Drug Courts as Health Neighborhood Partners
Series Objectives

• Explain the concept of the health neighborhood
• Reconceptualize the neighborhood as the source of tobacco cessation promotion and delivery
• Learn techniques to discuss public health goals in the language of neighbors outside traditional healthcare settings
• Identify elements of *systems* that can be the targets of program intervention
• Explore alternative approaches to developing health neighborhoods for criminal justice-involved individuals
Module Objectives

• Review the history and rationale of our current drug treatment court models
• Determine the need for new healthcare delivery models for drug court participants
• Identify potential barriers to programmatic success
• Identify opportunities for strategic alignment with drug courts
Introduction to Drug Treatment Courts

Rationale, Evolution, and Success
First-Generation Drug Courts

1. First specialized “drug court” was in New York City in 1974
2. Response to rapidly rising incarceration rates
3. Not all criminal cases are alike
4. Drug court offered a more efficient process
5. Potentially avoided incarceration and charges
Problems with Drug Courts

1. Specialization reduced processing times, but did not lower re-arrests
2. Increased case loads required case management strategies beyond most systems’ capacity
3. “Assembly line justice”
Second-Generation Drug Courts

1. First drug *treatment* court was in Miami-Dade County in 1989
2. Speed and efficiency vs. client-centered treatment
3. Assumption that drug treatment is the solution
4. Based in “therapeutic jurisprudence”
Dade County Structure

1. Participation is voluntary
2. Purchase or possession of drugs
3. Non-adversarial, judge-led procedures
4. Team-based approach
5. Shared decision-making protocol
6. Sanctions for violations
7. Frequent meetings between judges and clients
Dade County Timeline

• 12-18 months (or longer)
• Three phases
  • Detoxification
  • Stabilization
  • Aftercare
• Recommendation of discharge
• Judge’s review
• Graduation (with ceremony)
• Consistent non-compliance return to traditional criminal process
Drug Treatment Courts Work

• Fewer dropped cases
• Fewer rearrests
• Lower incarceration rates
• Fewer prison sentences
• Time to re-arrest was 2-3 times longer
• Fewer positive drug tests than those in electronic, intensive or standard probation monitoring/supervision
• Reduced or avoided subsequent justice-involvement creates significant cost savings (ROI)
Simple Drug Court Model

Addiction → Criminal Behavior
The Unmet Needs of Drug Court Participants

Health & Social Needs Burden
- Stigma
- Low SES
- Discrimination
- Chronic Stress
- Psychological Distress
- Coping Skills
- Environmental Exposure
- Industry Targeting
- Biology
- Access to Treatment

Addiction
Incarceration
Recidivism
Relapse
Poor Health
Simple Drug Court Model

Addiction  ➔  Criminal Behavior
New Drug Court Model

Risk Factors
- Low SES
- Discrimination/Stigma
- Chronic Illness
- ACES/Trauma
- Housing/Food Instability
- Employment status
- Ed. status

Addiction

Criminal Behavior

Justice-Involvement
10 Key Components of Drug Courts

1. Drug courts integrate alcohol and other drug treatment
2. Prosecution and defense counsel are non-adversarial
3. Early identification for participation
4. Access to a continuum of services.
5. Abstinence is frequently monitored
10 Key Components of Drug Courts Cont.

6. A coordinated strategy for compliance
7. Ongoing judicial interaction with each participant
8. Monitoring and evaluation measure goals and effectiveness
9. Continuing interdisciplinary education
10. Partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances program effectiveness
Health Neighborhood Components as Best Practice

4. Drug courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services.

10. Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court program effectiveness.
Considerations for Intervention Design
Social Ecological Model
Institutional Constraints

• Incarceration is a rural phenomenon but drug courts serve urban communities
• Sex workers and violent offenders often do not qualify
• No mental health training in law schools (e.g., for public defenders)
Personal Barriers

- Inaccurate beliefs about the needs for medical care
- Reside within a culture of underutilizing care
- Fear of discrimination and stigmatization
- Lack access to primary care
- Medical mistrust is present
- Literacy is an issue
- Transportation
- Cost of care
Drug Treatment Courts: Opportunities
Common Values

Public Health

Addiction Recovery

Criminal Justice
Sequential Intercept Model

- Initial law enforcement interaction
- Detention & Hearings
- Jails and Courts
- Incarcerated Period
- Re-entry/Discharge
- Community Corrections
## 5As Functions

<table>
<thead>
<tr>
<th>A</th>
<th>Function</th>
<th>Purpose</th>
</tr>
</thead>
<tbody>
<tr>
<td>Ask</td>
<td>Screening</td>
<td>Ensure services are delivered to all who are at risk and not to those</td>
</tr>
<tr>
<td></td>
<td></td>
<td>who are not</td>
</tr>
<tr>
<td>Advise</td>
<td>Motivation</td>
<td>Advise, especially from a physician, has the power to motivate a quit</td>
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<tr>
<td></td>
<td></td>
<td>attempt</td>
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<tr>
<td>Assess</td>
<td>Evaluation</td>
<td>Helps determine the intensity of the intervention</td>
</tr>
<tr>
<td>Assist</td>
<td>Exploration</td>
<td>Helps tailor cessation supports to meet the user’s unique needs</td>
</tr>
<tr>
<td>Arrange</td>
<td>Follow-up</td>
<td>Knowledge of future meetings is itself a motivation to succeed. Also</td>
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<td></td>
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<td>provides an opportunity to fine-tune the treatment plan</td>
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Screening

1. What screening instrument does the DTC use?
2. Does the screener ask about nicotine?
3. Can you add it?
4. Is tobacco use screened for in some other location?
   a) Prisons and some large jail systems have (quasi-)independent health services
   b) Some DTCs refer to specific behavioral health providers/orgs that might do basic screening during enrollment
Referral

1. What is the referral process the DTC uses?
2. Do they use a specific database of resources? Contracts or MOUs?
3. Do they already refer to the ASHline?
4. Do they refer to a community-based behavioral health organization?
   a) For drug counseling?
   b) For other mental health-related counseling?
   c) For tobacco cessation?
CASE STUDY 3

- Validated assessment instrument
- List of resource providers
- Better match between service and needs
- Better case manager retention
Tobacco Use Interventions

- Clinician advice
- Cognitive-Behavioral Therapy & Motivational Interviewing
- Individual counseling
  - > 4 sessions, > 10 minutes
- Psycho-educational groups
- Telephonic counseling
- Peer support
- Age-tailored self-help materials
- Cessation medications

- Screening
- Assessment
- Education
The 5As in the Health Neighborhood: Criminal Justice Involved
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