.

In developing this cost estimate, the Commission considered a range of data elements to determine the need for new and expanded drug courts. The Commission considered the current programs in operation, the volume of cases and probationers at each of the remaining divisions, and the substance abuse indicators of the probation population. The Commission considered best practices with respect to drug court capacity and recommended length of drug court participation. In addition, the Commission

considered the capacity and utilization of existing drug courts in making a determination of the need for additional resources.

The Commission recommends the following to provide access to 67 court locations throughout the Commonwealth including eight divisions of the Boston Municipal Court Department and the 59 divisional locations of the District Court Department:[12]

- Enhance the 27 existing drug courts with a consistent level of funding for staffing, training, and infrastructure;
- Establish three new drug courts that would address the needs of seven divisions; and,
- Use expanded staffing to provide drug court services to serve 37 new court jurisdictions through regional collaboration of personnel.

Commit Resources for Minimum Staffing Patterns at all Drug Courts

Currently the 27 drug courts are staffed by judges, probation officers, and clinicians who are not entirely dedicated to the drug court and have other responsibilities. The Commission found that it is optimal to have the following minimum staffing level at all existing as well as the proposed three new drug courts:

Dedicated Drug Court Probation Officers. The Commission found that the optimal staffing pattern of a drug court is one full-time dedicated drug court probation officer for each program. The primary responsibilities of this position will be:

- Managing Referrals: This probation officer will be focused on working with other probation officers, attorneys, and judges on identifying appropriate referrals to the drug court. The lack of full time probation staff at existing sites contributes to under-utilization of current drug court resources at some sites;
- Supervision of drug court participants – the probation officer will be responsible for the supervision of drug court participants during the time the participant is in the program;
- Staffing Meetings – the probation officer will be responsible for preparation of case materials and managing the agenda for the staffing meetings;
- Regional work – the probation officer will work with smaller regional courts to facilitate referrals, supervision, and use of technology for drug courts

Drug Court Clinicians. The Commission found that the optimal minimum staffing level is one-half full-time equivalent dedicated court clinician at each program. In parallel with the drug court probation officer, the primary responsibilities of this position will be:

- Evaluating Referrals: the clinician will be responsible for evaluating the substance abuse needs of the referrals to ensure that the proposed participants are suitable and eligible for drug court and making treatment recommendations;

[12] There are 62 District Court divisions. Six divisions are co-located (Framingham/Natick, Newburyport/Ipswich, and Gardner/Winchendon) resulting in 59 divisional locations.

- Supervision of treatment – the probation officer will be responsible for the supervision of drug court participants during the time the participant is in the program;
- Staffing Meetings – the clinician will be responsible for preparation of case materials for the staffing meetings;
- Regional work – the clinician will work with smaller regional courts to facilitate referrals, supervision, and use of technology for drug court participants

Clinical Supervisors. The Commission found that the minimum staffing level of one clinical supervisor for every eight full-time-equivalent court clinicians is optimal for drug courts. This will ensure the quality and consistency of the treatment services provided by the drug courts.

Expanded Use of Regional Drug Court Program Resources

As a result of complementing existing staff by providing a full-time probation officer and half-time court clinician for each drug court program, this can be used to support increased regionalization of drug court services and staffing. The Commission considered several models to expand the use of regional services. Recognizing the need to deliver drug court services in a cost-effective manner and to maintain enrollment levels at 125 or lower, the Commission recommends greater use of the regionalization of drug court services. This recognizes that regions should not be created that would create very large drug court caseloads or create unnecessary transportation burdens on drug court staff or participants. The benefits of regionalization would allow for probationers supervised at smaller courts to participate in the drug court programs at other court locations or to have drug court services provided at their court location. In consideration of the recommendation for regionalization, the Commission is also recommending the expanded use of technology to deliver drug court services.

For many of the courts and regions in the state, the Commission noted the significant issue of delivering quality drug court services to smaller and remote area courts in a cost effective manner. Often in smaller courts, Trial Court personnel are already doing multiple tasks. Devoting a specialized session for staffing meetings and a second session for dedicated drug court reviews can be difficult to accomplish with limited staff, courtroom space, and support personnel. Developing and retaining a sufficient pool of trained drug court personnel will also be challenging. The Commission is also cognizant that for drug court clients, the challenges of isolation, access to treatment, and transportation needs to be addressed. It is possible that drug court services can be integrated with regional support staff into the operations at many more court locations where there are smaller numbers of probationers and geographic challenges.

Another regionalization strategy is to increase local drug court sessions using shared staffing. If local sessions can be arranged, the drug courts can share regional special drug court coordinators across jurisdictions. Drug court judges can potentially be shared by changing venues or allowing for remote participation by video-conferencing technologies. This can be accomplished by the use of circuit personnel to staff sessions at smaller courts; to allow probation staff to have supervision at multiple sites, and to have treatment staff coordinate cases at multiple sites.

The Commission considered the impact of regionalization on models of probation supervision. Supervision can be retained at the local court or supervision can be transferred to the drug court. Both models can be used as the concept of regional delivery of drug court services expands and may be best adapted based on the unique conditions of the court location, the treatment and transportation needs of the probationer, and other factors. The increased use of cross-site case transfer will allow for transfer of cases across jurisdictions for judicial matters and can support the use of regional support staff for drug court services.

Increased use of technology.

Regionalization efforts can also be enhanced and supported by the increased use of technology. Technology can be used in three main areas: delivery of drug court services (including participation in drug court sessions), client supervision and monitoring, and staff training and professional development.[13] Some examples of technology include: the use of video-conferencing to support activities including participation in staffing sessions, probationer and/or staff participation in drug courts; and, technology assisted treatment; and the enhanced use of electronic communication for items such as meeting and session reminders for drug court participants.

Finding d) Evaluation of the Number and Type of Nonviolent Offenses Committed by Substance Addicted Defendants

> …*an evaluation of the number and type of nonviolent offenses committed by substance addicted defendants adjudicated in the Commonwealth*

The Commission considered the wide range of offenses associated with drug court participation. In particular, approximately one-fourth of all drug court participants are associated with current drug charges and that almost three-fourths are associated with a wide range of other offenses (See Figure 4).[14] The issues of substance abuse have manifested in a wide variety of criminal activity, particular property offenses. The Commission looked at various substance abuse indicators collected as part of their risk/need assessment of the adult risk/need probation population in the District Courts, indicating a widespread prevalence of substance abuse. For example, 77% of this population reported ever using illegal drugs.

The Commission found that best practices for selecting drug court participants involve three essential components:

- Objective definition of eligibility

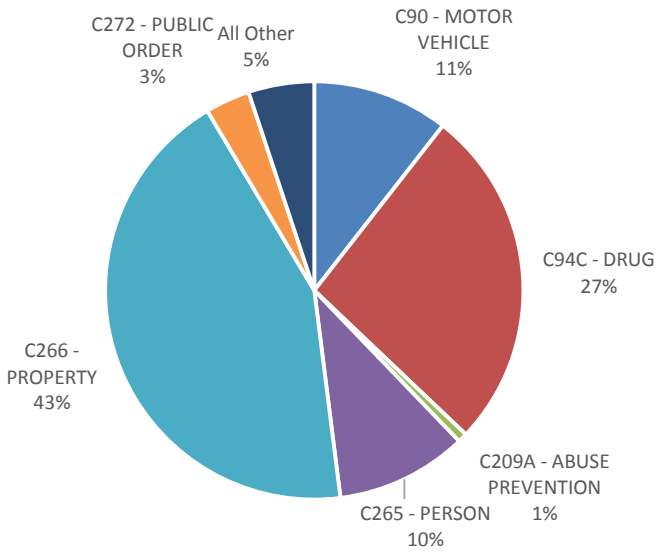
[13] Annie Schachar, Aaron Arnold, and Precious Benally, "The Future is Now: Enhancing Drug Court Operations through Technology", Bureau of Justice Assistance, 2015.

[14] Executive Office of the Trial Court, analysis of MassCourts data on drug court participants.

- Focus on identifying participants who are high-risk of criminal recidivism and high-need due to serious issues of addiction; and,
- Using validated objective screening tools to identify potential participants.

Research shows that selecting drug court participants in an objective manner, rather than relying on subjective assessments of suitability, will contribute to the success of the programs. Here success is the impact of the program on reducing recidivism, enhancing success on probation, and reducing the probability of further drug use.

Figure 4 Current Offense Drug Court Participants



Eligibility and exclusion criteria for the drug court are predicated on empirical evidence indicating which types of offenders can be treated safely and effectively in drug courts. Candidates should be evaluated for admission to the drug court using evidence-based assessment tools and procedures.[15]

Recognizing the public safety and effectiveness of the drug court program for supervising and treating offenders in the community, the Commission found that the Adult Drug Court Manual set forth eligibility criteria with respect to risk assessment rather than defining any exclusion based on offense or criminal history that was consistent with best practices.

The Commission finds adopting an evidence-based objective assessment that identifies offenders at high risk of offending and high need based on substance abuse as the appropriate target population for these valuable drug court resources.

Currently the Massachusetts Probation Service uses a set of three evidence-based risk assessment tools for determining eligibility for drug courts. These tools are used to determine risk and need, and to inform treatment placement:

[15] National Association of Drug Court Professionals, Adult Drug Court Best Practice Standards Volume 1

- ORAS – the Ohio Risk Assessment System is a dynamic risk/needs assessment tool used with adult offenders;[16]
- TCUDS – the Texas Christian University Drug Screen is used to assess substance abuse disorders and is useful in determining placement and level of care in treatment;[17] and,
- RANT – the Risk and Need Triage provides assistance to judges and other criminal justice professionals to assist in matching probationers with services that meet their criminogenic and clinical needs.[18]

Finding e) Development of a Definition of Nonviolent Substance Addicted Offender

…the development of a definition of nonviolent substance addicted offender

The Commission's charge included the development of a definition of nonviolent substance addicted offender. As one of the first steps in addressing this element of the charge, the Commission analyzed the number and type of criminal offenses with which substance addicted defendants currently in the court system are charged. The Commission found, similar to the range of crimes committed by drug court participants, issues of substance abuse manifested in a wide variety of criminal activity that ranged from less serious to more serious, manifesting as use related crimes – crimes that result from or involve individuals who ingest drugs, and who commit crimes as a result of the effect the drug has on their thought processes and behavior or economic crimes - crimes where an individual commits a crime in order to fund a drug habit.

The Commission also considered licensing standards used by the DPH for licensing substance abuse treatment programs.[19] DPH prohibits its licensees, when determining an individual's eligibility for a treatment program, from automatically excluding someone because of a history of criminal convictions.[20]

[16] https://www.uc.edu/corrections/services/trainings/offender_assessment.html

[17] http://ibr.tcu.edu/

[18] http://www.tresearch.org/tools/for-courts/rant/

[19] 105 CMR Department of Public Health 164.000 Licensure of Substance Abuse Treatment Programs.

[20] 105 CMR 164.070(A)(3) http://www.mass.gov/eohhs/docs/dph/regs/105cmr164.pdf

The Commission further considered eligibility standards used by drug courts in the Commonwealth. Drug courts use objective risk assessment criteria and target a demographic of primarily high risk/high need individuals.[21] This risk-need-responsively approach specifically includes an individual's history of varied/serious criminal behavior. (See Appendix B)

Figure 5 DPH Regulations for Licensees (Selected Sections)

105 CMR 164.000 Licensure of Substance Abuse Treatment Programs

164.070 Referrals and Admissions

(A) Admission and Eligibility Criteria:

(1) The licensee shall establish written admission eligibility criteria and procedures.

(2) Such criteria and procedures shall describe the licensee's method of determining, for each applicant, whether the licensee's level of care and program are suitable for the applicant.

(3) Such eligibility criteria shall not establish a category of automatic exclusion that is defined by a history of criminal conviction . . .

(G) The licensee may not deny admission to an individual solely because the individual uses medication prescribed by a physician outside the licensee's service or facility.

(H) Licensees may deny admission to individuals who refuse to provide information necessary to complete an assessment and treatment plan.

(I) The licensee may not deny re-admission to any person solely because that person

(1) withdrew from treatment against clinical advice on a prior occasion;
(2) relapsed from earlier treatment; or
(3) filed a grievance regarding an action or decision of the licensee.

[21] Individuals are both high risk and high need when they have serious substance use disorders, and they also have a history of poor response to standard treatment or antisocial personality traits. A high risk/high need offender is an individual who is addicted to illicit drugs or alcohol and is at substantial risk for reoffending or failing to complete a less intensive disposition, such as standard probation or pretrial supervision. Adult Drug Court Manual, p. 16-17.

As a result of its evaluation, the Commission found that assessing a substance addicted offender using a violent/non-violent standard excluded a large portion of offenders who are also the highest need offenders. The more constructive analysis was to adopt a standard consistent with drug court eligibility standards and, using objective risk assessment criteria, assess a substance use offender in terms of level of risk.

Finding f) Best Practice Standards for Drug Courts

> *. . . an examination of best practices relative to specialty courts that deal with substance addicted offenders, both within the Commonwealth and in other states;*

The Commission's enabling legislation charged Commission members to examine best practices relative to drug courts that deal with substance addicted offenders, both within the Commonwealth and in other states. In response to that charge, the Commission looked to the National Association of Drug Court Professionals (NADCP), a national non-profit 501(c)(3) corporation founded in 1994. The NADCP has released two volumes of the Adult Drug Court Best Practice Standards, completing a comprehensive compilation of research-based, specific, practitioner-focused drug court guidance.[22] The Standards bring to bear over two decades of research on addiction, pharmacology, behavioral health, and criminal justice and include lessons that will not only improve drug court, but will help improve the way the entire system responds to offenders living with addiction or mental illness. The standards are shown in Figure 6.

In its study of best practice standards, the Commission also reviewed the Adult Drug Court Manual published during the pendency of the Commission's tenure.[23] This manual lays out a "soup to nuts" guide to starting and operating an adult drug court in Massachusetts and it incorporates the NADCP Best Practice Standards. (See Appendix B). The Commission found that the Manual reflects best practices and that the Trial Court's management structure of drug courts through Departmental Directors of drug courts, the Specialty Courts Administrator, and the CoE will ensure that drug courts adhere to these standards.

[22] http://www.allrise.org/sites/default/files/nadcp/AdultDrugCourtBestPracticeStandards.pdf

[23] http://www.mass.gov/courts/docs/specialty-courts/adult-drug-court-manual.pdf

Figure 6 Drug Court Standards

I. TARGET POPULATION

Eligibility and exclusion criteria for the drug court are predicated on empirical evidence indicating which types of offenders can be treated safely and effectively in drug courts. Candidates are evaluated for admission to the drug court using evidence-based assessment tools and procedures.

II. HISTORICALLY DISADVANTAGED GROUPS

Citizens who have historically experienced sustained discrimination or reduced social opportunities because of their race, ethnicity, gender, sexual orientation, sexual identity, physical or mental disability, religion, or socioeconomic status receive the same opportunities as other citizens to participate and succeed in the drug court.

III. ROLES AND RESPONSIBILITIES OF THE JUDGE

The drug court judge stays abreast of current law and research on best practices in drug courts, participates regularly in team meetings, interacts frequently and respectfully with participants, and gives due consideration to the input of other team members.

IV. INCENTIVES, SANCTIONS, AND THERAPEUTIC ADJUSTMENTS

Consequences for participants' behavior are predictable, fair, consistent, and administered in accordance with evidence-based principles of effective behavior modification.

V. SUBSTANCE ABUSE TREATMENT

Participants receive substance abuse treatment based on a standardized assessment of their treatment needs. Substance abuse treatment is not provided to reward desired behaviors, punish infractions, or serve other non-clinically indicated goals. Treatment providers are trained and supervised to deliver a continuum of evidence-based interventions that are documented in treatment manuals.

VI. COMPLEMENTARY TREATMENT AND SOCIAL SERVICES

Participants receive complementary treatment and social services for conditions that co-occur with substance abuse and are likely to interfere with their compliance in drug court, increase criminal recidivism, or diminish treatment gains.

VII. DRUG AND ALCOHOL TESTING

Drug and alcohol testing provides an accurate, timely, and comprehensive assessment of unauthorized substance use throughout participants' enrollment in the drug court.

VIII. MULTIDISCIPLINARY TEAM

A dedicated multidisciplinary team of professionals manages the day-to-day operations of the drug court, including reviewing participant progress during pre-court staff meetings and status hearings, contributing observations and recommendations within team members' respective areas of expertise, and delivering or overseeing the delivery of legal, treatment and supervision services.

IX. CENSUS AND CASELOADS

The drug court serves as many eligible individuals as practicable while maintaining continuous fidelity to best practice standards.

X. MONITORING AND EVALUATION

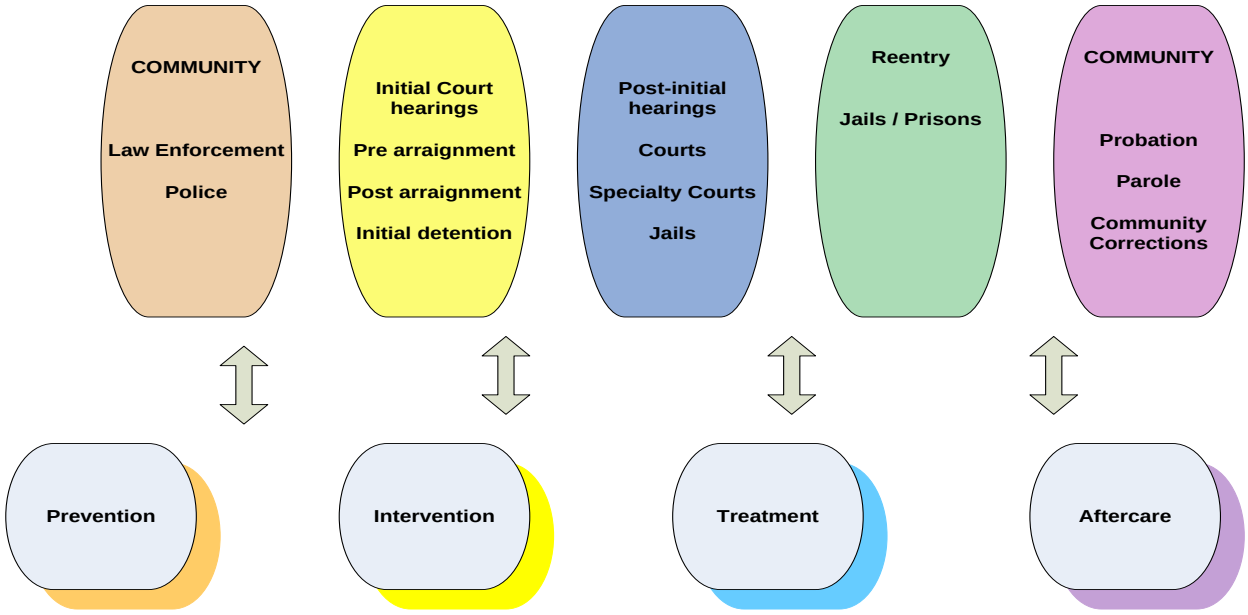
The drug court routinely monitors its adherence to best practice standards and employs scientifically valid and reliable procedures to evaluate its effectiveness.

Finding g) Substance Addiction Treatment Available in the Commonwealth

> *. . . an assessment of the quantity, quality and availability of effective, evidence-based addiction treatment programs in the Commonwealth; and*

The continuum of substance abuse treatment services in the Commonwealth involves multiple levels of care involving prevention, intervention, treatment, and aftercare. These services are often aligned with other continuums to provide services to, or intercept, where an individual may be in that continuum. For example the criminal justice continuum may be viewed as follows.

Figure 7 Continuum of Substance Abuse Treatment Model



Two examples of intercepts within the criminal justice continuum would be a Driver Alcohol Education program (DAE) which would be an intervention that would allow for the first time driving under the influence (DUIL) offender to do an educational program in lieu of losing their license and a treatment option for a second offender to enter a 14 day residential program with mandatory aftercare versus incarceration.

Data indicate that those individuals who are further along the continuums need or require higher intensity services to attain stability. Data also indicates that rates of use and addiction are higher in sub-populations such as those involved in the criminal justice system. Therefore individuals involved with drug courts are likely to require more services per capita than the general population.

To increase public safety it is important to develop integrated criminal justice and public and mental health solutions that prevent crime, address substance abuse and dependence prior to engagement, during engagement and after engagement in the criminal justice system and appropriately divert those at varying points along the continuum where possible.

The link between access to treatment and reduced engagement with the criminal justice system is clear. Substance abusers who lack treatment have more contact with the criminal justice system. Chronic drug users engage in crime 30% more than non-drug users.[24]

The need for services for those involved in the criminal justice is evidenced by approximately one quarter of the admissions to the Bureau of Substance Abuse Services in FY2015, or over 24,000 enrollments were reported as being on Probation at varying levels of care. (See Figure 8).

When examining access to services it is relevant to examine the full continuum of services, prevention, intervention, treatment and recovery. This also applies to the criminal justice system needs for services at different intercept points, including pre-arrest, pre-adjudication, post adjudication, diversion, incarceration, and release/re-entry to the community.

Availability of Treatment

The Bureau of Substance Abuse Services (BSAS) oversees the substance abuse and gambling prevention and treatment services in the Commonwealth. Responsibilities include: licensing programs and counselors; funding and monitoring prevention and treatment services; providing access to treatment for the indigent and uninsured; developing and implementing policies and programs; and tracking substance abuse trends in the state. In FY2014, BSAS served 85,823 individuals involving a total of 107,358 separate admissions.[25] In FY2014, at the time of admission, 53% indicated that the primary drug of use was heroin, 32% indicated alcohol, and 15% indicated other substances.[26]

The Substance Abuse Continuum in the Commonwealth has multiple service levels. Figure 8 lists some of these services with the percentages of those that reported to be involved with Probation for FY2015. The grid demonstrates the use of substance abuse services by those on probation. It is not reflective of all substance abuse services or use by other consumers. Typically, inpatient or “bedded” services exhibit greater wait times for access due to occupancy limits than do the ambulatory services.

[24] Michael French, et.al, "Can the Treatment Services Review be used to estimate the costs of addiction and ancillary services?" Journal of Substance Abuse, 12(2000), pages 341-361.

[25] Bureau of Substance Abuse Services, Description of Admissions to BSAS Contracted/Licensed Programs, FY2014.

[26] Ibid.

Figure 8 Substance Abuse Continuum of Care Services and Probation

SERVICE	% PROBATION
JAIL DIVERSION RESIDENTIAL	100.0%
2ND OFFENDER RESIDENTIAL	99.3%
DRUG COURT CM	95.1%
1ST OFFENDER (DAE)	93.4%
2ND OFFENDER AFTERCARE	90.5%
JAIL DIVERSION CM	49.7%
YOUNG ADULT RECOVERY HOME	46.9%
YOUTH RESIDENTIAL	38.0%
THERAPEUTIC RESIDENTIAL	37.5%
STATE PAROLE REENTRY CENTERS	37.0%
TEWKSBURY STABILIZATION	33.8%
ADOLESCENT RECOVERY HOME	32.5%
RECOVERY HOMES	31.7%
FAMILY INTERVENTION	29.9%
YOUTH STABILIZATION	29.5%
SOCIAL MODEL RESIDENTIAL	29.2%
OUT-PATIENT	27.4%
PERMANENT HOUSING	27.0%
TRANSITIONAL SUPPORT SERVICES (TSS)	22.4%
TRANSITIONAL HOUSING	20.7%
SECTION 35	20.5%
DAY TREATMENT	19.4%
CLINICAL STABILIZATION SERVICES (CSS)	18.2%
FAMILY RESIDENTIAL	14.6%
RECOVERY HIGH SCHOOL	13.3%
ACUTE TREATMENT SERVICES	10.1%
OFFICE BASED OPIOID TREATMENT	9.2%
ACUPUNCTURE	3.0%

Although not specific to those involved with the criminal justice system, the report submitted in April 2015 by the Center for Health Information and Analysis (CHIA) provides an examination of the substance use disorder continuum for the Commonwealth of Massachusetts, the accessibility of services and some of the identified barriers to access.[27] (See Appendix C).

Recent Changes to Number of Treatment Beds

There are on-going changes to the Commonwealth's system of substance abuse services. As shown in Figure 9, since the release of the CHIA report in April 2015, there has been a net gain the in the Treatment Bed Inventory in various service levels.

Figure 9 Change in Treatment Bed Inventory (CY2015 YTD)

Increase Beds

DATE ISSUED	LEVEL OF CARE	INCREASED BEDS
4/6/2015	TSS	5
6/17/2015	CSS	2
6/17/2015	Adult Residential	10
9/1/2015	Detoxification (3.7)	11
9/1/2015	CSS	8
9/11/2015	Adult Residential	4
10/1/2015	Adult Residential	8
		48

Decreased Beds

DATE ISSUED	LEVEL OF CARE	DECREASED BEDS
5/15/2015	Adult Residential	8
10/28/2015	Adolescent Residential	9
		17

[27] http://www.chiamass.gov/assets/Uploads/SUD-REPORT.pdf

Medically Assisted Treatment

In one of the Commission's exploratory meetings, Dr. Sarah Wakeman presented information to members about Medication Assisted Treatment (MAT) - the use of medications, in combination with counseling and behavioral therapies, to provide a whole-patient approach to the treatment of substance use disorders.[28] Many national and international professional bodies consider medication-assisted treatment (MAT) with methadone, buprenorphine, or extended-release injectable naltrexone (Vivitrol) an evidence-based best practice for treating opioid dependence.[29] Some of the most common MAT is shown in Figure 10.[30]

Currently, Massachusetts faces an opioid epidemic. The Commission found that effective use of MAT has the potential to deter individuals from involvement in the criminal justice system. Treatment modalities that support this diversion are important components of an integrated substance abuse strategy. Working with the medical community to ensure that there is sufficient access to MAT is also important to the effectiveness of this modality.

In 2012, injectable naltrexone, known as Vivitrol, was approved for the treatment of opioid dependence. This medication can be prescribed by any qualified health professional, including mid-level practitioners, and is given in the form of an injection on a monthly basis in the prescriber's office.[31] This MAT is currently in use in correctional agencies to assist re-entering offenders with the first injection provided while the offender is incarcerated with later follow-up treatment provided in the community.

Another MAT considered by the Commission is Suboxone (contains buprenorhphine) and used for treating opioid addiction. The

Figure 10 Medication Assisted Treatment (MAT)

Medications used in MAT

Buprenorphine

Buprenorphine is used in medication-assisted treatment (MAT) to help people reduce or quit their use of heroin or other opiates, such as pain relievers like morphine.

Methadone

Methadone is a medication used in medication-assisted treatment (MAT) to help people reduce or quit their use of heroin or other opiates.

Naltrexone

Naltrexone is a medication used in medication-assisted treatment (MAT) to treat both opioid and alcohol use disorders.

Naloxone

Naloxone is a medication used in medication-assisted treatment (MAT) to counter opioid overdose.

Source: www.samhsa.gov

[28] http://www.dpt.samhsa.gov

[29] http://store.samhsa.gov/shin/content//SMA14-4852/SMA14-4852.pdf

[30] http://www.samhsa.gov/medication-assisted-treatment

[31] Findings of the Opioid Task Force and Department of Public Health Recommendations on Priorities for Investment in Prevention, Intervention, Treatment and Recovery, June 10, 2014.

Commission has some concerns about the diversion of this substance to individuals not under medical treatment.

In 2014, the Substance Abuse and Mental Health Services Administration (SAMHSA) announced drug courts funded by SAMHSA could no longer prohibit drug court participants from taking medications to treat opioid use disorders. The Commission conducted a survey of current drug court sites and found that most had access to and were currently using a variety of medically assisted treatment options. The Lynn Drug Court is engaged in a pilot project to link drug court participants with the local health center to support the effective use of MAT along with other health related services.

Access to Treatment

Although Massachusetts has a fairly robust treatment system as opposed to other states, often times those with a Substance Use Disorder (SUD) are not always able to access the care needed in a timely manner. Barriers may include service capacity, design, benefit coverage, and inadequate knowledge about the continuum of care. In particular consumers often face challenges in accessing services for inpatient or "bedded" services which have capacity limits.

The Commission noted that availability of treatment is not sufficient and that issues around access need to be addressed as well. The commission considered some mechanisms to enhance access to treatment that will impact criminal justice users as well as the larger community of consumers.

Navigation Tools

The Commission heard testimony throughout its inquiries about the difficulties for professional and consumers to navigate the substance abuse treatment options. The Commission learned about the effectiveness of navigation tools provided for veterans as who are accessing services across a variety of agencies. Developing navigation tools that are useful to consumers and professional and that have timely information is important to continue.

New Statutory Automatic Insurance Coverage Mandate

Intended to increase access to addiction treatment, provisions were passed on October 1, 2015, Section 27 of Chapter 258 of the Acts of 2014, An Act to increase opportunities for long-term substance abuse recovery" went into effect.[32] The provisions of the statute generally require insurers in Massachusetts to "provide coverage for medically necessary acute treatment services and medically necessary clinical stabilization services for up to a total of 14 days." The statute also prohibits insurers from requiring preauthorization "prior to obtaining acute treatment services or clinical stabilization services."

[32] https://malegislature.gov/Laws/SessionLaws/Acts/2014/Chapter258

Promising Treatment Options

The Commission explored a number of promising treatment options including recovery coaching models and diversion programs. The Commission found that increased support of some of these promising options is warranted.

Recovery Support Services

BSAS is pro-actively expanding recovery support services within the ambulatory services model. These services are available to support community consumers as well as participants of specialty courts.

The recovery support services model includes community support positions (CSP), telephone support, and recovery coaching. These case-management services assist in arranging referrals to needed resources including insurance benefits, medical care, dental care, employment assistance, education and training and substance abuse treatment. Both the telephone recovery support and recovery coaches use evidenced based models. Providers must complete a certification training to be able to provide the services. The three essential components of recovery support services are:

- **Community support services** assist clients with issues that may impede day to day functioning and progress in maintaining recovery and be able to follow and work with an individual post discharge from a treatment program. The support services will be able to provide transportation to self-help meetings and follow up aftercare appointments as well as education to the client and client's family about connecting with support systems and needed resources;
- **Telephone recovery support** is a non-clinical service that offers a weekly structured phone session for a 12 week period for recovery support; and,
- **Recovery coaches** serves as a recovery guide or role model in the management of recovery and assists the individual to identify and overcome barriers to recovery, connects the individual with recovery support services and assists in motivation for follow through. BSAS has conducted 15 training sessions for certification of recovery coaches over the past four years. There are currently four more training sessions occurring to create a workforce to provide these services.

Diversion Programs

Diversion models should also be considered at earlier intercept points such as pre-arraignment and pre-adjudication. An example of such a program is the Essex District Attorney's Drug Diversion Program which is a pre-arraignment and post- arraignment program for non-violent offenders with substance abuse issues, primarily between the ages of 17 -26, who are charged with drug-related offenses. This program seeks to reduce drug abuse and improve public safety by offering treatment. The program provides eligible candidates the opportunity to receive comprehensive substance abuse treatment services in lieu of being prosecuted through the traditional court process.

The clinical evaluations and treatment are administered by a DPH licensed community vendor and includes inpatient and out-patient services and support designed to help the offender become drug-free, while the District Attorney's Office manages the case-management and compliance monitoring with treatment.

The Essex County Drug Diversion Program is currently operating in the Ipswich, Newburyport and Lynn District Courts. The case-management component provided by the District Attorney's Office has been supported by funding from the Bureau of Substance Abuse Services. This program strives to achieve the following goals:

- Young people identified by the District Attorney's office as eligible to enter the Essex County Drug Diversion Program will have a clinical evaluation followed by immediate access to treatment.
- Based on the clinical evaluation, the young adult will receive intensive treatment planning and treatment options.
- The program will have a strong case management component, and if participants fail to complete all treatment components, the participant is then subject to prosecution.

Peer Support Models

During one of its exploratory meetings, in a presentation by the MA Department of Veterans Services, the Commission learned about the peer support model in the context of veterans' treatment court. In this model, veteran mentors act as peer support to veteran participants who are better served by having a support system that includes veterans who understand combat experience and the different aspects of military service. Mentors develop a supportive relationship with participants to increase the likelihood that participants will remain in treatment, attain and manage sobriety, maintain law-abiding behavior and successfully readjust to civilian life.

The Trial Court recently was awarded a $975,000 three year grant from SAMHSA to enhance services being provided to Barnstable Drug Court participants with co-occurring disorders. The grant will support the addition of a Case Manager as well as a Peer Support Specialist into the Barnstable Drug Court. The Case Manager and Peer Support Specialist will utilize the MISSION model in delivering services.

SIM Mapping

The Sequential Intercept Model (SIM), developed by Patty Griffin, PhD and Mark Munetz, MD, provides a conceptual framework and action plan for communities to use to effectively divert persons with mental health and/or substance use disorders into treatment whereby reducing the risk of entering or penetrating deeper into the criminal justice system.[33] Mapping workshops bring together local key stakeholders from the criminal justice system, treatment providers, community advocates, and people with lived experience, to map out the key points or "intercepts" where people come in contact with the criminal justice system.

A facilitated analysis of the gaps and strengths at each intercept, for diverting people with behavioral health issues into treatment and services, culminates in an action plan for the community to work from. The Trial Court recently received a supplemental budget allocation of $300,000 over two years to fund a SIM Coordinator position who would work with the Trial Court and the CoE to:

- Coordinate all aspects of SIM mapping workshops including contact with local representatives, event management, and administrative support.
- Provide follow up support and technical assistance to communities who have hosted mapping workshops.
- Manage the project budget.
- Analyze and organize mapping workshop reports and create regular and timely reports for Trial Court leadership.
- Conduct trainings and presentations on the SIM project.
- Maintain regular communication with SIM trainers; provide professional development support as needed and available.
- Develop evaluation measures and provide ongoing evaluation of the SIM project.

[33] Griffin, Patricia, et.al., The Sequential Intercept Model and Criminal Justice, Oxford University Press, 2015.

Finding h) Estimating the Cost of Substance Addiction Treatment

> *. . . an assessment of the cost of expanding addiction treatment resources to meet the needs of the total annual number of nonviolent substance addicted offenders.*

Payment rates for substance abuse services are established by the Executive Office of Health and Human Services (EOHHS) in accordance with Chapter 257 of the Acts of 2008. As mentioned earlier there are a number of different levels of care which may have different rates established. Payment rates also vary between in-patient and ambulatory. Most ambulatory programs have the ability to increase caseloads as demand requires and are typically covered by insurers.

Some of the in-patient services such as Acute Treatment Services (detox) and Clinical Stabilization Services are also all covered by insurers and with the implementation of Section 27 of Chapter 258 of the Acts of 2014, a barrier of pre-authorization may now be addressed. These services do have capacity and access issues since due to the nature of "bedded" services with limits to occupancy totals. There are also barriers to the expansion of these services, such as structural limits of current facilities or finding community locations for new services, but the costs are basically covered by insurance payers.

Residential rehabilitation or recovery homes have funding as a major barrier to expansion since these services are almost completely paid for with state dollars and are not currently covered by any other insurance payers. The residential rate recently established by EOHHS as part of the Chapter 257 process is $100.08 per bed day for a cost of $36,529.20 annually.[34] On a recent review of drug courts, of the 524 participants, 236 or 45% were in or in need of, a residential placement. Based on the current established rate of $100.08 this translates into a cost of $8,620,891.20.[35] Estimates are that there would be an increase in enrollments of approximately 470 with the expansion of drug courts. Based on the 45% need factor for residential services, this would represent another 211 participants at a cost of $7,707,661.20.[36] Total projected costs for current and future drug court participants for residential substance abuse treatment is $16,328,552.40

Case-Management (CM) or community support services are covered by insurances, if the client meets certain criteria. In review of a DPH jail diversion program that offers CM services for a 9 month period, most of the participants do not meet the criteria established by the payers. It can be expected that this

[34] Computed as: 1 residential bed x 365 (days) x $100.08 = $36,529.20.

[35] Computed as: 236 participants x 365 days = 88,140 bed days x $100.08 = $8,620,891.20.

[36] Computed as: 470 x 45% = 211 x 365 days = 77,015 bed days x $100.08 rate = $7,707,661.20

will also apply to drug court participants. Based on expenditures in the DPH Jail Diversion program the cost to provide community case-management for up to 9 months is approximately $3,000 per participant. This would translate into a cost of approximately $1,572,000 for the current enrollments, if each participant received these services. An additional $1,410,000 would be needed for the projected increase in participants with expanded enrollments.

Section IV. Recommendations

Recommendation 1. Continued funding of drug courts to provide access across the Commonwealth to drug courts for every citizen of the Commonwealth.

To make a drug court services available to all those in need, the Trial Court has requested a total of $3.3 million in FY2017 for continued expansion of drug courts (see sidebar for breakdown of costs). This does not include the costs of maintaining established drug courts at optimal staffing levels or the cost of proposed regionalization services.

The Commission recognizes that resources may not allow for a physical court session in every jurisdiction and the Legislature may not be able to fund such an expansion. However, as discussed in finding c, the Trial Court is considering innovative and cost-effective ways to bring drug court services such as regional use of resources and increased use of technology.

Accordingly, the Commission recommends that the Legislature continue to fund drug court expansion across Massachusetts in a level commensurate to provide access to drug courts for every citizen of the Commonwealth who needs access.

Figure 12 Drug Court Operating Costs

The cost of operating a drug court in FY2016 includes:

- Probation Staff - $88,308 ($72,000 plus 22.65% in fringe)
- Specialty Court Clinician: one-half time clinician per site $52,000
- Supervising Clinician (one supervising clinician for every eight clinicians)
- Other costs of expanding specialty courts are:
  - Department of Veterans Services Peer Support Specialists - $250,000
  - CoE and the evaluation of drug courts - $525,000
  - Department of Publish Heath (BSAS) Residential Treatment Beds - $850,000

Recommendation 2. Formally adopt Volumes 1 and 2 of the National Association of Drug Court Professionals (NADCP) "Adult Drug Best Practice Standards."

These standards are the result of extensive consultation and research on the drug court model and represent the best thinking to date on how best to address the needs of the high risk/high need population.

These standards have already been incorporated into the Adult Drug Court Manual developed by the Trial Court.

Recommendation 3. Ensure adherence and fidelity to the Drug Court Best Practice Standards through the process of certification of Drug Courts.

The Trial Court has developed a certification process outlined in the Adult Drug Court Manual and will begin certification of drug courts in 2016 as outlined in Finding II. The CoE will oversee the certification process.

Recommendation 4. Use objective risk assessment to assess substance addicted offenders.

The Commission's charge included an evaluation of the number and type of nonviolent offenses committed by substance addicted defendants adjudicated in the Commonwealth and development of a definition of nonviolent substance addicted offender. As discussed in Finding (e), assessing a substance addicted offender using a violent/non-violent standard excludes high risk/high need offenders who are most in need of treatment resources, as well as supervision. Accordingly, the Commission recommends assessments of a substance addicted offender be defined in terms risk through objective risk assessment. The complement of risk/need assessment instruments in use at the Massachusetts Probation Service (ORAS, TCUDS, and RANT) should be supported.

Recommendation 5. Develop written policy on Medication Assisted Treatment in the court system.

The Commission recognizes the utility of MAT as an effective treatment for chronic opioid dependence as well as the utility of incorporating MAT into drug courts as a viable treatment option.

However, the Commission also acknowledges barriers to the use of MAT, e.g., availability which varies by region across the Commonwealth and potential stigma. Accordingly the Commission recommends the Trial Court develop a court systemwide policy regarding the use of MAT which accounts for these barriers.

Recommendation 6. Recommend SJC Standards on Substance Abuse be updated to incorporate current practices

The Chief Justice of the Trial Court and Trial Court Administrator are actively engaged in discussions with the SJC about potential updates to these standards. Since the publication of these standards, much of their substance has been incorporated into the court system. Further, the Trial Court is engaged with stakeholders, both inside and outside the criminal justice system, on issues surrounding substance use addiction and access to treatment services. This process to potentially update the standards is on-going.

Recommendation 7. Consideration should be given to expanding Diversion Models for pre-adjudicated offenders.

The Commission learned about the effectiveness of diversion programs and recommends their expansion. The Bureau of Substance Abuse Services has been funding a Diversion program through the Essex County District Attorney since 1997 with positive outcomes. This program operates at an annual cost of $250,000.

These programs can provide both pre-arraignment and post-arraignment programs for non-violent offenders with substance abuse issues, primarily between the ages of 17-26, who are charged with drug related offenses. The programs seek to reduce drug abuse and improve public safety by offering treatment.

The diversion programs provide candidates the opportunity to receive comprehensive substance abuse treatment services in lieu of being prosecuted through the traditional court process. The clinical evaluations and treatment plans are administered by a licensed DPH provider. Treatment includes appropriate inpatient and outpatient services, and support designed to help candidates become drug-free functioning members of society. Although insurance will be used to pay for some of the services, no one will be denied services based on an inability to pay.

Recommendation 8. Study peer support model for possible incorporation into drug courts.

The Commission recommends a study of applying the peer support model to other specialty courts, focusing on drug courts in particular. As noted earlier, the Barnstable County Drug Court is using grant funds to pilot the use of this model and the results of this pilot should be carefully studied.

Recommendation 9. Further expansion of the recovery coach model into publicly funded substance abuse treatment.

Representatives from the Gosnold Treatment Center also presented the Commission with information regarding its recovery coach program. Recovery coaches, another form of peer support, help move those in recovery through the process and provide structure and support. It is clear that the danger of relapse is especially high following completion of inpatient treatment, i.e., once an individual is released from a highly structured environment. Recovery coach services are a cost-effective way of keeping recovering addicts on track. Following up inpatient treatment with these services would break the cycle, preventing relapse reoccurrence and subsequent inpatient treatment.[37] The Commission also recommends continued exploration of technology within this model, particularly telephone support

[37] An example of the services provided by a recovery coach can be found in “Recovery coaches help former patients stay on track,” Cape Cod Times, May 17, 2015.

services. There is some use of this technology in the BMC drug court. Accordingly, the Commission recommends this model be further expanded into publicly funded substance abuse treatment.

Recommendation 10. Continued Funding of the Sequential Intercept Model (SIM) Initiative

As drug court services continue to expand, it is necessary to analyze and map out the resources, and identify gaps in resources, available to serve persons with mental illness or substance use disorders. The Commission recommends that the Trial Court accomplish this by implementing *Sequential Intercept Model* mapping workshops in court communities or regions across the state.

The Commission recognizes that local treatment resources continually shift. Additionally, the reports from each SIM workshop must be analyzed on a statewide level to identify common needs and shared solution to fill gaps in services. The Commission recommends that the Legislature continue to fund this initiative so that these collaborative mapping workshops may be completed and so that this analysis may be conducted on a continuing basis.

Recommendation 11. Support the development of a central navigation system for substance addiction treatment services.

The Commission recommends that the Commonwealth support the development of a central navigation system for substance addiction treatment services. Such a system should provide information that is accessible to consumers and professionals. The Commission recognizes that access to real-time information about treatment available and implementation of structures such as centralized intake processes will contribute to improved outcomes for substance addiction treatment and enhanced efficiencies throughout the system.

Recommendation 12. Conduct study regarding the effectiveness of Drug Courts in the Commonwealth.

As the Trial Court continues to expand the use of drug courts, the Commission understands the importance of on-going studies of the effectiveness of this model in Massachusetts. The CoE will undertake a comprehensive study regarding the effectiveness of drug courts and their contribution to reducing recidivism. This type of research is important to continuously improving services for substance addicted offenders.

Recommendation 13. Conduct a thorough independent study of structure of publicly assisted substance abuse treatment including comparison to other states

The Commission recommends that a comprehensive study of the publicly assisted substance abuse treatment system be conducted with a comparison to the organization of substance abuse delivery system in other states and a comparison of the rate of admissions in other states. The study should look at ways to improve patient navigation of the substance use disorder treatment spectrum, as well as the quantity and quality of drug and alcohol treatment programs. The use and financing of ambulatory services operated in community-based settings should be a focus on this investigation.

Section V. Summary

In summary, the Commission recognizes the impact of substance abuse on the lives and well-being of so many persons in the Commonwealth. The Commission found a need for a broadly based system-wide approach to substance abuse treatment and services that will address the needs of justice-system involved individuals as well as the population of the Commonwealth at large. Drug courts have a unique and important role in this system by addressing the needs of certain targeted defendants in the criminal justice system. The Commission is confident that a structure of well-managed and well-operated drug courts will contribute to public safety and the well-being of the community and participants. The Commission also recognizes that drug courts are not a solution to the substance abuse issues faced by the Commonwealth – these need to be addressed broadly and there needs to be improved access to and availability of treatment options. The Commission in its inquiry found a large number of promising treatment options and planning initiatives that should be supported to create an efficient and effective substance abuse system with drug courts being one part of the system.

Appendix A. Enabling Legislation

Section 42 of Chapter 258 of the Acts of 2014

There is hereby established a special Commission for the purposes of investigating and studying the development of criteria for mandated treatment or monitoring of nonviolent offenders with substance addictions and to expand effective, evidence-based addiction treatment programs for nonviolent substance addicted offenders.

The Commission shall consist of

- the court administrator or a designee and the director of the bureau of substance abuse services or a designee, who shall serve as co-chairs;
- the chief justice of the trial court or a designee;
- the attorney general or a designee;
- the secretary of public safety or a designee;
- the commissioner of the department of correction or a designee;
- the chair of the parole board or a designee;
- the commissioner of probation or a designee;
- the chief counsel of the committee for public counsel services or a designee;
- the commissioner of mental health or a designee;
- the secretary of the veterans' services or a designee;
- 2 members of the senate, 1 of whom shall be appointed by the senate minority leader;
- 2 members of the house of representatives, 1 of whom shall be appointed by the house minority leader;
- the president of the Massachusetts District Attorneys Association or a designee;
- the president of the Massachusetts Bar Association or a designee; and
- 2 members appointed by the governor, 1 of whom shall be a substance addiction treatment expert and 1 of whom shall be a mental health treatment expert.

Such investigation and study shall include, but not be limited to:

(a) an evaluation of the application and effectiveness of Standards on Substance Abuse, approved by the justices of the supreme judicial court on April 28, 1998, and recommendations to improve and ensure the consistent application of the standards in the courts;

(b) an evaluation and recommendations for improvement of specialty courts that address substance addictions, including current eligibility requirements or practices, availability of such courts and use of best practices in establishing quality of services;

(c) the optimum number and estimated expansion costs associated with the drug courts necessary to meet the needs of the total annual number of nonviolent substance addicted offenders;

(d) an evaluation of the number and type of nonviolent offenses committed by substance addicted defendants adjudicated in the commonwealth;

(e) the development of a definition of nonviolent substance addicted offender;

(f) an examination of best practices relative to specialty courts that deal with substance addicted offenders, both within the commonwealth and in other states;

(g) an assessment of the quantity, quality and availability of effective, evidence-based addiction treatment programs in the commonwealth; and

(h) an assessment of the cost of expanding addiction treatment resources to meet the needs of the total annual number of nonviolent substance addicted offenders.

The commission shall submit its report and findings, along with any draft of legislation, to the house and senate committees on ways and means, the joint committee on the judiciary, the joint committee on public health, the joint committee on mental health and substance abuse and the clerks of the house of representatives and the senate, not later than December 31, 2015.

Appendix B. Adult Drug Court Manual

Adult Drug Court Manual

2015

A Guide to Starting and Operating Adult Drug Courts in Massachusetts.

Executive Office of the Trial Court
One Pemberton Square, Boston, MA 02108

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Introduction

Beginning in 2013, the Trial Court of the Commonwealth of Massachusetts undertook a comprehensive review of its systems and policies. With input from court employees and stakeholders from across the system, a strategic plan was developed to chart the next ten years and beyond for the Trial Court system. In accordance with the plan, a policy statement to guide specialty courts and a statement of the mission of specialty courts were created. These documents are included in Appendix A. to this manual.

Drug courts and other specialty courts have been created pursuant to the inherent authority of the courts to sentence defendants within statutory requirements. The majority of drug courts in Massachusetts are post-disposition. Many defendants enter drug court as a result of a probation violation hearing. The mechanism for entry into drug court is by means of specific terms of probation. An order to "comply with any and all terms of the drug court" is entered on the probation order as a specific condition. The probationer must then comply with standard drug court conditions (such as remaining drug and alcohol free), as well as those conditions designed to meet an individual probationer's needs (such as participating in residential treatment).

The goals of the expansion of specialty courts in Massachusetts, including drug courts, are to reduce recidivism and to provide increased access and linkage to treatment and community resources. Drug courts utilize evidence-based best practices to improve outcomes. Drug court attempts to enhance the lives of individual participants by addressing the underlying causes for court involvement, while ensuring public safety.

To achieve these goals, the Trial Court has undertaken a number of initiatives, including the establishment of the Center of Excellence for Specialty Courts within the Executive Office of the Trial Court. This Center will assist in buttressing the work of the Trial Court and its partnering agencies by organizing continuing education and opportunities for dissemination of new literature and case law as it emerges.

The creation of this Manual is one of these initiatives. The purposes of this Manual are the following:

1. To identify the basic principles of evidence-based best practices applicable to adult drug court in the Commonwealth;
2. To develop a certification process applicable to adult drug courts in the Commonwealth;
3. To identify resources to assist existing drug courts in enhancing their practices and to prepare for the certification process; and
4. To identify resources to assist new courts in establishing adult drug courts that comply with evidence-based best practices and meet certification requirements.

The framework of the Manual comports with the national Ten Key Components of Drug Courts.[1] It addresses issues broadly to allow individual courts to account for local variations based on need and available resources.[2] It incorporates the Adult Court Best Practice Standards, Volume I (2013) and Volume II (2015).[3] In addition, the Manual is designed to provide guiding principles while permitting innovative practices as unanticipated needs arise, and as national best practices are enhanced and modified.

What are Drug Courts?

Drug courts are problem-solving courts that operate under a specialized model in which the judiciary, prosecution, defense bar, probation, law enforcement, substance use, mental health, and social service communities work together to provide treatment to people with substance use challenges, help individuals in the criminal justice system become productive citizens, and reduce recidivism.

Eligible persons with drug-addiction may be sent to Drug Court in lieu of incarceration or traditional probation. Drug Courts endeavor to keep individuals in

[1] *Defining Drug Courts: The Key Components*, National Association of Drug Court Professionals, Drug Court Standards Committee, Office of Justice Programs, Drug Court Program Office, 1997 http://www.nadcp.org/sites/default/files/nadcp/KeyComponents_0.pdf
[2] Many sections of this manual were derived from Michigan's drug court manual, *Developing and Implementing a Drug Treatment Court in Michigan*, November 2012. http://courts.mi.gov/Administration/SCAO/Resources/Documents/Publications/Manuals/Specialty/DC-PlanningImplementation.pdf
[3] *Adult Drug Court Best Practices Standards*, National Association of Drug Court Professionals, Volume I (2013) and Volume II (2015) http://www.nadcp.org/standards

treatment long enough for it to work, while supervising them closely. For a minimum term of one year, participants are:

- monitored for their engagement in substance use treatment and other services they require to get and stay clean and sober;
- held accountable by the Drug Court judge for meeting their obligations to the court, society, themselves, and their families;
- regularly and randomly tested for drug use;
- required to appear in court frequently so that the judge may review their progress; and
- rewarded for doing well or sanctioned when they do not live up to their obligations.[4]

Integrating a Drug Court into the Criminal Case Process

The majority of drug courts in Massachusetts are a post-adjudicative form of probation. Drug court participants are probationers who have been adjudicated, found guilty, or had criminal cases continued without a finding after admitting to sufficient facts, and are placed on supervised probation. Often drug court participants have served committed time for past crimes, or participants enroll in drug court as part of a split sentence in which they are placed on probation after serving committed time. Typically, the court orders drug court as a condition of probation, either at a sentencing hearing, or after finding a violation of probation. Violations of drug court conditions, such as failure to attend treatment or positive drug screens, are violations of probation. If there is probable cause for the violation, the drug court participant can be detained pending the final violation of probation hearing.[5] If a violation of probation is found by the judge, the judge can revoke probation and commit the drug court participant for a period of time or the judge can modify the conditions of probation.[6] Generally, revocation of probation happens only after the court has exhausted all intermediate sanctions and/or the

[4] http://www.nadcp.org/learn/what-are-drug-courts
[5] Dist. Ct. R. Prob. Viol. 3(b)(iii), 3(c)(vii), and 4(d) provides that probation violation hearings are to be held within 30 days of the service of the notice of violation, "except in exceptional circumstances," regardless of whether the probationer agrees to delay. Additionally, a court may order a probationer taken into custody pending the commencement and completion of a probation violation hearing. Dist. Ct. R. Prob. Viol. 6(h).
[6] Dist. Ct. R. Prob. Viol. 8(d).

probationer evinces unsuitability by committing a new criminal offense and posing a threat to public safety.

Assessment of Need and Target Population

The current mainstream drug court model in Massachusetts is a target population of "high risk/high need" offenders. A high risk/high need offender is an individual who is addicted[7] to illicit drugs or alcohol and is at substantial risk for reoffending or failing to complete a less intensive disposition, such as standard probation or pretrial supervision. Best Practice Standards I B. By comparison, individuals who are low-risk and/or low-need, who do not have these characteristics, tend to perform just as well in less intensive programs, such as standard probation and diversion.[8]

Resource Mapping

The resources available in a community to treat the drug court participants will be an essential factor in establishing and maintaining a drug court. Mapping is a process to identify the spectrum of substance use disorder treatment providers within the community. It is important for the court to consider the variety of treatment providers and types of treatment available, ranging from services for those who need residential treatment to those who need outpatient treatment. It is highly recommended that a sequential intercept mapping exercise be conducted to identify resources and gaps in services. This process will also set forth a plan to respond to identified gaps so that necessary resources are available to drug court participants.

[7] Diagnostic terminology is in flux in light of recent changes to the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders (DSM-5).* The terms *addiction* and *dependence* are defined in accordance with the American Society of Addiction Medicine (ASAM), which focuses on a compulsion to use or an inability to abstain from alcohol or other drugs. The ASAM definition is as follows: "Addiciton is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response." See **http://www. asam.org/for-the-public/definition-of-addiction**. Illicit drugs include addictive or intoxicating prescription medications that are taken for a nonprescribed or nonmedically indicated purpose.

[8] DeMatteo, David S., Douglas B. Marlowe, and David S. Festinger. 2006. *Secondary Prevention Services for Clients who are Low Risk in Drug Court: A Conceptual Model.* Crime & Delinquency. 52: 114-134.

Alternatively, drug court candidates may have their court cases transferred to a regional drug court supported by the resources necessary for that individual's treatment. Transfers should follow the process set forth in the departmental transfer policy.

In addition to requiring substance abuse treatment, many drug court programs offer ancillary services to their participants. These resources are sometimes a required part of the program, such as with community-based support groups, but are sometimes specific to a participant based on need. For example, a participant who is unemployed may be referred to vocational training. See Best Practices Standards VI.

Goals and Mission Statement

The drug court team should establish goals for the drug court that are specific to the target population and the identified needs within the community. Creating a mission statement is one way in which the drug court team can begin to identify the goals and objectives for the drug court. A mission statement should clarify the goals and values of the drug court, and the intent in establishing the drug court.

The mission statement can address why the community needs the drug court, and what benefits the drug court will provide. For example, an ultimate goal of drug court is to reduce recidivism. Other specific goals may include reducing the rate of overdose within a community, decreasing crimes that are often fueled by drug addiction, or addressing jail over-crowding concerns.

When constructing a mission statement, the team should consider accountability. Individual goals and general themes reflected in a mission statement should be attainable and measureable, and should focus on critical issues for the drug court.

Establishing measurable goals will also aid in data collection and grant writing. For example, "reduce substance abuse" is an important area of focus for drug courts, but as is, that goal is difficult to track and measure. Look at the things the drug court team plans to do to reduce substance abuse, such as increasing accountability through drug testing, requiring attendance at community-based support groups, and incorporating treatment into all phases of the program. In this manner ultimate goals can be tracked through a series of objectives.

Some goals may require a more qualitative measurement than data-driven study. For example, the drug court may wish to implement a one-time risk/needs assessment to help determine the level of service each participant requires. This goal can be measured relatively easily by determining whether or not such an assessment tool was implemented, but consider what other program objectives can be addressed by establishing this goal. The court may be able to track the success of participants in the program versus those not in drug court, and eventually make systemic changes based upon the results. In other words, this one-time goal should fit into the larger picture of the program's mission statement and ongoing goals.

A sample Mission Statement is included in Appendix B.

"Citizens who have historically experienced sustained discrimination or reduced social opportunities because of their race, ethnicity, gender, sexual orientation, sexual identity, physical or mental disability, religion, or socioeconomic status receive the same opportunities as other citizens to participate and succeed in the Drug Court." Best Practice Standard II. This means that the drug court provides equivalent access, equivalent retention, equivalent treatment, equivalent incentives and sanctions, and equivalent dispositions.

The Drug Court Team

Developing the Team

The drug court team is a group of professionals who are responsible for overseeing operations of the drug court and managing supervision of the drug court participants.

The judge is the leader of the drug court team. Other members may include a program coordinator, assistant district attorney, defense attorney, probation officer(s), clerk, case manager, specialty court clinician, treatment providers, local law enforcement, and representatives from local organizations that provide services to drug court participants.

To the extent possible, the team members remain consistent from session to session. This consistency is particularly important for the roles of judge and probation officer. It is recommended that these positions have a trained back-up who is available to fill in when necessary.

Certain positions and partners are essential for the operation of drug court, such as the judge, the probation officer, the clerk, and treatment providers. The prosecutor and defense attorney involvement is recommended, but at a minimum both should be advised of every court date and afforded an opportunity to appear. The drug court coordinator and specialty court clinician are emerging as part of recommended best practices, but these positions may not yet be available to all courts. A strong, well-coordinated team is essential to making drug court a success with the desired outcomes for drug court participants.

Although drug court teams are collaborative, membership in a drug court team anticipates that each team member will continue to perform his or her specific role and responsibilities. Defense counsel on the team, for example, must continue to zealously advocate for the rights of his or her client.

Team Roles and Responsibilities

All members of the drug court team must have a strong grasp of the following:

- Knowledge of substance use disorder including disorders related to addictions, and drug use, as well as mental health disorders, including trauma.
- Knowledge of non-pharmacological and pharmacological therapeutic options.
- Knowledge of gender, age, race, language, and cultural issues that may impact the offender's success.
- Knowledge of the impact that substance use has on the court system, the lives of participants, their families and the community at large.

All members of the drug court team are expected to perform the following:

- Participate fully as a team members, committed to the drug court mission and goals, and work as a full partner to ensure overall participant success.
- Contribute to the education of peers and colleagues as appropriate.
- Participate in on-going training opportunities within the state and nationally as available.

Judge

The drug court judge presides over drug court sessions and leads the team. The role of the drug court judge includes the following responsibilities:

- Heads the team.
- After considering input from team members, makes final decision on participant eligibility.
- Presides over drug court session.
- Makes all decisions in the drug court case, including the imposition of incentives or sanctions.
- Creates an appropriately collaborative atmosphere, and maintains an effective pace for the team.
- Ensures that the drug court team meets regularly to review participant progress and participant needs. Although the practice of judicial presence in staffing is a best practice according to the National Association of Drug Court Professionals, it is within the judge's discretion to decide whether or not to participate in the staffings.
- Effectively leads the team to develop and continuously improve all the protocols and procedures of the program.

Key support to the judge comes from the probation officer, the specialty court clinician, and drug court coordinator. When the specialty court clinician is not available, the primary support role falls to the probation officer. Similarly, the drug court coordinator, if available, assumes some of the roles that are otherwise taken on by the probation officer.

Probation Officer

The probation officer plays a crucial role in the success of drug courts. The probation officer actively monitors drug court participants inside and outside of the drug court setting. The role of the probation officer includes the following responsibilities:

- Assess and recommend participant eligibility.
- Complete intake process, which includes informing participants and their defense counsel of the drug court conditions and responsibilities, as well as the consequences of non-compliance.
- Monitor adherence with treatment and probation conditions.
- Develop partnerships and close working relationships with the treatment community.
- Coordinate the utilization of community-based services such as housing, entitlements, transportation, education, vocational training, job skills training and placement to provide a strong foundation for recovery.
- Develop post program services, client outreach, mentor programs and alumni associations when appropriate or feasible.
- Pursue working relationships with a variety of gender, race, age, and culturally specific treatment services, to make them available as needed.
- Ensure random and comprehensive drug and alcohol testing.
- Collect all relevant data on participants.
- Discuss with participants their progress in meeting treatment goals.
- Make suggestions for changes in services needed for an effective case plan.

Drug Court Coordinator

Ideally each court will have a drug court coordinator. When available, the coordinator takes on some of the administrative duties that would otherwise fall to the probation officer and/or specialty court clinician. These responsibilities include fostering a relationship with treatment providers, wrap-around services, and community groups, and assisting with data collection and data entry.

Specialty Court Clinician

The specialty court clinician works through the Department of Mental Health Court Clinic system and will be assigned to the drug court by DMH Forensic Services in collaboration with the Trial Court. Where available, the specialty court clinician is responsible for supporting probation in making sure participants are referred to the appropriate level of care. The specialty court clinician is a key resource for the judge and the team to make the right treatment decisions. If a specialty court clinician is not available, the responsibilities fall to the probation officer to make a fact-based referral to treatment and to work in concert with community-based treatment providers who can conduct clinical assessments to support placements in the proper level of care.

The role of the specialty court clinician includes the following:

- Complete a biopsychosocial assessment including clinical level of care assessment to determine level of care needs.
- Recommend appropriate treatment options for participants, typically in staffings.
- Engage treatment providers to best meet participant needs. Refer participants to treatment and assist in care coordination.
- Discuss treatment progress with treatment providers and participants in preparation for staffings.
- Provide direct support to participants.
- Inform drug court team on clinical perspectives.
- Expand and maintain relationships with treatment providers.
- Pursue working relationships with a variety of gender, race, age, and culturally specific treatment services, to make them available as needed.
- Provide care planning information and referrals for after-hours supports as needed.
- Engage the participants' families as appropriate.
- Work with probation and other members of the drug court team to ensure appropriate consents and releases of information are signed.

- Work with Department of Mental Health, Department of Public Health-Bureau of Substance Abuse Services, and providers to foster coordinated care opportunities.
- Coordinate with other court clinic staff who conduct evaluations if statutory evaluations become necessary (e.g., M.G.L. c. 123, §§ 12, 15, or 35).

Clerk

A drug court clerk is responsible for making docket entries and ensuring the appropriate files are present for drug court sessions. The clerk also facilitates the transfer of cases according to the Departmental transfer policy.

Prosecutor

A drug court prosecutor should be knowledgeable about substance use disorders and should make sentencing recommendations that include completion of drug court when warranted by the facts of the case and the defendant's criminal history. The assistant district attorney should also attend drug court staffings when possible, and all drug court sessions. As a member of the drug court team, the assistant district attorney ensures that community safety remains a primary concern.

Defense Counsel

Defense counsel must advocate zealously for a client's right at each stage of the proceedings in a drug court. Defense counsel advises the client of the risks and benefits of drug court. The defense attorney should attend drug court staffings when possible and all drug court sessions. If the participant has received a probation violation notice, he or she is entitled to be represented by counsel. Counsel should be appointed to represent the probationer at all stages of the probation violation hearing. Waiver of counsel at a probation violation hearing shall be accepted "only if the court determines that such waiver is being made knowingly and voluntarily." Dist. Ct. Prob. Viol. Rule 6(a).

Treatment Provider

The drug court treatment provider shares information regarding the progress and adherence to the treatment plan of a participant. In addition, the treatment provider

adds an important perspective and can advise the team based on clinical expertise in substance use disorders and recovery, mental health and trauma as well as other health conditions, as appropriate.

Law Enforcement

A drug court law enforcement representative serves as a link between the drug court team and the local and regional law enforcement community.

See Best Practices Standard VIII: Multidisciplinary Team and Standard III: Roles and Responsibilities of the Judge

Developing an MOU

A memorandum of understanding (MOU) describes the roles and responsibilities of each team member of a drug court. Generating such agreements at the outset of drug court can clarify roles and delineate responsibility for case management, reporting, and data. For example, will treatment providers report directly to the court on an individual's treatment progress, or will that information be relayed to the probation officer? Each drug court may decide whether to use a single MOU signed and dated by all team members, or separate MOUs for each team member. The duration and terms of the MOU should be included. A sample MOU is found in Appendix C.

In addition to MOU's with treatment providers, it is recommended that an MOU be executed in which the District Attorney's Office agrees not to prosecute participants who admit to a relapse to use. This MOU should also apply to the law enforcement member of the team.

Training on Drug Court Development

The Specialty Court Center of Excellence offers training on the fundamentals of beginning a drug court called Drug Court 101 for team members beginning the process of starting a drug court. The Center for Excellence, in conjunction with the Departmental Chief Justice also coordinates a Peer Mentorship Program, which matches experienced drug court judges and probation officers with new drug court teams. This is particularly

helpful in providing direct and specific guidance to teams as they begin the process of starting a drug court.

Several national organizations offer training on developing drug courts. These training programs educate on the fundamental steps for creating a drug court, and can apply considerations specifically related to a community's target population.

The Drug Court Planning Initiative	DCPI is a training program sponsored by the National Drug Court Institute (NDCI). DCPI is designed to assist jurisdictions in the planning and development of drug court programs. Each interactive DCPI training session is designed to familiarize participants with the building blocks of a drug court. Training participants have an opportunity to learn from and work with actual drug court practitioners and subject-matter experts throughout the DCPI process. http://www.ndcrc.org/node/1204
The National Drug Court Training and Technical Assistant Program	NDCTTAP is available through the Center for Court Innovation and provides an extensive listing of resources that have been created and shared by existing drug courts. Resources for various types of problem-solving courts are available, and include information and sample documents for nearly every aspect of a drug court program. http://www.drugcourtta.org/
American University	American University School of Public Affairs hosts the Bureau of Justice Assistance Drug Court Technical Assistance Program. A searchable publication and resources database, and various forms of technical assistance are available on line. http://www.american.edu/spa/jpo/initiatives/drug-court/

Participant Eligibility Criteria

It is important for each drug court to establish in writing clear, objective, and specific eligibility criteria for admitting candidates into drug court. Requirements that are too vague can lead to unintentionally disparate treatment, or perceptions that the drug court is unfair. The primary eligibility requirement for all drug courts is that the offender must have a substance use disorder. This will be discussed in greater detail in the section on Assessment. Currently, most drug courts in Massachusetts are post-adjudication. A second threshold eligibility requirement for these courts is that the participant must have been found guilty, pleaded guilty, or have admitted to sufficient facts to be found

guilty of a criminal charge or charges. The final threshold eligibility requirement for post-adjudication courts is that part or all of the participant's sentence must place the participant on probation.

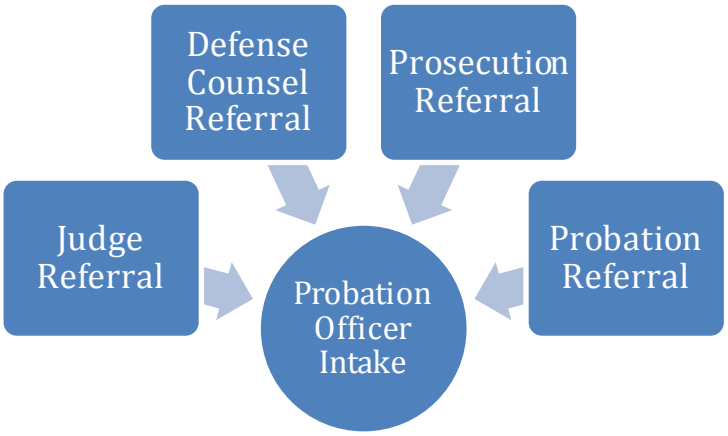
Determining other eligibility requirements can specifically address the needs and resources of each individual drug court. Factors to consider include the nature of the current offense, criminal history, drug of choice, residency, and whether treatment resources are available to meet the offender's needs. In addition, the participant must be deemed to be high risk/high need. This concept will be further discussed in the section on Assessment.

Disqualification criteria should be identified as well. These are factors that would render an individual ineligible for drug court. Disqualifications fall into two categories: criminal history disqualifications and clinical disqualifications. Current or prior criminal offenses may disqualify potential participants if it can be shown that offenders with such records cannot be managed safely or effectively in drug court. Criminal history disqualifications could include defendants who have a prior conviction for a sex offense or arson.. If adequate treatment is available, candidates should not be disqualified from drug court because of co-occurring mental health or medical conditions or because they have been legally prescribed psychotropic or addiction medication. See Best Practice Standards I.

Screening and Referral

Once eligibility requirements have been clearly articulated, potential drug court participants can be identified. A screening process must be established to determine that the eligibility requirements are met and the offender satisfies the basic drug court criteria. All drug courts in Massachusetts must use a standard evidence-based screening tools to evaluate drug court candidates. In addition to the screening tools, those performing the screening must evaluate the offender based on the established eligibility criteria specific to the particular drug court, such as whether the offender falls within the target population.

Referrals to Drug Court may come from a variety of sources. A defense attorney may inquire as to whether a client is eligible for drug court, a prosecutor or probation officer may recommend drug court as a probation condition, or a judge may ask that a defendant or probationer be screened for potential drug court participation.



Regardless of which source initiates a referral to drug court, there must be a clear avenue for receiving and screening referrals. The most common protocol is that the drug court probation officer or drug court coordinator receives all referrals. The probation officer then performs the screening utilizing both the screening instrument and the local eligibility criteria. The results of the screening are then reported by the probation officer to the court at the offender's next scheduled court appearance.

Assessment

Two types of assessments occur when an individual is referred to drug court. The first is an assessment to determine the scope of the participant's drug use. This includes a determination as to whether an individual qualifies as the high risk/high need target demographic for drug court. As noted earlier, the current mainstream drug court model in Massachusetts is a target population of "high risk/high need" participants. Individuals are both high risk and high need when they have serious substance use disorders, and they also have a history of poor response to standard treatment or antisocial personality traits. A high risk/high need offender is an individual who is addicted to illicit drugs or alcohol and is at substantial risk for reoffending or failing to complete a less intensive

disposition, such as standard probation or pretrial supervision. [See footnote 7 above] Best Practice Standards I B. Second, a more detailed assessment is performed to determine the type and level of treatment the participant needs to receive in drug court.

The substance use disorder and high risk/high need assessment is administered by the probation officer or specialty court clinician. The assessment is able to distinguish between people who have a documented serious drug use and those who misuse drugs, but are not dependent. It also measures the individual's level of risk, prognosis and amenability to treatment. These determinations should be made using the most advanced validated risk tool available.

After a candidate is assessed for substance use disorders, and risk/need, the team must also utilize an assessment process to determine what type of treatment the participant should receive. Generally, the specialty court clinician will complete a biopsychosocial assessment to determine level of care and/or coordinate with the local treatment provider who may have conducted as assessment as well. If a clinician is not available, the probation officer will identify a community based provider to conduct a clinical assessment to support placements in the proper level of care.

The probation officer should also explain drug court to the candidate, including the expectations of drug court. If the individual has a pending criminal case, the probation officer should only meet with the defendant if defense counsel is present or with the agreement of defense counsel. The probation officer should gauge the candidate's commitment to drug court. The individual must agree to be placed in drug court. The probation officer should give the candidate the Participant Handbook, a sample of which is contained in Appendix D, and discuss frequently asked questions.

Drug Court Participant Handbook

The sample handbook in Appendix D provides an example of what participants typically need to know. The handbook must be easy to read and informative, and it should be provided to every drug court participant and their counsel. Drug Court teams can use their discretion to amend the sample handbook according to the needs of each individual

drug court population. The handbook should also include information on resources such as crisis hotline and drug testing.

The judge decides whether an individual will be admitted into drug court. The judge's decision, however, is based on input from team members who have had contact with the candidate. The judge will consider assessment recommendations by the specialty court clinician and probation officer, and the prosecution and the defense attorney. The judge should also review an individual's criminal record and any other relevant information. It is imperative that the team does not apply subjective criteria or personal impressions to determine participants' suitability for the program. Best Practice Standards I A.

Intake

Once a participant is admitted into drug court by the judge, the probation officer will meet with the participant to complete an Intake Form. The participant is provided with several documents. First, all participants must read and sign the Order of Special Conditions and Addendum, a sample of which is found in Appendix E. By signing the Form, the participant waives his or her right to attorney representation,[9] waives his or her doctor/clinician confidentiality rights, and also agrees to follow the drug court rules. If applicable, the participant is advised about the process of staffing and waives his or her right to be present at staffings. All participants should be provided a copy of the relevant sections of Health Insurance Portability and Accountability Act (HIPAA) and relevant sections of the Code of Federal Regulations (42 CFR Part 2). Participants need to waive their confidentiality rights to facilitate communication among team members regarding substance abuse treatment information. If the participant has not already received the participant handbook, it should be provided to the participant by the probation officer.

[9] This waiver of counsel applies only to the regular court sessions and staffings. If the participant has received a probation violation notice, he or she is entitled to be represented by counsel. Counsel should be appointed to represent the probationer at all stages of the probation violation hearing. Waiver of counsel at a probation violation hearing shall be accepted "only if the court determines that such waiver is being made knowingly and voluntarily." Dist. Ct. Prob. Viol. Rule 6(a).

Treatment Services and Aftercare

A primary goal of drug court is to ensure the participant engages in and complies with treatment.

Programs vary with regard to the expected time frame between admission to drug court and the first substance use disorder treatment session. This time frame should be as short as possible. It is a best practice for a drug court participant to have his or her first session with a treatment provider within two weeks of being admitted to drug court.

The appropriate level of care should be determined by treatment professionals through the use of a validated evidence-based placement instrument. An individualized treatment plan should be developed for each participant. These plans should take into account general factors related to the participant's clinical needs, prognostic risks, and personal strengths and resources. Given that treatment modalities are determined by these individual risks and needs, it is important to ensure that the program accepts participants with needs that can be met by the types of treatment available in the community.

In addition to the ability to meet the level of care needed by a particular participant, it is important that a new drug court consider **cultural** and **gender** issues. Research indicates that cultural sensitivity can improve the therapeutic relationship and improve treatment outcomes. Research also shows that holding separate treatment groups for men and women

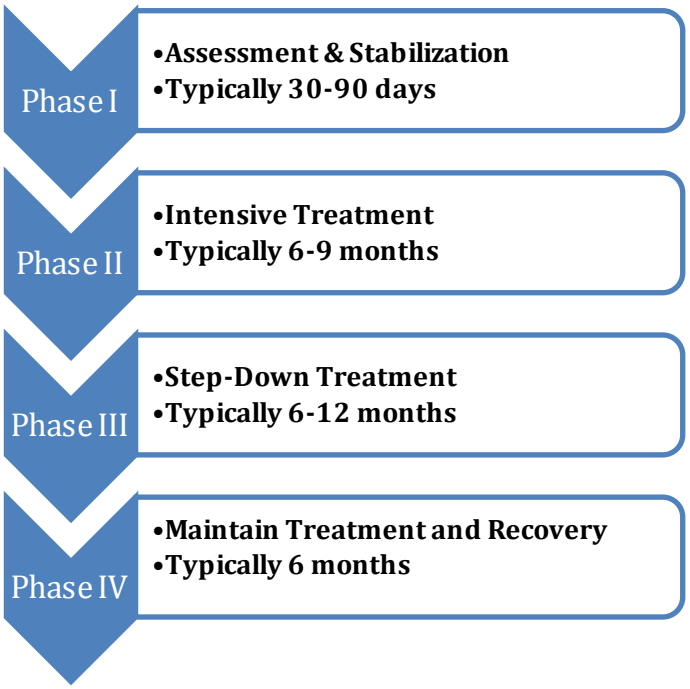
tends to produce better outcomes, especially for women.

Both the substance use disorder and mental health symptoms should be addressed in order to most effectively treat participants with co-occurring mental health disorders. The treatment plan should be comprehensive in addressing both substance use disorder issues and mental health issues, such as depression, anxiety, and trauma-related issues, including post-traumatic stress disorder. See Best Practice Standards V.

Phases

A drug court typically consists of four structured phases, with advancement through the phases based on objective criteria. The phase structure focuses on progressive goals for the participant. As participants progress, they are promoted to a higher phase where in-court monitoring is reduced and requirements are changed. For example, when promoted, the number of court appearances per week may be lessened and a new requirement to complete a GED may be instituted.

It typically takes an individual 16-27 months to complete all phases. The minimum amount of time a participant can be in drug court is 12 months, and the suggested maximum is 3 years.[10] All phases, except the first, should have a minimum time period. The amount of time a participant remains in each phase should fall within standard guidelines, but may relate to their individual criminogenic risks. Each court will design their phases to fit local needs and resources, but the following phase structure represents a typical model:



[10] http://www.nadcp.org/learn/what-are-drug-courts

Phase I: Assessment & Stabilization

The first phase is **Assessment & Stabilization**. The typical duration of Phase I is 30-90 days. The requirements of Phase I are a full assessment by a treatment provider, random and comprehensive drug and alcohol testing multiple times a week, weekly meetings with the probation officer, and attendance at a weekly or bi-weekly court status hearing before the judge. The court-appearance requirement, and weekly meeting with a probation officer requirement, may vary depending on whether the participant is receiving in-patient treatment.

Criteria to complete Phase I are full compliance with treatment, report from treatment provider that the participant is stable in recovery, and self-help programs are in place.

Phase II: Intensive Treatment

The second phase is **Intensive Treatment**. The typical duration of Phase II is 6-9 months. The requirements of Phase II are random and comprehensive drug and alcohol testing multiple times a week, reporting to the probation officer every week or every other week, appearing in court before the judge weekly or every other week, and treatment in accordance with the individualized treatment plan. Often participants in Phase II are in residential treatment, or structured living environments that include treatment.

Typical criteria to complete Phase II are 90 days of negative drug tests, on-going intensive treatment, and the participant exhibits pro-social and healthy behaviors.

Phase III: Step-Down Treatment

The third phase is **Step-Down Treatment**. The typical duration of Phase III is 6-12 months. The requirements of Phase III usually include random drug testing multiple times a week, reporting to the probation officer less frequently, attending drug court less frequently, and the use of wrap-around services specific to the participant's needs.

Typical criteria to complete Phase III are 9 months of negative drug tests, completion of supervised probation requirements, compliance with treatment, employment or

attending school, and a written application letter to the drug court for advancement to Phase IV.

Phase IV: Maintain Treatment and Recovery

The final phase is to **Maintain Treatment and Recovery**. The typical duration of Phase IV is 6 months. Phase IV allows the participant more independence in their access to treatment and wrap-around services, and requires the participant to be more self-sufficient. Typical requirements of Phase IV include random drug testing, reporting to probation less frequently, attending drug court less frequently, and use of wrap-around services. Often, the participant is required to have a hair follicle test to document 90 days of sobriety.

Graduation

Completion of Phase IV is graduation from drug court. Once a participant graduates from drug court, probation may be terminated and the graduate is no longer under probation supervision.

Typical requirements to graduate drug court are the following:

- successful completion of all four drug court phases,
- substance free for 12 consecutive months,
- passing a 90-day hair drug test,
- treatment provider approval for graduation,
- progress toward vocational, educational, and employment goals,
- a written graduation application,
- community service,
- suitable residence,
- a continued care plan, and
- a sponsor.

Certain requirements may be flexible, while others are not. The team must decide in advance which requirements must be met in their entirety and the level of flexibility built into the other requirements.

Graduation is formally recognized with a graduation ceremony during the drug court session. Generally, a certificate of graduation is signed by the judge and awarded to the participant. The drug court team should determine how to hold graduation ceremonies; for instance, whether they will be for individual or multiple participants, and who might be notified of the ceremonies (participants' families, friends, local stakeholders). If the local news media will be invited to the graduation ceremony, the participants must sign a release agreeing to be identified.

Incentives and Sanctions

When a participant deserves recognition for compliance or fails to meet expectations, the judge should impose appropriate incentives or sanctions, respectively. Consequences for participants' behavior must be predictable, fair, consistent, and administered in accordance with evidence-based principles of effective behavior modification. See Best Practices Standards IV. Incentives and sanctions are used to address a participant's progress, or lack of progress. A full list of incentives and sanctions is included in the Participant Handbook in Appendix D. Possible incentives and sanctions are listed below.

The most successful programs utilize a variety of mid-range responses to participants' behaviors.[11] Starting in the middle of the incentives and sanctions range allows programs to increase or decrease their responses to violations or achievements.

INCENTIVES - NADCP states that incentives are "critical for producing long-term behavioral improvements." In fact, giving incentives to individuals who are high-risk is especially effective because these participants are desensitized to punishment and are unaccustomed to being rewarded. Incentives do not need to be costly (courtroom applause or verbal praise from the judge) and can be individualized. For example, if a

[11] See *Principles of Evidence-Based Sentencing and Dispositional Reform,* the National Association of Drug Court Professionals (NADCP) http://www.nadcp.org/sites/default/files/nadcp/NADCP%20Principles%20of%20Evidence-Based%20Sentencing.pdf.

participant enjoys writing, an incentive might be allowing the participant to read a poem he or she wrote.

Drug court teams should determine what specific incentives and sanctions will be given for specific participant behaviors. This encourages fairness among participants and allows participants to predict the consequences of their actions. Making clear what rewards a participant might expect, or the consequences they will face for negative behavior, will help the participants to understand their roles and responsibilities in drug court.

Evidence-based best practices require that the Drug Court utilizes a range of sanctions. "For goals that are difficult for participants to accomplish, such as abstaining from substance use or obtaining employment, the sanctions increase progressively in magnitude over successive infractions. For goals that are relatively easy for participants to accomplish, such as being truthful or attending counseling sessions, higher magnitude sanctions may be administered after only a few infractions." Best Practice Standards IV E.

INCENTIVES	**SANCTIONS**
• APPLAUSE	• COMMUNITY SERVICE
• BOOKS	• COURT APPEARANCES INCREASED
• MBTA PASSES	• CURFEW IMPOSED
• COURT APPEARANCES DECREASED	• DETENTION
• COURT APPEARANCES ENDED	• DRUG TESTING INCREASED
• CURFEW EXTENSION	• ESSAY
• ENTRY INTO GIFT DRAWING	• HOME DETENTION
• EARLY GRADUATION	• JAIL
• EARLY DISMISSAL FROM REVIEW HEARING	• LETTER OF APOLOGY
	• PHASE DEMOTION
• GIFT CERTIFICATE	• PHASE TIME EXTENDED
• JUDGE SHAKES HAND	• PROBATION REPORTING INCREASED
• JUDICIAL PRAISE	• SIT IN CUSTODY IN COURTROOM
• PERMISSION TO TRAVEL	
• PHASE PROMOTION	
• PROBATION REPORTING DECREASED	

It is important to distinguish incentives and sanctions from therapeutic adjustments. "Participants do not receive punitive sanctions if they are otherwise compliant with their treatment and supervision requirements but are not responding to the treatment interventions. Under such circumstances, the appropriate course of action may be to reassess the individual and adjust the treatment plan accordingly. Adjustments to treatment plans are based on the recommendations of duly trained treatment professionals." Best Practice Standards IV G.

If the judge is considering whether to impose a sanction for an alleged failure, it must be done in the context of a probation violation hearing. The probationer is entitled to notice of the alleged violation, has the right to counsel, and has the opportunity to be heard. The hearing is conducted pursuant to the District/Municipal Court Rules for Violation of Probation Hearings.

Each drug court team must make a decision about use of phase demotions. Phase demotions can be significantly more demoralizing to participants than other sanctions that may be equally effective in correcting the participant's behavior. An important factor that should frame this discussion is the need for consistency among and between participants. Phase requirements and program expectations should be clearly stated in the program contract or handbook, and then adhered to and supported by the team. For example, if the program requires 180 days of sobriety for graduation, allowing a participant with a recent relapse to graduate may create an appearance of unfairness to other participants.

Drug Testing

Reliable, regular, and observed drug testing is an essential component of drug court. Drug testing provides an objective means of determining recent use. It also serves as a deterrent to future use, because participants know they could be tested at any time and face consequences for using drugs. Drug testing also identifies participants who remain abstinent and can guide incentives or rewards.

Testing should be conducted on a random basis and at different times of the day or night, including weekends. Less frequent but truly random testing can be more beneficial than daily testing as long as the participant believes that he or she could be tested at any time. Creating a system that ensures the random nature of testing is a recognized best practice. See Best Practice Standards VII.

Depending on regional resources, drug testing can be conducted by the probation department, the sheriffs' offices, the office of community corrections, or a combination of these resources. The collection and custody of drug testing specimens should be performed in accordance with best practice standards.

Prior to their admission into drug court, defendants are informed, that failure to produce a sample and production of a questionable sample, i.e., a sample with low creatinine, will be considered a failure or positive test and that the tests are presumptively valid. If a participant disputes a result and seeks a confirmatory test, the court should have the ability to re-test for confirmation of the original test results. The judge has the option of ordering the participant to pay for the re-test, unless it is negative.

Participants should also be advised that the nonmedically indicated use of intoxicating or addictive substances, including alcohol, marijuana and prescription medication is prohibited, regardless of the licit or illicit status of the substance. Best Practice Standard IV. F. Drug court participants are required to advise their medical providers that they have a history of substance use disorder and must request that non-addictive medications be prescribed, if medically appropriate. See sample form at Appendix I. The drug court team should rely on expert medical input to guide these determinations.

Reports from Treatment Providers

Successful drug courts rely heavily on the effectiveness of treatment. Cooperation and communication between the court and treatment is essential. The court must receive complete and accurate reports from treatment providers about the compliance and progress of drug court participants. This can take the form of written reports, oral

reports to the probation officer, or the attendance of treatment providers at staffings to report directly to the judge and the drug court team. All treatment providers must sign confidentiality waivers, as discussed further in the section on Confidentiality. The court must determine the scope of information the treatment provider must provide to the court. The court may issue a HIPAA Order which will further facilitate the information sharing essential to a successful drug court.

Staffings

Prior to holding the drug court session, the drug court team holds a "staffing." The staffing is attended by team members. It is a best practice is for the staffing to be led by the judge. Judicial participation, however, is discretionary and not mandatory to drug court. The purpose of the staffing is to update team members on the progress of each participant scheduled to appear that day in court, and to discuss any potential issues.

The drug court team will need to determine which team members will attend each staffing meeting. The probation officer and treatment providers are the primary means of learning about the participant's progress. Treatment performance and compliance with other probation conditions are discussed, which helps to prepare the judge for the court session that immediately follows the staffing. By supporting and reinforcing the goals of the treatment providers, the likelihood of a successful outcome for the participant is enhanced.

If information is provided in the staffing that may support a potential sanction, defense counsel is appointed to represent the probationer. If defense counsel is not present, discussion of that participant is deferred until counsel is available.

Staffings are distinguished from staff meetings. Staff meetings are held on a less frequent basis, usually quarterly or twice a year, and there is no discussion of individual cases. The purpose of the staff meeting is to discuss the drug court program generally, brainstorm about ways to improve, identify upcoming trainings, and to reflect on the progress and direction of the program.

Court Session

The drug court session follows the staffing, usually immediately or later the same day. The drug court session is a docket dedicated solely to drug court participants. Cases are scheduled for hearing, and each participant scheduled that day for a hearing will personally appear before the judge. Participants attend the court session as a group and remain in the courtroom as each fellow participant interacts with the judge. This allows participants to see the consequences of others' actions and builds a sense of mutual support among participants. Best practices suggest that the judge should interact with each participant for at least three minutes. In addition, while it may be natural to spend a longer period of time with a participant who is struggling, evidence shows that it is more effective to spend more time praising a participant who has made progress during the week.

Although many programs set rigid guidelines for the frequency of judicial reviews determined by program phase, research indicates that low-risk offenders are successful with fewer judicial reviews than high-risk offenders. The National Association of Drug Court Professionals (NADCP) indicates in their publication, *Principles of Evidence-Based Sentencing and Dispositional Reform,* that high criminogenic risk offenders require "close and continuous monitoring of substance use, criminal activity, and treatment attendance. In addition, frequent status reviews are required by a criminal justice professional, typically a judge, who has the authority to impose meaningful and substantial rewards for accomplishments and sanctions for infractions." Research shows that holding status reviews for high-risk participants less often than biweekly or monthly will have little effect on improving their behavior or reducing substance use.

Continuum of Treatment Services

"The drug court should provide or refer participants for treatment and social services to address conditions that are likely to interfere with their response to substance abuse treatment or other services (responsivity needs), to increase criminal recidivism (criminogenic needs), or to diminish long-term treatment gains (maintenance

needs)." Best Practice Standards VI A. "In the first phase of drug court, participants should receive services designed primarily to address responsivity needs, such as housing, mental illness symptoms, withdrawal, and substance-related cravings. In the interim phases, participants receive services designed to resolve criminogenic needs that frequently co-occur with substance use disorder, such as criminal-thinking patterns and family conflict. In the later phases, participants should receive services designed to maintain treatment gains by enhancing their long-term adaptive functioning, such as vocational or educational counseling." Best Practice Standards VI. B.

The continuum of treatment services available to the drug court participants should include a range of treatment services of varying intensity, from acute to stabilization to support services when needed. Not all participants will need residential placements. Other services, including inpatient rehabilitation services, which are short-term residential treatment (12-30 days); intensive outpatient services, outpatient services, medication assisted treatment, and sober houses are various examples of the continuum of care that may be needed for participants.

In addition to treatment options, drug court participants are supported by additional services that further sobriety. Such services include mental health, health and dental services, housing assistance, self-help groups, workforce development, education, job readiness and training programs, employment search, family therapy, parenting education, therapy for children, phone counseling, recovery support network, community groups, and recovery coaches. See Best Practice Standards VI

Program Monitoring, Data Collection, and Evaluation

Evaluation is a critical component of the drug court concept. The quality of the evaluation depends upon accurate and thorough data collection throughout the duration of the drug court. It is important to think ahead about how to evaluate the effectiveness and performance of the drug court program. See Best Practice Standards X.

There are generally two types of evaluations that might take place in a drug court. The first is called a process evaluation, which tells the team what is, or is not, working in

the program's day-to-day operations. For instance, the court may examine its screening process to ensure that potential participants are being screened quickly and efficiently. Or, the court may review its drug testing protocol to ensure that participants are being tested frequently and randomly, and that accurate test results are available in a timely manner.

The second type of evaluation is an outcome evaluation, which measures the effectiveness of the program. Such an evaluation might look at the graduation rate in the program, and the recidivism rate of both successful and unsuccessful participants. A comparison group of similar offenders handled by traditional methods will be beneficial to have for baseline information and comparison.

Data can be used by drug courts over time to ensure that evidence-based practices are utilized by each agency involved in the drug court.

Recommendations that establish data tracking and capturing methods will be available from the Center of Excellence. The Center of Excellence will identify metrics necessary to generate both process and outcome evaluations, and will provide courts with guidance on how to utilize MassCourts for these purposes.

Confidentiality

In general, confidentiality in drug court is addressed by three federal statues: the Health Insurance Portability and Accountability Act (HIPAA), 42 CFR Part 2, and 42 USC 290(dd). It is recommended that a drug court engage in two best practices to address confidentiality considerations:

1) Before a defendant is admitted into drug court, the court should require the execution of a consent form by the participant that meets HIPAA requirements. See Appendix H for a sample consent form.

2) When a defendant is admitted into drug court, the court should issue an order requiring treatment providers to disclose relevant treatment to the drug court team. See Appendix G for a sample order.

HIPAA

HIPAA was enacted to improve health care by establishing standards for the electronic transmission of certain health records. It prohibits certain entities from disclosing a patient's health information without proper consent or authorization. HIPAA does not apply to the courts, law enforcement, or probation officers.[12]

HIPAA also does not apply to correctional facilities or law enforcement having lawful custody of an inmate or detainee if the protected health information (PHI) is necessary to provide healthcare to the individual, to protect the individual, other inmates, security officers or employees, or for the federal administration, maintenance of safety and security of the facility including law enforcement. [13]

That said, HIPAA may apply to the treatment providers who are members of the team. Treatment providers who fall within HIPAA cannot discuss any patient health information, which includes "any individually identifiable health information; broadly defined to include any part of a medical record or payment history" unless consent is given or pursuant to court order.

HIPAA Order

Federal regulations permit a HIPAA-covered entity to disclose any protected health information in the course of a judicial proceeding in response to an order of court and only to the extent that the PHI is expressly authorized by such an order.[14] The court can issue an order requiring that treatment providers disclose relevant treatment information about a drug court participant to the drug court team. Although not required by the rule, the order should acknowledge that disclosure of the information will be used by members of the drug court team for drug court purposes, that no re-disclosure will occur, and that the order expires upon the participant's termination or graduation from the drug court program. Finally, any order should provide that the disclosure should be the "minimum necessary to accomplish the intended use,

[12] Marlowe, Douglas B. and Hon. William Meyer (ret.), *The Drug Court Judicial Benchbook*, National Drug Court Institute, § 9.5, © 2011, citing the National GAINS Center.
[13] Id., citing 45 C.F.R. § 165.512(d)(5).
[14] Id., citing 45 C.F.R. § 165.512(e)(1).

disclosure, or request."[15] Thus, the court should limit the disclosure to whether the individual attended treatment, participated in treatment, prognosis, and any information the treatment provider believes is necessary to put the drug court participant's compliance with treatment in context. A sample order is contained in Appendix G.

42 CFR Part 2

42 CFR Part 2, prohibits the release of identification and alcohol or other drug-use information from any program that is assisted or regulated by the federal government. [16] The programs covered by 42 CFR Part 2 must (1) involve substance abuse education, treatment, or prevention, and (2) be regulated or assisted by the federal government.[17] This is a very broad definition, as the first part includes not only diagnosis and treatment, but also referral for treatment. Thus, a court employee who administers an alcohol or other drug screening and assessment or a judge who orders substance abuse treatment as a condition of probation or drug court participation arguably brings the court within the ambit of the federal definition of the program.[18]

The second part of the definition is also broad, as it covers both direct and indirect funding and assistance. The regulations include (1) any entity being a recipient of any federal funds, including funds not used for alcohol or other drug diagnosis, treatment, or referral; (2) activities conducted by a state or local governmental unit, which through revenue sharing or otherwise receives federal funds that could be (but are not necessarily) spent on a substance abuse program; or (3) a program that receives tax exempt status or the program has donors who receive income tax deductions for

[15] Id., citing 45 C.F.R. § 164.502(b), 164.514(d). Technically, the "minimum necessary" requirement does not apply when the participant has consented to disclosure, but the better practice in drug courts is that the standard applies regardless of the existence of consent.
[16] Marlowe, Douglas B., *The Drug Court Judicial Benchbook*, National Drug Court Institute, § 9.5, © 2011.
[17] Id. § 9.6
[18] Id., citing Jeffrey Tauber et al., Nat'l Drug Court Inst., *Federal Confidentiality Laws and How They Affect Drug Court Practitioners 6* (1999).

contributions to the program.[19] Thus, any state or local court system would almost certainly qualify as being a recipient of federal assistance.[20]

Regardless of whether the drug court meets the two tier qualification for being a federally assisted program, the drug court judge is going to be the recipient of treatment information protected by federal confidentiality laws.[21] When a court receives information protected by the federal confidentiality laws, the court is prohibited from re-disclosing such information, absent proper consent or those limited authorized disclosures permitted without consent.[22]

42 USC 290(dd)

42 USC 290(dd) states that, "records of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to substance abuse education, prevention, training, treatment, rehabilitation, or research, which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States shall . . . be confidential." There are two exceptions to this code and those apply, "within the Uniformed Services or within those components of the Department of Veterans Affairs furnishing health care to veterans; or between such components and the Uniformed Services."

Specifically, the law prohibits the sharing of substance abuse treatment records and pertains to "any program or activity relating to substance abuse education, prevention, training, treatment, rehabilitation or research which is directly or indirectly

[19] Marlowe, Douglas B., *The Drug Court Judicial Benchbook*, National Drug Court Institute, § 9.6, © 2011.
[20] Id. § 9.6, n.19, noting that not all courts have read the regulations in such an expansive manner. See e.g., *Ex parte Execution*, 773 So.2d 431, 431 (Ala. 2000) (holding that the treatment program must receive the federal funds, and not just the University of Alabama at Birmingham). See also *United States v. Zamora*, 408 F. Supp. 2d 295, 295 (S.D. Tex. 2006) (relying on the 42 C.R.R. § 2.12(e)(2) exception and stating that the treatment program itself not the hospital must receive direct federal assistance and noting emergency room exception); *Ctr. For Legal Advocacy v. Earnest*, 320 F.3d 1107, 1111-1112 (19th Cir. 2003) (holding, consistent with amendment to federal regulations, that referrals to substance abuse treatment providers by emergency rooms does not make emergency rooms a program unless the ER's primary function is AOD treatment or the ER holds itself out to the public as providing such services).
[21] Id., citing Tauber, et al., supra note 13, at 8.
[22] Id., citing 42 C.F.R. § 2.32, 2.35; see Legal Action Cntr., supra note ___, at 35-36, 135-136.

assisted by any department or agency of the United States," which is interpreted to include any state or local court system. While drug test results are not protected unless used for diagnosis or treatment, because of the therapeutic use of drug testing results in drug courts, these records should be considered protected under federal confidentiality laws.

Consent Form

Because it is important that the court and treatment providers maintain ongoing communication and exchanges of information regarding drug court participants, those participants are required to sign a valid consent form, allowing the disclosure of their treatment information. (Appendix H) There are two requirements for a valid consent form: advisement of the participant's rights under the law, and the actual consent. The consent form must reflect the name of the drug court participant, the name of the person(s) permitted to disclose information, the name of the program disclosing information, the purpose of the disclosure, and what kind of information may be disclosed.

If a consent form is not signed, failure of team members to follow these three laws can result in hefty fines, loss of all federal funding, loss of state licenses, and criminal charges. In addition, the consent form should include a statement concerning how the staffing will be conducted. The participant's written consent to a discussion of his or her progress within the staffing and a waiver of his or her right to be present at staffing should be obtained.

After Drug Court

Graduation from drug court is not graduation from the challenges of a substance use disorder, which can be a chronic and relapsing condition. While substance use

management continues after graduation, the tools learned in the drug court need to be utilized every day if long-term sobriety is to be achieved.[23]

Some participants struggle to maintain their sobriety after court supervision and accountability abruptly end at graduation. As a result, some drug courts choose to begin an alumni group as an option for participants who could benefit from continued support from the court and other drug court participants.

Due to worry over support and accountability diminishing, some participants relapse shortly before graduation as a means to remain in the program. Thus, some programs institute step-down groups. These are groups in which participants can receive support prior to graduation. Participants may join when promoted to the final phase of the program or at a designated time before their scheduled graduation (for example, during their last three months of participation). Some courts require participation in an alumni or step-down group, while other programs make participation optional.

Alumni programs can engage in a variety of activities, including planning sober social events, publishing newsletters, participating in subsequent drug court graduations, and developing 12-step meetings for the court's alumni.

Some programs engage alumni as mentors for current participants. These mentors provide a support system for new participants as they navigate drug court. Drug court mentors provide support and encouragement to new participants, provide transportation for participants, attend graduation ceremonies, plan sober social activities, and sometimes serve as sponsors in 12-step groups.

The Office of Justice Programs Drug Court Clearinghouse and Technical Assistance Project at American University prepared a comprehensive report on Drug Court Alumni strategies. The report, entitled, *Good Beginnings: Development and Maintenance of Drug Court Alumni Groups*, can be accessed the through the American

[23] Herrera, Ismael, *Lee County Drug Court Launches Alumni Group*, Copyright ©2015 - 20th Judicial Circuit of Florida.
http://www.ca.cjis20.org/home/main/articledisplay.asp?Article=59567.htm

University website at http://www1.spa.american.edu/justice/documents/247.pdf.

Drug Court Certification Process

The Center of Excellence for Specialty Courts

In 2014, the Trial Court, working in partnership with the DPH-BSAS and DMH, contracted with the University of Massachusetts Medical School's Program of Law and Psychiatry to create the Center of Excellence for Specialty Courts. The Center of Excellence is organized around five core areas: research, evaluation, training, legal research and support, and outreach. The Center of Excellence will perform the following core functions:

- Perform a range of long-term projects, analyze data, and guide policy change and improvement.
- Assist the Trial Court evaluation teams in conducting evaluations of specialty courts to improve operations and to comply with evidence-based best practices.
- Research developments in case law and federal and state legislation relevant to specialty courts, and provide analysis of the impact of any legal developments on the operations of specialty courts in Massachusetts.
- Remain informed on current substance use, mental health, and social science research that impacts specialty courts, and provide information and analysis of how such research impacts special court operations in Massachusetts.

The mission of the Massachusetts Center of Excellence for Specialty Courts is comprised of the following:

- Standardize positive outcomes for those participating in specialty court programs.
- Act as a groundbreaking laboratory of data and ideas.
- Provide technical assistance to judges, probation officers, and other specialty court team members.

- Foster collaboration across state agencies to coordinate resources in more efficient and effective ways.

Adult Drug Court Certification Process

The purpose of the drug court certification process is to support adult drug courts throughout Massachusetts in utilizing nationally-recognized best practices for program operation. The certification process goals are 1) to educate drug courts on national best practices, 2) ensure that drug court participants are enrolled in effective drug courts, and 3) ensure that drug court operations are consistent with providing participants with all constitutionally protected rights. The Center of Excellence will coordinate and provide trainings, and may act as a liaison for the drug court to enroll in national trainings. The Center of Excellence will also serve as a resource to applicant drug courts in the creation of policies and procedures, mission statements, and the development of other documents or procedures specific to that drug court which are necessary for certification. In addition, the certification process will include the varied and innovative approaches to drug courts, and will foster and support drug courts designed to address specific community needs consistent with evidence-based practices.

The adult drug court certification process begins with an application submitted by the drug court team to the Center of Excellence. The application must be submitted at the direction of the departmental Chief Justice.

Once the Center of Excellence possesses a completed application, the certification process will begin with a document review, conducted by the certification team. The Trial Court will establish a certification team consisting of at least one judge, one probation officer, and a treatment provider or specialty court clinician. The document review will include the drug court's policy and procedures manual, its mission statement, the participant handbook, a list of drug court team members, and copies of any team members' drug court training certificates.

After the document review, the certification team will conduct a site visit to see the drug court in operation and to meet the members of the drug court team. The

certification team may engage in additional conversations with the presiding justice or other drug court team members after the site visit.

The certification team will then write a report to the departmental Chief Justice. If the report recommends certification, the departmental Chief Justice will review and forward the report to the Chief Justice of the Trial Court. The Chief Justice of the Trial Court will review the report and recommendation of the certification team and make the final certification determination. A copy of the certification issued by the Chief Justice of the Trial Court will be provided to the drug court Presiding Justice and the departmental Chief Justice. Certifications will remain active for 3 years.

If the certification team is unable to recommend certification, it will transmit a report to the departmental Chief Justice. This report will outline the steps recommended to achieve certification. The report will include an action plan for the Center of Excellence to assist the drug court in meeting this goal, and a time frame after which the certification team will reconsider the drug court for certification. The departmental Chief Justice will be responsible for monitoring the adoption of the certification recommendations put forth by the certification team.

Appendices

Appendix A: Specialty Courts Mission

The Mission of the Specialty Courts is to:

Provide innovative judicial processes, practices, and collaborations that increase public safety by reducing recidivism for targeted populations for whom tradition deterrence methods have not been effective.

Trial Court Policy for Specialty Court Sessions

The Massachusetts Trial Court is committed to establishing new specialty court sessions (also known as problem-solving court sessions) and to enhancing existing drug and other specialty court sessions. By using evidence-based best practices, these court sessions target individuals with underlying medical, mental health, substance use disorders and other issues that contribute to these individuals coming before the courts with greater frequency. The goal of specialty court sessions is to reduce recidivism and to improve public safety.

A hallmark of a specialty court session is the integration of treatment and services with judicial case oversight and intensive court supervision. By providing focused case management with consistent accountability to the court, specialty court sessions promote improved outcomes which reduce recidivism and enhance public safety. We are fortunate that peer-reviewed, evidence-based practices necessary for maximum efficacy of specialty court sessions have been adopted in Massachusetts and are designed to protect all due process, equal protection, and constitutional rights of defendants in the existing specialty court sessions. The objective of our specialty courts is to operate in accordance with proven evidence-based practices.

The following policy is promulgated to provide direction and guidance to those courts within the departments of the Trial Court that currently operate specialty court sessions and for those courts that seek to establish specialty court sessions. The policy is intended to ensure effective and efficient programs and services, while allowing for innovation and flexibility in the operation of specialty court sessions. Because the goals, as well as the evidence-based practices, are vastly different for the various specialty court sessions, specific policies and procedures applicable to each type of specialty court session will be established in separate operating guidelines.

I. Establishment of New Specialty Court Session.

A new specialty court session may be initiated by the Chief Justice of the Trial Court, the Chief Justice of a department, or upon the submission of a written plan by a first justice of a court after consultation with the clerk/register/clerk-magistrate, chief probation

officer and chief court officer. The written plan shall include the following information and must be approved by the Chief Justice of the Department.

A. Describe the particular need for and the anticipated benefits of the proposed specialty court session, including the support within the community of the following: potential treatment and service providers and clinicians; justice partners, such as prosecutors, defense counsel and law enforcement; and court personnel, such as clerk magistrates, case managers, probation officers and judges.

B. Describe with specificity the operational needs and the resources available to the particular court, identifying community services and treatment resources, and any issues of court staffing, workload and court security.

C. Describe the specific procedures and protocols to be followed for participant eligibility and screening, specialty court session operations, and probation supervision.

D. Describe the training needs prior to the establishment of a specialty court session, and how these needs will be met.

E. Describe any foreseeable concerns relating to the collection and submission of statistical data and case information.

F. Describe any foreseeable operational issues, and how they will be resolved prior to the establishment and implementation of a specialty court session in the particular court.

G. Describe the targeted outcomes for the specialty court and how those results will be documented, measured and evaluated.

II. Interdepartmental Transfers.

Where appropriate, a Trial Court justice at a court that does not maintain a specialty court session, in consultation with the presiding justice of the specialty court session, may seek approval by his/her departmental Chief Justice for an interdepartmental transfer of a case to a specialty court session in accordance with existing transfer procedures.

III. Data Collection and Privacy/Confidentiality Rights.

In order to evaluate the effectiveness of specialty court sessions and to provide data necessary for future planning purposes, the Executive Office of the Trial Court, in consultation with the departmental Chief Justices and the Commissioner of Probation, shall establish and maintain uniform means of collecting and analyzing data and statistics on cases handled in specialty court sessions. All data gathering and statistical analysis shall be conducted and maintained in a manner and format that complies with existing law and which does not compromise the privacy and confidentiality rights of individual participants.

IV. Grant Funding.

In accordance with the Trial Court's grant policy, a justice of a specialty court session shall obtain the prior authorization of that court's departmental Chief Justice before seeking funding or other assistance from any federal, state, municipal, non-profit or other agency, organization or corporation. In addition, said justice shall notify the Grants Manager of the Executive Office of the Trial Court of any such efforts to obtain outside funding and shall comply with the Trial Court grant policy.

Appendix B: Sample Drug Court Mission Statement

The mission of the (city/town/region) _____ Drug Court is to promote public safety and the quality of life for the probationer and the community by providing structure and support for sobriety and recovery for court-involved individuals. The aim is to assist participants in regaining health, finding and enjoying new friends, repairing damaged family relationships, and meeting their responsibilities to their families, friends, community, the Court and themselves.

Appendix C: Sample Memorandum of Understanding

Appendix D: Sample Participant Handbook

The Franklin County Substance Abuse Intervention Project
known as
Drug Court

The Substance Abuse Intervention Project is a special session of the Greenfield District Court and the Orange District Court that promotes sobriety and recovery for individuals where substance abuse is a central factor in their court involvement.

Greenfield District Court
425 Main Street
Greenfield, MA 01301

For more information, contact:
John Jones
Assistant Chief Probation Officer
413-774-5531, ext. 274

Orange District Court
One Court Square
Orange, MA 01364

For more information contact:
Stephen Wheeler
Chief Probation Officer
978-544-8281, ext. 234

Conditions of probation are established in the docket, the probation order, and the drug court order. If there is a conflict between those orders and this Handbook, a probationer must comply with the Court's orders.

This handbook is subject to change.

September 2013

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REMEMBER:

THIS IS ABOUT YOU.

It is not about the person sitting next to you.

THIS IS ABOUT YOUR PROGRESS.

Each Drug Court participant comes with different strengths and needs.

Rewards and sanctions are matched to each person's strengths and needs.

You will undermine your own success if you waste energy comparing yourself to others.

BE ENCOURAGED BY YOUR OWN SUCCESS!

Mission Statement

The mission of the Franklin County Substance Abuse Intervention Project (Drug Court) is to promote public safety and the quality of life for the probationer and the community by providing structure and support for sobriety and recovery for court-involved individuals. The aim is to assist participants in regaining health, finding and enjoying new friends, repairing damaged family relationships, and meeting their responsibilities to their families, friends, community, the Court, and themselves.

Entering Drug Court

The Substance Abuse Intervention Project is a special session of the Greenfield and Orange district courts. An overview of requirements can be found on pages 5-6 for Greenfield and pages 7-8 for Orange.

Referral

Referrals to Drug Court come from attorneys and probation officers from the Greenfield District Court, Orange District Court, Franklin Superior Court and Franklin Probate and Family Court.

Eligibility

Typically, the Case Management Team reviews an individual's criminal record and history of substance abuse and treatment to determine if he or she is likely to benefit from the Drug Court program. The Team may include a judge, probation officer, court administrator, treatment provider, defense attorney, prosecutor, and representative of the sheriff's department.

You may benefit from the program if:

- You have an identified substance abuse or alcohol problem.
- You have no pending trials for matters of a serious nature.
- You are motivated for treatment.
- You are able and willing to participate in all aspects of the program.

If admitted to Drug Court you are required to review with your attorney and then sign both the Drug Court Order which contains the core requirements of the program and to sign consent forms for the release of confidential information. A copy of the Order and Release of Information forms is located from pages 15-20. Upon acceptance, you enter Phase I (also known as the assessment phase). You will be responsible for knowing the contents of this manual.

Program Progress

Participants who do well regain some of their health, find and enjoy new friends, repair damaged family relationships, and meet their responsibilities to their families, friends, community, the Court, and themselves. The journey is not always smooth, however, and the judge may impose sanctions when a participant fails to adhere to the program's requirements.

The program's basic requirements are as follows:

- Be honest in all matters pertaining to the program;
- Comply with all laws and court orders;
- Comply with phase requirements;
- Comply with testing requirements; cooperate with home and work visits;

- Be on time for all court, counseling, medical and employment appointments;
- Do not consume alcohol (including over-the-counter products containing alcohol);
- Do not have alcoholic beverages in your residence;
- Do not use illicit drugs;
- Do not use over-the-counter products containing alcohol unless approved in advance by probation; (Check every label.)
- Do not use prescribed drugs (except in an emergency) until approved by probation;
- Do not use prescribed drugs except as prescribed by a physician who has been made aware of your addiction and participation in Drug Court;
- Do not enter a business where alcoholic beverages are the primary product for sale;
- Do pay court assessments and perform community service as ordered.

Sanctions include, among other things:

- Admonishment by the Judge;
- Additional self-help meetings or exercises;
- Additional written reflections on self-help meetings;
- Additional drug or alcohol testing;
- Community service;
- Reading, research, or essay writing;
- Day in the Dock;
- Immediate detention;
- Financial penalties;
- Return to an earlier phase;
- Extension of probation;
- Additional supervision (including electronic monitoring);
- Termination from Drug Court;
- Incarceration.

If the Judge believes a participant is not responding to his or her treatment plan, that plan may be modified, even in the absence of a violation of probation. A modification may include any condition aimed at assisting you with recovery including, for example:

- Individual counseling;
- Additional individual counseling;
- An intensive outpatient program;
- Residential treatment;
- Other counseling groups or programs as recommended.

Recognition for successes and progress may include:

- A positive report from the probation officer to the Judge in the court session;
- A positive report from the treatment provider to the Judge in the court session;
- Praise from the Judge;
- A lifesaver from the Judge;
- An incentive from the Judge;
- Applause from drug court participants and staff;
- Movement from one phase to the next;
- A decrease in weekly requirements;
- Graduation, with a diploma;
- The possibility of an early termination of probation or reduction in supervision.

Prescription Medication Requirements

Drug Court participants are required to inform their physicians that they are in Drug Court and that they have an addiction.

If your doctor prescribes a medication in response to an illness or injury, you must notify your probation officer and the Drug Court's treatment representative immediately and bring in documentation of any medication prescribed. You must sign a release allowing Drug Court staff to talk with your physician about your use of the medication.

You will fill prescriptions at only one pharmacy. Upon request you must bring your medication to your probation officer. You must obtain permission from your probation officer before refilling any prescription. Any unused medication must be turned in to your probation officer.

You must see your own doctor for all your medical needs. The Emergency Room should be used for life-threatening situations only.

If you have a chronic condition that requires ongoing use of certain medications, such as narcotic pain medication, and the Case Management Team becomes concerned about your dependence on that medication, the Team may determine that you are not eligible to continue with the Drug Court Program.

Personal Behavior Rules

There are expectations about how participants behave in Drug Court and in all meetings that are part of the program, including treatment groups. These expectations include the following:

- Turn off all cell phones, pagers and other electronics;
- Refrain from using profanity or obscene language;

- Show respect for the Court by wearing clean clothing. At a minimum, this means no hats, tank tops, shorts, or clothing bearing drug or alcohol related themes.
- Do not form private relationships with one another while in drug court.

This includes sexual relationships and, more generally, conversations containing material you would not be willing to share in group.

Greenfield Drug Court Overview and Requirements

The Drug Court Program involves five steps towards recovery, beginning with an assessment period during Phase I and ending with graduation at the end of Phase V. The program takes a minimum of 13 months to complete successfully. Whether it will take longer depends upon you. You will participate in the following:

Weekly Court Session - Greenfield District Court - Wednesdays at 2:00 p.m.

This is a public court session. Unless excused, you must attend the whole session (which usually lasts less than one hour). You will bring an A.A. attendance card, a treatment verification slip and, during Phase I, an AA reflection sheet.

The Judge calls each person to the front individually. Usually individuals closest to graduation are called first. A probation officer gives a report about that person's attendance at self-help meetings and about results of drug screens that week. A treatment liaison gives a summary of that individual's treatment attendance, attitude and participation. Then the Judge has a brief conversation with that participant.

Self-Help Meetings (A.A., N.A., Smart Recovery)

Participants in Drug Court attend a minimum of 5 self-help meetings per week. You may be required to attend more meetings if the Judge determines it will be in your best interest. You will have the person leading each meeting sign a verification card, and then you will bring the card to each Drug Court session. If you are excused from a treatment session, you must attend and verify a sixth self-help meeting.

During the first phase, participants write reflections about each self-help meeting they attended and submit the reflections to the Judge at each court session.

Treatment

All Drug Court participants are required to engage in a substance abuse evaluation through the court-approved clinic program treatment (ServiceNet) to determine what treatment will be most appropriate. Treatment may include individual counseling with a substance abuse counselor, the Partial Hospitalization Program, the Howard Street After-Care Program, and Court Clinic programs through ServiceNet, Clinical and Support Options (CSO) or other approved programs.

To arrange the initial evaluation the participant must contact the Intake Coordinator at ServiceNet at the beginning of Phase I at (413) 772-2935, then push 3 for Intake when prompted. Make sure to specify that you are a participant in Drug Court and need an assessment with Helen Lincoln-White or her designee.

As you move from one phase to another, you will complete a phase plan with the assistance of the ServiceNet treatment provider. The provider may also assist you in preparing to write the essay required to move from one phase to another.

Random Screens through the Franklin County Sheriff's Department

Every Drug Court participant in Greenfield is assigned a color. Every morning (including weekends and holidays) a tape recording accessed at the number below announces what color will be screened that day. The message is available from about 6 a.m. until 12 noon.

Telephone number to call for recorded message: (413) 774-2296.

If your color is to be screened that day, you must report to the Franklin County House of Correction that day during the hours listed below.

Where: Franklin County House of Correction
160 Elm Street
Greenfield, MA

When: Every day (seven days a week including holidays)
8 a.m. until 12 noon

Failure to call in time to arrive for testing, to report for testing, or to complete a test could result in the issuance of a notice of violation of probation and in the imposition of a Drug Court sanction. The probation department may conduct additional random tests at other times than those indicated on the recorded message.

Orange Drug Court Overview and Requirements

The Drug Court Program involves five steps towards recovery, beginning with an assessment period during Phase I and ending with graduation at the end of Phase V. The program takes a minimum of 13 months to complete successfully. Whether it will take longer depends upon you. You will participate in the following:

Weekly Court Session: Orange District Court - Tuesdays at 8:30 a.m.

Drug court participants report to Probation at 8:30 a.m. This is a public court session. Unless excused, you must attend the whole session (which lasts less than one hour). You will bring an A.A. attendance card and a treatment verification slip, and, during Phase I, an AA reflection sheet.

The Judge calls each person to the front individually. Usually individuals closest to graduation are called first. A probation officer gives a report about that person's attendance at self-help meetings and about results of drug screens that week. A treatment liaison gives a summary of that individual's treatment attendance, attitude and participation. Then the Judge has a brief conversation with that participant.

Self-Help Meetings (A.A., N.A., Smart Recovery)

Participants in Drug Court attend a minimum of 5 self-help meetings per week. You may be required to attend more meetings if the Judge determines it will be in your best interest. You will have the person leading each meeting sign a verification card, and then you will bring the card to each Drug Court session. If you are excused from a treatment session, you must attend and verify a sixth self-help meeting.

Treatment

All Drug Court participants are required to engage in treatment and must participate in a Substance Abuse evaluation through the court-approved clinic program to determine what treatment will be most appropriate. Treatment may include individual counseling with a substance abuse counselor, the Partial Hospitalization Program, the Howard Street After-Care Program, and Court Clinic programs through CHD, Clinical and Support Options (CSO) or other appropriate programs.

To arrange the initial evaluation the participant must contact the CHD Intake Coordinator at the beginning of Phase I at (800) 232-0510. Make sure to specify that you are a participant in Drug Court and that you need an assessment.

As you move from one phase to another, you will complete a phase plan with the assistance of the CHD treatment provider or coordinator. The provider may also assist you in preparing to write the essay required to move from one phase to another.

Random Screens

Every Drug Court participant in Orange is required to be available for a drug screen every day of the week including weekends and holidays. Every morning after 8:30 a.m. you must call the number below. A recorded message will instruct you if you must report to the Orange District Court for a screen that day.

Telephone number to call: (978) 544-8281 extension 228

On Monday through Friday, if you are required to report for a screen, you must do so between 8:30 A.M. and 1:00 P.M. or 2:00 P.M. and 3:00 P.M.

On Saturdays, Sundays and holidays, if you are required to report for a screen, you must do so between 10:00 A.M. and 12:00 Noon.

Failure to report for testing, or to complete a test will be considered a failed test which may result in the issuance of a warrant for your arrest, a notice of violation of probation and in the imposition of a Drug Court sanction. The probation department

may conduct additional random tests at other times than those indicated on the recorded message.

Phase I -Assessment Period

The assessment period is at least five weeks long, during which time you are expected first and foremost to be honest, to comply with all Drug Court obligations and to stay clean and sober.

During the weekly public court session, the Judge calls up each person individually and hears a report from the probation officer and treatment provider about that person's week. When it is your turn, the Judge will review your progress, inquire about your situation, offer encouragement and congratulations for successes and sanctions or interventions for failures. You will stay for the whole meeting. When you have been able to comply with Drug Court requirements for five weeks successfully, you may move to Phase II.

Getting clean and sober is tough. You will have to make real changes in your lifestyle and behavior. It is hard to give up old habits and old "friends" and build new ways. Honesty is a critical ingredient to getting clean and sober. Being able to ask for help is important because most people find they are not able to do it on their own.

Bring your self-help meeting card, AA reflections sheet and treatment verification with you to each Drug Court session.

Phase I Requirements

- BE HONEST.
- Familiarize yourself with this handbook.
- Schedule a substance abuse evaluation with Helen Lincoln-White. Intake number is 413-772-2935, then push 3 for Intake.
- Sign releases so Drug Court personnel can communicate with therapists and doctors.
- Attend the weekly Drug Court session. (In Greenfield, arrive by 2:00 p.m. on Wednesdays. In Orange, arrive by 8:30 a.m. on Tuesdays.)
- Attend 5 self-help meetings each week. Have your card signed at each meeting, and bring your card to the Drug Court session.
- Write reflections about each AA meeting you attend using the form provided at Drug Court. Bring the week's reflection sheet to each Drug Court session.
- Attend an approved treatment program, and have the counselor verify your attendance on the form provided at Drug Court. Bring your verification to each Drug Court session.
- Develop a personal Relapse Prevention Plan.
  Submit to random screens.
- One week in advance of moving to Phase II, submit a brief statement about what changes you have made to your lifestyle and behavior.

Phase II

During Phase II, you can expect that your life will continue to change in many ways. The Judge may want to know how you are adjusting to the schedule and routines of Drug Court. You will begin to meet people who are in recovery through AA, NA and/or Smart Recovery groups, and the Judge will encourage you to take advantage of contacts you make there. You will be encouraged to get a temporary sponsor. In treatment, you can expect to focus on early relapse prevention. Before you move to the next phase, you will reflect on the changes you are experiencing and will be asked to write an essay about those changes. The essay must be submitted the week before you move to the next phase.

Generally an individual completes Phase II after 12 weeks of successful sobriety.

Phase II Requirements

- BE HONEST.
- Attend the weekly Drug Court session.
- Attend 5 self-help meetings each week. Have your card signed at each meeting, and bring your card to the Drug Court session.
- Attend an approved treatment program and have the counselor verify your attendance on the form provided at Drug Court. Bring your verification to each Drug Court session.
- Submit to random screens.
- Get a primary care physician and schedule a physical exam.
- If not already done, complete a psychological assessment and engage in individual or family counseling if recommended and ordered by the Judge.
- Revise your Relapse Prevention Plan as necessary.
- One week in advance of moving to Phase III, submit a brief statement on how being honest with yourself and others has changed you, your living situation or your relationship with others.

Phase III

The move to Phase III recognizes that you have completed the milestone of (at least) 90 days clean and sober. Experience has shown that many individuals at this stage of recovery still need external structure and reporting to continue with their sobriety.

During Phase III, you will begin to develop your own individual structure for staying clean and sober. Toward the end of Phase III, the Judge will ask you to put together a Phase IV Plan with a treatment provider that describes what that structure is. The Phase IV Plan covers your personal plans and goals for treatment, peer support, education, work, housing, health and recreation while you are in Phase IV.

Phase III Requirements

- BE HONEST.
- Attend the weekly Drug Court session. (Arrive by 2:00 p.m. on Wednesdays in Greenfield. In Orange, arrive by 8:30 a.m. on Tuesdays.)

- Attend 5 self-help meetings per week. Have your card signed at each meeting, and bring your card to the Drug Court Session.
- Attend an approved treatment program and have the counselor verify your attendance on the form provided at Drug Court. Bring your verification to each Drug Court session.
- Submit to random screens.
- Review your Relapse Prevention Plan and modify it as needed.
- Behave in a way that serves as a good role model to new participants.
- Get a sponsor.
- One week in advance of moving to the next phase, submit a Phase IV Plan.
- One week in advance of moving to the next phase, submit a brief statement on how you stay clean and sober when stressed; provide an example of a situation where in the past you might have turned to substances.

Phase IV

During Phase IV, you will continue to meet the same requirements as earlier phases, except that you will come to Drug Court every other week. Most participants begin to work on achieving some of their Phase IV Plan goals in addition to maintaining their sobriety. In Phase IV Drug Court participants are expected to be in stable substance-free housing.

Toward the end of Phase IV, the Judge will ask you to work on a Phase V Plan with a service provider, which covers the same categories as the Phase IV Plan. The Phase V Plan will reflect your long-range life goals and strategies for recovery during Phase V and for the time beyond graduation from Drug Court.

In general, individuals move to Phase V after 12 weeks of continuous sobriety in Phase IV.

Phase IV Requirements

- BE HONEST.
- Attend the Drug Court session every other week.
- Attend 5 self-help meetings each week. Have your card signed at each meeting, and bring your card to the Drug Court session.
- Stay in touch with your sponsor regularly and consider doing the Steps.
- Attend an approved treatment program and have the counselor verify your attendance on the form provided at Drug Court. Bring your verification to each Drug Court session.
- Submit to random screens.
- Review your Relapse Prevention Plan and modify it as needed.
- Behave in a way that serves as a good role model to new participants.
- Be in stable substance-free housing.
- One week in advance of moving to the next phase, submit a Phase V Plan.
- One week before moving to the next phase, submit a brief statement about what your plans are for maintaining your sobriety after your probation is terminated and outlining any changes you believe would help you maintain your sobriety

over the long term. Describe whether you have felt this secure in your sobriety in the past and what you must do to make your current success last.

Phase V

Phase V offers a safety net for you as you continue to strengthen your recovery. You still will be required to fulfill your treatment, peer support and screening obligations, but you will attend the Drug Court session once every four weeks. Participants must meet their Drug Court commitments successfully in Phase V for 12 consecutive weeks in order to graduate from the Program.

Phase V Requirements

- BE HONEST.
- Attend the Drug Court session every fourth week.
- Attend 5 self-help meetings each week. Have your card signed at each meeting, and bring your card to the Drug Court session.
- Attend an approved treatment program and have the counselor verify your attendance on the form provided at Drug Court. Bring your verification to each Drug Court session.
- Submit to random screens.
- Maintain an active relationship with your sponsor.
- Review your Relapse Prevention Plan and make modifications as necessary.
- Behave in a way that serves as a good role model to new participants.
- Find employment, enroll in an educational program or demonstrate a structure to your life that allows you to be productive and healthy.
- One week in advance of graduation, submit an essay describing the qualities and benefits that you have gained through your recovery and whether and how you might help others do the same. You may also comment in a separate statement about positive and negative aspects of the Drug Court Program from your perspective.

Graduation

To graduate, you must have two consecutive phases of sobriety.

Before you graduate, you may be asked to come to a case conference meeting to give the Case Management Team your ideas about the Drug Court experience. Are there ways that it could be improved? What was helpful for you? What was not?

Graduation from Drug Court does not necessarily end your probation period, so check with your probation officer to see what orders (such as drug screens) are still in place for you once you graduate.

Graduation is held during the Drug Court session. You may invite others to be present to watch your graduation which marks an ending and a beginning. All graduates of the Substance Abuse Intervention Program have demonstrated courage, persistence, growth

Appendix C: Sample Memorandum of Understanding

and grit. By your success, you will give hope to those who are following behind you. You are encouraged to return on occasion to give hope and inspiration to others going through the program.

Graduating from the Drug Court signifies that you have gained proficiency in recognizing triggers that lead to your abuse of substances and in finding and using available tools and resources to avoid a relapse.

Continued success is assured if you continue to use what you have put together during Drug Court by making use of the resources and skills that have enabled you to reach this point.

You remain in charge of and responsible for your own future.

Appendix E: Drug Court Order of Special Conditions

COMMONWEALTH OF MASSACHUSETTS

FRANKLIN, SS.

Trial Court of the Commonwealth
District Court Department
Orange Division
Complaint No.

COMMONWEALTH OF MASSACHUSETTS

v.

Order Of Special Conditions Relating To

The Franklin County Substance Abuse Intervention Program

("Drug Court")

As you have agreed to enter the Franklin County Substance Abuse Court Intervention Program (hereinafter, "Drug Court"), IT IS ORDERED that you comply with the following special conditions of probation:

1. Be honest in all matters pertaining to the Drug Court program.
2. Comply with all phase requirements.
3. Do not consume alcohol or alcoholic beverages; do not have alcoholic beverages in your residence; do not enter a business where alcoholic beverages are the primary product for sale.
4. Do not use prescription drugs except when taken according to directions and pursuant to a valid prescription from a medical practitioner.
    - A. Do not accept a prescription for a narcotic without first advising the prescribing physician of your addiction history, your participation in Drug Court, and your treatment program.
    - B. Fill prescriptions at only one pharmacy.
    - C. Do not use prescribed drugs until approved by probation unless it is a verified emergency.

D. Provide a copy of every new prescription to your probation officer no later than the day after it is written; if the courthouse is closed then on the next day it is open.

E. Immediately produce all prescription drug containers and drugs for inspection upon request.

F. Do not use non-prescription drugs or products which might interfere with the accuracy of a drug screen.

G. Sign any releases needed to confirm your compliance with this order.

5. Do not use over-the-counter products which contain alcohol unless approved in advance by probation. (Check every label.)

6. Submit to drug and alcohol screens including random testing as directed. Failure to screen will be viewed as a positive test result.

7. Cooperate with home and work visits.

8. Comply with all conditions of Drug Court. You shall:

A. Comply with orders for placement and treatment in a non-residential or residential program ordered by the Court.

B. Participate in self-help programs approved by your probation officer at least five (5) times each week unless ordered otherwise by the Court.

C. Produce proof of participation in required self-help programs at the Drug Court session and when ordered to do so by your probation officer.

D. Attend group therapy or counseling meetings and/or individual therapy or counseling sessions as ordered at a place determined by the treatment provider.

E. Verify attendance at required group therapy or counseling meetings and/or individual therapy or counseling sessions when you appear at the Drug Court session and as ordered by your probation officer.

F. Be on time for all court, counseling, medical and employment appointments.

G. Obtain a sponsor.

H. Comply with such other conditions as may be required from time to time by this Court, the treatment provider, or your probation officer.

I. Appear at each session of the Drug Court unless excused in advance by the Court.

J. Comply with all conditions of probation imposed by this and any Court including the payment of money and performance of community service.

K. Satisfy the Court that you have gained control of your addiction or of your abuse of substances including alcohol and drugs, that you are employed if employable or have otherwise created a stable environment for yourself, and that you have a plan that will help you avoid the dangers of a relapse after graduation.

L. Other special conditions:

12. By signing below, you agree to the terms of this Order, you acknowledge having read the Drug Court handbook and this order including the addendum below, you understand that you are giving up your right to insist that the judge not hear anything about your case unless you or your attorney are present, and you acknowledge that failure to comply with any condition identified in this order may result in discipline including termination from the Franklin County Substance Abuse Intervention Program (Drug Court) and, after hearing, imposition of different terms of probation or incarceration.

_____ _____

Defendant Defendant's Attorney

Date: _____ _____

Justice

ADDENDUM TO ORDER OF SPECIAL CONDITIONS

1. The judge, probation officers, and treatment consultants or providers will meet to review your progress in the Drug Court program. Those drug court team review meetings may also be attended by defense attorneys, prosecutors, police officers, and the sheriff or the sheriff's representative. By agreeing to participate in this program, you agree to waive your right to be present and your right to be represented by an attorney at these meetings.

2. Your progress and the appropriateness of assigning rewards and sanctions may be discussed at drug court team review meetings. No sanction will be imposed until you are before the judge at which time you have a right to be represented by an attorney. If you request an attorney but cannot afford to hire one, an attorney will be assigned to represent you. Your attorney will be informed of any information provided to the judge ex parte or discussed at the review meeting which may affect the judge's decision. You may request that a different judge handle your probation violation hearing.

3. To participate in the Drug Court, you must sign a release of confidential information which will permit those who participate in the review meetings to share information about your identity, diagnosis, urinalysis results, treatment attendance or non-attendance, cooperation with treatment, progress in treatment, and prognosis. If you refuse to consent or withdraw your consent, you may be terminated from Drug Court.

4. If you move your residence to a location that falls under the jurisdiction of a different drug court, your entire case may be transferred to that court. For example, if you live in Greenfield when sentenced, but then move to Orange, your entire case may be transferred to the Orange District Court. Your probation order from the original court will continue to be in effect.

Appendix F: Medical Drug Disclosure

I am a participant in the Orange District Court Drug Court. I am required to submit to random screens for drugs and alcohol.

If you believe I should be prescribed a narcotic for my condition, please prescribe the least addictive drug available and prescribe it in the smallest quantity reasonable in the circumstances.

Please file this disclosure with my medical record and sign a copy for me to submit to my probation officer.

_____ _____

(Patient's printed name) (Patient's Signature)

_____ _____

(Signature of Medical Provider) (Date)

_____

(Address)

_____

(City/Town & State)

_____

(Telephone)

Appendix G: HIPAA Order

HIPAA ORDER

For The Limited Release Of Specific Substance Abuse Treatment Records

This matter is before the Court for consideration of the limited release of specific substance abuse treatment records. The Court makes the following findings:

1. On _____, the defendant was referred to or accepted into the Franklin County Substance Abuse Intervention Project ("Drug Court").

2. As a condition of participation in the drug court program, the defendant must attend substance abuse treatment and the drug court team must monitor the defendant's progress in substance abuse treatment including mental health and medical treatment.

3. The defendant has voluntarily and knowingly signed a HIPAA and 42 C.F.R. Part 2 compliant release.

4. The information necessary to monitor the defendant's progress in substance abuse treatment includes: defendant's identity, defendant's diagnosis, defendant's urinalysis results, defendant's treatment attendance or non-attendance, defendant's cooperation with treatment, defendant's progress in treatment, and defendant's prognosis. This treatment information is the minimum necessary to carry out the purpose of the disclosure. See 45 C.F.R. § 165.502(b)(11) and 42 C.F.R. § 2.13(a). Any potential injury from disclosure to the defendant, the defendant's physician-patient relationship, or treatment is outweighed by the public interest in the defendant's success in the drug court program.

IT IS THEREFORE ORDERED THAT:

1. Any provider of substance abuse treatment including mental health and medical treatment shall provide to the drug court team (as reflected in the HIPAA/42 C.F.R. Part Consent to Release Form or team member replacements) the following information: defendant's identity, defendant's diagnosis, defendant's urinalysis results, defendant's treatment attendance or non-attendance, defendant's cooperation with treatment, defendant's progress in treatment, and defendant's prognosis. The drug court team is comprised of individuals responsible for monitoring the defendant's progress.

2. The treatment provider shall continue to provide the treatment information until defendant's successful completion of the term of probation or termination from the drug court program or further court order, whichever shall first occur.

3. The drug court team shall not re-disclose the information received pursuant to this Order, except as may be provided by law or to carry out official duties in accordance with the drug court program.

SO ORDERED this _____day of _____, 20____.

_____

David S. Ross
Associate Justice of the District Court

Appendix H: HIPAA and CFR Release

CONSENT FOR THE RELEASE OF

CONFIDENTIAL PROTECTED HEALTH INFORMATION:

I, _____, authorize the _____ Drug Court, the _____ Court Probation Department employees supervising my case(s), those serving as Drug Court coordinators and case managers, and those participating in Drug Court case management conferences and their supervisors including treatment providers and law enforcement representatives, to communicate with, share, and disclose to one another all of my substance abuse treatment information including my identifying information, my mental health, psychiatric, and medical information, my diagnoses, my urinalysis and other substance testing results, my attendance or lack of attendance at treatment sessions and appointments, my cooperation with treatment, my progress in treatment, and opinions concerning my prognosis. The purposes of the disclosure are to inform the above of my attendance and progress in treatment and to assist them in evaluating and managing my recovery from substance abuse. I am willing to have information relating to drug or alcohol use, AIDS or HIV status disclosed to the above-identified parties.

I understand that my non-identifiable information will be used for evaluation purposes of Massachusetts Drug Courts.

I understand that my alcohol and/or drug treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records, 42 C.F.R. Part 2, and the Health Insurance Portability and Accountability Act of 1996 (□HIPAA□), 45 C.F.R. Parts. 160 & 164. I also understand that I may revoke this consent at any time except to the extent that action has been taken in reliance on it, and that in any event this consent expires automatically at the end of my term of probation or upon further court order, whichever shall first occur. Any revocation must be in writing.

I understand that I might be denied services if I refuse to consent to the disclosure for purposes of treatment, payment, or health care operations, if permitted by state law. I will not be denied services if I refuse to consent to a disclosure for other purposes.

I recognize that hearings are held in an open and public courtroom and it is possible that an observer could connect my identity with the fact that I am in treatment as a condition

of participation in Drug Court. I specifically consent to this potential disclosure to third persons.

I understand that if I refuse to consent to the disclosure or attempt to revoke my consent prior to the expiration of this consent, that such action is grounds for immediate termination from the Drug Court.

I acknowledge that I have been advised of my rights, have received a copy of this form and have had the benefit of legal counsel or have voluntarily waived my right to an attorney. I am not under the influence of drugs or alcohol. I fully understand my rights and I am signing this consent voluntarily.

My consent to disclosure specifically includes the following and those who assist them in their work:

: Judges who preside over Drug Court including _____, _____;

: Probation Department employees including _____, _____;

: Law enforcement employees including _____;

: Treatment employees including _____, group leaders, and individual counselors;

: Treatment providers and employees including group leaders and individual counselors;

: My medical care providers _____

9 _____

Defendant:_____ Date: _____

Witness: _____ Position: _____

PROHIBITION OF RE-DISCLOSURE OF CONFIDENTIAL INFORMATION

This notice accompanies a disclosure of information concerning a client in alcohol/drug treatment, made to you with the consent of such client. This information has been disclosed to you from records protected by federal confidentiality rules (42 C.F.R. Part 2). The federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 C.F.R. Part 2. A general authorization for the release of medical or other information is **NOT** sufficient for this purpose. The federal rules restrict any use of this information to criminally investigate or prosecute any alcohol or drug abuse patient.

Massachusetts Drug Courts Contact

Executive Office of the Trial Court
One Pemberton Square, Boston, MA 02108

Appendix C. Access to Substance Use Disorder Treatment in Massachusetts

CENTER FOR HEALTH
INFORMATION AND ANALYSIS

ACCESS TO SUBSTANCE USE DISORDER TREATMENT IN MASSACHUSETTS

APRIL 2015

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and analysis

EXECUTIVE SUMMARY

This report, required by Section 30 of Chapter 258 of the Acts of 2014, "An Act to increase opportunities for long-term substance abuse recovery," describes the continuum of care for substance use disorder (SUD) treatment in Massachusetts, evaluates coverage for those services across payers, including commercial health insurance,[1] MassHealth and the Department of Public Health's Bureau of Substance Abuse Services (BSAS). The report further examines the accessibility of SUD services based on provider availability and provides a description of specific potential barriers to treatment access.

BACKGROUND

Approximately 10% of the Massachusetts population suffers from SUD.[2] According to the Substance Abuse and Mental Health Services Administration (SAMHSA), "substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home."[3] The National Institute of Drug Abuse (NIDA) defines addiction as "a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences."[4] Due to the chronic nature of SUD, many individuals relapse and require continued treatment and services. Ensuring proper access to SUD treatment has gained increasing urgency, as fatalities in Massachusetts related to opioid overdose are projected to have increased by 46% from 2012 to 2013.[5]

1 This report reflects the commercial health insurance market that is fully-insured. However, it is important to understand that the majority (58%) of employer-sponsored health insurance is self-insured. See http://chiamass.gov/enrollment-in-health-insurance/. Self-insured plans are often administered by commercial health insurers and often utilize the same benefit package and approach to coverage as the fully-insured market. However, self-insured plans are not required to meet state mandated benefit requirements.

2 According to the National Survey on Drug Use and Health (NSDUH), approximately 10% of Massachusetts residents age 13 and older meet the criteria for abuse or dependence of alcohol and/or illicit drugs. Approximately 3.6% meet criteria for both an SUD and a mental health condition. SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2009-2012. Dependence or Abuse Past Year Ages 12+.

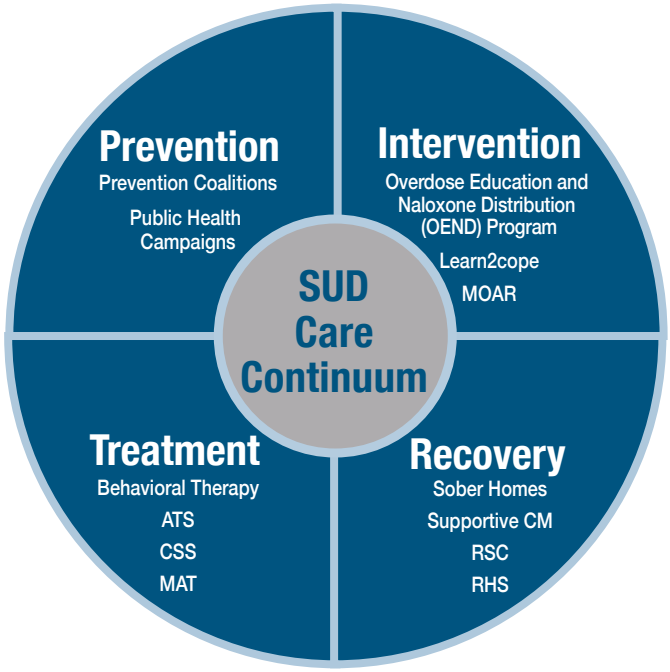
3 SAMHSA, (2014) *Mental and Substance Use Disorders*; accessible at: http://www.samhsa.gov/disorders.

4 National Institute on Drug Abuse (NIDA) website Media Guide, (2014). The Science of Drug Abuse and Addiction: The Basics. Accessible at: http://www.drugabuse.gov/publications/media-guide/science-drug-abuse-addiction-basics.

5 Governor Baker Announces Initial Steps to Combat Opioid Addiction Coverage, Press Release from Governor Baker, February 19, 2015.

A DESCRIPTION OF THE CONTINUUM OF CARE FOR SUBSTANCE USE DISORDER TREATMENT

For the purpose of this report, the SUD care continuum is described in four categories – prevention, intervention, treatment and recovery. There is no one correct way for patients with SUD to move through the continuum, given the risk of relapse with this chronic condition. Individuals should be able to move across and within the different SUD services based on their varying needs.



Prevention

Prevention strategies are the first part of the continuum of care and are primarily funded by BSAS. Initiatives focused on prevention are aimed at educating the general public, particularly adolescents and young adults, on techniques to reduce the risk of developing SUD.[6] These prevention strategies help individuals to develop the knowledge, skills and attitudes to make good choices, identify and understand risky use of substances, and avoid or stop harmful behaviors before the behavior becomes problematic.

Intervention

Intervention strategies are the second part of the continuum of care and, as with prevention, are primarily funded by BSAS. These initiatives focus on early identification of SUD and the beginning of treatment, as well as strategies to help reduce fatal overdoses, such as the Overdose Education and Naloxone Distribution (OEND) program. Other BSAS intervention efforts include providing funding to groups that support and advocate for individuals and families dealing with addictive disorders, such as the Massachusetts Organization for Addiction Recovery (MOAR) and Learn2Cope. In addition, BSAS is currently funding five Family Intervention Pilots focused on engaging adolescents, youth and their families on the need for treatment.

6 See description of prevention on the SAMHSA website, accessible at: http://www.samhsa.gov/prevention.

Treatment

The third part of the SUD care continuum is treatment. Treatment for SUDs is paid for primarily by commercial insurers, MassHealth and/or BSAS, depending on the particular services. Depending on the substance an individual is using, there are different treatment needs. For opioids, alcohol and benzodiazepines, treatment often starts with detoxification followed by clinical support services (CSS) and/or transitional support services (TSS). Effective treatment for SUDs includes behavioral therapy as well as use of medications when appropriate. For those with opioid addiction, studies show that it is most effective to combine behavioral therapy with medication assisted treatment (MAT).[7, 8] Medications that have been shown effective in treating opioid addiction include methadone, buprenorphine, and naltrexone. In addition, acamprosate and disulfiram have been shown effective in treating alcohol addiction.[9]

Recovery

The fourth part of the SUD continuum of care, recovery support services, which are primarily paid for by BSAS, are essential to assisting individuals and families affected by SUD to attain and maintain recovery. Many individuals find support at Recovery Support Centers (RSCs) through peers that have been through similar experiences. These drop-in centers offer a drug-free environment and a variety of activities including classes, leisure activities and support group meetings. BSAS also supports Recovery High Schools (RHSs) which provide a structured school environment for high-school aged youth in recovery to support these teens to maintain their recovery and complete their education. Though not covered by commercial health insurers, MassHealth or BSAS because they do not provide medical services, sober homes are another recovery support. Sober homes provide a group home environment for men or women trying to maintain their sobriety.

KEY FINDINGS

Evaluation of Access to the Care Continuum and Specific Barriers to Care

Services across the SUD continuum are available in Massachusetts, but the existence of a range of services does not mean that people with SUD are always able to access the care they need at the time they need it. Barriers to access include service capacity and design, benefit coverage, and inadequate information about the SUD care continuum.

Service Capacity

While not all patients in treatment follow the same service path, patients in acute treatment services (ATS) often seek clinical stabilization services (CSS); and those in CSS may seek to move to transitional support services (TSS). Bed capacity limitations in one area of the SUD system may impact access in other settings along the continuum. Key barriers in service capacity include:

1. Individuals report difficulty locating acute treatment services (ATS) for detoxification, and when discharged from ATS, difficulty locating available slots in stabilization services, residential services or community-based support services.[10]

7 U.S. Preventive Services Task Force, Final Recommendation Statement: Alcohol Screening and Behavioral Counseling Interventions in Primary Care; accessible at: http://www.uspreventiveservicestaskforce.org/Page/Document/RecommendationStatementFinal/alcohol-misuse-screening-and-behavioral-counseling-interventions-in-primary-care.

8 Institute for Clinical and Economic Review. Management of Patients with Opioid Dependence: A Review of Clinical, Delivery System, and Policy Options; Final Report 2014. The New England Comparative Effectiveness Public Advisory Council. Released June 20, 2014; accessible at: http://cepac.icer-review.org/wp-content/uploads/2014/04/CEPAC-Opioid-Dependence-Final-Report-For-Posting-July-211.pdf.

9 National Institute on Drug Abuse (NIDA). (2012). Principles of Drug Addiction Treatment: A Research-Based Guide (Third Edition) accessible at: http://www.drugabuse.gov/publications/principles-drug-addiction-treatment-research-based-guide-third-edition/evidence-based-approaches-to-drug-addiction-treatment/pharmacotherapies.

10 Consumer Advocate Focus Group, December 2014.

2. Individuals and families report long wait times and difficulty accessing CSS and TSS services.[11] Not all patients move from ATS to CSS or TSS, but patient flow between services is impacted by both bed availability and lengths of stay. Currently there are nearly three times the numbers of ATS beds (868) as CSS (297) or TSS beds (331).[12] Because the average length of stay in ATS (one week) is shorter than in CSS (two weeks) or TSS (four weeks), the number of patients leaving ATS each week is much greater than the number of new CSS or TSS beds vacated each week. Access to long-term residential programs is hampered by similar bed capacity and patient flow issues.
3. Due to the relatively high SUD treatment utilization rate of young adults (see Figure 3.3),[13] providers assert the need to tailor long-term residential programs to meet the needs of this population.[14] Services such as family support groups, recovery coaching, recovery specialists, aftercare, and life skills training were identified by providers as being of high-value to this population.[15] Similar program adjustments may be beneficial for populations with challenges in addition to SUD such as homelessness, unemployment, HIV, hepatitis C, criminal justice involvement or disengagement from their families.[16]
4. Sufficient outpatient SUD treatment capacity is crucial to a responsive, efficient SUD system of care and may reduce reliance on inpatient services. However, outpatient capacity is currently difficult to assess. There are no standards or reliable methods for assessing the adequacy of outpatient service capacity. There is a lack of data available to evaluate the capacity of licensed programs and the number of FTE providers offering services at each level of the SUD care continuum.
5. Access to buprenorphine is impacted by the limited number of providers that have received the required waiver from the Federal Drug Administration (FDA) to administer buprenorphine, and only a subset of these providers actively treat patients with SUD.[17] Additionally, waivered providers are not allowed to treat more than 100 patients.[18]

Service Design

Program services are sometimes limited in ways that hamper the ability to treat clients in the most effective manner. For example, there are 38 well-established methadone programs across the Commonwealth that provide methadone maintenance therapy combined with behavioral counseling. However, other Medication Assisted Treatment services such as the provision of buprenorphine and naltrexone are not available through these programs, limiting clients' treatment options at these programs to just methadone.

Benefit Coverage

Cost sharing requirements and non-quantitative treatment limits (NQTL), such as medical necessity standards, utilization review and fail-first policies present potential barriers to accessing SUD treatment. While managed care techniques are intended to reduce inappropriate care (thus reducing overall cost while maintaining quality), they may in some cases also restrict appropriate care.

1. Cost sharing requirements.

   Copayments vary significantly among commercial plans and products.[19] Copayments – particularly for patients receiving daily services, such as methadone treatment – may present a barrier to accessing care.

11 *Ibid*.

12 Special BSAS Report: Licensed Programs as of November 11, 2014.

13 2012 Commercial health plan utilization data, All-Payer Claims Database.

14 Residential Provider Focus Group, December 2014.

15 *Ibid*.

16 *Ibid*.

17 Massachusetts Department of Public Health, 2014, Findings of the Opioid Task Force and Department of Public Health Recommendations on Priorities for Investments in Prevention, Intervention, Treatment and Recovery.

18 http://buprenorphine.samhsa.gov/waiver_qualifications.html.

19 Health Insurance Carrier Surveys, December 2014.

2. Non-Quantitative Treatment Limits (NQTLs).

   Under federal parity laws, any NQTL policy must be applied in a non-discriminatory manner, and not more frequently or stringently for SUD treatment than for medical or surgical treatment. A 2013 national study examining benefits after MHPAEA was enacted but before final regulations were issued found multiple examples of NQTLs that were applied more strictly for behavioral health services than for medical/surgical services.[20] This national study may inform discussions of parity compliance in Massachusetts, but it is important to note that the study's findings are not directly applicable to the current Massachusetts healthcare market, as it was based on a nationally representative sample of large employer benefits in 2010. Parity compliance in Massachusetts is monitored by the Division of Insurance and the Attorney General's Office, who require detailed filings from carriers regarding their policies and procedures related to mental health parity compliance. NQTLs of particular concern to providers and consumers include medical necessity criteria, utilization reviews, and fail-first policies.[21]

   a. Medical Necessity Criteria. Carriers are required to develop medical necessity criteria according to processes required under section 16 of M.G.L. c. 176O. The American Society of Addiction Medicine (ASAM) has developed a widely recognized and utilized set of criteria to determine medical necessity. Both plans and providers report being guided by the ASAM assessment guidelines in constructing their own medical necessity criteria. However, these medical necessity criteria differ across carriers and from the criteria applied by providers for treatment. Provider focus group participants indicated that the differences in medical necessity criteria can lead to an administrative burden on providers as well as potential variation between a plan and a provider's medical necessity determinations.[22] Generalization as to whether carrier or provider criteria are more appropriate cannot be made, since decisions about appropriate care must be based on an individual's particular needs and circumstances.[23]

   b. Utilization Reviews.[24] Although the prior authorization process for patients seeking acute treatment services and clinical stabilization services will be eliminated in Massachusetts as of October 2015 for the fully-insured market, health insurance carriers may conduct concurrent utilization reviews related to these admissions.[25, 26] Utilization reviews have been demonstrated to reduce utilization, though no determinations around the appropriateness of this reduction can be made.[27]

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20 Between passage of MHPAEA in 2008 and the release of final regulations during November 2013, some carriers showed improvement in parity compliance but not perfect compliance. *Consistency of Large Employer and Group Health Plan Benefits With Requirements of the Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act Of 2008*, November 2013 accesible at: http://www.dol.gov/ebsa/pdf/hhswellstonedomenicimhpaealargeemployerandghpbconsistency.pdf.

21 Consumer Advocate Focus Group, December 2014; ATS Focus Group, December 2014.

22 ATS Focus Group, December 2014.

23 Compass Health Analytics, Inc. (2014). Actuarial Assessment of Chapter 258 of the Acts of 2014: "An Act to increase opportunities for long-term substance abuse recovery". Acute Treatment and Clinical Stabilization Services and Substance Abuse Treatment Preauthorization, Center for Health Information and Analysis.

24 According to M.G.L. c. 176O, section 12, "(a) [u]tilization review conducted by a carrier or utilization review organization shall be conducted pursuant to a written plan, under the supervision of a physician and staffed by appropriately trained and qualified personnel, and shall include a documented process to (i) review and evaluate its effectiveness, (ii) ensure the consistent application of utilization review criteria, and (iii) ensure the timeliness of utilization review determinations.

A carrier or utilization review organization shall adopt utilization review criteria and conduct all utilization review activities pursuant to said criteria. The criteria shall be, to the maximum extent feasible, scientifically derived and evidence-based, and developed with the input of participating physicians, consistent with the development of medical necessity criteria pursuant to the provisions of section 16. Utilization review criteria shall be applied consistently by a carrier or a utilization review organization and made easily accessible and up-to-date on a carrier or utilization review organization's website to subscribers, health care providers and the general public; provided, however, that a carrier shall not be required to disclose licensed, proprietary criteria purchased by a carrier or utilization review organization on its website, but must disclose such criteria to a provider or subscriber upon request. If a carrier or utilization review organization intends either to implement a new preauthorization requirement or restriction or amend an existing requirement or restriction, the carrier or utilization review organization shall ensure that the new or amended requirement or restriction shall not be implemented unless the carrier's or utilization review organization's website has been updated to reflect the new or amended requirement or restriction."

25 For additional information on utilization review, see Appendix Two.

26 Sections 9, 21, 23, 25, and 27 of Chapter 258 of the Acts of 2014, "An Act to increase opportunities for long-term substance abuse recovery."

27 Compass Health Analytics, Inc. (2014). Actuarial Assessment of Chapter 258 of the Acts of 2014: "An Act to increase opportunities for long-term substance abuse recovery". Acute Treatment and Clinical Stabilization Services and Substance Abuse Treatment Preauthorization, Center for Health Information and Analysis.

c. Fail-first policies restrict coverage for higher levels of care unless a patient has attempted and "failed" at a lower level of care. These policies, while intended to encourage the use of appropriate levels of care, in some cases may also frustrate provider and patient attempts to access specific treatments.

Inadequate Information about the Care Continuum

Individuals seeking treatment and their families may not fully understand or receive information on the full range of appropriate treatment options and their availability within the Commonwealth.[28] Providers may also not understand the continuum of treatment options, or how to help patients access the appropriate services.[29] The lack of shared understanding of the continuum of care – and associated best practices – may exacerbate misunderstandings between patients, providers, and insurers about available options and best practices.

Cultural Competency within the Care Continuum

A recent Massachusetts study found the current behavioral health workforce to be insufficient to meet the needs of Massachusetts' diverse population, including a lack of capacity to offer services in a patient's native language.[30] Even when an interpreter is used, studies show that patients who do not speak the same language as their providers have worse outcomes and higher dropout rates. There is some evidence that provider racial/ethnic concordance with patients can improve retention in care.[31]

28 Massachusetts Department of Public Health, 2014, Findings of the Opioid Task Force and Department of Public Health Recommendations on Priorities for Investments in Prevention, Intervention, Treatment and Recovery.

29 *Ibid*.

30 *Op. cit*. Alegria, et. al.

31 *Ibid*.

I. SUBSTANCE USE DISORDERS AND COVERAGE IN MASSACHUSETTS

1.1 SUBSTANCE USE DISORDERS (SUD)

According to the Substance Abuse and Mental Health Services Administration (SAMHSA), "substance use disorders occur when the recurrent use of alcohol and/or drugs causes clinically significant impairment, including health problems, disability, and failure to meet major responsibilities at work, school, or home."[32] The National Institute of Drug Abuse (NIDA) defines addiction as "a chronic, relapsing brain disease that is characterized by compulsive drug seeking and use, despite harmful consequences."[33] NIDA further explains that brain imaging studies of people with addiction show physical changes in areas critical to judgment, decision making, learning and memory, and behavior control.[34] These changes may modify how the brain works, potentially contributing to the compulsive and destructive behaviors common to addiction. Changes in the brain may also complicate efforts to recover, even among people demonstrating readiness. Vulnerability to addiction varies among people, with genetic factors accounting for as much as 40 to 60%, while other contributing factors include age and presence of other medical and mental health conditions, as well as trauma history, developmental stage, social support, and environmental and cultural factors.[35]

Addiction can contribute to other medical issues, increasing the risk of lung or cardiovascular disease, stroke, cancer, and mental health disorders.[36] Given these co-occurring medical issues, individuals with SUD often have high overall medical expenses. According to a study of Medicaid costs in six states, Medicaid beneficiaries with SUD have an overall higher disease burden than patients with other behavioral health disorders, requiring more medical care and higher medical expenditures.[37] Alcohol and other substance related disorders are two of the top 10 causes of hospital readmissions among adult Medicaid patients ages 18-64.[38]

SUDs are both preventable and treatable. Similar to other chronic diseases, addiction can be managed successfully. Behavioral therapy combined with medication assisted treatment has proven to be successful in helping people to recover from the effect of substance use on their brain and behavior, and to regain control of their lives. However, the chronic nature of addiction means that relapse is a risk.[39] Addiction relapse rates are similar to those for chronic medical illnesses such as diabetes, hypertension, and asthma, which also have both physiological and behavioral components (see Figure 1.1).[40] As with other chronic conditions, substance use relapse may indicate a need for renewed intervention or modification of treatment and continuous support to better meet the individual's needs.

32 SAMHSA, (2014) *Mental and Substance Use Disorders*, accessible at http://www.samhsa.gov/disorders.

33 National Institute on Drug Abuse (NIDA) website Media Guide, (2014). The Science of Drug Abuse and Addiction: The Basics; accessible at http://www.drugabuse.gov/publications/media-guide/science-drug-abuse-addiction-basics.

34 Fowler JS, Volkow ND, Kassed CA, Chang L. (2007). Imaging the addicted human brain. *Science and Practice Perspectives* 3(2):4-16.

35 National Institute on Drug Abuse (NIDA). (2014). Drugs, Brains, and Behavior: The Science of Addiction; accessible at http://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/addiction-health.

36 *Ibid*.

37 Clark, R. E., Samnaliev, M. & McGovern, M. P. (2009). Impact of substance disorders on medical expenditures for Medicaid beneficiaries with behavioral health disorders. *Psychiatr Serv*. Jan ;60(1):35-42.

38 See Table 3; Conditions With The Largest Number of Hospital Readmissions by Payer, 2011, Statistical Brief 172, Healthcare Cost and Utilization Project (H-CUP), Agency for Healthcare Research and Quality (AHRQ), April 2014. Alcohol was 5th and other substance related disorders were 10th in the top 10 list.

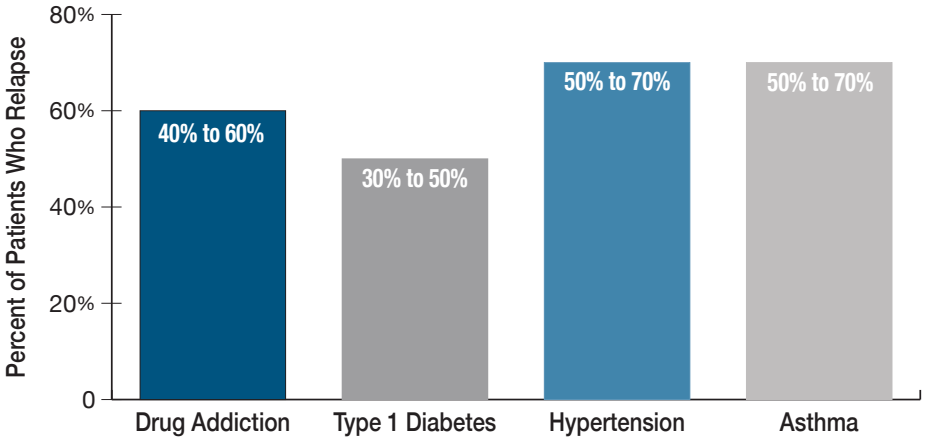
39 National Institute on Drug Abuse (NIDA). (2014). Drugs, Brains, and Behavior: The Science of Addiction; accessible at; http://www.drugabuse.gov/publications/drugs-brains-behavior-science-addiction/addiction-health.

40 McClellan, AT, Lewis, DC, O'Brien, CP, and Kleber, HT, (2000). Drug Dependence, A Chronic Medical Illness: Implications for Treatment, Insurance, and Outcomes Evaluation, JAMA, 284(13): 1689-1695.

Nationally, only 11% of individuals with SUD receive treatment. Of those who do not receive treatment, 2% reported that they were unable to access services, while the vast majority (95%) report not feeling a need for treatment.[41] While overall treatment rates nationally remain low, there was a dramatic increase (346%) in opioid treatment admissions between 2001 and 2011.[42]

SUD affects all demographics. National rates of SUD are highest among 18 to 25 year-olds, who had a combined alcohol and drug dependence rate of 23.1% in 2012 and 2013, 2.7 times higher than the rate among adults ages 26 and older.[43] In addition, there is evidence of disparities in access to treatment. Racial and ethnic minorities who need treatment are less likely to access services when controlling for socioeconomic status and criminal justice history.[44]

Figure 1.1 Comparison of relapse rates between drug addiction and other chronic illnesses



Source: JAMA, 284:1689-1695, 2000

1.2 SUBSTANCE USE DISORDERS IN MASSACHUSETTS

In Massachusetts, 10% of the population meets the diagnostic criteria for SUD[45] with dependence or abuse rates for alcohol and drugs higher than the national average for all age categories, except 12-17 year olds.[46] Most people who meet the criteria for SUD do not receive treatment. The potential effects of untreated SUD can be serious. Between 2000 and 2012, fatal opioid overdoses in Massachusetts increased by 90%,[47] and are projected to have increased an additional 46% between 2012 and 2013.[48]

41 Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health 2011 and 2012, Tables 5.51A and 5.53A, SAMHSA.

42 SAMHSA's Treatment Episode Data Set (TEDS) 2001-2001; National Admissions to Substance Abuse Treatment Services.

43 Substance Abuse and Mental Health Services Administration. (2013). Results from the 2012 National Survey on Drug Use and Health: Summary of National Findings (HHS Publication No. SMA 13-4795, NSDUH Series H-46).

44 Cook BL, Alegria M. Racial-ethnic disparities in substance abuse treatment: the role of criminal history and socioeconomic status. Psychiatric services. Nov 2011;62(11):1273-1281.

45 According to the National Survey on Drug Use and Health (NSDUH), approximately 10% of Massachusetts residents age 13 and older meet the criteria for abuse or dependence of alcohol and/or illicit drugs. Approximately 3.6% meet criteria for both an SUD and a mental health condition. SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2009-2012. Dependence or Abuse Past Year Ages 12+.

46 SAMHSA, Center for Behavioral Health Statistics and Quality, National Survey on Drug Use and Health, 2012-2013 combined.

47 BSAS, Opioid Overdose Response Strategies in Massachusetts, 2014.

48 Governor Baker Announces Initial Steps to Combat Opioid Addiction Coverage, Press Release from Governor Baker, February 19, 2015.

1.3 COVERAGE OF SUBSTANCE USE DISORDER TREATMENT SERVICES IN MASSACHUSETTS

Coverage for SUD has increased over the last several years in Massachusetts, through a combination of expanded access and coverage in both commercial and publicly-funded or subsidized health care coverage. Coverage expansions under Massachusetts' 2006 health reform and the Affordable Care Act (ACA) provide greater access to health coverage to young adults and to lower and middle income, childless adults and parents who previously did not qualify for MassHealth. In addition to expanded coverage, commercial health insurance carriers have increased the amount and types of SUD treatment services covered, to meet both behavioral health parity laws, and the ACA's essential health benefits requirements.[49] Under the federal Mental Health Parity and Addiction Equity Act, health plans that provide coverage for mental health and substance use disorder treatment must refrain from applying financial requirements, quantitative treatment limits, and non-quantitative treatment limits to mental health or SUD treatment in a way that is more restrictive or more stringent than those applied to medical or surgical treatments.[50] Similarly, Massachusetts laws and the ACA require insurers to cover medically necessary SUD treatment services on a non-discriminatory basis.[51]

In Massachusetts, beginning in October 2015, health insurance carriers[52] will be:

- Prohibited from requiring prior authorization for certain SUD services, including ATS or CSS,[53] administered by a provider that is certified or licensed by DPH. ATS and CSS facilities will be required to notify the patient's health insurer and provide an initial treatment plan to the insurer within 48 hours of accepting the patient. Health insurers may begin to conduct utilization review on day 7 of a stay.[54] Appendix Two includes detailed information on the current prior authorization and continued stay (CS) reviews by commercial health insurers and MassHealth managed care plans as of December 2014.
- Required to pay for covered services provided by Licensed Alcohol and Drug Counselors I (LADC-I).[55]

Blue Cross Blue Shield Massachusetts currently reimburses broadly for methadone treatment services provided by Opioid Treatment Programs; several other carriers cover methadone treatment for certain populations in certain circumstances. As of July 1, 2015, all commercial health insurers will also reimburse for methadone maintenance services, although decisions have not yet been announced regarding accompanying copayments and medical necessity criteria.[56] MassHealth requires coverage of methadone maintenance services.

There are also several service capacity expansions in progress, including the addition of:

- 32 ATS and 32 CSS beds recently added in Quincy with 32 ATS and 32 CSS beds to be added in Greenfield
- Four office-based Opioid Treatment Programs utilizing buprenorphine and injectable naltrexone in federally qualified health centers (FQHCs)
- Six community-based youth-focused SUD treatment programs
- Extended hours of operations at existing Recovery Support Centers and addition of three Centers
- Ten Learn2Cope chapters, a family support organization.

In addition to this expanded capacity, BSAS is working to implement in 2015 a Central Navigation System and pilot six regional assessment centers. Together, these activities will assist consumers and their families to access the full continuum of SUD treatment services in Massachusetts. (See Section 2.3 for a discussion of SUD coverage on a service-by-service basis.)

49 45 CFR Parts 147,155 and 156. Patient Protection and Affordable Care Act; Standards Related to Essential Health Benefits, Actuarial Value, and Accreditation: Department of Health and Human Services, Final Rule. February 25, 2013.

50 MHPAEA: Paul Wellstone and Pete Domenici Mental Health Parity and Addiction Equity Act, Pub. L. No. 110-343, §§ 511-512 (2008).

51 See MGL c. 32A §22, c.175 §47B, c.176A §8A, and c.176B §4A.

52 These requirements do not apply however to self-insured plans that make up a majority of the marketplace.

53 Both ATS and CSS are described in further detail in Section 3.3.

54 See sections 9, 19, 21, 23, 25, and 27 of Chapter 258 of the Acts of 2014. For additional information on utilization review, see Appendix Two.

55 See sections 10, 20, 22, 24, and 26 of Chapter 258 of the Acts of 2014.

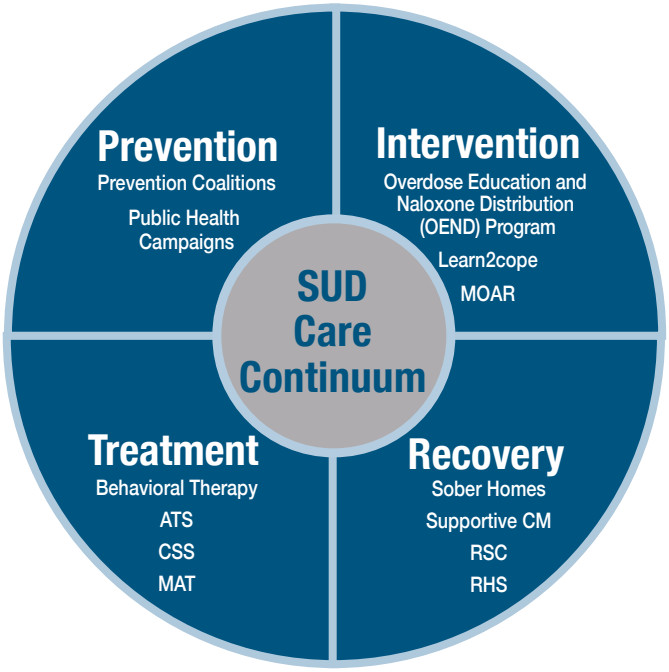
56 MAHP Member Health Plans Aggressively Move to Address Opioid Crisis, Press Release, February 6, 2015; accessible at; http://www.mahp.com/unify-files/MAHPMethadoneCoverageRelease.pdf.

II. SUD TREATMENT SERVICES: CONTINUUM OF CARE

2.1 OVERVIEW OF SUD TREATMENT SERVICES CONTINUUM

A comprehensive approach to address SUD includes activities that can be grouped into four major categories: prevention, intervention, treatment and recovery. Each aspect of the continuum plays an important role in the prevention and treatment of SUDs for all Massachusetts residents. This section will explore these different categories, describe available services and detail who pays for which services.

Figure 2.1 SUD Care Continuum



Patients do not move through the SUD continuum in only one way; due to the SUD's chronicity and the related risk of relapse, individuals often move across and within the different SUD treatment services, depending upon their particular needs. Many individuals will complete detoxification on several occasions over the course of treatment, and will also utilize other services on the continuum at different points in their recovery process.

2.1.1 PREVENTION

Prevention strategies are the first part of the care continuum and are primarily funded by BSAS. Initiatives focused on prevention are aimed at educating the general public, particularly adolescents and young adults to reduce the risk of developing SUD.[57] These prevention strategies help individuals to develop the knowledge, skills and attitudes to make good choices, identify and understand risky use of substances, and avoid or stop harmful behaviors before the behavior becomes problematic. Prevention strategies often supported by BSAS funding take root in local communities and are tailored to their unique characteristics. Environmental prevention strategies aim at restricting youth access to alcohol and other drugs.

57 See description of prevention on the SAMHSA website, accessible at: http://www.samhsa.gov/prevention.