

## Note

### **Treating the Disease or Punishing the Criminal?: Effectively Using Drug Court Sanctions To Treat Substance Use Disorder and Decrease Criminal Conduct**

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In 1969, forty-four percent of individuals entering the District of Columbia jail system tested positive for heroin, a statistic used to link substance use to crime.<sup>1</sup> Two years later, President Nixon declared a “war on drugs,” attempting to address substance abuse and its negative impact on society.<sup>2</sup> Despite the ongoing “war on drugs,” thirty-five years after its inauguration over half of all state inmates abused drugs the year before their admission to prison.<sup>3</sup> The lack of change in the correlation between drug use and criminal activity in those thirty-five years suggests that traditional threats of punishment and probation do not deter drug use by the majority of individuals

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1. See *Thirty Years of America's Drug War*, FRONTLINE, <http://www.pbs.org/wgbh/pages/frontline/shows/drugs/cron> (last visited Nov. 2, 2014); see also JANINE M. ZWEIG ET AL., URBAN INST., 2 THE MULTI-SITE ADULT DRUG COURT EVALUATION: WHAT'S HAPPENING WITH DRUG COURTS? A PORTRAIT OF ADULT DRUG COURTS IN 2004, at 7 (Janine M. Zweig et al. eds., 2011) (“A large and impressive research literature shows that substance use and abuse are linked to crime and criminal behavior.”).

2. *Thirty Years of America's Drug War*, *supra* note 1.

3. Press Release, Bureau of Justice Statistics, Methamphetamine Use Increasing Among State and Federal Prisoners (Oct. 11, 2006), <http://www.bjs.gov/content/pub/press/dudsfp04pr.cfm> (finding fifty-three percent of state inmates and forty-five percent of federal inmates had abused or been addicted to drugs the year prior to admission to prison).

struggling with addiction. Something other than the President's war on drugs and long periods of jail time was needed to address the correlation between addiction and incarceration.<sup>4</sup> A possible solution emerged in Miami in 1989, with the first drug court.<sup>5</sup>

Evidence suggests that drug courts can successfully reduce drug use and criminal behavior, both during and after a defendant's drug court participation.<sup>6</sup> Due to its apparent success, the drug court model has been replicated in a variety of "problem-solving courts," which address conditions, such as alcoholism and mental illness, that contribute to criminal activity.<sup>7</sup> Drug courts obtain results by integrating treatment, close supervision, frequent drug testing, sanctions for court violations, and incentives for compliant behavior.<sup>8</sup> Although drug courts achieve desirable results for both the participants and society as a whole, the rules governing responses to court violations vary greatly among courts and are not grounded in recent medical definitions of substance use disorder.<sup>9</sup> The lack of consistent administration of sanctions and termination from drug courts leaves appellate courts with little guidance when fielding challenges from drug court participants.<sup>10</sup> Drug courts are filling a unique and essential niche in the criminal justice system yet are vulnerable to criticism because of this procedural inconsistency.<sup>11</sup>

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4. See JEFF TAUBER & C. WEST HUDDLESTON, NAT'L DRUG COURT INST., *DUI/DRUG COURTS: DEFINING A NATIONAL STRATEGY*, at vii (Mar. 1999) (noting the success of drug courts in "slow[ing] the revolving door" of the criminal justice system).

5. JEFFREY TAUBER & KATHLEEN R. SNAVELY, NAT'L DRUG COURT INST., *DRUG COURTS: A RESEARCH AGENDA 1* (Apr. 1999).

6. *Id.* at 2.

7. See Mitchell B. Mackinem & Paul Higgins, *Introduction to PROBLEM-SOLVING COURTS: JUSTICE FOR THE TWENTY-FIRST CENTURY?* vii-x (Paul Higgins & Mitchell B. Mackinem eds., 2009); see also TAUBER & HUDDLESTON, *supra* note 4, at vii (recommending the development of DUI courts based on the drug court model).

8. TAUBER & HUDDLESTON, *supra* note 4, at 4.

9. See TAUBER & SNAVELY, *supra* note 5, at 6 (recognizing the need for additional research on rules governing sanctions and incentives).

10. *E.g.*, *Washington v. Cassill-Skilton*, 94 P.3d 407, 410 (Wash. Ct. App. 2004).

11. See, e.g., Eric J. Miller, *Drugs, Courts, and the New Penology*, 20 *Stan. L. & Pol'y Rev.* 417, 418 (2009) ("[D]rug courts . . . rest upon a series of controversial methodological assumptions underlying the selection of the court as the locus of treatment provision and management. The court's methodology implicates political issues of coercion and freedom . . .").

Due to their continued expansion, it appears as though drug courts are here to stay. Even assuming, however, that drug courts are a normatively positive alternative to traditional probation and punishment, there inevitably will be individuals who cannot resist the impulse to use drugs and thus violate the conditions of the drug court. Although scholarship has focused on the structure of the drug court, there is currently a lack of scholarship regarding how to administer the procedures in drug court, assuming the courts' structure is jurisprudentially sound. There is also a lack of scholarship regarding how to best respond to those individuals who are unable to comply with the conditions of the court. This Note fills that current gap in scholarship, addressing a specific type of drug court: a court that only admits participants with diagnosed severe substance use disorder; a court that admits participants based on their disease, rather than the crimes they have committed;<sup>12</sup> and a court with a medical professional or treatment representative as a member of the drug court team, present to inform the judge of the medical nature of certain court violations.<sup>13</sup>

This Note argues that sanction administration in drug courts can and should be different from the processes in other criminal proceedings and traditional probation because of the need to treat participants' underlying disease. Part I discusses medical advances in addiction studies, the evolution of drug courts, procedures in those courts, and recent probation reform. Part II analyzes innovations in probation and drug courts, specifically the procedures for responding to probation and drug court violations. Part III introduces a procedure for administer-

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12. When discussing model drug courts throughout, I will refer to them simply as drug courts. I limit my analysis to that specific type of drug court because it is limited by the severity of the disease of the participant. As further developed below, my proposal requires comparing the nature of the disease with the nature of the violation when determining drug court sanctions. Thus, although this Note's solution could be applied in other contexts, it will be most relevant and applicable for drug courts that restrict their participants to those diagnosed with severe substance use disorder. Currently only thirty-eight percent of drug courts are limited to those diagnosed as "addicted" or "dependent." ZWEIG ET AL., *supra* note 1, at 27.

13. Treatment is recognized as a "primary function" of drug courts and is the major activity drug court participants must participate in. *Id.* at 48.

This Note also assumes that the two primary goals of drug courts are rehabilitation and crime prevention. Drug courts present a unique opportunity to achieve both goals, because treating the underlying disease of substance use disorder increases the likelihood of rehabilitation and reintegration into society and decreases the likelihood of future crimes and harm to society. *See infra* note 37 and accompanying text.

ing sanctions in drug courts that incorporates medical knowledge of substance use disorder and the benefits such a system would have on not only court participants but also appellate courts. Additionally, Part III responds to potential concerns with this Note's proposed solution. This Note ultimately proposes that the procedure for administering sanctions should vary based upon whether the sanction is in response to a disease-driven act or a non-disease-driven act, to better reflect and uphold drug courts' unique role in treating severe substance use disorder, an underlying cause of criminal activity.

## I. THE EVOLUTION OF DRUG COURTS AND PROBATION REFORM

Drug courts emerged to address addiction and its correlation to criminal activity. In order to understand the purpose of drug courts within the broader context of probation and sentencing, it is important to first understand the disease of substance use disorder, the history of drug courts, and the differences between drug courts and traditional probation. Section A begins by discussing the disease of substance use disorder, commonly referred to as addiction. Section B addresses the emergence of drug courts, including their procedures, structures, and the way they integrate an understanding of substance use disorder into the disposition of a case. Finally, Section C discusses some of the challenges facing probation and recent innovations in probation.

### A. THE NATURE OF ADDICTION

Substance use disorder, commonly referred to as addiction, is a "misunderstood and deadly disease."<sup>14</sup> Despite the beliefs of some skeptics<sup>15</sup> and Supreme Court dicta,<sup>16</sup> in 2011 the Ameri-

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14. Marvin D. Seppala, *Addiction: The Disease That Lies*, CNN HEALTH (July 16, 2013, 6:02 PM), <http://www.cnn.com/2013/07/15/health/addiction-relapse-cory-monteith>; see also Peter W. Kalivas & Charles O'Brien, *Drug Addiction as a Pathology of Staged Neuroplasticity*, 33 NEUROPSYCHOPHARMACOLOGY 166, 166 (2008) ("The last 20 years of research has made it clear that addiction to drugs is based on pathological changes in brain function produced by repeated pharmacological insult to the brain circuits that regulate how a person interprets and behaviorally responds to motivationally relevant stimuli.").

15. See, e.g., NAT'L INSTS. OF HEALTH, RETHINKING DRINKING: ALCOHOL AND YOUR HEALTH, NIH Pub. No. 13-3770, at 1 (2010) (suggesting that most people can quit drinking without professional treatment); Morris B. Hoffman, *The Drug Court Scandal*, 78 N.C. L. REV. 1437, 1469-74 (2000) (summarizing criticisms of the disease theory of addiction); Stanton Peele, *Ain't Misbehavin'*:

can Society of Addiction Medicine redefined addiction as a brain disease, as opposed to a social or behavioral disorder.<sup>17</sup> Additionally, in 2013 the American Psychiatric Association released the Fifth Edition of the Diagnostic and Statistical Manual of Mental Disorders (DSM-V), containing new nomenclature and criteria for diagnosing addiction.<sup>18</sup> As currently defined by leading medical literature, addiction, or substance use disorder, is a “primary, chronic disease of brain reward . . . and related circuitry. . . characterized by inability to consistently abstain.”<sup>19</sup> The DSM-V lists eleven diagnostic criteria for substance use disorder, divided into four categories:

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*Addiction Has Become an All-Purpose Excuse*, 29 SCIENCES 14, 16 (1989) (“[R]epeated attempts to prove that addiction is a clear-cut medical condition have been, at best, inconclusive.”); David J. Hanson, *Is Alcoholism a Disease?*, ALCOHOL PROBS. & SOLUTIONS, <http://www2.potsdam.edu/alcohol/Controversies/Is-Alcoholism-a-Disease.html> (last visited Nov. 2, 2014) (arguing that the medical definition of addiction is sociological and fluctuates, and the disease model was put forward to “provide[] an excuse and relieve[] [addicts] of responsibility for their behaviors”).

16. See *Traynor v. Turnage*, 485 U.S. 535, 550–51 (1988) (discussing the split of medical authority regarding whether alcoholism is a disease, and stating that there is little evidence that alcohol use is involuntary and that addicts are not responsible for their use). It should be noted that this case is over fifteen years old, and therefore lacks the benefit of medical research regarding addiction.

17. *Addiction Now Defined as Brain Disorder, Not Behavior Problem*, LIVE SCIENCE (Aug. 15, 2011, 10:32 AM), <http://www.livescience.com/15563-addiction-defined-brain-disease.html>. The American Society of Addiction Medicine redefined addiction after a four-year study that involved over eighty experts. *Id.*

18. See AM. PSYCHIATRIC ASS’N, *DSM-5 Implementation and Support*, DSM-5 DEV., <http://www.dsm5.org> (last visited Nov. 27, 2014) (released May 2013); see also Charles O’Brien, *Addiction and Dependence in DSM-V*, 106 ADDICTION 866, 867 (2010) (discussing changes to the definition of addiction in DSM-V).

19. Am. Soc’y of Addiction Med., *Public Policy Statement: Definition of Addiction* 1 (Aug. 15, 2011), [http://www.asam.org/docs/public-policy-statements/1definition\\_of\\_addiction\\_long\\_4-11.pdf](http://www.asam.org/docs/public-policy-statements/1definition_of_addiction_long_4-11.pdf); see AM. PSYCHIATRIC ASS’N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS: DSM-5 483 (5th ed. 2013) [hereinafter DSM-V], available at <http://dsm.psychiatryonline.org/content.aspx?bookid=556&sectionid=41101782#103440577> (“An important characteristic of substance use disorders is an underlying change in brain circuits that may persist beyond detoxification, particularly in individuals with severe disorders.”); see also Alan I. Leshner, *Addiction Is a Brain Disease, and It Matters*, 278 SCIENCE 45, 46 (1997) (arguing that because addiction is tied to changes in brain structure and function, it is primarily a brain disease); Seppala, *supra* note 14 (“[A]ddiction is a brain disease . . . [that] resides in the limbic system, a subconscious part of our brain that is involved with memory, emotion and reward.”). *But see* Gene M. Heyman, *Is Addiction a Chronic, Relapsing Disease?*, in DRUG ADDICTION AND DRUG POL-

## (A) Impaired Control

- (1) consume more than intended;
- (2) desire to cut down but unsuccessful at doing so;
- (3) great deal of time revolves around substance and use;
- (4) cravings;

## (B) Social Impairment

- (5) failure to fulfill obligations;
- (6) continued use despite persistent social or interpersonal problems;
- (7) give up important social activities to use;

## (C) Risky Use

- (8) use when physically hazardous;
- (9) use despite physical and psychological problem exacerbated by use;

## (D) Pharmacological Criteria

- (10) increased tolerance;
- (11) withdrawal.<sup>20</sup>

An individual experiencing six or more simultaneous symptoms—described by DSM-V as an individual who chronically relapses—has “severe” substance use disorder.<sup>21</sup> Because substance use disorder is a brain disease, treatment must reverse or compensate for brain changes.<sup>22</sup> Also, because substance use disorder is a chronic disease, relapses are the “norm” in early recovery.<sup>23</sup>

Substance use disorder not only affects the drug user’s health and functionality but also affects society as a whole.

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ICY 81, 107 (Philip B. Heymann & William N. Brownsberger eds., 2001) (arguing that referring to addiction as a brain disease minimizes or does not account for those who quit and recover from their addiction).

20. DSM-V, *supra* note 19, at 481–84.

21. Severe substance use disorder is similar to the term “addiction.” The term “addiction,” however, was omitted from DSM-V because of its uncertain definition and negative connotations. *Id.* at 485. Throughout this Note, I use the term “addiction” and “severe substance use disorder” interchangeably.

22. Leshner, *supra* note 19, at 46; *see also* SHELLI B. ROSSMAN ET AL., URBAN INST., 3 THE MULTI-SITE ADULT DRUG COURT EVALUATION: THE DRUG COURT EXPERIENCE 40 (Shelli B. Rossman et al. eds., 2011) [hereinafter ROSSMAN ET AL., THE DRUG COURT EXPERIENCE] (discussing the complexity of treatment and the importance of addressing both the underlying addiction and how to become a functioning member of society).

23. Leshner, *supra* note 19, at 46.

Many addicts commit crimes to finance their addiction<sup>24</sup> or commit crimes while under the influence of a substance.<sup>25</sup> Individuals suffering from addiction flood traditional corrections systems, with high rates of recidivism the norm—criminal behavior and its resultant costs to society are thus intertwined with severe substance use disorder.<sup>26</sup> Drug courts emerged to relieve the traditional corrections system and address both problems in one forum.

#### B. DRUG COURTS AND THE ADMINISTRATION OF SANCTIONS IN THOSE COURTS

The war on drugs and subsequent implementation of zero tolerance approaches to drug use dramatically increased arrests and incarceration for drug offenses as early as the 1960s.<sup>27</sup> Not only was the incarceration increase costly for taxpayers<sup>28</sup> but it also resulted in “increased poverty, neglected families, and . . . [other] problems for already disadvantaged neighborhoods.”<sup>29</sup> Because traditional courts lacked effective tools to deal with the underlying nature of severe substance use disorder, drug courts emerged to fill the missing niche in the correctional system.<sup>30</sup>

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24. William N. Brownsberger, *Drug Users and Drug Dealers*, in *DRUG ADDICTION AND DRUG POLICY* 51, 67–68 (Philip B. Heymann & William N. Brownsberger eds., 2001).

25. *Id.*

26. See, e.g., DOUG McVAY ET AL., JUSTICE POLICY INST., TREATMENT OR INCARCERATION: NATIONAL AND STATE FINDINGS ON THE EFFICACY AND COST SAVINGS OF DRUG TREATMENT VERSUS IMPRISONMENT 6–10 (2004), available at [http://www.justicepolicy.org/uploads/justicepolicy/documents/04-01\\_rep\\_mdtreatmentorincarceration\\_ac-dp.pdf](http://www.justicepolicy.org/uploads/justicepolicy/documents/04-01_rep_mdtreatmentorincarceration_ac-dp.pdf).

27. See Greg Berman, *Problem-Solving Justice and the Moment of Truth*, in *PROBLEM-SOLVING COURTS: JUSTICE FOR THE TWENTY-FIRST CENTURY?* 1, 8 (Paul Higgins & Mitchell B. Mackinem eds., 2009); Richard C. Boldt, *A Circumspect Look at Problem-Solving Courts*, in *PROBLEM-SOLVING COURTS: JUSTICE FOR THE TWENTY-FIRST CENTURY?* 13, 25 (Paul Higgins & Mitchell B. Mackinem eds., 2009) (finding that the war on drugs impacted the case load and day-to-day functioning of traditional courts).

28. See Berman, *supra* note 27, at 8 (estimating that United States taxpayers could save forty-six billion dollars if addicted defendants in the criminal justice system were linked to treatment instead of incarceration).

29. JOANN MILLER & DONALD C. JOHNSON, *PROBLEM SOLVING COURTS: A MEASURE OF JUSTICE* 32 (2009).

30. See Boldt, *supra* note 27, at 13; see also John A. Bozza, *Benevolent Behavior Modification: Understanding the Nature and Limitations of Problem-Solving Courts*, 17 *WIDENER L. J.* 97, 104 (2007) (arguing that two aspects of drug courts differentiate them from traditional probation: (1) the systematic use of behavioral consequences; and (2) the consistent involvement of judges to

Drug courts are special dockets within a court system that serve addicted individuals.<sup>31</sup> Most require both an eligible charge<sup>32</sup> and a clinical assessment to participate.<sup>33</sup> Participants undergo random drug and alcohol testing, some form of treatment, and intensive (highly structured and supervised) probation.<sup>34</sup> Since the first drug court was implemented in 1989,<sup>35</sup> not only has the number of drug courts greatly expanded but problem-solving courts for a variety of anti-social conditions, such as alcoholism and mental illness, have also been implemented.<sup>36</sup> The proliferation of drug courts and problem-solving courts is due in large part to reduced recidivism rates and net costs to the government,<sup>37</sup> although skeptics have challenged the empirical validity of statistics regarding drug court effica-

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dispense consequences). *But see* Hoffman, *supra* note 15, at 1440 (arguing that jurisdictions rushed to implement drug courts without seriously considering their effectiveness).

31. *See, e.g.*, WEST HUDDLESTON & DOUGLAS B. MARLOWE, NAT'L DRUG COURT INST., PAINTING THE CURRENT PICTURE: A NATIONAL REPORT ON DRUG COURTS AND OTHER PROBLEM-SOLVING COURTS IN THE UNITED STATES 7 (2011).

32. Eligible charges may include nonviolent drug offenses, theft, or other crimes stemming from the participant's underlying addiction. *Id.*

33. ZWEIG ET AL., *supra* note 1, at 3. An eligible charge most often means a non-violent offense. *Id.*

34. HUDDLESTON & MARLOWE, *supra* note 31, at 7.

35. TAUBER & SNAVELY, *supra* note 5, at 1.

36. *See* Mackinem & Higgins, *supra* note 7, at ix (noting the existence of 3,204 problem-solving courts and 2,147 drug courts by 2007); *see also* TAUBER & HUDDLESTON, *supra* note 4, at x (expanding drug court philosophy to DUI courts in 1998). Problem-solving courts have been defined as "[L]ocal courts that seek to remedy detrimental community conditions through sustained attention and . . . therapeutic interventions with individual offenders who experience debilitating personal conditions." Mackinem & Higgins, *supra* note 7, at vii. Although there are various models for drug courts, the majority (fifty-eight percent) follow a post-plea model. HUDDLESTON & MARLOWE, *supra* note 31, at 1.

37. *See* TAUBER & SNAVELY, *supra* note 5, at 2 (finding drug courts both successful at engaging and retaining felony offenders and cost-effective); David J. Hanson, *DWI Courts: Effectively Addressing Drunk Driving*, in PROBLEM-SOLVING COURTS: JUSTICE FOR THE TWENTY-FIRST CENTURY? 73, 84 (Paul Higgins & Mitchell B. Mackinem eds., 2009) (finding DUI court participants four times less likely to receive another DUI than non-DUI court participants); Mitchell B. Mackinem & Paul Higgins, *Adult Drug Courts: A Hope Realized?*, in PROBLEM-SOLVING COURTS: JUSTICE FOR THE TWENTY-FIRST CENTURY? 33, 41 (Paul Higgins & Mitchell B. Mackinem eds., 2009) (finding an average reduction of thirty-two percent in recidivism as compared to non-drug court participants). *See generally* HUDDLESTON & MARLOWE, *supra* note 31, at 9–10 (synthesizing various research on the effectiveness of drug courts at both reducing crime and saving the government money).



cy.<sup>38</sup> The growth in drug courts may also reflect a broader transition from punitive and retributive punishment to therapeutic and restorative justice,<sup>39</sup> reflected in the most recent drafts of the Model Penal Code.<sup>40</sup> Research repeatedly focuses on reductions in recidivism and cost saving to the government.<sup>41</sup> But the National Drug Court Institute recognizes that there is less research regarding the structural design of drug court programs and the application of sanctions to court participants.<sup>42</sup>

Principles such as collaboration, enhanced information, community engagement, individualized justice, accountability, and treatment outcomes universally guide drug courts,<sup>43</sup> but the implementation of courts varies dramatically state-to-state.<sup>44</sup> To ensure participant accountability and eventual graduation from—or completion of—drug courts, all drug courts administer graduated sanctions, a system of increasingly adverse consequences for subsequent violations,<sup>45</sup> to respond to violations of the drug court contract.<sup>46</sup> Sanctions are defined as penalties, “specified or in the form of moral pressure, that act[] to ensure compliance or conformity.”<sup>47</sup> The entire drug court

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38. See, e.g., Hoffman, *supra* note 15.

39. See Mackinem & Higgins, *supra* note 7, at viii; see also MILLER & JOHNSON, *supra* note 29, at 19 (noting that problem-solving courts derive from multiple legal positions, including legal pragmatism, therapeutic jurisprudence, law-and-literature, and legal realism). Although problem-solving courts arguably derive from many legal positions, this Note assumes that therapeutic and restorative justice are the guiding principles of problem-solving courts.

40. MODEL PENAL CODE: SENTENCING, reporters' intro. at xx-xxiii (Tentative Draft No. 3, 2014) (on file with author).

41. See, e.g., MCVAY, *supra* note 26, at 6–10.

42. TAUBER & SNAVELY, *supra* note 5, at 5, 6 (noting the need to assess “the structural design of drug court programs” and the varying application and rules regarding sanctions).

43. See Berman, *supra* note 27, at 2–3 (listing underlying principles); Mackinem & Higgins, *supra* note 7, at viii (discussing the importance of collaboration).

44. See TAUBER & SNAVELY, *supra* note 5, at 1.

45. Adele Harrell & John Roman, *Reducing Drug Use and Crime Among Offenders: The Impact of Graduated Sanctions*, 31 J. DRUG ISSUES 207, 209 (2001). For a history of the meaning of the term graduated sanctions see Faye S. Taxman et al., *Graduated Sanctions: Stepping Into Accountable Systems and Offenders*, 79 PRISON J. 182, 184–86 (1999).

46. See TAUBER & SNAVELY, *supra* note 5, at 6 (“The application of sanctions and incentives is universal among drug courts . . .”); Christine H. Lindquist et al., *Sanctions and Rewards in Drug Court Programs: Implementation, Perceived Efficacy, and Decision Making*, 36 J. DRUG ISSUES 119, 120 (2006).

47. AM. CORR. ASS'N, RECLAIMING OFFENDER ACCOUNTABILITY: INTERMEDIATE SANCTIONS FOR PROBATION AND PAROLE VIOLATORS 5 (Edward E. Rhine ed., 1993).

team—including the judge, prosecutor, defense attorney, probation officer, and treatment liaison—typically determines sanctions.<sup>48</sup> Although sanctions are a part of every drug court's program, the "rules governing their application vary."<sup>49</sup>

The diversity of sanctions used in drug courts exceeds sanctions traditionally used in courts, probation, and parole.<sup>50</sup> Although all drug courts rely on some form of graduated sanctions, potential sanctions range from a verbal reprimand or writing an essay to civil contempt, jail time, or termination from the court.<sup>51</sup> In particular, the use of jail as a sanction varies considerably, with some programs recommending no more than five days in jail, others no more than thirty, and many more with no ceiling on jail time.<sup>52</sup> This can lead to arbitrary or excessive punishment, undermining drug courts' validity and therapeutic efficacy.<sup>53</sup>

Another variation between drug courts is the predictability of sanctions. In some drug courts, the participation contract outlines violations and the sanctions they trigger.<sup>54</sup> In many

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48. Lindquist et al., *supra* note 46, at 139.

49. TAUBER & SNAVELY, *supra* note 5, at 6.

50. Lindquist et al., *supra* note 46, at 141.

51. *See id.* at 130 tbl.3; *List of Incentives and Sanctions*, NATIONAL DRUG COURT RESOURCE CENTER, <http://www.ndrc.org/content/list-incentives-and-sanctions> (last visited Nov. 2, 2014); *Sanctions and Incentives from Operational Drug Courts Throughout the Nation*, AM. U. JUST. PROGRAMS OFF., <http://jpo.wrlc.org/handle/11204/2388> (follow "3022.pdf" hyperlink) (last visited Nov. 2, 2014).

52. *See, e.g., Denver Drug Court Incentives and Sanctions Guidelines*, NAT'L DRUG CT. RESOURCE CENTER, <http://live-ndrc-nadcp.gotpantheon.com/content/denver-drug-court-incentives-and-sanctions-guidelines> (last visited Nov. 2, 2014) (thirty days maximum); *List of Incentives and Sanctions*, *supra* note 51 (five days maximum); RHODE ISLAND ADULT DRUG COURT, CONTRACT, <http://www.courts.ri.gov/PublicResources/forms/Superior%20Court%20Forms/Adult%20Drug%20Court%20-%20Contract.pdf> (last visited Nov. 2, 2014) (no maximum jail time).

53. *See, e.g., This American Life: Very Tough Love* (Mar. 25, 2011), available at [http://www.thisamericanlife.org/sites/default/files/TAL430\\_transcript.pdf](http://www.thisamericanlife.org/sites/default/files/TAL430_transcript.pdf) (describing a particularly punitive drug court, where the judge imposed sanctions and jail sentences far more severe than the original charge permitted).

54. *See, e.g., DRUG COURT: DEFENSE PACKET MATERIALS*, available at <http://www.co.clark.wa.us/courts/documents/DRUGCOURTOPT-INPACKET.pdf> (last visited Sept. 28, 2014) (differentiating sanctions based on the number of positive urinalyses and the phase of the drug court program the participant is in); *see also* Jeremy Travis, *But They All Come Back: Rethinking Prisoner Reentry*, SENT'G & CORRECTIONS: ISSUES FOR THE 21ST CENTURY 5 (May 2000), available at <https://www.ncjrs.gov/pdffiles1/nij/181413.pdf> (describing drug court contract with specified sanctions).

others, however, the drug court agreement (or “contract”) is silent on when sanctions will be imposed, leaving broad discretion with the judge and team to determine sanctions on a case-by-case basis.<sup>55</sup> Both appellate courts and academics have challenged the variability in sanctions and termination from the court, currently undermining the legitimacy of problem-solving courts.<sup>56</sup> Ultimately, this variability raises the question: What procedure is best for both the participant and society as a whole?

### C. CHALLENGES FACING TRADITIONAL PROBATION

The need for probation violation reform has been recognized in traditional probation system. Sanctions are also an increasingly key component of probation and parole, and innovations in probation and parole can inform drug court procedures. Probation and parole violations contribute from thirty to eighty percent of new prison intakes and account for more than half of the growth in the correctional population since 1990.<sup>57</sup> Probation revocation policies therefore have a “significant impact on

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55. See *Dunson v. Commonwealth*, 57 S.W.3d 847, 849 (Ky. Ct. App. 2001) (“Decisions to terminate from Drug Court are made on a case-by-case basis and are not made according to precise guidelines.”); DRUG COURT AGREEMENT, MONTGOMERY COUNTY, MD., available at <http://www.montgomerycountymd.gov/circuitcourt/resources/files/drugcourtagreeementrevised.pdf> (silent on sanctions); see also William M. Burdon et al., *Drug Courts and Contingency Management*, 31 J. DRUG ISSUES 73, 78 (2001) (criticizing the imbalance between sanctions and rewards in active drug courts); Lindquist et al., *supra* note 46, at 133 (finding that the majority of judges preferred individualization of sanctions, based in part upon the participant’s compliance with the spirit of the program and commitment to recovery).

56. Harold Pollack et al., *How To Make Drug Court Work*, WASH. POST (Apr. 26, 2013 11:14 AM), <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/04/26/how-to-make-drug-courts-work> (arguing that sanctions can include lengthy terms of confinement and exceed traditional sentences). *But see* *State v. Perkins*, 661 S.E.2d 366, 367 (S.C. 2008) (stating that the state supreme court has no authority to “evaluate and assess the manner in which the [drug court] administrators execute the rules and regulations of the [drug court]”).

57. See, e.g., Faye S. Taxman et al., *Graduated Sanctions: Stepping Into Accountable Systems and Offenders*, 79 PRISON J. 182, 183 (1999); Angela Hawken & Mark Kleiman, *Managing Drug Involved Probationers with Swift and Certain Sanctions: Evaluating Hawaii’s HOPE*, NAT’L INST. OF JUSTICE, (Dec. 2, 2009), available at <https://www.ncjrs.gov/pdffiles1/nij/grants/229023.pdf>; see also Sadhbh Walshe, *Probation and Parole: A Study in Criminal Justice Dysfunction*, GUARDIAN (Apr. 26, 2012 3:50 30 PM), <http://www.theguardian.com/commentisfree/cifamerica/2012/apr/26/probation-parole-study-dysfunction> (finding that probation and parole violations accounted for over one-third of prison admissions in 2005, half due to new crimes and half due to technical violations of terms of release).

[the] prison population.”<sup>58</sup> As the probation system lacks efficient means to adjudicate single violations, the imposition of sanctions rarely occurs in traditional probation, and when imposed, sanctions tend to be “too rare and too delayed.”<sup>59</sup> When probationers can get away with violating the terms of probation without immediate consequence, they are less likely to comply with those conditions.<sup>60</sup> Because over half of probationers fail to comply with the terms of their release, there has been a movement toward graduated sanctions for violations of probation conditions.<sup>61</sup>

Graduated sanctions were introduced to increase compliance in traditional probation. The key deterrence principles of “certainty, swiftness, and progressiveness” guide graduated sanctions.<sup>62</sup> A predetermined sanctions “menu,” which forms a behavioral contract, outlines and mandates given sanctions.<sup>63</sup> The reduced discretion increases the certainty of the sanctions. In 2004, Hawaii became the first state to implement significant probation reform, through Project HOPE.<sup>64</sup> Project HOPE is a high-intensity supervision program characterized by swift, predictable, and immediate sanctions for detected violations.<sup>65</sup> Project HOPE has been referred to as a coerced abstinence program and is not as therapeutically focused or intensive as drug courts.<sup>66</sup> Project HOPE includes five significant innovations in the field of probation:

(1) an initial warning hearing, which informs participants each violation will result in jail time;

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58. AM. CORR. ASS'N, *supra* note 47, at vi.

59. Hawken & Kleiman, *supra* note 57, at 6; *see also* AM. CORR. ASS'N, *supra* note 47, at 6 (“[T]he messages we send can make all the difference between effective supervision and setting offenders up for failure.”); Steven S. Alm, *A New Continuum for Court Supervision*, 91 OR. L. REV. 1181, 1184 (2013) (suggesting that probation officers often delay administering sanctions until the offender can be characterized as “not amenable to probation”); Taxman et al., *supra* note 45, at 189 (arguing that when violations are not immediately addressed, offenders are less likely to adhere to conditions of probation).

60. *See* Taxman et al., *supra* note 45, at 189.

61. *Id.* at 184–85.

62. *Id.* at 187.

63. *Id.* at 190.

64. *Hope Probation*, HAWAII ST. JUDICIARY, [http://www.courts.state.hi.us/special\\_projects/hope/about\\_hope\\_probation.html](http://www.courts.state.hi.us/special_projects/hope/about_hope_probation.html) (last visited Nov. 2, 2014); *see also* Alm, *supra* note 59, at 1185.

65. *Id.*

66. *See* HUDDLESTON & MARLOWE, *supra* note 31, at 17.

- (2) swift hearings following violations;
- (3) treatment for those who cannot stop using drugs or alcohol on their own;<sup>67</sup>
- (4) the ability of judges to supervise large numbers of probationers; and
- (5) targeting the toughest populations.<sup>68</sup>

Participation in Project HOPE reduces the likelihood of recidivism and probation revocation.<sup>69</sup> Due to these successes, Project HOPE currently serves as a model for probation reform.

Traditionally, punitive punishment has not been effective at reducing incarceration rates for individuals on probation or individuals struggling with severe substance use disorder.<sup>70</sup> Fortunately, the movement toward graduated sanctions for probation violations, and diverting high-risk populations into drug courts, has proven that it is possible to lower the rates of incarceration and recidivism in historically highly incarcerated populations.<sup>71</sup> Drug courts currently employ graduated sanctions and progressive punishment, but not in a uniform way. A challenge facing drug courts is what sanction policy will facilitate recovery and reintegration for the largest possible number of offenders, without undermining public safety, and whether that sanction policy should be transparent and uniform. This challenge, and a possible solution for drug courts, is addressed below.

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67. It is important to note that treatment is not a core component of Project HOPE because Project HOPE is not specifically geared towards those who are addicted. Therefore, although parts of Project HOPE may inform sanctions in a drug court, the two systems are distinct and serve different needs. *See id.*

68. Alm, *supra* note 59, at 1185–86.

69. After one year, HOPE probationers were fifty-five percent less likely to be arrested for a new crime, seventy-two percent less likely to use drugs, sixty-one percent less likely to skip appointments with their probation officer, and fifty-three percent less likely to have their probation revoked. “*Swift and Certain*” *Sanctions in Probation Are Highly Effective: Evaluation of the HOPE Program*, NAT’L. INST. JUST. (Feb. 3, 2012) [hereinafter *Swift and Certain*], <http://www.nij.gov/topics/corrections/community/drug-offenders/Pages/hawaii-hope.aspx>.

70. *See* Leshner, *supra* note 19, at 46 (“If [addicts] have a brain disease, imprisoning them without treatment is futile. If they are left untreated, their recidivism rates to both crime and drug use are frighteningly high . . .”).

71. *See* Mackinem & Higgins, *supra* note 37, at 41; *Swift and Certain*, *supra* note 69.

## II. ATTEMPTS TO INTEGRATE KNOWLEDGE OF SUBSTANCE USE DISORDER AND DETERRENCE PRINCIPLES INTO THE CRIMINAL JUSTICE SYSTEM

Recently, there has been significant reform in the administration of sanctions in both probation and problem-solving courts.<sup>72</sup> Section A analyzes the use of graduated sanctions in probation, illustrated through Project HOPE. Section A concludes that although Project HOPE should inform drug court procedure, because Project HOPE does not specifically serve offenders suffering from severe substance use disorder, it should not be the sole model for sanctions in drug courts. Section B discusses the wide array of sanctions currently used in drug courts and the ways in which many of those sanctions do not align with current medical knowledge of severe substance use disorder.

### A. A LESSON FROM PROBATION REFORM

Project HOPE leads the reform movement in traditional probation. This Section analyzes the extent to which Project HOPE's procedures should be incorporated into a model drug court. Subsection A.1 analyzes swift hearings following court violations and Subsection A.2 analyzes the extent to which Project HOPE's deterrence principles apply to a model drug court population. This Section concludes that swift hearings should be an essential component of drug court procedures, but sanctions and deterrent principles must be modified to reflect the drug court population, as opposed to Project HOPE's general population.

#### 1. The Importance of Swift and Certain Hearings

Project HOPE's success is due in part to its integration of deterrence theory into the probation program. The effectiveness of sanctions increases with the swiftness and certainty of the sanction.<sup>73</sup> Project HOPE participants receive both swift and

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72. See *infra* Parts II.A, II.B.

73. See Dale A. Parent, *Structuring Policies To Address Sanctions for Absconders and Violators*, in AM. CORR. ASS'N, *supra* note 47, at 7, 10; Harold G. Grasmick & George J. Bryjak, *The Deterrent Effect of Perceived Severity of Punishment*, 59 SOC. F. 471, 471 (1980); see also Raymond Paternoster, *Decisions To Participate in and Desist from Four Types of Common Delinquency: Deterrence and the Rational Choice Perspective*, 23 LAW & SOC'Y REV. 7, 9 (1989) ("The active decision maker is . . . repeatedly making offending decisions, which may be affected by . . . an ongoing reassessment of sanction threats.").

certain sanctions following violations. The general principle that guides the warning hearing and swift hearings is consistency.<sup>74</sup> Participants are told at the warning hearing that they “can count on a jail sanction for every violation.”<sup>75</sup> Then, the general consistent message introduced at the warning hearing is enforced through “swift hearings”<sup>76</sup>—over seventy percent of hearings are held within seventy-two hours of a detected violation.<sup>77</sup> At those hearings, probationers are sentenced to a certain amount of time in jail, which increases with each successive violation.<sup>78</sup> This is starkly different from the traditional probation response, where probation violations pile up until the court intervenes with a revocation hearing—a drastic response—substantially after the initial violations.<sup>79</sup> Project HOPE’s swift response and certainty of jail time moved away from the traditional revocation hearing response, thereby increasing the likelihood of compliance with probation conditions.<sup>80</sup>

Although Project HOPE has been incredibly successful for populations of offenders that previously violated probation, especially individuals charged with serious felonies, it is not explicitly for individuals suffering from severe substance use disorder.<sup>81</sup> Recognizing the need for additional treatment and supervision for “chronically addicted offenders,” Hawaii has a separate drug court specifically for individuals with substance use disorder.<sup>82</sup> Therefore, although some procedures in Project HOPE should inform drug court procedures, it is important to consider the underlying assumptions guiding the “swift” and “certain” response and whether those assumptions are as applicable to a drug court population limited to individuals with severe substance use disorder.

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74. See Alm, *supra* note 59, at 1186; Hawken & Kleiman, *supra* note 57, at 9.

75. Alm, *supra* note 59, at 1185 n.13. Those violations include, but are not limited to, failing a drug test, failing to meet with a probation officer, and not going to treatment. See, e.g., Hawken & Kleiman, *supra* note 57, at 56.

76. Alm, *supra* note 59, at 1185.

77. *Id.*

78. *Swift and Certain*, *supra* note 69.

79. See, e.g., Taxman et al., *supra* note 45 (“The probation system’s failure to respond to noncompliant probationers encourages defiance by creating an environment that tolerates inattention to the importance of adherence to the release conditions.”).

80. See *id.* at 183.

81. See Alm, *supra* note 59, at 1187–88.

82. *Id.*

## 2. The (In)Applicability of Deterrence Principles to Individuals with Severe Substance Use Disorder

The underlying assumption of deterrence theory—that an active and rational decision maker makes the choice to re-offend or use based on a given sanction<sup>83</sup>—does not apply with the same force to individuals suffering from severe substance use disorder, who are unable to control the impulse to use a substance in response to certain stimuli.<sup>84</sup> Severe substance use disorder is characterized by an “impairment in behavioral control, craving, [and] diminished recognition of significant problems with one’s behavior . . . .”<sup>85</sup> There is a cognitive break down in reasoning that leads to “compulsive” use.<sup>86</sup> Although Project HOPE participants receive jail time for every violation,<sup>87</sup> the possibility of one night in jail may not effectively deter an individual suffering from severe substance use disorder because that individual has less control over the impulse to use depending on the nature of the situation and relevant stimuli.<sup>88</sup> Additionally, spending time in jail does not treat the underlying addiction and impulse to use drugs.<sup>89</sup> Drug court sanctions must be implemented so that instead of merely punishing a person for relapsing—a predictable and compulsive act for an individual with severe substance use disorder—the sanctions treat and respond to the chemical addiction, especially during early phases of abstinence.<sup>90</sup>

Project HOPE, however, does not implement “certain” sanctions solely for their deterrent effect. The other benefit of

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83. *Cf.* Paternoster, *supra* note 73, at 9 (describing an active decision maker in the sanction evaluation process).

84. *See* DSM-V, *supra* note 19, at 485 (describing an individual with severe substance use as “chronically relapsing” and compulsively taking drugs).

85. *See, e.g.*, Am. Soc’y of Addiction Med., *supra* note 19, at 1.

86. *See* Steven E. Hyman, *The Neurobiology of Addiction: Implications for Voluntary Control of Behavior*, 7 *AM. J. BIOETHICS* 8, 9–10 (2007) (discussing the impact of addictive drugs on the prefrontal cortex and cognitive control).

87. Alm, *supra* note 59, at 1185 n.13.

88. *Cf.* Kalivas & O’Brien, *supra* note 14, at 166 (describing how addictive drugs impact behavioral responses). That is not to say that jail is never an appropriate sanction. Jail as a potential sanction has been a key component of the success of drug courts. *See* ROSSMAN ET AL., *THE DRUG COURT EXPERIENCE*, *supra* note 22, at 86. As discussed in Part III, jail should be used in response to certain violations. *See infra* Part III.

89. Leshner, *supra* note 19, at 46 (“[I]f we know that criminals are drug addicted, it is no longer reasonable to simply incarcerate them. If they have a brain disease, imprisoning them without treatment is futile.”).

90. *See* Leshner, *supra* note 19, at 46.



certain sanctions is that the certainty of the sanctions increases participants' perception of a just and fair program.<sup>91</sup> Procedural justice—the idea that participants are more likely to view the criminal justice system positively if they believe that their case was processed in a fair manner—also guides the certainty aspect of Project HOPE.<sup>92</sup> This fairness increases compliance with the program and participants' positive perception of the program.<sup>93</sup> Because drug court participants are likewise more likely to comply if they believe they are being treated in a fair manner, it is important that the administration of sanctions in drug courts is guided by principles of procedural justice.<sup>94</sup>

Drug courts currently utilize some, but not all, of the procedures implemented in Project HOPE.<sup>95</sup> There are, however, elements from Project HOPE that should be integrated into drug court procedures to produce courts that are more effective.

#### B. CURRENT PROCEDURES FOR ADMINISTERING SANCTIONS IN DRUG COURTS

The procedures for administering sanctions vary greatly among drug courts. However, some general trends can guide a discussion of drug court sanctions. As is discussed below, the majority of drug courts do not have a written schedule of sanctions or provide that schedule to participants,<sup>96</sup> do not clearly differentiate between disease-driven and non-disease-driven acts when administering sanctions,<sup>97</sup> and do not respond to violations as “swiftly” as Project HOPE.

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91. See Alm, *supra* note 59, at 1186.

92. Cf. ROSSMAN ET AL., THE DRUG COURT EXPERIENCE, *supra* note 22, at 84–85 (describing procedural justice).

93. See Alm, *supra* note 59, at 1186.

94. See ROSSMAN ET AL., THE DRUG COURT EXPERIENCE, *supra* note 22, at 85 (noting that drug court participants are more likely to comply with the program if they believe they are being treated in a fair manner).

95. See, e.g., MINN. JUDICIAL COUNCIL, MINNESOTA OFFENDER DRUG COURT STANDARDS 6–8 (2009), available at [http://www.mncourts.gov/Documents/0/Public/Problem\\_Solving\\_Courts/Offender\\_Drug\\_Court\\_Standards\\_-\\_031109.pdf](http://www.mncourts.gov/Documents/0/Public/Problem_Solving_Courts/Offender_Drug_Court_Standards_-_031109.pdf) (discussing behavioral contract, graduated sanctions, and swift hearings).

96. See *infra* Part II.B.1.

97. See *infra* Part II.B.2.

## 1. The Drug Court Contract

Although most drug courts require a written contract to participate,<sup>98</sup> the majority of those contracts do not include a schedule for the administration of sanctions.<sup>99</sup> Written schedules for sanctions are considered a “best practice” for drug courts, but “just under half of courts have written schedules of sanctions . . . and, only two-thirds of those that do provide their written schedules to the participants.”<sup>100</sup> By not providing a “sanction menu” to drug court participants, drug courts are not ensuring a “certain” response, therefore decreasing the deterrent effect of sanctions and participants’ perception of fairness.<sup>101</sup> Evidence from Project HOPE suggests that the drug courts with high-predictability sanctions are the most likely to deter noncompliance with drug court conditions. However, empirical evidence from the Multi-Site Drug Court Evaluation (MADCE) calls that assumption into question.

Recognizing the array of outcome achievement among drug courts, the MADCE studied the impact of specific policies and practices on drug court participant outcomes.<sup>102</sup> Data was compiled from the MADCE Adult Drug Court Survey and from interviews with 1,781 offenders across twenty-three drug courts.<sup>103</sup> The MADCE found that medium-predictability sanctions (as opposed to high or low-predictability) have the greatest impact on reducing crime and subsequent drug use.<sup>104</sup>

The study on the predictability of sanctions<sup>105</sup> found statis-

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98. See, e.g., Travis, *supra* note 54, at 5.

99. See ZWEIG ET AL., *supra* note 1, at 59 (finding that only 44.4% of drug courts have written schedules for sanctions, and only 67.1% of courts that do have a sanction menu publish that schedule to drug court participants); see, e.g., DRUG COURT AGREEMENT, MONTGOMERY COUNTY, MD., available at <http://www.montgomerycountymd.gov/circuitcourt/resources/files/drugcourtagreementrevised.pdf> (silent on sanctions).

100. ZWEIG ET AL., *supra* note 1, at 5.

101. See Parent, *supra* note 73; Harold G. Grasmick & George J. Bryjak, *The Deterrent Effect of Perceived Severity of Punishment*, 59 Soc. F. 471, 471 (1980); see also Paternoster, *supra* note 73, at 9 (“The active decision maker is repeatedly making offending decisions affected in part by an ongoing reassessment of sanction threats.”).

102. SHELLI B. ROSSMAN ET AL., URBAN INST., 4 THE MULTI-SITE ADULT DRUG COURT EVALUATION: THE IMPACT OF DRUG COURTS 121–22 (Shelli B. Rossman et al. eds., 2011) [hereinafter ROSSMAN ET AL., THE IMPACT OF DRUG COURTS]. For additional information on the study’s design methods see *id.* at 122–24.

103. *Id.* at 124–25.

104. *Id.* at 144.

105. *Id.* at 140.

tically significant differences between high-, medium-, and low-predictability sanctions with regard to preventing drug use and criminal behavior.<sup>106</sup> Medium-predictability courts were courts that formally communicated how and when participants would be sanctioned for non-compliance but retained some flexibility in applying the sanctioning schedule.<sup>107</sup> Both medium-predictability and low-predictability courts were over two times more likely to prevent criminal conduct than high-predictability courts.<sup>108</sup> And drug courts with medium-predictability sanctions outranked both high-predictability and low-predictability courts at preventing substance use.<sup>109</sup> This suggests that high-predictability sanctions, most similar to the Project HOPE model, are not the most effective at deterring crime and substance use with the drug court population. Perhaps this is because medium- and low-predictability sanctions give the judge greater discretion to account for the medical aspect of violations and factor in medical knowledge to the administration of sanctions. Even given that discretion, medium-predictability sanctions ensure the judge is accountable to participants and responds within certain published limitations.

## 2. Differentiating the Sanction Based on the Violation

Recently, drug court scholars have criticized drug courts' responses to certain violations.<sup>110</sup> First, scholars have criticized drug courts' response to relapse, the ultimate violation. Relapse is a daily threat for an addict, even one who has been sober for decades.<sup>111</sup> Some scholars suggest that for individuals with severe substance use disorder, relapse should be a time to give additional support rather than a time to punish.<sup>112</sup> Therefore, in early stages of a drug court program, relapses should be responded to with increased treatment, not greater sanctions.<sup>113</sup> DSM-V classifies an individual as being in early remission if no

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106. *Id.* at 144.

107. *Id.* at 5.

108. *Id.*

109. *Id.* at 144–51.

110. See generally Douglas B. Marlowe, *Drug Court Practitioner Fact Sheet, Behavior Modification 101 for Drug Courts: Making the Most of Incentives and Sanctions*, NAT'L DRUG CT. INST. (Sept. 2012), [http://ndcrc.org/sites/default/files/fact\\_sheets.pdf](http://ndcrc.org/sites/default/files/fact_sheets.pdf).

111. Travis, *supra* note 54, at 5. Therefore, a common saying in the recovery community is live "a day at a time." *Id.*

112. *Id.*

113. Marlowe, *supra* note 110, at 5.

criteria for substance use disorder have been met for at least three months and as being in sustained remission if no criteria have been met for twelve months or longer.<sup>114</sup> Once a participant has more sobriety time and has progressed past early remission, the participant will have more control over their impulse to use, and it may be more appropriate to sanction a relapse.

Second, scholars have suggested administering sanctions based on the nature of the violation. For those drug courts that do provide a sanction menu to their participants, there is no indication that any court explicitly differentiates sanctions based upon the nature of the violation and its relationship to substance use disorder.<sup>115</sup> The activities most commonly sanctioned include: supplying a positive urinalysis; skipping a urinalysis; skipping treatment, a meeting, or an appointment; attitude; absconding; and receiving new charges.<sup>116</sup> For an individual with severe substance use disorder in early remission, some of the listed sanctioned activities may be compulsive or addiction-driven.<sup>117</sup> For example, supplying a positive urinalysis or committing a new offense while under the influence would mean an individual has relapsed. But severe substance use disorder is a brain disease, characterized by a change in circuitry that hinders the ability to control the craving to use.<sup>118</sup> Therefore, punishing relapses may be inappropriate, especially for an individual in early remission.<sup>119</sup> Depending on the participant, situation, and relevant stimuli, it may be impossible to deter a relapse in early recovery in an uncontrolled environment.<sup>120</sup> Therefore, punishment will not effectively reduce the criminal behavior and the underlying addiction.

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114. DSM-V, *supra* note 19, at 491. The only criteria that may still be present is having a “craving[ ] or strong desire” to use. *Id.*

115. This conclusion is based on my search of publicly available Drug Court contracts and the conclusions of the MADCE.

116. Lindquist et al., *supra* note 46, at 129.

117. See, e.g., Kalivas & O’Brien, *supra* note 14, at 166. The National Drug Institute has recently recommended distinguishing between distal and proximal behavioral goals. Proximal behavioral goals are behaviors a participant is already capable of and should involve more severe sanctions than distal (long-term) behavioral goals. Marlowe, *supra* note 110, at 7.

118. See *supra* Part I.A.

119. See Travis, *supra* note 54, at 5 (“The moment of relapse is an occasion to work harder to support the individual offender, not an occasion to shun or exile him.”).

120. See, e.g., Kalivas & O’Brien, *supra* note 14, at 166.

Additionally, independent of the decision to use, individuals with severe substance use disorder satisfy additional criteria—such as the inability to fulfill obligations—that may hinder compliance with drug-court criteria including meeting with probation officers, supplying urinalyses, and attending court on a regular basis.<sup>121</sup> These non-drug-related behavioral symptoms should also be addressed therapeutically where necessary, as opposed to punitively, if they result from the underlying medical condition.

Courts that employ high-predictability sanctions, without an opportunity to vary the sanction based on the nature of the violation, lack the flexibility to respond therapeutically, as opposed to solely punitively. Because courts fail to respond therapeutically as necessary—decreasing the probability of abstinence and future criminal conduct—the majority of drug courts do not fulfill their role in the criminal justice system as effectively as possible and, therefore, are arguably an unnecessary alternative to traditional probation.

### 3. Swift and Not-So-Swift Hearings

Although drug courts respond to probation violations more swiftly than the practice in traditional probation, they still respond less swiftly than recommended by the Project HOPE model. The majority of Project HOPE participants are brought before the court within seventy-two hours of any violation.<sup>122</sup> When responding to positive drug tests, forty-eight percent of drug courts sanction an individual within one week of a violation, whereas forty-one percent wait until the participant's next court appearance, which could be anywhere from a few days to a month away.<sup>123</sup> For sanctions for infractions other than positive drug tests, more courts tend to wait until the next court hearing.<sup>124</sup> This delay decreases the deterrence effect of the sanctions and therefore the efficacy of the drug court.

Drug courts have made substantial strides toward improving probation outcomes for drug offenders, but there is room for improvement. Drug courts should internalize the lessons from Project HOPE and apply Project HOPE's procedure and philosophy to the drug court population. By integrating knowledge of

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121. See DSM-V, *supra* note 19, at 481–84 (listing an inability to fulfill obligations as one criteria of substance use disorder).

122. Hawken & Kleiman, *supra* note 57, at 13.

123. ZWEIG ET AL., *supra* note 1, at 60.

124. *Id.* at 61–62.

substance use disorder, deterrence principles, and procedural justice to the administration of sanctions, drug courts can more effectively combat addiction and its correlation to criminal activity.

### III. INTEGRATING KNOWLEDGE OF SUBSTANCE USE DISORDER INTO THE IMPLEMENTATION OF SANCTIONS IN DRUG COURTS

Now that the scientific community has greater knowledge of the nature of substance use disorder and its impact on behaviors, this knowledge should be incorporated into the administration of sanctions in drug courts. To the extent it is possible to deter addicts from relapsing or violating conditions of the court, drug courts should integrate principles of deterrence theory. However, drug courts must also maintain a therapeutic component and respond in a medically appropriate manner to violations that result from the disease of substance use disorder. The major areas in which drug court sanction administration should be clarified are the initial behavioral contract and the sanction menu, which will be discussed in Section A and Section B, respectively. Section C discusses the impact the proposed contract and sanction menu will have on the appellate process. Section D concludes by addressing some possible challenges to this Note's solution and why the proposed procedure is preferable to those currently utilized by drug courts.

#### A. THE BEHAVIORAL CONTRACT

The majority of drug courts, similar to Project HOPE, require a behavioral contract for participation.<sup>125</sup> However, most contracts do not inform participants of the potential sanctions for violating the contract.<sup>126</sup> By not specifying the potential sanctions in the contract, drug courts reduce the deterrent effect of sanctions and decrease the perception of procedural justice in the drug courts.

Sanctions have the greatest deterrent effect if they are certain.<sup>127</sup> Project HOPE has exemplified that the presence of a behavioral contract that outlines key sanctions can have a significant impact on compliance with probation procedures.<sup>128</sup>

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125. ZWEIG ET AL., *supra* note 1, at 4. Interestingly, two-thirds of those contracts require a waiver of rights to challenge the procedures. *Id.*

126. *Id.* at 5.

127. Taxman et al., *supra* note 57, at 187.

128. *Swift and Certain*, *supra* note 69.

Currently, the majority of drug courts do not include a sanction menu similar to Project HOPE. If there is no sanction menu, or the sanction menu is never shared with drug court participants, participants will not be certain of whether their actions will result in a sanction. Therefore, they are less likely to be deterred from violating a condition of the drug court where deterrence is more probable. Drug courts should incorporate some principles from Project HOPE to increase the deterrent effect of sanctions, specifically the language from the “warning hearing.”

At a Project HOPE warning hearing, the sanctions for violating conditions of probation are clearly communicated to court participants. The warning hearing includes the following messages:

“I think you can succeed on probation . . . .”<sup>129</sup>

“You are the one responsible for making sure that you comply with your conditions of probation . . . . [Y]ou are making a deal with me to follow the rules.”<sup>130</sup>

“You are being brought here to court today so I can clearly spell out what the consequences will be if you don’t follow the rules of probation.”<sup>131</sup>

“[I]f you fail a drug test, if you fail to meet with your probation officer when you are supposed to, or you fail with other terms of your probation, such as not getting an assessment, not going to treatment, etc.—you will go to jail.”<sup>132</sup>

“[I]f you violate the rules, there will be consequences, and they will happen right away. But it’s all about choices.”<sup>133</sup>

Participants of Project HOPE are successful in part because they know the consequences of their actions—they know that every violation of a probation condition will result in time in jail.<sup>134</sup> The certainty increases both the deterrent effect of the sanction and the perception of procedural justice because every participant is subject to the same warning hearing and the same sanctions. Many of the messages in Project HOPE’s warning hearing should also be conveyed to drug court participants through the behavioral contract and an initial hearing.

The drug court contract must, however, account for the fact that it is serving a different population than that present in

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129. Hawken & Kleiman, *supra* note 57, at 56.

130. *Id.*

131. *Id.* at 57.

132. *Id.*

133. *Id.*

134. *See* Alm, *supra* note 59, at 1186.

Project HOPE. The sanction menu this Note proposes is designed for drug courts limited to participants with severe substance use disorder and therefore less able to control to impulse to use in early and sustained remission.<sup>135</sup> Although the Project HOPE warning hearing states “it’s all about choices,”<sup>136</sup> research has established that an individual with severe substance use disorder experiences a change in brain chemistry that affects their ability to make rational choices regarding use.<sup>137</sup> Therefore, a behavioral contract for drug courts should convey that non-disease-driven violations will be responded to with a certain sanction (such as a limited amount of jail time). In contrast, disease-driven violations—or violations that result from an inability to respond rationally to certain stimuli—will be responded to with increased therapeutic treatment. A sample behavioral contract for a drug court could include the following language:

I think you can succeed in drug court. You are here to address both your underlying disease and the criminal behavior that has resulted from that disease. You are responsible for your success and ensuring that you follow the rules of this court.

You are making a deal with me to follow the rules of this court. You are being brought here today so that I can tell you what the various consequences will be if you do not comply with the conditions of this court.

However, you are in drug court because you have a medical disease. In order to recover from that disease, you must rewire your brain chemistry. This can take time. If you violate the conditions of this drug court because of the compulsive nature of your disease, we will respond therapeutically. This will likely mean more intensive treatment and will be based on the recommendation of medical professionals. However, if you are in sustained remission, choose to use non-compulsively, or violate a condition of this court non-compulsively, you will go to jail.

If you violate a condition of your participation in this court, there will be a response. It may be a sanction or it may be increased therapy. But either way it will happen right away. The responses of this court will be based on your choices and actions.

This sample contract is modeled after the warning hearing administered to Project HOPE participants,<sup>138</sup> but accounts for the fact that drug courts serve individuals who are suffering from a disease and have less control over certain choices in the early phases of the drug court program and recovery. There-

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135. See *supra* notes 113–14 and accompanying text.

136. Hawken & Kleiman, *supra* note 57, at 57.

137. See *supra* Part I.A.

138. See Hawken & Kleinman, *supra* note 57, at 56–58.



fore, instead of referring to relapse consequences as sanctions—implying that the participant has done something wrong—relapse consequences are referred to as therapeutic responses. This semantic distinction accounts for scientific literature that addicted individuals cannot control the urge to use in response to certain stimuli,<sup>139</sup> and so the court response to disease-driven violations should be distinct from the court response to non-disease-driven violations.

The sample contract also aligns with the best practices found in the MADCE study.<sup>140</sup> Courts with high-predictability sanctions have a sanction menu, publish the menu to participants, and the menu is (almost) always followed by the judge.<sup>141</sup> High-predictability courts are most similar to Project HOPE but were less effective with the drug court population.<sup>142</sup> By contrast, medium-predictability courts, or courts that had a sanction menu but either did not publish the sanction menu or allowed the judge greater discretion when administering sanctions, were the most effective.<sup>143</sup> Therefore, the behavioral contract should be classified as “medium predictability” and state that non-disease-driven violations will be responded to with a specific, limited sanction, whereas the judge will have more discretion when responding to disease-driven violations.

Having a transparent contract will also increase the perception of procedural justice among drug court participants. Drug court participants are more likely to comply with the program if they feel as though they are being treated in a fair and consistent manner.<sup>144</sup> The behavioral contract makes clear that every non-disease-driven violation will be responded to with a sanction. In a study, the threat of jail was found the most effective sanction by both court participants and staff.<sup>145</sup> Therefore, similar to findings by Project HOPE, jail is the most appropriate sanction for those behaviors that can be deterred and do not require a therapeutic response. The study likewise found that

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139. See, e.g., Kalivas & O'Brien, *supra* note 14, at 166.

140. The MADCE study discussed in Part II.B found that high-predictability sanctions were less effective than both medium-predictability and low-predictability sanctions at preventing relapse and criminal activity. See *supra* notes 102–09 and accompanying text.

141. See ROSSMAN ET AL., THE IMPACT OF DRUG COURTS, *supra* note 102, at 140, 144.

142. *Id.* at 144–51.

143. *Id.*

144. ROSSMAN ET AL., THE DRUG COURT EXPERIENCE, *supra* note 22, at 85.

145. Lindquist et al., *supra* note 46, at 132.

the majority of participants thought sanctions should be tailored to the individual.<sup>146</sup> The contract accounts for that individualization by granting more flexibility with regard to disease-driven violations. The behavioral contract should go on to clarify what the specific sanctions and therapeutic responses may be, in order to bolster both its deterrent effect and the perception of procedural justice.

#### B. DIFFERENTIATING COURT RESPONSES BASED ON THE NATURE OF THE VIOLATION

The behavioral contract should also outline the specific sanctions and therapeutic responses to various violations of drug court conditions. When the consequences are outlined, participants are more likely to be deterred from violating drug-court conditions—because the consequences are certain—and are also more likely to view the drug court as fair.

##### 1. The Disease-Driven v. Non-Disease-Driven Distinction

Currently, the majority of drug courts do not distinguish between therapeutic responses and sanctions for court violations in their behavioral contract. For example, the majority of drug courts “sanction” every positive urinalysis.<sup>147</sup> But punishing an individual with severe substance use disorder for a predictable manifestation of their disease does not align with the medical community’s knowledge of addiction and what behaviors are capable of being deterred. Instead, drug court consequences should be divided into two categories—disease-driven and non-disease-driven violations. This distinction would address the underlying tension between punishing the “sick” addict and punishing the “criminal” offender.<sup>148</sup> Recognizing this distinction would also increase the likelihood of participant success in drug court programs because many behavioral goals are unattainable in early recovery.<sup>149</sup> Drug courts should support the struggling addict, as opposed to merely punishing the violation, thereby enhancing the therapeutic component of the program and the likelihood of recovery for participants.

Whether a violation is disease-driven or non-disease-driven should be medically determined. In determining whether an act

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146. *Id.* at 133.

147. ZWEIG ET AL., *supra* note 1, at 60.

148. See Mackinem & Higgins, *supra* note 37, at 36.

149. *Cf.* Marlowe, *supra* note 110, at 5 (explaining that substance-dependent individuals need time and effort to achieve sustained sobriety).

was disease-driven, the medical professional member of the drug court team would assess whether the act was compulsive.<sup>150</sup> The medical professional would consider similar criteria to that used in diagnosing severe substance use disorder, including whether there was a strong craving, whether the violation was in response to a stimuli that is associated with use, and whether the substance use was chosen over an important social or occupational activity.<sup>151</sup> Because the drug court team includes treatment providers, the treatment provider should make a recommendation, based on their medical judgment to the judge as to whether the violation was disease-driven.<sup>152</sup> This procedure will not only clarify the roles of various members of the drug court team but will also ensure drug courts are responding medically where necessary—an essential reason justifying their development as an alternative to traditional probation. The next question that arises is what those various therapeutic responses should be.

## 2. Possible Therapeutic and Punitive Responses

Most drug courts provide a range of treatment modalities, ranging from inpatient treatment to counseling and relapse prevention.<sup>153</sup> For repeated disease-driven violations, participants should be warned that they will be moved to a more intensive treatment regimen. For example, someone in counseling would move to outpatient treatment, and someone in outpatient treatment would move to inpatient treatment. The fact that the increase in treatment would be judicially coerced does not undermine the effectiveness of the treatment.<sup>154</sup> Intensifying the treatment regimen would both serve as a judicial response to court violations and ensure the participant is getting the level of treatment they need to abstain from using. In early remission, abstinence may need to be coerced via a controlled environment, and responding therapeutically will give

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150. Cf. Hyman, *supra* note 86, at 9 (stating that modern definitions of addiction focus on issue of voluntarily control and compulsive use).

151. See DSM-V, *supra* note 19, at 491.

152. See, e.g., ZWEIG ET AL., *supra* note 1, at 8. Typically, the entire drug court team, including the judge, prosecutor, defense attorney, treatment liaison, and drug court program provider, determines sanctions. Lindquist et al., *supra* note 46, at 139–40. The judge, however, has the final say in what sanction will be administered. *Id.*

153. See, e.g., ZWEIG ET AL., *supra* note 1, at 4, 48–53.

154. ROSSMAN ET AL., THE DRUG COURT EXPERIENCE, *supra* note 22, at 45.

the court the tools it needs to ensure it provides optimal therapeutic responses as necessary.

However, before the serious consequence of intensifying treatment regimens, the court and treatment provider should have greater flexibility in administering therapeutic consequences. Other therapeutic responses could include writing a letter of apology or essay, journaling, a life skills assignment, community service, observing a victim impact panel, or visiting a morgue.<sup>155</sup> Each of those therapeutic responses would educate the participant about the underlying nature of their substance use disorder and help change the participant's response to behavioral and social cues that previously triggered using.<sup>156</sup> The behavioral contract should list these possible consequences and the ultimate therapeutic consequence of increasing the treatment regimen.

Jail should not be the presumed response to disease-driven violations. Jail is currently the most common sanction administered in drug courts, followed by increased treatment.<sup>157</sup> However, as discussed above, jail does not treat the underlying addiction or change brain chemistry.<sup>158</sup> And, depending on the stimuli and environment leading to relapse, jail will not effectively deter an individual in early remission from using.<sup>159</sup> Therefore, jail should be reserved as a sanction for those violations that are non-disease-driven, not as a therapeutic response to relapse in early remission.

Although the consequences for violations will not be as "certain" as those for Project HOPE participants because it will vary based on the participant's therapeutic needs, all participants will know that there will be a response to disease-driven violations by the court, including relapse. That response will be based on a medical recommendation and tailored to the individual participant. Further, the response will address their un-

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155. These possible therapeutic responses are derived from a list of sanctions provided by the National Drug Court Research Center. They are all listed as sanctions, not as therapeutic responses. Each of these sanctions is considered low or moderate severity. See *List of Incentives and Sanctions*, *supra* note 51.

156. See Leshner, *supra* note 19, at 46 (noting that treatment must not only treat the disease, but also behavioral and social cues).

157. Lindquist et al., *supra* note 46, at 130 (listing sanctions from most to least common).

158. See *supra* note 30 and accompanying text.

159. See, e.g., Kalivas & O'Brien, *supra* note 14, at 166.

derlying medical condition. This uniformity will enhance the perception of procedural justice.

Non-disease-driven violations can be addressed more uniformly in the behavioral contract. Responses to non-disease-driven violations should be referred to as sanctions, to distinguish them from the therapeutic responses discussed above. Sanctions should be presumed for individuals in sustained remission or for non-disease-driven violations. Because drug court participants in sustained remission act more rationally than compulsively, deterrence theory and Project HOPE should guide the sanction menu. Therefore, those sanctions should be certain, administered swiftly, and progressive. Because jail is the most effective deterrent, similar to Project HOPE every voluntary violation should be sanctioned with a brief time in jail.<sup>160</sup> This sanction should be included in the initial behavioral contract.

The responses must also be swift. The majority of Project HOPE participants are brought before the court within seventy-two hours of violations, whereas the same cannot be said of drug court participants.<sup>161</sup> To improve the efficacy of sanctions, the hearings should be held as soon as possible or at least within the seventy-two hour period used by Project HOPE.<sup>162</sup> Waiting until the next court appearance, perhaps a month or more away, will not maximize court efficacy or sufficiently differentiate drug courts from traditional probation.

These distinctions should be incorporated into the behavioral contract discussed above. The behavioral contract should clearly outline the responses to various violations and set limitations on judicial discretion. The contract should state that the court will respond differently to violations that are disease-driven and non-disease-driven, and violations by individuals in early remission versus sustained remission or remission. The contract should also state what those responses will be to a certain extent but leave room for therapeutic modifications based on the needs of the participants. A model behavioral contract could include the following language:

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160. See Lindquist et al., *supra* note 46, at 132.

161. See *supra* notes 122–24 and accompanying text.

162. This will of course add additional burdens on the court system and could be a source of criticism. However, my proposal is limited to those drug courts that serve individuals with severe substance use disorder. By limiting the number of participants drug courts serve—and serving only those who need the therapeutic component the most—drug courts could more effectively use their resources and reduce the cost of the programs.

You are in drug court because you are addicted to a substance. In this court, we want to help treat that underlying addiction so that you can become sober, a productive member of society, and stop committing crimes. However, we recognize that in early recovery complete abstinence is not always possible. You have a chemical response in your brain that reduces your ability to control using. If you violate the terms of this program because of that underlying chemical response, we will respond therapeutically, based on the recommendation of the treatment provider. That response may include: writing a letter of apology or essay, journaling, a life skills assignment, community service, observing a victim impact panel, or visiting a morgue. If you continue to violate conditions as a result of your substance use disorder, we will increase your treatment regimen.

However, your disease does not insulate you from responsibility for your behaviors. If you violate a condition of this court non-compulsively, you will go to jail, at first for one night and for increasingly longer periods of time for additional violations (up to a predetermined limit).<sup>163</sup> Also, once you have been symptom-free for twelve months and are in remission, you will have more tools to control the desire to use. If you use at that point, you will be sent to jail. Between three and twelve months there will be a presumption you could control the desire to use—although a medical professional may rebut that presumption—and you will likewise be sent to jail for using. Whether you are able to control your consumption will be based on the recommendation of your treatment provider and on your remission status.

This model behavioral contract would go on to include a sanction menu, outlining the various sanctions and therapeutic responses of the drug court. By stating that violations for non-disease-driven acts will result in jail time, the court will deter those behaviors that are most readily deterred. Also, because jail time is a sanction administered to every person for non-disease-driven violations, the process will be viewed as fair and participants will be more likely to comply with the conditions of the court.

The contract also differentiates between disease-driven and non-disease-driven violations and therefore clarifies the dueling roles of the drug court: treating the addiction and punishing the offender. The participant will be informed that the court does not intend to punish him or her for acts that directly result from severe substance use disorder—a medical illness he

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163. It is important that the court sets a limit on the number of days spent in jail. There are horror stories of drug courts that send people to jail as a sanction and leave them in jail for longer than they would have been held if they had been sentenced in a traditional court. *See This American Life: Very Tough Love*, *supra* note 53. These stories undermine the validity of the drug courts and their ability to therapeutically respond to offenders. This Note would tentatively recommend a maximum jail limit of thirty days as a sanction, prior to considering expulsion from drug court.

or she cannot control in certain situations. Instead, the court wants to help treat the addiction. There is less need for uniformity in therapeutic responses because the behavior is not capable of being deterred and treatment must be tailored to the individual. However, the procedure will likely be viewed as fair because every participant will receive a therapeutic response for disease-driven violations, leading up to a more intense treatment regimen.

### C. APPELLATE REVIEW

A final benefit of the behavioral contract is that it provides clear guiding principles for appellate courts that are reviewing the decisions of drug courts. As mentioned before, appellate courts are currently wary to question the judgments of drug court judges regarding sanctions and court termination. For example, the Supreme Court of South Carolina stated that it has no authority to “evaluate and assess the manner in which the [drug court] administrators execute the rules and regulations of the [drug court].”<sup>164</sup> Other courts have questioned whether therapeutic decisions need to be on the record<sup>165</sup> or if participants are guaranteed the minimal due process protections of revocation hearings.<sup>166</sup> Some drug court contracts even require participants to relinquish all rights to an appeal or challenge of any court processes.<sup>167</sup> Appellate courts’ wariness to question the decisions of drug courts stems in part from the lack of guiding principles regarding sanctions and court termination.

This Note’s solution provides both drug courts and appellate courts with the tools to ensure procedural justice for participants and adequate review on appeal. First, the drug court will be constrained by the sanctions limited in the behavior contract. Second, therapeutic responses must be documented by the opinion of the medical professional on the drug court team. Because sanctioning decisions will have to be grounded in a medical determination, appellate courts will be able to deter-

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164. *State v. Perkins*, 661 S.E.2d 366, 367 (S.C. 2008).

165. *E.g.*, *In re Tyler T.*, 781 N.W.2d 922, 925 n.15 (Neb. 2010) (citing *Torres v. Barbary*, 340 F.3d 63 (2d Cir. 2003); *Harris v. Commonwealth*, 689 S.E.2d 713 (Va. 2010); *State v. Rogers*, 170 P.3d 881 (Idaho 2007); *People v. Anderson*, 833 N.E.2d 390 (Ill. App. Ct. 2005); *State v. Cassill-Skilton*, 94 P.3d 407 (Wash. Ct. App. 2004)).

166. *Barrickman v. Commonwealth*, No. 2004-CA-000890-MR, 2006 WL 73464, at \*2 (Ky. Ct. App. Jan. 13, 2006).

167. *See ZWEIG ET AL.*, *supra* note 1, at 76.

mine whether the sanction or therapeutic response was appropriate, based on the record, the behavioral contract, the sanction menu, and a consideration of the underlying purposes of rehabilitation and crime prevention.

Drug court behavioral contracts should outline the expectations for participants and the possible sanctions that will be administered. However, the contract should also distinguish between sanctions and therapeutic responses and give examples of possible drug court responses in each of those categories. Such a contract will deter where deterrence is possible, uphold the underlying purposes of treating addiction and reducing crime, increase the perception of procedural justice by drug court participants, and provide appellate courts with specific guidance when reviewing drug court case dispositions.

#### D. SOME POTENTIAL CRITICISMS AND RESPONSES TO THOSE CONCERNS

The solution proposed by this Note is subject to two distinct but interconnected concerns. The first issue is that it is hard to determine whether an act is disease- or non-disease-driven, and this solution will not add clarity or consistency to the current system. Building on the first concern, the second concern is that the implementation of therapeutic responses, as opposed to punitive responses, will allow offenders to abuse the system and fail to change their behaviors.

The first possible criticism is that a medical professional will be unable to determine whether an action is disease-driven or non-disease-driven. This concern, however, may have carried more weight prior to the implementation of DSM-V. DSM-V lists eleven specific actions that constitute symptoms of substance use disorder.<sup>168</sup> Assuming that the disease model correctly captures addiction, medical professionals should be able to apply the DSM-V criteria for substance use disorder to determine whether a violation was disease-driven. The medical professional may first consider whether the violation falls within one of the eleven categories, and then consider whether the response was due to a certain stimuli that is associated with using. A certain amount of subjectivity will be inherent in any diagnosis regarding a brain disorder, but that does not mean that a medical professional is unable to make those classifications,

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168. See DSM-V, *supra* note 19, at 481–84.



especially with the clear criteria and guidance provided by DSM-V.

The second criticism is grounded in the concern that responding therapeutically to court violations will “encourage[] the abdication of individual responsibility for outrageous conduct.”<sup>169</sup> A non-punitive response allows behavior that would normally be classified as criminal conduct, such as violating a condition of probation by using, to go unpunished. In considering the concern, it is important to first note that under this Note’s proposal not all violations are responded to therapeutically. Therapeutic responses will only be administered for those behaviors that directly result from the compulsive nature of severe substance use disorder. All other violations will be responded to with a swift and punitive response. This criticism is also based on the faulty premise that individuals with severe substance use disorder are responsible for, or able to control, all their actions. This premise has been rejected in DSM-V, which discusses the genetic and neurobiological components of substance use disorder,<sup>170</sup> and therefore discounts the assumption that the decision to use can be encouraged or discouraged in all situations. This Note’s proposal will hold individuals responsible for their behavior when it is appropriate to do so—when there is a non-disease-driven violation of drug court conditions.

Furthermore, it is important to note that there may come a point at which an individual is unable to comply with the conditions of the court, or abstain, to the point that it undermines public safety. As noted above, both rehabilitation and public safety are guiding jurisprudential foundations for drug courts.<sup>171</sup> At that point, the court may determine that the needs for public safety outweigh the potential for rehabilitation and terminate the individual’s participation in drug court. Although the termination procedures are beyond the scope of this Note, the solution does not suggest that rehabilitation and treatment must come above the need for public safety. Instead, the two should be pursued contemporaneously where possible. This Note concedes that eventually a drug court may determine that treatment is no longer a feasible option. However, in keeping with the principles of procedural justice, it is important that if such a determination is made, it is based on the countervailing

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169. Peele, *supra* note 15, at 21; see also Hanson, *supra* note 15 (arguing that the disease model provides an excuse for poor behavior).

170. See DSM-V, *supra* note 19, at 494.

171. See ZWEIG ET AL., *supra* note 1 and accompanying text.

purposes of the drug court and is reviewable by an appellate court.<sup>172</sup> By clarifying the standards for administering sanctions, or the ultimate sanction of drug court termination, appellate courts will have the tools needed to review court decisions and ensure court participants are treated fairly and in a manner consistent with procedural justice.

### CONCLUSION

People addicted to substances were historically viewed as “weak” and unwilling to lead moral lives.<sup>173</sup> Science has since taught us that addiction is a chronic and progressive disease characterized by an inability to control substance use. Research has also shown that addiction leads to crime. Drug courts emerged to address both the underlying disease of substance use disorder and the criminal behavior that manifests from that disease. Currently, however, the majority of drug courts do not clearly distinguish these two purposes when responding to drug court violations.

Drug courts should clarify their procedures for administering sanctions. Knowledge of substance use disorder, deterrence theory, and procedural justice should guide responses to violations. The responses should be included in a behavioral contract that is administered at the beginning of drug court participation. The contract should distinguish between therapeutic responses to disease-driven violations, such as the recently sober addict who cannot yet control the impulse to use in response to certain stimuli, and sanctions for non-disease-driven violations. In moments of relapse, especially in early remission, the addicted participant should be supported and medically responded to, not punished for his or her underlying disease and compulsive behavior. Whereas for non-disease-driven violations, jail should be administered as a sanction in order to most effectively deter those violations and increase the perception of fairness among in drug court participants.

Sanctions need to be clarified in drug courts. This Note’s recommendation for responding to drug court violations would most effectively balance and uphold the therapeutic and punitive components of drug court, leading to a safer society with

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172. *But cf.* State v. Perkins, 661 S.E.2d 366, 367 (S.C. 2008) (stating that the state supreme court has no authority to “evaluate and assess the manner in which the [drug court] administrators execute the rules and regulations of the [drug court]”).

173. Leshner, *supra* note 19, at 45.

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less crime committed by individuals suffering from severe substance use disorder.