The City Court of Buffalo (New York)

BUFFALO DRUG TREATMENT COURT

PROCESS EVALUATION

2001

Prepared for

The Hon. Thomas P. Amodeo, Chief Judge
And
The Hon. Robert T. Russell, Presiding Drug Court Judge

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" Interdiction, through arrest and prosecution are critical, but we must come to grip with the fact that Demand drives the drug market", " If we are to turn the tide of illegal drug use and abuse in the city of Buffalo, we must develop a better understanding of addiction and we must develop a comprehensive Judicially driven community approach
Chief Judge, Buffalo City Court
The Honorable Thomas Amodeo

"Extensive research confirms that treatment is the most cost effective way to combat drug use, abuse and drug related crime. Treatment courts are clearly the most sane and effective way to logically deal with the overwhelming problems caused by drugs in the criminal justice system "
Presiding Drug Court Judge, Buffalo City Court
The Honorable Robert T. Russell

"The City of Buffalo was bold enough to rethink traditional roles….judges stepping off the bench and stepping into the community … Reaching outside the walls of the adversarial process to work together to solve the problems of substance abuse and crime.

Hank Pirowski
Buffalo Drug Court Coordinator

Who am I, and what have I done.

This person inside me, living on the Run

I gave up my freedom, to those I don't know.

Stepping on myself. Refusing to grow.

Hanging the streets, and walking the roads,

I saw a little addict and said,

"Hey Climb Aboard." He jumped on my shoulder,

And that's where he sits, feeding on my strength,

And getting his kicks. He got big and I asked

Him to leave. He laughed in my face, and said,

"Forever you shall grieve," who am I, and what have I done, this

person inside me, living on the Run

Feeling along and starting to fall,

I heard a deep voice, my name I heard called.

Called with such power, I fell to my knees,

Shaking in fear I asked, "Who's calling me please?"

He said, "I am God, the one with much heart

I'll replace your sanity and put hope into your life!"

From out of the darkness, I saw, a bright ray.

"This is how we'll do it, you'll attend N.A, A.A

By taking these steps, I want you to know

Things will get better, but we got to go slow

I said, "my Lord, But how can this be, that you

Continue to love, and have Faith in me

He said "I created this world for that,

You are mine! You'll make it, my Dear,

One day at a time.

Drug Court Graduate

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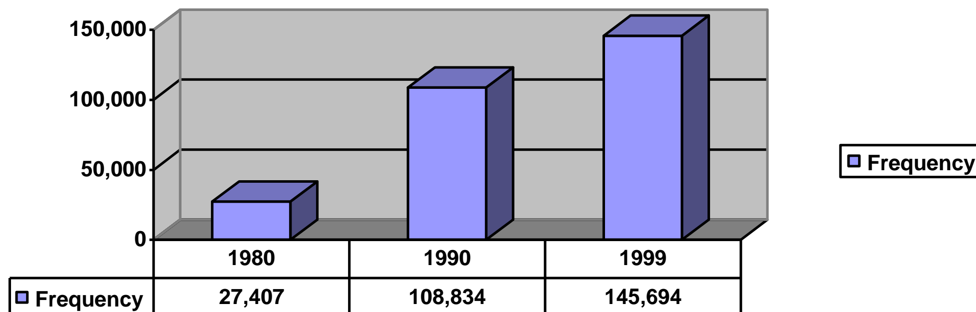
Executive Summary

New York State

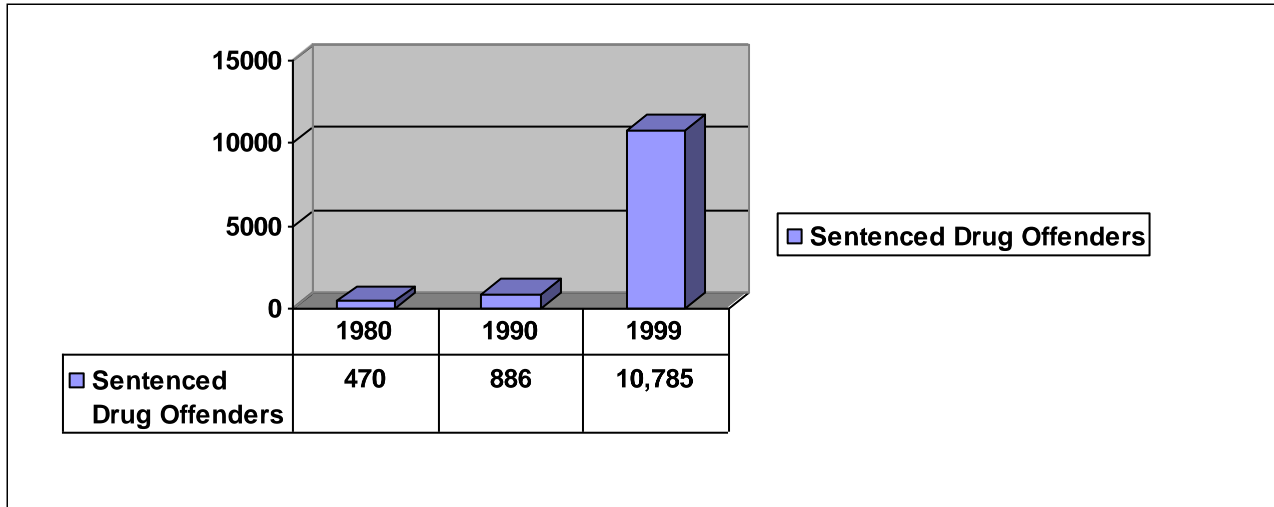
New York State's "war on drugs' has been waged since the early 1970's. In 1973 Governor Nelson Rockefeller in response to a burgeoning heroin epidemic announced anti-drug policies that were premised on new law enforcement strategies and strict mandatory sentencing laws. In the last two decades, New York State's criminal justice system has been confronted with a staggering number of drug cases, the volume of which has risen by over four hundred percent in twenty years.



	1980	1990	1999
Frequency	27,407	108,834	145,694

In 1980 for example, data from the Division of Criminal Justice Services (DCJS) indicates there were 27,407 drug arrests in New York State. By 1990 this number had risen to 108,834: and by 1999 it was 145,694. This vast expansion has come at a great price to the public and has taken a significant toll on the courts. It should be noted that during this time frame, the state Office of Court Administration (OCA) reported that the number of judgeships in the states court system increased by only 15%. (Given these numbers there can be little dispute that drug cases have put a serious strain on the courts and have transformed the work of the courts, particularly the states misdemeanor courts and particularly those in the states largest` cities) In the face of swollen, drug heavy dockets, judges in such courts can often only spend minutes per case, as they are forced to focus on the speed of their disposition. Such dispositions, can at times have little effect, as the same drug offenders are arrested again and again. Apart from the practical difficulties created by this volume of cases, the financial cost of adjudicating them has been extraordinary over the year. OCA has indicated that the states lower courts spent $151.5 million handling misdemeanor cases in fiscal year 1999-2000. On the felony side, the number of drug cases

brought in the states upper courts is more than five times what it was in 1980. In the case of misdemeanors, the financial cost has been huge. The states upper courts spent $278.7 million handling indictments and approximately $115 million to adjudicate.



In 1980 the number of felony drug offenders sentenced to New York state prisons was less than 500; in 1999, it was nearly 11,000. These numbers become all the more startling when it is understood that the annual cost of imprisoning a state inmate is nearly $29,000. What this means is that the state now spends $650 million a year to incarcerate drug offenders in state prison. These figures do not even address the thousands of drug offenders who are in local jails, where the costs to incarcerate can be even higher. These figures reflect only drug crimes: keep in mind the tens of thousands of quality of life crimes as well as the thousands of drug related property and other crimes that are committed by addicts every year.

Buffalo, New York

Buffalo is the second largest city in the state of New York and the third largest city in the New York – New England region. Just fewer than 300,000 people live in the city of Buffalo. The metropolitan area has a population of over 1,000,000. The emergence of crack cocaine in the late-1980s had an unprecedented impact on Buffalo's criminal justice system. In an effort to stem the street drug dealing and the crime and violence associated with illegal drug use, the arrest and prosecution of drug offenders dramatically escalated. Central Police Services reported that between 1989 and 1996, the crime rate in Buffalo surpassed both regional and national rates. Violent crimes increased more than twice as fast in Buffalo as it did nationwide and property crimes increased by 26.3% while falling 2.5% nationally. The city's drug arrest rates outpaced other municipalities and towns in New York State. In Erie County, drug arrests for persons under the age of twenty-one increased 42.2% between 1980 and 1994, Buffalo's increased 709.6%. Since 1990, a record number of drug offenders have been arrested, tried and convicted in the City of Buffalo. In 1990, Buffalo City Court processed 23,300 cases, by 1997 it rose to 35,898. It is estimated that 40% of these cases were drug-specific charges and almost 70% drug related. This fact has resulted in congested court calendars, overcrowded jails, and consumption of scarce local justice and treatment resources. The average daily population of the Erie County Holding Center, a facility designed to hold no more than 610 inmates, increased to 860 inmates an increase of 46% that is widely attributed to the rising detention of substance abusing offenders. All of these factors placed challenges on the local criminal justice system. As a result of this war on drugs, greater numbers of drug offenders were arrested, prosecuted, and convicted. However, drug offenders received little, if any, treatment services. This resulted in a perceived revolving door syndrome where drug offenders cycled in and out of the justice system. The traditional system had rarely provided substance abuse treatment to defendants in any systematic way and, in many cases, provided little or no threat of sanctions to drug offenders.

Buffalo City Court

Troubled by the devastating impact of drugs and drug-related crime on the community as well as the criminal justice system, Buffalo City Court implemented the Buffalo Drug Treatment Court (BDTC). The BDTC was established in January 1996 following more than a year of planning and preparation that began in the spring of 1994. The BDTC is part of a national and statewide effort to integrate criminal justice case processing and substance abuse treatment. Its purpose is to use the authority and power of the Court to keep offenders in treatment with the expectation of improved treatment outcomes, lower relapses, higher treatment completion rates and, more importantly, for our community a reduction in crime and recidivism. The Criminal Justice Task Force in preparation of a federal planning grant application initially drove this effort. The "Drug Court Movement" has been supported and disseminated by the U.S. Department of Justice through its Office of Drug Court Programs. In 1995 Buffalo City Court received a planning grant from that office to plan and develop the court. An implementation grant award followed this in January of 1996**.** This innovative approach to low-level drug offenses brought significant change to the way the court system did business. This new approach integrated substance abuse treatment, sanctions, and incentives with case processing that placed nonviolent drug-involved defendants in judicially supervised habilitation programs.

THE BDTC ACCEPTED ITS FIRST PARTICIPANT IN JANUARY OF 1996.

From January 1996, through December 2001, the Buffalo Adult Drug Treatment Court (BDTC) has assessed and managed 1,740 cases. The BDTC has proven the ability to engage and maintain participants in long-term treatment and other services who have had limited treatment exposure in the past. It also provides consistent, regular and closer supervision than by those under other forms of criminal justice supervision in the community. The average length of program participation for graduates is 478 days. It has been suggested that the BDTC has reduced the number of new crimes that untreated offenders would likely have committed, if not involved in the program. Preliminary review of participant characteristics has indicated that participant/offenders are most likely to be young males, primarily members of cultural and ethnic minority groups, and to have low educational attainments. Two thirds of offenders are under thirty five (35) years old, twenty two (22) percent of this population were under twenty five (25)

and forty six (46) percent were age twenty five (25) to thirty (30). The majority of the involuntary failures were men. The racial and ethnic data showed that 69 percent of the potential participant pool are member of minority groups (58 percent African American, 9 percent Hispanic and 2 percent “other”) and thirty-one (31) percent were Caucasian. Only one quarter graduated from High School, although about 60 percent received either a high school diploma or its equivalent. Of the parents reporting having children, less than half reported having custody of their children. Less than half (43%) were medically insured. The primary drugs of addiction were crack-cocaine (42%), alcohol (27%), and heroin (14%).

CHAPTER 1: PROJECT DESCRIPTION

This final project report is being has been prepared by Recovery Solutions Consulting and Training Inc. in order to satisfy the requirements of our contract with the administrative offices of New York States 8th Judicial District. This report focuses on our process evaluation of the Buffalo Adult Drug Treatment Court and was made possible by funds provided by United States Department of Justice Drug Courts Program Office (DCPO). These funds were awarded to New York States Office of Court Administration (OCA) on behalf of the 8th Judicial District and more specifically Buffalo City Court under DCPO's Grant program.

From December 1995 to December 2001, The BDTC attempted a series of enhancements to meet the needs of the target population and to provide additional access to treatment and other supporting activity involving outreach and coordination of services. The focus of this contract is on process rather than outcomes or results obtained. The emphasis on process occurs for a number of reasons. First, the length of the contract and the available resources did not allow for an outcome study. Second, and most important it was necessary to complete and document the process of these courts in order to measure outcomes in the future.

A need exists for information on programs that work and confirmation on why they work. Drug Court programs and specifically cost effective programs must include research and evaluation components before implementation begins. It is important to know the extent to which a program is effective after it is fully implemented.

Where outcomes are evaluated without knowledge of implementation, the results seldom provide a direction for action. Decisions often lack information about what produced the observed outcomes. Unless one knows that a program is operating according to design, there may be little reason to expect it to produce the desired outcomes (Patton, 1986)

" Without Research and Evaluation the Drug Court Field can neither move forward nor achieve ultimate success. Research and Evaluation are the critical elements in the ongoing development of Drug Court programs, and will play a crucial role in their future".

General Barry McCafrey

This program evaluation was designed to help complete and document the BDTC process, and provides suggestions for designing an outcome and impact study for the future. This project recognizes evaluation as a means of keeping track of how each phase of the program is working in a methodical, organized, well thought out way. Evaluation is not simply a means of **“proving”** you have achieved what you set out to achieve, but more importantly evaluation research is a tool that can be used to **improve** the overall functioning of the program.

The planners of the BDTC had recognized that evaluation is research that includes:

- The development of evaluation questions:
- The identification of appropriate data (information) sources;
- The collection, recording, and analyzing of data: and
- The presentation and dissemination of findings.

The evaluation activities and methods have become “applied” in their use. “Applied” simply dictates that evaluations answer the questions of decision-makers, and presents results and recommendations that are readily useful to managers and practitioners.

> **“ The most important purpose for a program evaluation is not to prove but to improve”**
> **Dobbin and Gatowski 2001**

A focus on process is a focus on how something happens rather than the outcomes or results obtained. Process evaluations are aimed at understanding the dynamics of how a program, organization, or relationship exists. Think of this as part of a problem solving sequence or scenario modeling: (1) identifying a problem (2) creating and putting to use a program of activities designed to reduce the effects of the problem (3) evaluating these program activities: and then (4) adopting or modifying program activities the evaluation suggests will reduce the problem satisfactorily.

The process evaluation includes predictive and cost avoidance outcomes. COST AVOIDANCE measurement will look at dollars saved through the social service system, incarceration time, case processing time, and some preliminary recidivism data (limited to the length of the program where recidivist behavior may not coincide with long term follow up evaluation).

> “To get to where your going, you need to know where you are”

CHAPTER 2: LITERATURE REVIEW

Introduction

It is extremely useful to bring prior research findings to bear when evaluating this or any other drug court program. This discussion is also useful since it places the BDTC in the national context and provides some background information regarding the design and development of the program. This chapter is designed to provide a discussion of drugs and crime that has served as the momentum for a movement toward drug courts in the United States. This chapter also provides a review of the different types of drug court programs that exist while concentrating on treatment drug courts. These findings are helpful in explaining the design of this evaluation and future outcome and impact study recommendations.

Drugs and Crime

More than half of all individuals brought into the criminal justice system have substance abuse problems. Many of these individuals are non-violent offenders, who repeatedly cycle through the court, corrections, and probations systems. Drugs, drug use, and crime are linked and progress in reducing drug use, will have a direct and positive impact on reducing crime (ONDCP, 1995). Drugs and crime are related in a number of ways. First, there are drug-defined offenses. These include laws regulating the possession, use, distribution, or manufacture of illegal substances. Second, there are drug-related offenses motivated by the user's need for money to support continued use; and offenses connected with drug distribution itself (BJS, 1992).

A study by the National Institute of Drug Abuse (NIDA) found a high incidence of criminal activity among drug users who are not in treatment (BJS, 1993). Approximately one-half of the respondents in the study reported legal sources of income, but one-half also reported illegal sources. Overall, 17% of state prison inmates in 1991 and 13% of convicted jail inmates in 1989 said they committed their offense to obtain money for drugs. According to the Bureau of Justice Statistics (BJS) in 1991 approximately 31% of state prison inmates were under the influence of drugs or alcohol at the time of the offense (BJS, 1993). Fifty percent of state prison inmates have used drugs in the month before the offense. According to the Drug Use Forecasting system looking at a sample of adult males arrested in 1993 in 23 cities found 54% to 81% tested positive

for drugs at the time of their arrest. In an ongoing study funded by the federal government under the Arrestee Drug Abuse Monitoring (ADAM) Program, 68.6% of arrestees who were booked into Detention Centers who voluntarily provided urine samples tested positive for an illicit substance. Finally, the BJS estimates that 79% of state prisoners have used drugs at some point in their lives. Inmates incarcerated for robbery, burglary, larceny, and drug trafficking most often committed their crimes to obtain money for drugs. Inmates who committed homicide, assault, and public-order offenses were least likely to commit their offense to obtain money for drugs (BJS, 1994). Nationally, state and local police made over an estimated one million arrests for drug law violations in 1997 (FBI, 1997). The number of drug trafficking convictions in State courts more than doubled between 1986 and 1990 and drug offenders comprised a third of all persons convicted of a felony in State courts in 1990. In addition, 77% of persons convicted of drug trafficking in 1990 were sentenced to some kind of incarceration and 23% were sentenced to probation. The average prison sentence for persons convicted of drug trafficking was six years and two months. Of which the estimated time to be served was one year and 11 months. Thirty-five percent of persons convicted of drug possession were sentenced to prison and have an average sentence of four years and one month of which the estimated time to be served was 13 months. 29% of persons convicted of drug possession were sentenced to jail and 36% to probation (BJS, 1995). In a study of drug offenders sentenced to probation in 32 counties and 17 states in 1986, 49% were re-arrested within the 3-year period. One out of three was arrested for a drug offense. Drug abusers were more likely to be re-arrested than non-abusers.

The Inception of Drug Court

Drug courts have proliferated over the last few years. As of April 2001, drug courts had been implemented in some 500 jurisdictions (Cooper). One important impetus was the Violent Crime Control and Law Enforcement Act of 1994, which contained provisions calling for federal support for the planning, implementation, and enhancement of drug courts for nonviolent offenders. This federal support has helped to accelerate the growth of drug courts. Between 1995 and 1997 alone, the U.S. Department of Justice, through its Drug Courts Program Office, provided a total of $56 million in funding to drug courts. This included 151 planning grants to

help jurisdictions develop a drug court design, 99 implementation grants to start new drug courts and 29 enhancement grants to expand existing drug courts (DCPO, 1997). Another driving force behind the development of drug courts came with the enormous increase in the number of drug-related arrests and the resulting criminal cases that flooded the nation's courts. Historically, it was common practice to deal leniently with felony drug arrestees who had no prior arrests or convictions. More recently arrest, conviction, and sentencing trends in State and Federal courts indicate an increasingly punitive response to drugs. The response of state and local courts to increasing drug cases has been to primarily focus on case processing. With an increasing emphasis on not treating drug cases too leniently, rapid and efficient case processing has become more difficult. With this recognition came a sense of frustration that law enforcement policies and correctional policies alone could not adequately address this problem. Understanding began to develop that the "war on crime" and the "war on drugs" policies of the 1980's that had stressed attacking the supply and demand of drugs had not had the hoped for impact. The large increase in criminal caseloads that were largely driven by the increase in drug cases also served to further aggravate the problem. In response to increasing drug-related arrests and caseloads some courts began to respond by seeking new methods of improving case flow management, increased resources, and establishing specialized courts that focused on drug cases.

Types of Drug Courts

According to the Department Of Justice, there currently exist two categories of drug courts. The first type merely expedites the processing of drug offense cases. These drug courts are based on the premise that many cases can proceed through the court system at a faster pace than otherwise if appropriate routes for disposition are available. In this type of system, cases are not processed simply based on their chronological order but by using a variety of case management procedures. This type of drug court **is** primarily concerned with the proper case management of drug cases, which, in theory, will lead to a reduction of court backlogs. While this is true, this type of drug court also places some emphasis on drug treatment, counseling, - and rehabilitation (Cooper, 1994). The second type of drug court, treatment drug courts, seek to change the behavior of drug using defendants' using court-monitored and mandated substance use treatment. **The Buffalo Drug Court uses a combination of the two types.**

Treatment Drug Courts

The 1994 Crime Act authorizes grants only for those drug courts that have court monitored drug treatment, and does not provide grants for those that merely expedite the processing of drug offense cases.

According to a recent report by the Drug Court Resource Center (DCRC), drug treatment courts typically use one of two approaches to the processing of drug cases (GAO, 1995). In the first approach, deferred prosecution, the offender waives his/her right to a speedy trial and is placed in a drug treatment program. Upon satisfactory completion of the program, the case is dismissed and the defendant avoids a possible misdemeanor and/or felony conviction. In the second approach, post adjudication, the defendant is tried and convicted of a drug charge, but the sentence is deferred until the defendant undergoes treatment and either completes or withdraws from the program. In this approach, the defendant has increased incentive to do well in the program since the judge when determining the sentence considers any progress toward rehabilitation. **Both of these approaches are components of the BDTC. Additionally the judge may also impose Drug Court in response to probation violations where substance related behavior is identified.**

While eligibility criteria may vary slightly from one drug court to another, drug courts generally accept defendants who have substance abuse problems and have been charged with a nonviolent, drug offense. Additionally, most drug courts do not accept defendants who have been charged with a violent offense in the past. It should be noted that under the Crime Act of 1994, drug courts that allow current or past violent offenders into the program may not be awarded federal grants (GAO, 1995). **The BDTC adheres to the guidelines set forth in the Crime Act of 1994.**

The principal objective of drug courts is to change the behavior of drug-using offenders, thereby reducing crime, by using the authority of the court (GAO, 1995). In collaboration with prosecutors, defense attorneys, treatment facilities, law enforcement agencies and others, judges oversee drug court hearings, track defendants' progress in treatment, and impose appropriate incentives and sanctions. In the end, defendants are given more lenient sentences or, in some cases, have charges completely dismissed in exchange for compliance with and successful

completion of the prescribed treatment program. While some basic elements of drug court programs are the same, many vary in their established criteria for eligibility for the program, length of program, and prescribed sanctions.

The effectiveness of drug courts should be evaluated based on the question: Do drug courts make a difference? In other words, is there a reduction in recidivism, an increase in time to re-arrest, and a reduction in drug use among defendants who successfully complete drug court programs as opposed to defendants who were not exposed to drug court treatment? It should be noted that many of our nation's drug courts began in the early 90's and making firm conclusions as to their effectiveness is difficult to determine as no emphasis was placed on collecting data. (GAO, 1995)

Drug Court Programs

While there has been a large amount of variation and diversity in the design and implementation of drug courts, some core elements among treatment drug courts have been recognized across the United States (NIJ, 1994). Variations have existed in regards to the stages of criminal processing, court structure, treatment program components and target populations. Core elements that have been identified include:

(1) Judicial leadership and the judicial role in treatment drug courts,
(2) Collaboration among criminal justice, courts, treatment agencies, and community organizations,
(3) Target populations,
(4) Treatment program and operational procedures,
(5) Compliance and enforcement of program conditions,
(6) Anticipating the impact of drug court and its resource implications,
(7) An integrated management information system capacity,
(8) Funding sources,
(9) Implementation plan,
(10) Training and orientation of drug court professionals, and
(11) An evaluation strategy and periodic review of impact (NIJ, 1994).

Summary of Research Findings

In summary there are several comparisons that can be made between the effectiveness of the drug court approach and the traditional case approach (DCCTAP, 1996a). This comparison is of particular importance since it is hypothesized that the existence of the drug court approach as opposed to the traditional case approach leads to a greater reduction in substance use and crime. First, there is evidence of a reduction in drug usage among drug court participants compared to traditional case approach participants. Traditionally, substance abusers have received little treatment after conviction. In addition to receiving very little treatment most are not monitored for drug use. Because drug courts are designed to treat and monitor drug use, not only is it possible to accurately measure continued drug use but these programs are designed to treat and reduce drug use. Second, it appears that a reduction in drug use as measured by urinalysis among drug court participants leads to more favorable outcomes as measured by recidivism (Belenko, 1998). There is evidence that the drug court approach leads to reductions in recidivism. It is well documented in the literature that as substance use increases so does criminal activity. When compared to matched groups drug court participants have lower rates of recidivism. Third, there is more intensive supervision for drug participants than for other offenders. This supervision is more intensive and immediate than would have been provided to a typical drug court participant prior to the program. Fourth, because of the more intensive supervision, drug courts have a greater capacity to deal swiftly with relapse. This is of particular importance when it is recognized that substance abuse and addiction is often a chronic and persistent disorder. Historically, the failure to maintain sobriety has been followed by a new arrest. Drug courts are given more options in responding to incidents in relapse. These options focus on obtaining compliance from the offender in discontinuing drug use. Finally, the drug court approach is endowed with the capability of integrating drug treatment services with other ancillary social services that promote long-term abstinence and recovery. The traditional case approach is not designed to perform these functions and hence is not able to impact other factors (vocational, employment, family) that are needed by drug abusers.

In addition to making comparisons with the traditional case approach, it is also possible to present other findings from Drug Courts. These findings include that drug court programs have reported higher participant retention rates than for traditional drug treatment programs

(DCCTAP, 1996a). Drug Court programs have also generally found that the nature and extent of addiction and drug usage among Drug Court participants vary widely. Drug Court participants have reported that close supervision provided by the judge together with intensive and strict monitoring and treatment services are the keys to success. Most programs also report that Drug Courts are more cost effective than traditional methods of dealing with this type of offender. In addition to reporting cost savings it has been generally found that drug court programs are enabling agencies to more effectively allocate criminal justice system resources.

There is also some evidence that jurisdictions are beginning to target more serious offenders. This is a conscious policy decision by some agencies to use scarce resources for persons with more serious substance abuse problems rather than those with less severe problems who might be served through other programs and a recognition that traditional probation and incarceration have failed to prevent further drug use and criminal activity (DCCTAP, 1996a).

Conclusion

- The BDTC is following national norms regarding the design and development of the effective Drug Court. National guidelines have been drawn up by the Drug Court Program Office (DCPO) and the National Association of Drug Court Professionals (NADCP) that should be followed when designing and developing new drug courts. The U.S. Department of Justice, through its Drug Courts Program Office, has published a manual entitled: *Defining Drug Courts: The Key Components (I* 997) that discusses critical components that have been proven nationwide. The BDTC has been designed with these components as a guide in developing a quality program. It would be beneficial if these components were reviewed regularly and any changes or improvements be made promptly.
- Clearly, the BDTC promotes the safety and well being of the community. The intensive mandatory continuous supervision that the drug court judge provides for every participant provides a much higher level of community supervision than available through the traditional system. It also appears to promote longer and more sustained treatment and other services.

CHAPTER 3: METHODOLOGY

Introduction

During our initial contract cycle, there were two primary goals, (1) to conduct a process evaluation by examining the drug court program's established goals, design, and structure and assess its intermediate impact upon participants, and (2) to establish a framework that would be used in the future to conduct an outcome evaluation and evaluate the program's long-term success. A number of tasks were completed to meet these two goals and this section describes the methodology for reaching these goals. The " independent process evaluation was to measure the effectiveness of the BDTC as well as the establishment of a baseline of information for future evaluations". This activity was accomplished through the use of focus groups and structured instruments that were designed to encapsulate both process and impact results in quantitative and qualitative forms. Individual and group interviews were held to promote ownership, empowerment and investment in this effort. The evaluation design included the examination of the current operating of the BDTC and assessing process, situational factors and program impact. All results and findings were also used to compare and clarify how the evolution of the BDTC was similar and or different from the national critical elements and key components.

Activities

- **Collection, compilation, and analysis of all available quantified data, including reviews and assessments of prior reports and case management and treatment files.**
- **Systematic review of process and all available outcome indicators of past performance.**
- **Interviews with team members (Judge, coordinator, public defender and assistant district attorney) and participants.**
- **Interactive focus groups using a structured instrument addressing issues and status of program.**

The evaluation included twenty-five site visits by the evaluator (Rick Washousky, Recovery Solutions Consulting and Training Inc.). The BDTC team and participants were interviewed on site in semi-structured interviews. Each interview lasted approximately one hour. The focus groups that were held separately (participant, team and partners)) lasted approximately two hours. The purposes of these groups

were to clarify what the important issues, strengths, and weaknesses are, and to pursue these perceptions and concerns in detail. The framework used by this approach to documenting the program provides a basis for specifying its uniqueness. The evaluation formatted a program logic model, including descriptions of all program components and the relationships between program components. The approach presented here are fully explained and demonstrated in "Assessing the Effectiveness of the Criminal Justice Programs" Assessment and Evaluation Handbook series Number 1, January 1994. The model established a baseline for the process evaluation:

(1) To identify critical elements (Key Components) and status of implementation.

(2) To determine if the components are being implemented as designed and expected and,

(3) To determine if improvements can be made to current operations.

*D*rug Court Survey

One of the *first* tasks completed was a survey of the BDTC. In this survey we included a number of different subject areas. Content analysis found in:

❖ Program Information	❖ Buffalo City Court description
❖ Partner profiles	❖ Component profiles
❖ Eligibility Criteria	❖ Incentives and Sanctions
❖ Court Processes	❖ Supervision
❖ Information Dissemination	❖ Treatment Information
❖ Rehabilitation and Aftercare	❖ Program Funding
❖ Community Involvement	

This information collected was used to provide a general description of the BDTC and the following questions were developed for each Component.

Graduation Criteria

How is the case resolved, based on successful or unsuccessful completion of the treatment court?
What are the graduation criteria?
What is the Anticipated length of program?

Screening

How and by whom are eligible offenders identified?
What is the average length of time between arrest and transfer to Treatment Court?
What is the average length of time between arrest and enrollment in Treatment?

Assessment

Who is responsible for conducting the clinical assessment?
What is the time frame for conducting the initial assessment?
What are the assessment criteria?
Will a standardized instrument be used?

Sanctions and incentives

How will sanctions be used?
Are sanctions graduated?
Are sanctions individualized?
What are incentives?
How will incentives be used?

TREATMENT COURT TEAM

JUDGE – Hon.Robert T. Russell

COORDINATOR – Hank Pirowski

ADA – Barry Zavah

PD – Danielle Maichle

Evaluator – Richard Washousky

Database Manager – Jose Ferrer

Case Processing

How does a case enter the Treatment Court?
How often will the court convene?
How often does the participant appear before the Judge?
Will the Team meet for a staffing prior to a scheduled appearance?

Confidentiality And Ethics

Is there a clear understanding?
How will you ensure confidentiality?
What are the ethical issues and how will they be addressed?

Treatment and Toxicology

Who will provide the treatment?
Is treatment individualized?
Is a complete continuum of care available?
By who, how, and frequency of tests performed.

Community Supervision

Who is responsible?
How is case management defined?
What services are available?
How frequently are cases monitored?

CHAPTER 4: Lessons Learned, Critical Elements and The Ten Key Components

Although self-evaluation (Program Monitoring) has proven its worth to the BDTC, its most important result has been to produce knowledge about lessons learned and the identification of critical components or elements that are essential for success, self-sufficiency, and institutionalization. The BDTC "Keys to Self Sufficiency" are Ownership, Empowerment, Problem Solving, Accountability, Recovery, Learning by doing, Hope and Motivation and these keys are built in throughout the program components.

Principles Underlying Best Practice in the BDTC

- Provide comprehensive assessment - treatment linked to offender's needs
- Use full continuum of care - one size does not fit all
- Provide sufficient duration - serious needs require serious time
- Assure appropriate and rigorous BDTC supervision - frequent contacts, urine testing
- Access to BDTC Judge - swift & certain response to problems with graduated sanctions
- Leave treatment to licensed providers - respect their role, expertise
- Make available case management - coordinate linkage, keep communication lines active
- Maintain ongoing supports - AA/NA, alumni groups, periodic support counseling
- Maintain workgroups and teambuilding - ongoing meeting for oversight, problem solving

The following section, presents the ten (10) Key Components of Drug Courts and the BDTC's implementation and condition on each and it identifies their use in the successful accomplishment of both programmatic and organizational objectives. The "Key Components" presented below detail 10 characteristics of Drug Courts that were developed by the National Association of Drug Courts Professionals (NADCP) standards committee.

KEY COMPONENTS

(1) **DRUG COURTS INTEGRATE ALCOHOL AND OTHER DRUG TREATMENT SERVICES WITH JUSTICE CASE PROCESSING.**

The Buffalo Drug Treatment Court has been designed to enroll the non-violent substance abuser, which has met eligibility requirements, into a comprehensive and coordinated program of drug and rehabilitation services. **The goal of the program is to break the cycle of drugs and crime by substituting an effective treatment alternative, which is premised on mandatory attendance and monitored abstinence/recovery as an alternative to incarceration**. Drug Court procedures have changed the process for the non-violent drug addicted defendants who appear in Buffalo City Court. Instead of handling cases in a strictly punitive manner, the Drug Court supervises the treatment for addiction, which is the primary reason for the participant's involvement within the criminal justice system. The program relies on the personal involvement of a single Drug Court Judge who closely monitors the participation of the defendant throughout the recovery system.

In contrast to traditional case processing, the judge, prosecutor, defense council, C.O.U.R.T.S. PROGRAM (COURT OUTREACH UNIT: REFERRAL AND TREATMENT SERVICE) and treatment providers work collaboratively in a non-adversarial manner to encourage the defendant's success. Buffalo's Drug Court extends beyond the court and courtroom staff to include social service agencies, health care providers, job-training representatives, and the local colleges and universities.

(2) USING A NON-ADVERSARIAL APPROACH, PROSECUTORS AND DEFENSE COUNSEL PROMOTE PUBLIC SAFETY WHILE PROTECTING PARTICIPANT'S DUE PROCESS RIGHTS;

The meaning of " Due Process " is essential to understanding our freedoms under the 4th, 5th, 6th and 14th amendments of our Federal Constitution. " Due Process " may easily be understood by the use of the phrase fundamental fairness.

In the Drug Court the defense attorney as well as the prosecutor review the charges against the defendant and any information from the police reports and other documents that may be available.

The prosecutor will generally ensure that the candidate for the Drug Court meets the established program criteria. In addition, he will review treatment progress reports and ask the judge to impose sanctions when the participant fails to comply with program requirements; and may seek to remove participants who show no progress or who are arrested again for some kind of criminal activity.

The defense attorney will advise defendants about their constitutional rights (e.g. right to council, right to speedy trial) and practical options, including participation in the Drug Court, as well as explanation of how various treatment outcomes will affect the disposition of their case. If a defendant opts to participate in the program, they will encourage and support the defendant's participation and compliance with program conditions. In the Drug Court the prosecutor and the defense attorney facilitate a unique form of " Due Process ", both are part of the team working under the color of the law, to assist a participant recover their dignity and resume a productive, healthy, drug-free, law abiding life.

(3) ELIGIBLE PARTICIPANTS ARE IDENTIFIED EARLY AND PROMPTLY PLACED IN THE DRUG COURT;

The BDTC requires an initial screening for drug abuse/dependency completed and determined within the first two days of arraignment or referral. Upon acceptance, treatment intervention begins within twenty-four hours. Eligible non-violent offenders are directed into a comprehensive treatment program which includes both individual and group counseling, random as well as scheduled drug screens, peer support groups and linkage to appropriate social service agencies. Appearances in the Drug Court are immediate upon case transfer with the consent of the district attorney, public defender, Drug Court Judge and the treatment coordinator. Initially status hearings are scheduled at two-week intervals and eventually decrease to once a month, based on participant's progress.

(4) DRUG COURTS PROVIDE ACCESS TO CONTINUUM OF ALCOHOL, DRUG AND OTHER RELATED TREATMENT AND REHABILITATION SERVICES;

The BDTC screening process is designed to identify and determine who can benefit from treatment and matches the participant to an appropriate level of care. Placement into an established treatment system is based upon, but not limited to, the reported substance abused, social and psychological risk factors, geographical location (relationship of residence and location of provider) and insurance coverage. Assessment of participant's progress is routinely done though established licensed and accreditation policies and procedures for case conferences. The BDTC will direct eligible non-violent drug offenders and drug related offenders into a comprehensive treatment program which will include counseling, random and scheduled drug screening, peer-support groups and linkage services with community agencies. Quality assurances are met by utilization review, continued stay review and regularly scheduled Consortium staff meetings. All individual treatment planning and delivery are reviewed in accordance with N.Y. State licenser for continuous quality improvement performance standards and measures. Established

procedures are operationalized to assess individual and group therapy sessions, including participant's progress who is diverted from incarceration to comprehensive outpatient or inpatient integrated rehabilitation services.

The addiction treatment protocols or modalities that are followed in engaging and treating participants are those presently modeled from the American Society of Addictions Medicine and accredited by the Joint Commission on the accreditation of Health Care Organizations.

(5) ABSTINENCE IS MONITORED BY FREQUENT ALCOHOL AND DRUG TESTING;

The BDTC utilizes frequent urine testing as both a supervisory device and a therapeutic tool. It appears that, for some participants urine testing is an important way to prove objectively to themselves as well as the court, that they are making progress. For others, testing can be an external source of motivation that helps them achieve abstinence. Drug testing is a vital part of AOD treatment and provides a tool for determining progress and for making decisions about changes in the treatment plan. The BDTC has developed standards for urine testing for Drug Court treatment providers within the service delivery system. Instant urinalysis tests are also available to the Drug Court Judge to address suspicious behavior (missed appointments at the clinic; failure to meet clinical standards; failure to cooperate with testing at the clinical level).

6) A COORDINATED STRATEGY GOVERNS DRUG COURT RESPONSES TO PARTICIPANTS COMPLIANCE.

The BDTC contract is the structural cornerstone of the program. The contract holds the participant accountable for his/her behavior. The Drug Court, C.O.U.R.T.S. PROGRAM, and the treatment consortium are all committed to the terms of the contract, making themselves accountable to the defendant and to each other for the contracts promised consequences. Empowerment is the flip side of accountability. The Drug Court contract clearly outlines the

consequences of compliance and non-compliance, thereby empowering the defendant to take ownership of their own behavior throughout the recovery process. This allows the Drug Court to be realistic in its demands and expectations of behavior as defendants make their own decisions about levels of participation and the known consequences. It appears that through the ownership process the defendant is given the opportunity to become a participant rather than a self-described victim of the program.

7) ONGOING JUDICIAL INTERACTION WITH EACH DRUG COURT PARTICIPANT IS ESSENTIAL;

The approach taken in the BDTC is based on the Judge's authority in status proceedings. Defendants are required by the Judge to account for their behaviors or progress in open court. This unique judicial role is distinct from other treatment experiences. The close involvement of the Judge creates a relationship, which may be unique for the participants, since it combines authority with responsibility. It is essential for the Judge to have timely, accurate information on the participant's treatment progress. In this role the Judge in many respects becomes the manager or supervisor of the entire treatment process, encouraging where possible and using the authority of the court to empower the defendant to take responsibility for his or her actions.

(8) MONITORING AND EVALUATION MEASURE THE ACHIEVEMENT OF PROGRAM GOALS AND GAUGE EFFECTIVENESS;

The BDTC/C.O.U.R.T.S. Program Database was designed and implemented by the BDTC /C.O.U.R.T.S.Program staff. Internal development of the database has led to an inherent flexibility to make modifications as found necessary to gather and manage information for both monitoring daily activities and the evaluation activity.

The Buffalo D.M.I.S. system has the ability to track and report both defendant and system level data. Data needed for program monitoring and management can be obtained from records maintained for day to day program operations, such as return court dates, dispositions, status reports from treatment agencies, attendance records, urine results, the extent and nature of AOD

problems among those assessed, sanctions, incentives, treatment services and defendant characteristics (e.g. drug use, demographic data). Management and monitoring data can be assembled in useful formats for regular reviews by program staff and managers.

(9) CONTINUING INTERDISCIPLINARY EDUCATION PROMOTES EFFECTIVE DRUG COURT PLANNING, IMPLEMENTATION, AND OPERATIONS.

The education and training component of the Buffalo Drug Court has been addressed through a continuing education partnership with Erie County Community College. Through the spirit of commitment and collaboration " TREATING THE DRUG COURT CLIENT SEMINAR SERIES " has been developed and implemented for the purpose of maintaining the highest levels of professionalism and service while solidifying relationships amongst the treatment delivery system and the criminal justice system.

(10) FORGING PARTNERSHIPS AMONG DRUG COURTS, PUBLIC AGENCIES, AND COMMUNITY BASED ORGANIZATIONS GENERATES LOCAL SUPPORT AND ENHANCES DRUG COURT PROGRAM EFFECTIVENESS.

The Hon. Robert T. Russell " Presiding Drug Court Judge ' has taken the leadership role, in the formation of partnerships among representatives of the court, treatment providers, educators, police department, probation department, social service agencies, community based organizations, health agencies and local religious leaders. The partners meet regularly to provide direction and guidance in the growth and further development of the Drug Court.

The Buffalo Drug Court Team is active in the promotion of community involvement through informational meetings, forums, public speaking engagements, local college and university appearances, and other community outreach efforts. The Buffalo City Court Drug Court is a circular system, with each part of the system linked to, dependent upon, and responsible to the other parts.

Observations:

Taken together, the BDTC appears to have been implemented as originally intended and to have significantly achieved it's stated goals. The program has successfully overcome barriers to program implementation through the development of an effective collaboration of Court personnel, the District Attorney's office, the public defenders office, the legal community and a team of treatment providers, and through the development of formal written procedures. The successful development of the COURTS Program comprised of representatives from major licensed providers is particularly notable. The historical competitive orientation among these providers, a competition that has been recently been exacerbated by the forces of reduced funding and the in-roads of managed insurance, has been successfully minimized to serve the best interests of the defendant and the Court.

The BDTC has also effectively addressed the need for accurate and timely information regarding defendant's substance use that is key for effective supervision and treatment. In addition to the described system for routine and consistent reporting by providers, supervised urine toxicology examinations during Court sessions, and performed at the Judge's discretion, have been implemented. These examinations provide immediate feedback to the Court that can be directly addressed prior the end of that Court session.

CHAPTER 5: BDTC PROGRAM AND COMPONENTS DEVELOPMENT

Pre- Planning Grant May 1994

The Criminal Justice Task Force

Despite the ever-increasing caseload and limited resources, the judiciary in Buffalo proved a progressive commitment in adopting new practices that appear to have enriched the local process of administering justice. Chief Judge of Buffalo City Court, Thomas P. Amodeo, the Presiding Drug Court Judge Robert T. Russell and the Project Director Hank Pirowski, in cooperation with their colleagues and leaders from the criminal justice offices and treatment agencies, organized a local "Criminal Justice Task Force" (CJTF see appendix a). The CJTF exemplified the principle that judges should lead the movement for systemic reform, while at the same time soliciting and incorporating the ideas presented by the participation of our community's diverse constituencies. Judges Amodeo and Russell continue to co-chair the court's CJTF. It is a partnership of key criminal justice and community leaders that recommends policies to improve the coordination and development of court-driven treatment programs (e.g., Drug Court, COURTS Program, Juvenile Drug Court, and Domestic Violence Court).

The CJTF: (1) identifies and evaluates problems; (2) develops goals and strategies for addressing these problems; and, (3) oversees the implementation of solutions to the problems. The members of the CJTF recognized that problems like an overwhelming court caseload or an insufficient program alternative may adversely affect many agencies simultaneously and can rarely be solved alone. It appeared that broad-based cooperation among criminal justice agencies is the most effective means to overcome most problems. The CJTF had found that creative offender programs and criminal justice innovations such as **Drug Courts** were dependent upon easy access to treatment programs and that they appeared to work best when they meet the needs of offenders while focusing on both systems goals and objectives. Since most offenders abuse or are dependent on alcohol and or illegal substances and most of the crimes they have committed are considered drug "related", reductions in offender usage is a logical crime reduction strategy. It appeared providing treatment to substance abusing offenders had become accepted public policy based on an understanding that treatment works to reduce substance abuse and subsequently a reduction in criminal activity in some offenders.

Although each system has a different mission there were similar goals and objectives. Treatment focused primarily on the offender as an individual with a treatable disorder. The Justice system's priority is public safety, accomplished in part through forms of punishment in order to correct behaviors, which are considered by law harmful or offensive to society. Management and treatment of substance abusers among offenders required a case management approach that links systems while achieving a balance between criminal justice and treatment system objectives. (If this was to be effective primary substance abuse treatment must be complimented with ancillary health, educational and social service agencies).

The planners (CJTF) envisioned a Drug Court' based on the premise that intense judicial supervision coupled with treatment intervention immediately following arrest and release from custody created a significant opportunity for successful supervision and treatment of drug addicted defendants who are processed through the criminal justice system.

Through judicial monitoring of substance dependent offenders, the Drug Court's protects our community by decreasing drug-related crimes and reducing recidivism. A goal of the BDTC was to promote positive interaction and effectiveness between the criminal justice system, community treatment agencies, and offenders. Many elected officials, leaders in the law enforcement community, the New York Bar Association, community groups, and religious leaders supported this initiative.

C.O.U.R.T.S. PROGRAM

(COURT OUTREACH UNIT: REFERRAL AND TREATMENT SERVICE)

In early 1995, Buffalo City Court concluded that if it were to move in the direction of establishing a Drug court it would need to develop and implement an **onsite Pre-Trial and Post Adjudicated "treatment brokerage"/case management service that would meet the demands of two separate** systems: The Criminal Justice System and the Substance Abuse Treatment delivery system. The program was built upon research that treatment works whether it is voluntary or mandated through the power of the court. In July 1995, with a substantial grant from Buffalo's **Margaret L. Wendt Foundation** ($85,000) Buffalo City Court, in partnership with the City of Buffalo and the County of Erie announced the opening of the COURTS PROGRAM. This occasion was the first time a private local foundation had ever awarded a grant to a City Court. This allowed for the further development of the **BUFFALO DRUG TREATMENT COURT** (December 1995)

The **mission** of the COURTS PROGRAM is to intervene in the criminal justice continuum as early as possible for the purpose of identifying, screening and referring substance-abusing offenders to treatment. Through treatment and the closely managed community reintegration process, the COURTS PROGRAM aimed to **break** the cycle of addiction, criminality, arrest, prosecution, conviction, incarceration, release, relapse, associated criminality, and re-arrest. **The COURTS PROGRAM is considered a neutral organization that is not allied with any particular mode of treatment**. It is viewed as the "Gateway" or entry points to the BDTC and the treatment community. Buffalo City Court **manages** the program and the ten full time counselors (resource specialists/case managers) are guided by placement criteria established by the court. Defendants referred to the COURTS PROGRAM are placed with a participating member of our established treatment consortium. Placement is based upon, but not limited to, reported substance abuse or other problems, social and psychological risk factors, geographical location (relationship to residence vis-a-vis location of provider), client preferences, and the defendant's ability to pay (insurance issues).

[1] The “COURTS PROGRAM” identifies, screens and refers appropriate offenders to an established TREATMENT CONSORTIUM (see appendix b) as an alternative or supplement to current judicial sanctions and procedures. The COURTS PROGRAM is responsible for monitoring the defendant’s compliance with individually tailored service plans for abstinence, employment, and improved social-personal functioning. The COURTS PROGRAM reports treatment outcomes to the Judge assigned to the defendant’s case. Defendants who violate conditions set by the Judiciary are remanded to the judicial system for continuance of proceedings and/or possible sanctions. The COURTS PROGRAM combines the influence of legal sanctions for possible or proven crimes with judicial dispositions such as: deferred prosecution, creative community sentencing, diversion, and pre-trial intervention to motivate treatment cooperation.

Community Partnership for Change

The COURTS PROGRAM staff is provided “IN KIND”($460,000 annually) by the city’s Divisions of Substance Services and Youth, the Beacon Center, Bry-Lin, Erie County Medical Center, Horizon Human Services, Lakeshore Community Mental Health, Buffalo General Hospital and the Substance Treatment and Rehabilitation program of Sisters of Charity Hospitals. The program is also supported by interns (six per semester) provided by a partnership with four local colleges and universities. The collaborative element of the COURTS PROGRAM also includes cooperation with the court and courtroom staff, programmatic linkage to a 40-member consortium of licensed community-based treatment providers, social service agencies, health care providers and voc-ed services.

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[1] Formed in 1995 through a collaborative effort of Buffalo Mayor Anthony M. Masiello and Chief Judge Thomas P. Amodeo, The Hon. Robert T. Russell. The COURTS Program, under the direction of Henry G. Pirowski, is one of the nation’s “top 10” court-based initiatives (cf. US Department of Justice, A Guide to Successful Adjudication Partnerships). Its success centers on providing judges with a centralized, court-based unit that directly reports to the Court the progress of defendants as they comply with the Court’s mandates or sanctions. It tracks and monitors defendants throughout their stay in treatment recovery programs and brokers the treatment needs of defendants with a local consortium of treatment providers. Also, it is the treatment gateway for defendants who participate in Buffalo’s Drug Court (the Hon. Robert T. Russell, Presiding). Since 1995, the COURTS Program has received national recognition for its innovative approach. Such honors include the New York State Bar Association Public Service Award for the Furtherance of Justice (1995), the US Conference of Mayors’ City Livability Award (First Place/Large City Category, 1996). As a result of this effort, at its annual conference in 1997, the National Association of Drug Court Professionals selected Buffalo’s Drug Court as a National “ Drug Court Mentor Site”

Buffalo City Court's Components

Under a traditional judicial paradigm, criminal justice professionals often view a court-mandated treatment recovery service as an aberration of the administration of justice. The CJTF data supported the claim that these services complement the court's primary responsibilities of adjudicating disputes, protecting the public's safety while sentencing the most serious offenders to jail.

The process by which an accused offender moves from arrest to full discharge of sentence has many decision points. These points have many variations and decision-makers (e.g., Judges, Public Defenders, and Assistant District Attorneys) with various associated decision outcomes. At several points, a Judge may refer a defendant (PRE-ADJUDICATION, subordinate to the risk of flight) or order a defendant (POST-ADJUDICATED) who has current drug or drug-related charges or a history related to Alcohol or Drugs (e.g., petit larcenies, prostitution, disorderly conduct) to the COURTS Program for drug screening and or evaluation. Pre-trial referrals occur before individuals plead guilty or been convicted by a Judge or Jury. While these individuals are technically innocent, they are referred by the Court to seek a screening/evaluation for a possible substance abuse problem.

The CJTF experience with the COURTS Program dictated that defendants fully realized the broad authority of the Court through their periodic court appearance that consequently initiates and provokes behavioral change. In effect, the power of the Court reinforces treatment outcomes and holds offenders more accountable for their behavior

Overview

The criminal justice system can be viewed as a continuum, the stages of which involve personnel from various justice agencies. Throughout the stages of the continuum, efforts are focused on the common goal of protecting public safety. Major areas of criminal justice processing are:

Arrest

Arraignment

Plea bargaining (negotiations leading to disposition or trial)

Diversion Program

Trial

Pre=sentencing

Sentencing

Probation

Jails and prisons

Parole or mandatory release.

To provide the most effective services, AOD abuse treatment teams (COURTS Program Staff) and providers must work within each phase of the criminal justice system. Personnel should focus on system points of contact at every possible juncture. An understanding of the case-flow process at every stage from arrest to release has enhanced coordination. Ongoing communication for managing AOD-involved offenders is critical.

Buffalo Police Department

From 1996 to 2001, the Buffalo Police made over 100,000 arrests; of which sixty-five (65%) were misdemeanors charges (20,000 were drug arrests) and thirty-five (35%) were felony charges (10,000 + were drug arrests). The Police Department held 66,000 of these defendants in custody to await arraignment in Part 1 of Buffalo City Court. It should be noted that custodial defendants are arraigned within twenty-four (24) hours of their arrest.

Buffalo City Court

Buffalo City Court is a municipal court chartered by New York State and is a member of New York's Unified Court System/Office of Court Administration (NYSOCA). There is one Chief Judge and eleven other Judges elected for ten-year terms each by the citizens of the City of Buffalo. It has original jurisdiction over many offenses under the New York State Penal Law, including violations, misdemeanors, certain categories of vehicular and traffic matters, and preliminary jurisdiction over felony offenses.

Excluding felony cases, Buffalo City Court has full jurisdiction from arraignment to trial. With regard to felony cases, Buffalo City Court has jurisdiction only from arraignment to the felony hearing stage. At the felony hearing a City Court judge determines, after an evidentiary hearing,

whether there is sufficient evidence to hold defendants for the action of an Erie County Grand Jury. Superior Courts have singular jurisdiction over felony cases. The NYSOCA divides each new calendar year into thirteen equal, four-week terms. City Court Judges are assigned to sit in different terms on a rotational basis. During each term, the Chief Judge assigns two judges to sit in the "intake" parts of City Court (i.e., Parts 1 and 2). Part 1 handles custodial cases for arraignment and Part 2 handles non-custodial cases (i.e., defendants who have been issued an appearance ticket in lieu of being held in custody and, those issued summons) for arraignment. Intake judges rotate through part I and Part II every other week within the intake term. This system assures an even assignment of criminal cases to all judges throughout each term of City Court. The average intake per judge is approximately 1200 cases.

The judge has a goal of resolving their intake cases within the intake term. Unresolved cases remain with the arraigning judge and are "held-over" for resolution at a later date

Docketing Procedures

The administrative requirements that the court must meet in order to process the cases of all defendants (over 33,000 new filings and transfers in 2000 alone) are overseen by the Chief Clerk of Buffalo City Court and are performed daily on a manual basis.

The Chief Clerk's Office acquires all case records generated by the Police Department by sending a clerk to Central booking each morning to receive the files of all defendants arrested within the previous twenty-four hours. A clerk hand delivers this case paperwork to the court's Office of Criminal Records, which assigns a Docket Number (i.e., separate number) to each case. Multiple charges still constitute the issuance of only one docket number. The number sequence begins with the calendar year, followed by the alpha prefix signifying the type of proceeding, followed by a five-digit docket number (e.g., 01M-00001). The alpha abbreviation succeeding the calendar year denotes whether the case is a (F) felony, misdemeanor (M), violation (V) or traffic offense (T). The alpha prefix for multiple charges is determined by the most serious charge. In cases involving one or more co-defendants, each defendant is assigned a separate docket number for their case file. However, cases involving co-defendants are noted with the other co-defendants' docket numbers referenced on the case file jacket.

Once a docket number has been assigned, the case proceeds to arraignment that occurs in Part 1 of Buffalo City Court. Part 1 convenes at 9:30 a.m. each day of the year for all custodial defendants arrested by the Buffalo Police Department.

Public Defender/Defense Counsel

Of the 27,478 new filings or transfers in 1997, The legal Aid Bureau of Buffalo inc. (Public Defender Unit) indicated in its 1997 annual report that it received 19,744 new cases (4,361 felonies, 12,775 misdemeanors and 2,608 violations) or approximately 74% of all cases in the Buffalo City Court. The 12 attorneys within the Public Defender Unit made 53,045 court appearances, for an average of approximately 2.7 appearances per case. The Nature of dispositions were as follows: cases dismissed on motion before trial or hearing - 8,859, Guilty pleas Where Highest Crime Charged was a misdemeanor - 1,889, Violation - 5,443, Infraction – 266 and 2,021 warrants were issued for non-appearance. The average case takes between 60 to 90 days from the day of arrest to disposal.

The Erie County Holding Center

The Erie County Holding Center (ECHC) admits annually approximately 20,000 inmates. As such, it represents the second largest jail in New York State, smaller only than the jail at Ricker's Island. It is estimated that as many as 50%-60% of these inmates have serious alcohol and/or substance abuse problems. (IADM, 1999). Moreover, many of these inmates have co-existing mental, emotional and vocational issues that further compound problems in their lives. Many of these individuals do not have adequate employment skills needed to obtain sustainable earnings. Upon release, consequently, these individuals become applicants for social services, placing increased financial expenses to the County. Not only are these individuals lacking career skills, they also lack remedial academic skills resulting in only entry level employment options (often below the poverty level). It becomes increasingly difficult to get them off social services, once received, as their employment opportunities are limited by the lack of skills and legal history.

Observations

The role of the prosecutor and defense counsel in the BDTC diverge markedly from that in other courts. Both the prosecutor and defense counsel have agreed from the outset that Drug Court proceedings will be non-adversarial, and that the over-riding purpose is to achieve the successful treatment and rehabilitation of the defendant. The prosecutor and defense counsel appear at every Drug Court session and participate fully in Drug Court Staffing sessions prior to court. All parties accept that relapse is a frequent aspect of treatment, and that it is best dealt with through both appropriate sanctions and support applied by the Court. All information regarding defendants' participation in the Drug Court is available to the prosecutor and defense counsel at their request.

There is no evidence to suggest that the existence of the BDTC places more pressure on defense attorneys or defendants to accept plea offer. The Court does not apply any pressure on defense attorneys to recommend to their clients their participation in Drug Court. In contrast, defense attorneys have recognized and sought Drug Court as an opportunity for their clients to avoid onerous mandatory sentencing requirements while simultaneously addressing their chemical dependency and associated life problems.

It is currently estimated that Erie County, New York spends approximated 30 million dollars each year to deal with this criminal population with few gains being produced. It is difficult to determine the additional expenses in social services, non-compensated health care, and recidivism rates, case disposition expenses, and case processing time and dollars for officer time and transportation. However, it is abundantly clear that this population represents an enormous fiscal drain on the Western New York economy.

CHAPTER 6: BDTC PROCESS

The Buffalo Drug Court Program: A Pathway to Recovery

The BDTC is a courtroom created to assume the responsibility for managing cases involving drug-using offenders through intensive judicial supervision and treatment. The BDTC brings to bear the full weight of all interveners (e.g., the judge, probation officers, correctional and law enforcement personnel, prosecutors, defense counsel, drug testing, rehabilitation and treatment specialists, vocational, educational, and employment specialists).

The BDTC is a court system integrated with treatment and community resources which focuses on the development of an individualized outcome based treatment program for each defendant. BDTC is characterized by immediacy, continuity, accountability and sustainability. Core components of BTC include: drug treatment, sanctions and incentives, judicial supervision, collaborative implementation, and information sharing.

The primary goal of the BDTC is to enroll the non-violent substance abuser, which has met eligibility requirements, into a comprehensive and coordinated program of drug and rehabilitation services. The primary objective is to break the cycle of drugs and crime by substituting an effective treatment alternative that is premised on mandatory attendance and monitored abstinence rather than incarceration. The drug court has changed the manner in which the non-violent drug addicted defendants are processed through Buffalo City Court. The BDTC relies on the personal involvement or mentoring of a Drug Court Judge who closely monitors the participation of the defendant throughout the recovery process.

Target Population

Eligible candidates for participation in the BDTC are non-violent offenders who satisfy the drug-screening criteria. Both misdemeanors and limited felony possession charges are eligible for the BDTC. Misdemeanor offenses included for participation are drug possession, other theft-related offenses, petit larceny, prostitution and criminal trespass cases. The felony offenses considered, are those for Criminal Possession of a Controlled Substance in the Third Degree, in violation of Section 220.16-1 of the NYS Penal Law, where the amount seized is less than 300 milligrams;

and Criminal Possession of a Controlled Substance in the Fifth Degree, in violation of Section 220.06-5 of the NYS Penal Law, where the amount seized is less than 1000 milligrams.

General Exclusionary - guidelines for the Drug Court consist of automatic exclusion where the defendant's current case includes charges of sex offense, domestic violence, child abuse and drug sales. A violent offender is generally defined as a person who either (a) is charged with or convicted of an offense, during the course of which the offender carried, possessed, or used a firearm or other dangerous weapon; caused the use of force against another person; or caused the death of, or serious bodily injury to another person; without regard to whether proof of any of the elements described herein is required to convict; or (b) has previously been convicted of a felony crime of violence involving the use or attempted use of force against a person with the intent to cause death or serious bodily harm. Although not part of the Drug Court's initial target population, plea and treatment procedures are being developed to include certain drug-driven class D & E felonies as well as violations of probation.

Intake and Assessment Procedures/Screening Instruments

Custodial and non-custodial defendants may be referred to participate by their defense council, the prosecutor, and judges presiding in Buffalo City Court as well as the Superior Courts. Defendants in custody are referred to the Drug Court within the statutory time frames required for arraignment.

Prior to defendants being admitted, the Court Coordinator and/or Court staff members ensure that all appropriate parties (prosecutors, defense counsel, etc.) are consulted, and that a timely clinical assessment of Drug Court candidates is performed. Representatives of several local licensed chemical dependency treatment providers that are assigned in kind to the COURTS Program perform this 25-minute assessment prior to the Drug Court session. The treatment team may meet with the Judge in chambers prior to the onset of the Court session to review their findings and to make recommendations for the treatment, rehabilitation, and housing of the defendants. The defendants are then seen in open Court, at which time the Judge reviews the expectations and conditions of participation. If accepted into the program and before they leave the Court, defendants are provided telephone numbers, contact persons and a treatment

admission appointment. They are expected to attend this appointment and begin treatment immediately. The defendant is then scheduled to reappear before the Drug Court in one week to ensure their compliance with the initial Court directives.

The Drug Court Judge, at his own discretion, may defer the formal admission of a defendant into the program subject to their successful completion of a 2-week trial period. In order to "pass" a 2-week trial phase, the defendant must:

- Attend the initial treatment program comprehensive assessment and orientation;
- Attend all scheduled treatment sessions;
- Comply with the drug testing order; and
- Return to court as ordered.

Program Staff in the performance of their initial screenings use no formal, comprehensive screening instruments beyond the electronically OASIS (NY State Office of Alcoholism and Substance Abuse) approved Screening Form that is the foundation of the Buffalo MIS system. It is felt that the use of such measures would not materially improve the quality of the screening assessment while creating unwarranted technical challenges that would impede Court efficiency. However, the individual treatment providers that receive referrals from the Court subsequently perform comprehensive chemical dependency assessments using a variety of methods that may include the use of a published formal screening tool such as the ASI. On the basis of this more comprehensive assessment, a treatment plan inclusive of all treatment, rehabilitation, housing and self-help participation goals and expectations are developed. This plan is forwarded to the Court and serves as a baseline guide for the Court's evaluation of defendants' progress and compliance.

Observations*:*

Participation in the Drug Court is entirely voluntary, and defendants are fully apprised, prior to their admission, of the requirements, procedures, incentives and sanctions associated with participation. Defense Counsel is fully informed of these parameters, and has full access to all Court information regarding their client. Additionally, defendants may chose to discontinue their participation in the Court, with the prior understanding of the application of consequences previously associated with their charge and/or conviction.

Role of Judge

This is a unique untraditional judicial role and in many respects, the judge becomes the manager, or supervisor, of the entire treatment process, encouraging where possible, and using the authority of the court to empower the defendant to take responsibility for his or her actions.

The focus and direction of the Drug Court program are provided through the effective leadership of the BDTC Judge. This role requires that the Judge work in close collaboration with the treatment consortium as well as with other Court staff and related criminal justice agencies in decision-making and the sharing of resources. As this would suggest, the BDTC model requires that the Judge fulfill several additional roles that vary from those in other courts. These included:

- To preside at all BDTC sessions.
- To meet with the Drug Court Staff (treatment team) prior to each BDTC session. This allows the judge to consult with team members, to discuss the status, progress, and compliance of participants, and to ensure that the Court is receiving treatment information that is sufficient and timely for Court determinations.
- To meet with the Drug Coordinator to ensure that the Court operates smoothly, address staffing and budgetary matters, ensure the effective operation of the treatment provider team, and ensure that the full range of treatment options are available to defendants.
- To maintain a non-adversarial atmosphere in the Drug Court. All individuals functioning for or with the Court must see their job as the facilitation of the participant's rehabilitation.
- To encourage and motivate defendants to seek rehabilitation through both sanctions and incentives, and including informal and more frequent Court appearances to maximize the Judge's impact and ensure close monitoring.
- To conduct BDTC sessions in open court so that all participants may benefit by observing others as they progress (or fail to progress) in the program.
- To serve as a primary program spokesperson and advocate. This includes presentations with government, the legal community and criminal justice agencies to educate them regarding the program, and to develop collaborative relationships.

Ongoing Judicial Oversight

The BDTC maintains continuous supervision over the recovery process of each participant by means of frequent status hearings, urinalysis and progress reports compiled and delivered by the C.O.U.R.T.S. Program to the presiding Drug Court Judge and the Drug Court Team. Drug usage or failures to comply with conditions set by the Drug Court are responded to promptly.

Monitoring Procedures/Impact on Court System

The BDTC is notable for the closeness of the monitoring of participant's status. This is made possible by the active, weekly participation of the on-site representatives of the treatment providers who are assigned to the court. Off site treatment partners forward a written "Drug Court Progress Report" (attached) to the Courts Program. The BDTC monitoring unit enters the compliance data into the MIS. The Drug Court Coordinator and case management team reviews the reports immediately prior to each Court appearance for all defendants. This report includes:

- Documentation of all dates on which the defendant failed to appear for treatment,
- The results of breathalyzer and urine toxicology evaluations;
- The defendant's general attitude and compliance;
- Their current treatment regimen;
- Other associated self-help, vocational, and other services; and
- Provider recommendations.

Immediately prior to the Court session, the BDTC team led by the Judge reviews these progress reports. The Judge is apprised fully regarding defendant's circumstances and treatment recommendations. The coordinator and treatment representatives subsequently participate in the Judge's interview of the defendant in open Court (status hearing), and there receive directives from the Judge regarding approved modifications in the treatment, supervision and monitoring regimen. In order to ensure communication, the Drug Court Coordinator ensures the completion of a contemporaneous record of these directives that is distributed to all treatment providers.

It should be noted that treatment providers are required to immediately notify the Court and the Court Coordinator regarding any significant changes in the defendant's status that may seriously hamper the defendant's participation or that may pose a risk to the community. Most treatment

provider team representatives communicate with the Drug Court Coordinator on a near-daily basis to keep the Coordinator apprised of the status of individual defendants and to stay current with Court procedures, activities and schedules.

The Contract

Upon referral to the BDTC, the defendant enters into a written contract (pre-Adjudicated). Pursuant to the contract (appendix C), the defendant agrees to abide by all the procedures and requirements of the court, including, but not limited to, mandatory treatment attendance and monitored abstinence. The defendant is also advised of the possible sanctions the court can impose for non-compliance as recognized by the program guidelines. Graduated sanctions range from in court admonishment to short periods of incarceration.

Standards for Urine Testing

- Inpatient: at admission a broad screen will be done. Following admission screen, repeat screens for positives will be done every 2-3 days or until there are two negative results. Ruins will be repeated as needed (for suspicious behavior, or after program passes). Primary drugs of abuse should be tested at least weekly until discharge.
- Outpatient: at first visit a broad screen will be done. Urine tests will be administered at least twice per week until results are negative for a period of one month. Following this, repeat ruins every five visits, for two months, or until discharge. Positive results initiate restart of original urine scheduling until negative screens is achieved.
- Court status hearings: instant urinalysis tests are available to the Drug Court Judge to address suspicious behavior (missed appointments at clinic; failure to meet clinical contact standards; failure to cooperative with urinalysis screening at the clinical level).

Sanctions: (Response to Relapse and Non – Compliance)

The BDTC recognizes that relapse is part of the recovery process. Recovery in general is a long-term process and the BDTC anticipates that a significant number of participants may relapse.

The Court enforces a graduated set of sanctions that are designed to motivate defendants' compliance and ensure the safety of the community. All defendants sign a compliance contract (attached) that includes an enumeration of examples of non-compliance and associated sanctions. Examples of non-compliance include the defendant's failure to:

- Attend any mandated treatment appointments;
- Attend any scheduled Court appearances;
- Remain drug-free as evidenced by 100% negative urine toxicology results; and
- Lead a law-abiding life as reflected by re-arrest/conviction.

The team addresses non- – compliance issue and responses at staffing held prior to appearance. The Judge considers the severity, extent, and overall record of defendants' compliance in determining appropriate sanctions. The failure to appear for a scheduled Court appearance immediately results in a bench warrant for the arrest of the defendant. Other sanctions include:

- In-Court admonishment;
- Intensified or extended treatment as recommended by the treatment providers;
- Increased frequency of Court appearance;
- Change in urinalysis requirements or frequency,
- Penalty box,
- Community service
- A period of incarceration; and
- Termination from the Drug Court and imposition of the prior sentence.

Sanctions are one means of addressing relapse (as well as other concerns) with the goal of assisting participants regain abstinence. Graduated sanctions are utilized to hold participants accountable and to bring participants into compliance with rules and requirements of the BDTC.

Incentives

The BDTC recognizes that a participant's progress is incremental in nature and uses incentives to acknowledge successes and progress. Incentives are used to motivate participants to continue their efforts in reaching their treatment goals. The indicators of progress include abstinence validated through urinalysis results, completion of phases and or other milestones (i.e. 60, 90, 120, 180 days clean), positive comments from the primary therapist and engagement in other positive activities such as jobs, training and education. Incentives include verbal acknowledgements and praise from the BDTC team, certificates and ultimately graduation.

Completion Criteria

Completion of the BDTC will be based on achievement of the following goals:

- Continued abstinence from all illicit substances, including alcohol;
- Development of a relapse prevention plan;
- Commitment to community support system (AA or NA);
- Completion of identified individual goals;
- Continued adherence to all conditions set by the Court.
- Achieving employment or enrolled as a full time student

In most cases Defendants who were charged with misdemeanor offenses and have successfully completed the BDTC will have their case Adjourned in Contemplation of Dismissal with the conditions of continuing care and random urine testing throughout their conditional discharge period.

Graduation From Drug Court is indeed " a commencement", that is, a beginning of a lifelong effort.

Presiding BDTC Judge, Robert T. Russell

Observations:

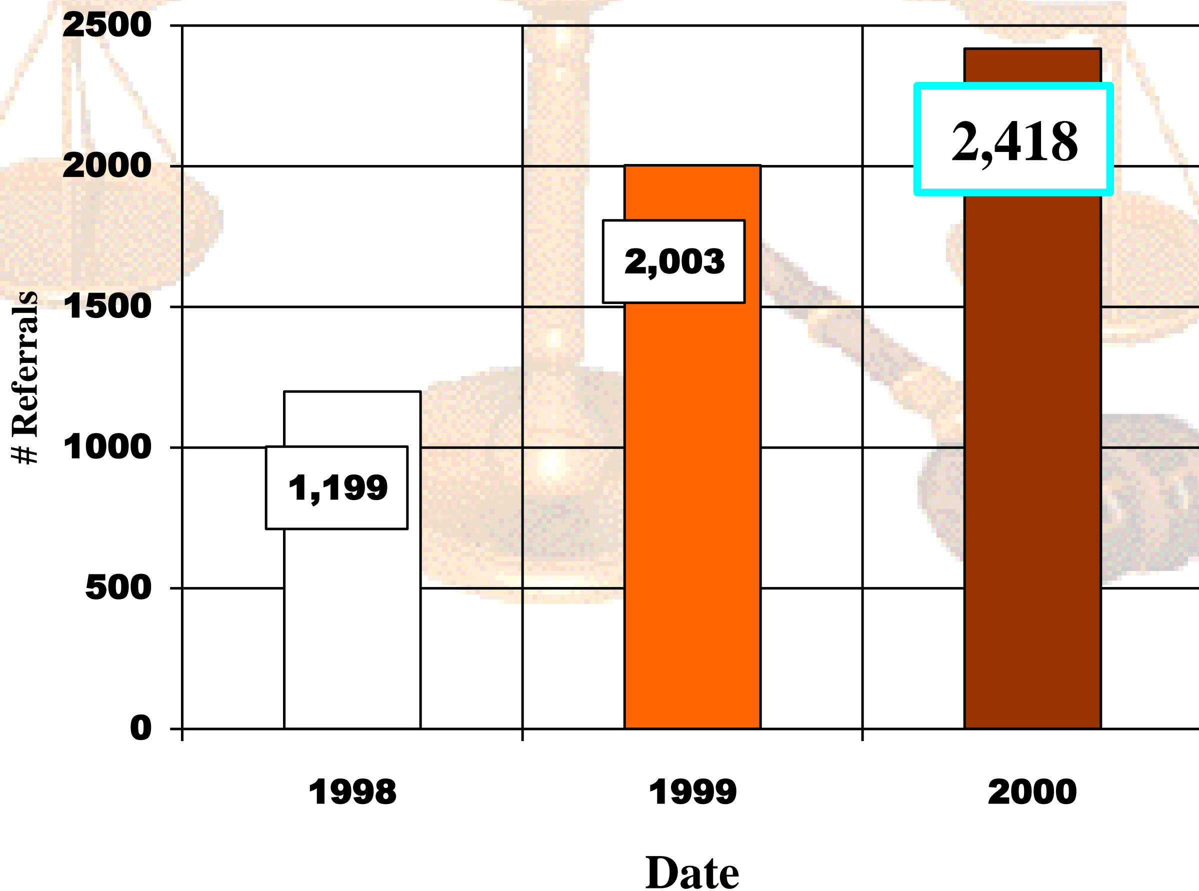
The BDTC strategy was based on a conscious decision to focus on the cause of the growing number of drug-related cases rather than simply on the number of cases. This occurred since it was decided that it would be worthwhile to attempt to give defendants an opportunity to change by offering a demanding program of drug treatment. Rather than simply operating as a point of referral to treatment, the BDTC approach established itself as an integral part of the treatment process. It was based upon the unorthodox view that the various parties within the court would work on a **team approach** rather than the traditional adversarial approach. In this way the judge, prosecutor, and defense attorney would work in a setting that encouraged a treatment approach. In addition, this system experiment recognized treatment providers as integral and important partners in this experiment. The combination of these two components; the role of criminal justice system officials (primarily the judge) in the courtroom and the existence of outpatient drug treatment programs is central to the BDTC model.

The BDTC is different form other courts in that the pressure on defendants is inherent to the intensive monitoring and supervision of their compliance with treatment and abstinence from all mood-altering substances. This pressure is seen as critical for the effectiveness of both the BDTC and treatment. It is widely recognized in the treatment community that powerful externally applied incentives are often critical in clients' overcoming the pathological denial and resistance that frequently undermines treatment efforts. Given the often-devastating effects of substance abuse on individuals, their families and the greater community, and the range of beneficial effects of treatment and recovery, the added pressure on defendants appears to be justified.

CHAPTER 7: ABILITY TO PROVIDE EFFECTIVE TREATMENT

- NYS has the largest, most extensive alcohol and substance abuse system in the country.
- NYS Office of Alcoholism and Substance Abuse Services (OASAS) – Is the single state agency responsible for alcohol and substance abuse services
- Licenses and oversees 1,350 treatment providers
- 115,000 individuals in care
- 1,700 prevention programs
- 13 ATCs, Central and Field Offices, BCJS

Drug Court: The Fastest Growing CJ Referral Source in NY (OASAS, 2002)



The Role of Managed Care

Concern about health care costs, coupled with the perception that much care is unnecessary or provided inefficiently, has given rise to new techniques for managing health benefits and holding clinicians accountable for services provided (Institute of Medicine 1989). Using these techniques means that access to quality care must be carefully balanced with the demands of cost containment through a process known as **"Managed Care".**

What is Managed Care

The term "MANAGED CARE" generates a great deal of fear and confusion. For the purpose of simplicity, " Managed Care" can be described as an organized system of care which attempts to effectively balance access, quality and cost of services by:

- Intensive Case Management
- Utilization Management
- Provider Selection
- Cost Containment

It is essential to understand that managed Care Organizations (MCOs) are vendors of a service who have negotiated service contracts with a governmental agency. These service contracts are designed to achieve specific financial, administrative, system development and clinical goals.

Managed Care Models

Managed Care has moved and is moving through several "generations", conflict and confusion often exist between the fiscal objectives (cost containment) and the clinical objectives of providing appropriate quality care in an effective timely manner to all those who are eligible and found appropriate for services. A basic understanding of managed care can be helpful in understanding managed care behavior and the maturity of systems (Center for Substance Abuse Treatment 1994; Waxman 1994).

1. The first generation of managed care focused on reducing costs by restricting access to services through such means as overly rigid utilization review, limited benefits and large co-payments.
2. The second generation managed care organizations (MCOs) manage benefits. They focused on the development of provider networks, selective contracting, increased treatment planning and less rigid utilization review process.

3. Third-generation MCOs focus on managing the care of enrollees by emphasizing treatment planning and carrying out more active management of clients through the course of their treatment(s). This involves enhancing the breadth and "seamlessness"of the continuum of care and actively using the least restrictive treatment settings that are clinically appropriate. The MCO may provide highly individualized clinical management for individuals who are at high risk for multiple readmissions or who are particularly hard to treat.
4. A fourth generation-now being aspired to-is for MCOs to manage by outcomes. This model seeks to focus primarily on the outcomes of treatment and allows greater provider autonomy regarding how these outcomes are achieved. To the extent that the field moves towards this "outcomes management" model, research and clinical findings will be fed back to treatment programs, which in turn provide new data for further analysis. This will create a self correcting treatment system.

Implications

The Drug Court as well as the substance abuse field has not been exempt from having to adapt itself to Managed Care approaches now in place or those being established in numerous settings.

In both the local alcohol and substance abuse treatment (AOD) field and the BDTC, there is a movement toward using a variety of treatment models to ensure access to quality treatment while conserving valuable healthcare resources.

IT would appear that healthcare professionals (clinicians, case managers, resource specialists etc.) must focus on matching patients to appropriate, specific treatment rather than placing patients in established programs. The success of Judicially supervised, clinically driven treatment depends on the importance of an accurate diagnosis. However, it is not only a diagnosis of addiction, but also the severity of the addiction that must determine the kind of treatment an individual patient should receive.

This complete determination can result in:

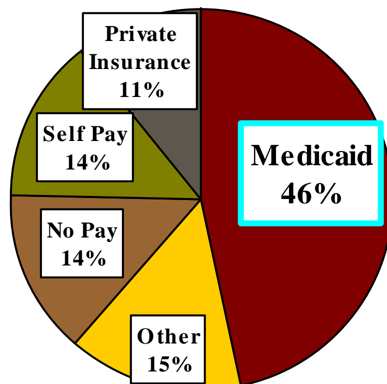
- Placement of patients in the correct level of care.
- Seamless movement of patients within the continuum of care (less intensive or more intensive when appropriate).
- Matching patients individually to a variety of treatment modalities at all levels of care.
- Maintenance of clinical integrity.

The "**retooling**" of the addictions treatment system necessary to promote individualized treatment within a "Managed Care" environment required a shift that had broad implications for the AOD field that included:

- The development of a uniform set of clinically based placement criteria.
- Programs expanding their continuum of care that will provide multiple levels of care with flexible lengths of stay.
- Payers reimbursing and funding all levels of care so that patients can be placed and moved around among the most efficient and effective settings.
- Clinicians becoming more skilled at comprehensive assessment and have a broader knowledge of placement criteria and treatment modalities for better patient-treatment matching.
- Patients receiving care that is not only more cost effective but more cost efficient.
- As patients receive treatment in the least intensive yet safe setting, they can test recovery skills in situations as close to "real world" conditions as possible (community reintegration).

It would appear that Healthcare costs can no longer support inefficient care born out of programs with one level of care and one treatment protocol for all patients regardless of the clinical heterogeneity assessed, or too often not assessed. Patients who present for treatment are becoming increasingly diverse. There is a greater gender and ethnic mix and as a group they are polydrug users, many having a dual diagnosis (mental illness and substance abuse) and experiencing psychological and social impoverishment. Consequently, staff skills and treatment options must also become more diverse.

Medicaid is Important to Treatment Providers



- **Medicaid is the single largest payer source and accounts for two-thirds of all public treatment funding**
- **The highest level of No Pay and Self Pay are CJ clientS**

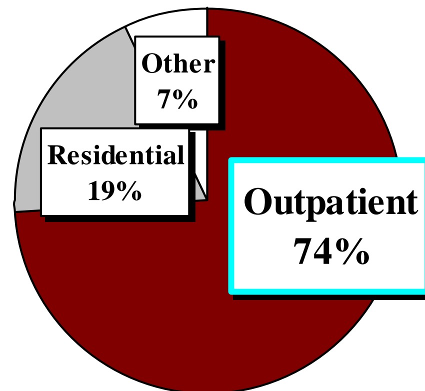
Common Criticism of Managed Care

❖ **Emphasizes short–term cost cutting at the expense of long-term outcomes and savings.**	❖ **Is inexperienced in managing special populations (e.g., ethnic/racial minorities, criminal justice referrals, injection drug users)**
❖ **Is used as a means to diminish or eliminate AOD treatment services, or to undertreat AOD clients.**	❖ **Uses overly restrictive interpretations of "medical necessity" that contradict or otherwise neglect basic tenets of AOD treatment. Makes referral decision based on general policies and procedures rather than on individual client needs**
❖ **Overemphasizes cost containment and underemphasizes quality of care, program content, staffing, and clinically oriented concerns. Utilizes gatekeepers who are poorly trained and /or inexperienced in AOD treatment services.**	❖ **Has inadequate grievance procedures**
❖ **Sets arbitrary limits on the duration, type, or access to treatment**	❖ **Refuses to purchase longer-term residential care (e.g., recovery homes, therapeutic communities)**
❖ **Restricts methadone maintenance as a treatment option for opiod-addicted individuals**	❖ **Has fiscal incentive to delay, deny, or restrict care.**
❖ **Relies excessively on outpatient treatment models**	❖ **Is based on the needs of the employed and not the unemployed or underemployed**
❖ **Lacks national standards and is unregulated**	

Summary

Within the Managed Care environment, as provider's struggle with the pressures of cost containment, accountability and documentation, it often seems there is little time to focus on the patient. Yet, if the BDTC is able to protect access to quality care, Managed Care organizations and the treatment community must work together to make the transition to new cost conscious systems of care that incorporate careful assessment and individualized treatment.

The fundamental principle of the Buffalo Drug Treatment Court participant placement system is that the participant be placed in a level of care that has the appropriate resources (staff, training, and services) to assess and treat the participant's condition according to the severity and the participant's health and level of functioning.



Participant Distribution 12-31-01

The BDTC and the Western New York Consortium of Alcohol and Substance Abuse Providers follows national, state and local guidelines to determine levels of care for service participants. These guidelines include Dimensions for intoxication and/or withdrawal, Biomedical condition, Emotional/mental heath status, treatment acceptance/resistance, Recovery environment, Relapse potential. The New York State Office of Alcohol and Substance Abuse Services (OASAS) has reported that the Western New York Treatment System is currently underutilized and that Service Capacity is expandable if found necessary.

Many local providers have assimilated the American Society of Addiction Medicine Patient Placement Criteria, 2nd edition. as well as, using the Comprehensive Assessment and Diagnostic Summary developed through the Erie County consortium of Alcohol and Substance Abuse Providers and Treatment Subcommittee as the standard admission evaluation screening for all admissions. Neither of these products is a substitute for the clinical expertise of qualified assessors.

Continuum of Care Issues

- Choice of Treatment Levels (movement)
- Inpatient vs. Outpatient
- "Failed Outpatient"
- Medical Necessity
- Self help groups **NOT a treatment level**
- Treatment Availability

Gerald Schulman M.A. FACATA
Consultant, Buffalo Drug Treatment Court

Levels of Care ASAM Patient Placement Guidelines

Level I: Outpatient Treatment

- Non residential
- Less than 10 hours per week

Level II: Intensive Outpatient Treatment

- Non residential
- 10 or more contact hours per week in a structured program

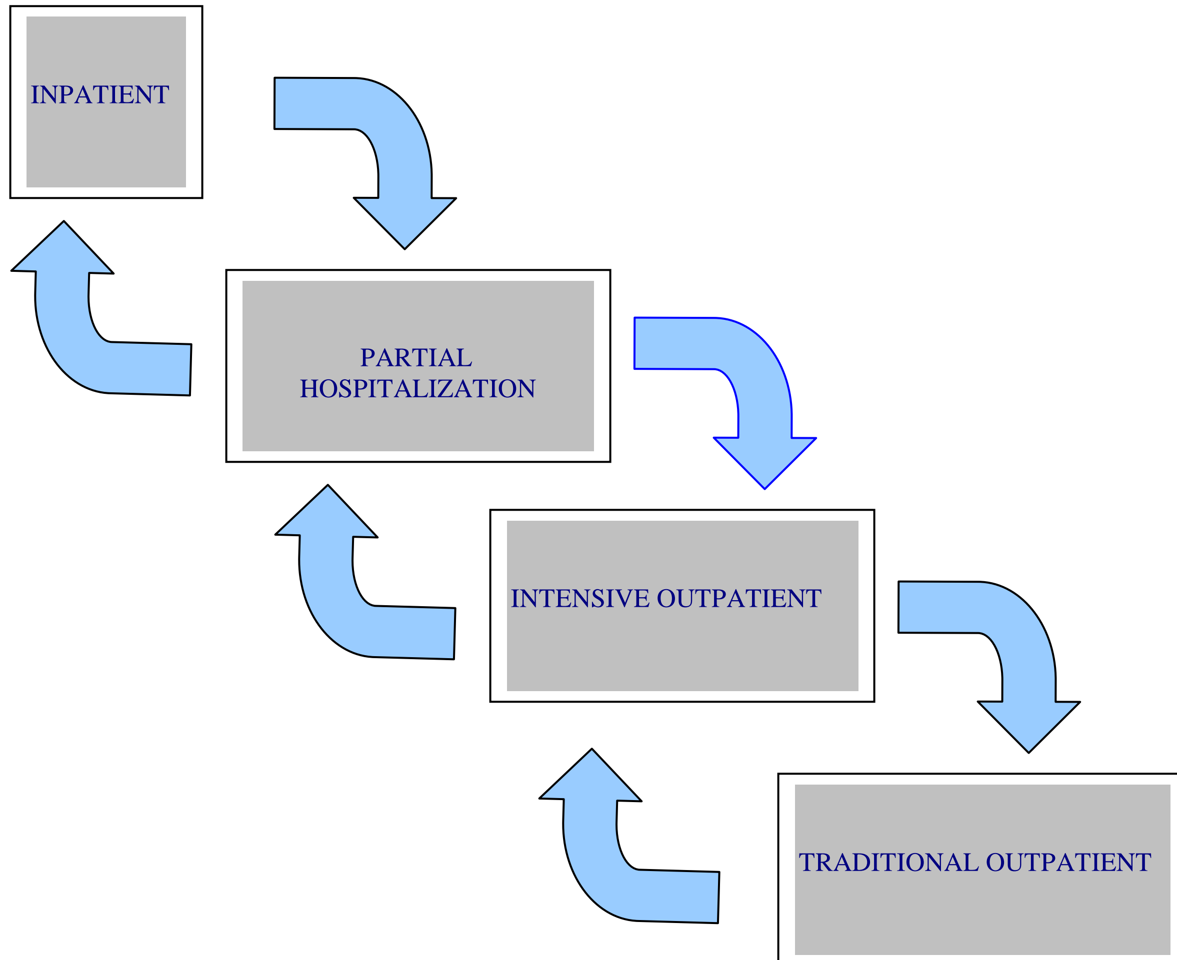
Level III: Medically Monitored Intensive Inpatient Treatment

- Residential
- 24 hour, professionally directed evaluation, care and treatment
- For patients with sub-acute medical and emotional/behavioral problems that are severe enough to warrant inpatient care

Level IV: Medically Managed Intensive Inpatient Treatment

- Residential
- 24 hour, professionally directed evaluation, care and treatment
- For patients whose acute medical and physical/emotional/behavioral problems are severe enough to require primary medical and nursing care

BDTC CONTINUUM OF CARE FOR CHEMICAL DEPENDENCE TREATMENT



ENTER ANTWHERE ON THE CONTINUUM

MOVE UP OR DOWN, DICTATED BY PARTICIPANT PROGRESS AND NEEDS

USE AS MANY OR AS FEW LEVELS AS APPROPRIATE

Levels of care for alcohol and drug treatment referral are inclusive for; Crisis Services, Outpatient, Inpatient, and residential treatment.

Crisis Services: Inpatient Medical Detoxification (hospital-based), Inpatient Medical Supervised Withdrawal, Ambulatory Medically Supervised Withdrawal, Medically Monitored Withdrawal (residential) (Detoxification and Withdrawal), Crisis Services (detoxification and Withdrawal) are designed for individuals who: (1) are at risk or moderate to severe withdrawal symptoms; (2) are incapacitated by substances; (3) have an alcohol or substance condition and require acute care for acute physical or mental conditions; (4) are intoxicated and are experiencing situational crisis related to homelessness, potential domestic violence or abuse, disorderly conduct, or other conditions requiring immediate placement in a short-term controlled residential or impatient setting; or (5) have a history of alcohol or substance dependence and are unable to abstain without admission to a supervised setting, but who may be motivated to engage in treatment and recovery services. Minimum services include monitoring of withdrawal symptoms and vital signs, motivational counseling, assessment and placement.

Outpatient: Standard Clinical Service, Intensive Clinical Services, Rehabilitation Services and Methadone Maintenance Services

Outpatient services are the central integrating component of the alcoholism and substance abuse treatment system. Assessment and referral services to determine appropriate placement and make the needed treatment referral are provided on an outpatient basis. Outpatient treatment is designed for individuals who have a dependence or abuse condition, but who are able to participate and comply with treatment outside a 24-hour treatment setting. Outpatient services are part of a continuum of care with also include crisis, inpatient and/or residential treatment. Using supervised community residential services often enables an individual to be treated on an outpatient basis rather than requiring inpatient or residential treatment. A significant other may be provided clinical services when services are expected to establish or restore normal functioning interfered with by adverse effects of a close relationship with a dependent or abuser.

Inpatient: Inpatient Treatment Services

Inpatient treatment services are designed to initiate the treatment and recovery process for individuals who are unable to participate in or comply with treatment outside 24- hours structured treatment setting. These medically supervised services are provided in licensed

inpatient rehabilitation programs operated by general hospitals, psychiatric hospitals, and freestanding facilities including OASAS operated inpatient units. Inpatient treatment includes medical management and/or monitoring of physical or mental complications and co morbidities that may be present. Inpatient services include basic clinical services (individual, group and family counseling, alcohol and substance education, special purpose counseling, groups counseling for special populations, services to significant others, HIV education, supportive counseling and referral) as well as activities therapies, social services, and medical and psychiatric consultation. Discharge planning begins at admission and includes evaluation of the individual's need for continuing alcoholism and substance abuse services and referral to appropriate residential and/or outpatient services.

Residential: Residential Treatment Services, Supervised Community Residential Services

Residential Treatment Services are designed for individuals who are unable to participate in or comply with treatment outside a 24 hour structured treatment setting and who have substantial deficits in functional skills. These services seek to enhance the social and functional skills of individuals who may be isolated from conventional social relations, engage in inappropriate social behaviors, have poor personal care skills and/or have difficulties with activities of daily living. Residential treatment services consist of basic clinical services, and educational and employment services (provided directly or through referral)

Community Residential Services are designed to provide a safe, alcohol and drug-free therapeutic domestic environment for persons who are homeless or whose home environment does not support treatment and recovery.

Factors Influencing Access to Treatment

Obstacles to Access	Factors Promoting Access
❖ **Not identifying individuals in need of treatment**	❖ **Effective screening, assessment, AOD training**
❖ **Not reaching clients in the locations in which they enter the "system" (i.e., courts, criminal justice system)**	❖ **Satellite sites, systematic linkage, training**
❖ **Long waiting periods for appropriate service**	❖ **Services within 72 hours, depending on severity of clinical need**
❖ **Multiple steps, places, and people needed to access services**	❖ **Widely available and simplified intake processes**
❖ **Arbitrary service limits**	❖ **Individualized treatment plans**
❖ **Automatic "fail first" policies (e.g., the client must fail a less intense level of treatment before a more intense level is made available)**	❖ **Individualized comprehensive assessment used to guide appropriate placement**
❖ **Geographic inaccessibility**	❖ **Geographically well distributed sites located on transportation lines**
❖ **Resource, intensive review and appeal procedures**	❖ **Highly efficient, publicly known utilization review processes**
❖ **Excessive and clinically inappropriate exlusionary**	❖ **Restricted ability to exclude specified types of hours/days of operation**
❖ **Cultural, gender, and / or ethic insensitivities**	❖ **Priority placed on cultural competence development**
❖ **Restrictive co-payments**	❖ **Elimination of co-payments**
❖ **Unknown, untimely, or non-objective appeal processes**	❖ **Widely known, timely, objective appeals**
❖ **Lack of transportation**	❖ **Transportation available as needed**
❖ **Patient placement criteria that are nonstandarized, financially driven, and / or subjectively applied**	❖ **Patient placement criteria that are collaboratively developed, clinically driven, objective, and standardized**

Observations:

Once in the program, the participant passes through three distinct phases: detoxification, stabilization, and aftercare. The drug court judge continuously monitors the client and urinalyses are performed during each of these three phases.

When a relapse into drug use occurs, as it commonly does, particularly during the first phase (64%) participants are almost always given another "second chance." Whether drug use is detected through urinalysis, or through self-admission, the BDTC team as well as the primary clinical counselor helps the client to recognize the event or events that triggered the relapse. In this way, the participant is able to recognize when they are at risk for relapse and can find ways to cope with these situations. If relapse occurs during the first phase, the Team may recommend that the participant attend individual or group counseling. When relapse occurs during the second or third phase, the counselor may modify the participants treatment plan to include more frequent drug testing, and move forward the date of the clients' next court appearance. In addition, the counselor may require the client to attend counseling sessions on a more frequent basis. In extreme cases, cases in which a client frequently tests positive for drugs, the judge may return the client to phase one. The judge very rarely expels a client from the program. Even when clients are very uncooperative, and not engaged in treatment, Judge Russell, prefers to send the client to jail for a period of time rather than remove them from the program completely.

CHAPTER 8: SUMMARY RESULTS: THE FIRST SIX YEARS

Recidivism

Pre BDTC	Post BDTC
The BDTC planning committee estimated that at least half of all defendants convicted of drug possession would recidivate with a similar offense within 3-to 12 months. It appeared that the more a defendant had been arrested for a drug offense, the more likely he or she would recidivate. The perception locally of the "Revolving Door" was founded on this perception. A high percentage of defendants arrested and or convicted of drug possession were also arrested for quality of life crimes while they were actively using illicit substances, and a substantial percentage have either committed violent offenses or were considered likely to do so, particularly as their addictions progresses.	The BDTC in comparison is experiencing a significant reduction in recidivism among graduates as well as participants. Depending upon participant characteristics (age, gender, ethnicity, etc.) and the degree of social dysfunction (housing, educational history, employment status, family situation, medical condition, etc.), recidivism among BDTC participants has ranged between 15 and 20 percent for those engaged (arrests while participating in program).

IMPACT: BDTC participants on the average reported spending at least $50-$150 per day on drugs before entering the program and many of the crack addicted reported spending considerably more ($200-$500). Most reported that the money to maintain their drug habits was derived from theft and other criminal activity. The BDTC tests participants for drug use on a regular basis (at least twice weekly), information regarding drug use by participants is available to the court on an ongoing basis, and is responded to with appropriate sanctions. Consequently, the drug use of defendants participating in drug court program is substantially reduced and significantly lower than that reported for non-drug court defendants. The significant reduction in drug use is confirmed by urinalysis reports for BDTC participants and is well over 85 percent negative.

Supervision

Pre BDTC	Post BDTC
Under the traditional adjudication process supervision of defendants released before trial usually consists of a weekly call-in and periodic reporting to pretrial services during the pretrial period (usually 60 to 120 or more days following arrest); after conviction, supervision usually consists of monthly reporting to a probation officer. Urinalysis is generally conducted only periodically, and treatment services provided only if available. The court's involvement occurs only when probation violations are reported—generally when new crimes are committed. Bench warrants may be issued for defendants who fail to appear for court hearings, but their actual execution (e.g., the defendant's arrest) may not occur for months and is often triggered only be a new arrest.	Recognizing that substance addiction is a chronic and recurring disorder, the BDTC maintains continuous supervision over the recovery process of each participant, through frequent court status hearings, urinalysis, and reports from the treatment providers to the BDTC judge. Exit Response from drug court participant in the final phase of participation indicated that the close supervision and encouragement provided by the drub court judge, coupled with the programs intensive treatment and rehabilitation services and ongoing monitoring, were critical in promoting their success in the program.

IMPACT -. Drug usage or failure to comply with other conditions of the BDTC were detected and responded to promptly. Status hearings were held on a regular basis (as needed). Immediate responses—such as enhanced treatment services, more frequent urinalysis (daily, if necessary), imposition of community services requirements, and incarceration—are some of the options the BDTC judge used to respond to program noncompliance. It should be noted that more then 80% of the participants interviewed had been in at least one treatment program during the previous 3 years, which they had left unsuccessfully. Interviews with participants suggest that judge's supervision, coupled with drug court treatment services and strict monitoring, is key to their success.

Integration of services

Pre BDTC	Post BDTC
Although there was a strong correlation between drug abuse and attributes of social dysfunction exhibited by drug users, such as poor reading skills, dysfunctional family relationships, and low self esteem, Buffalo City Court did not have the resources to address these problems when sentencing drug using offenders. At best, they referred them to a treatment program and/or special skills class, with no regular monitoring of their participation or its results, absent a violation of probation filed by the probation officer.	A fundamental premise of the BDTC, is that cessation of drug abuse requires not only a well-structured treatment delivery system but coordinated and comprehensive programs of other rehabilitation services to address the underlying co-morbidity problems of the drug user, and promote his or her long-term reentry into the community. While abstinence is a primary objective of the BDTC, no participant can successfully complete the program without also addressing needs relating to his/her long-term rehabilitation. As noted earlier, in addition to abstinence, the BDTC requires participants to obtain a high school or GED certificate; obtain or maintain employment; and develop mentor relationships within the community to sustain them after they leave the BDTC.

IMPACT - Despite rigorous requirements the BDTC is retaining a significant percentage of the defendants enrolled, and consequently, having a more significant impact on participants' lives than traditional supervision. Despite the high risk populations that the BDTC targets. Data reflects an average retention rate of more than 70 percent (the total of graduates plus active participants)

Observations

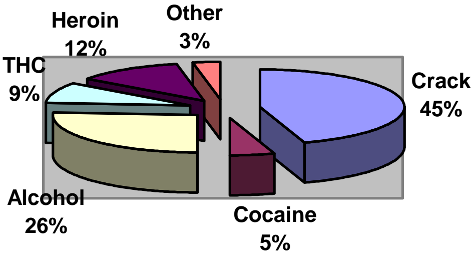
- The nature of extent of addiction among drug court participants varies widely but generally tends to be severe.
- Most drug court participants appear to have significant histories of substance addiction, frequently 12 or more years.
- The primary drugs of addiction are crack-cocaine (37%), alcohol (26%), and heroin (13%).
- Marijuana and alcohol use, in conjunction with other substance, was also reported by 78% of the program participants.
- Overall 86% of participants are poly-substance abusers
- Only one quarter graduated from High School, although about 60 percent received either a high school diploma or its equivalent.
- The Erie County Holding Center (ECHC) admits annually approximately 20,000 inmates. As such, it represents the second largest jail in New York State, smaller only than the jail at Ricker's Island. It is estimated that as many as 50%-60% of these inmates have serious alcohol and/or substance abuse problems. (IADM, 1999).
- BDTC participants on the average reported spending at least $50-$150 per day on drugs before entering the program and many of the crack addicted reported spending considerably more ($200-$500).
- What we find is that the greater proportion of those involved in drug court are male; however, the persons who are most likely to become disengaged are female.
- Females are more likely to fail to appear than males

PRIMARY DRUG OF CHOICE		
	Male	**Female**
Crack	232	359
Cocaine	65	44
Alcohol	267	215
Marijuana	185	74
Heroin	143	101
Other	32	23

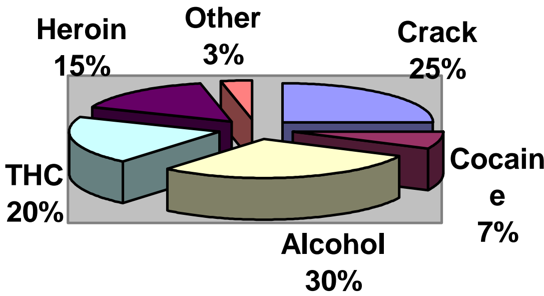
N =1740

The results of this analysis indicate that for females, cocaine and crack are the primary drugs of choice (49%). The pattern is similar for males. Of the 482 males and females that reported alcohol as their primary substance, 360 (74%) reported crack as their secondary drug of choice. Overall 1,311(75.3%) participants were identified as poly-substance abusers. Additional concerns were raised with the high-risk behaviors of the heroin dependent, 86% were IV users, However, the majority of non-IV users were young male's (25) whose primary route of ingestion was sniffing or smoking. It would appear that the BDTC population is similar to the National, State and Local treatment provider findings that most all clients today are poly substance dependent. Many of which have co-morbid mental health diagnoses, developmental disorders, and functional limitations in basic skills of living, learning and working.

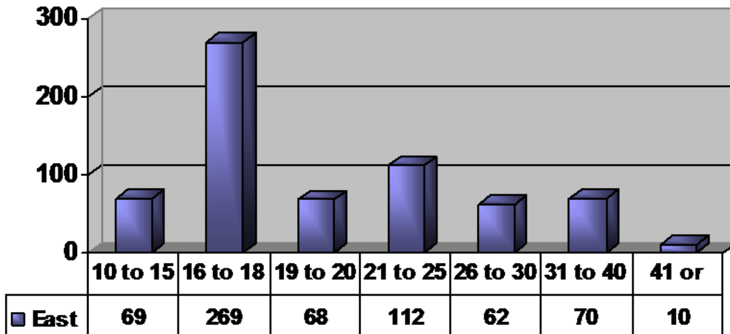
Drug Status on Females

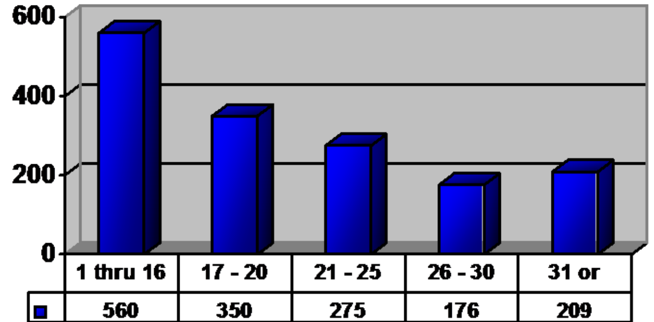


Drug Status on Males



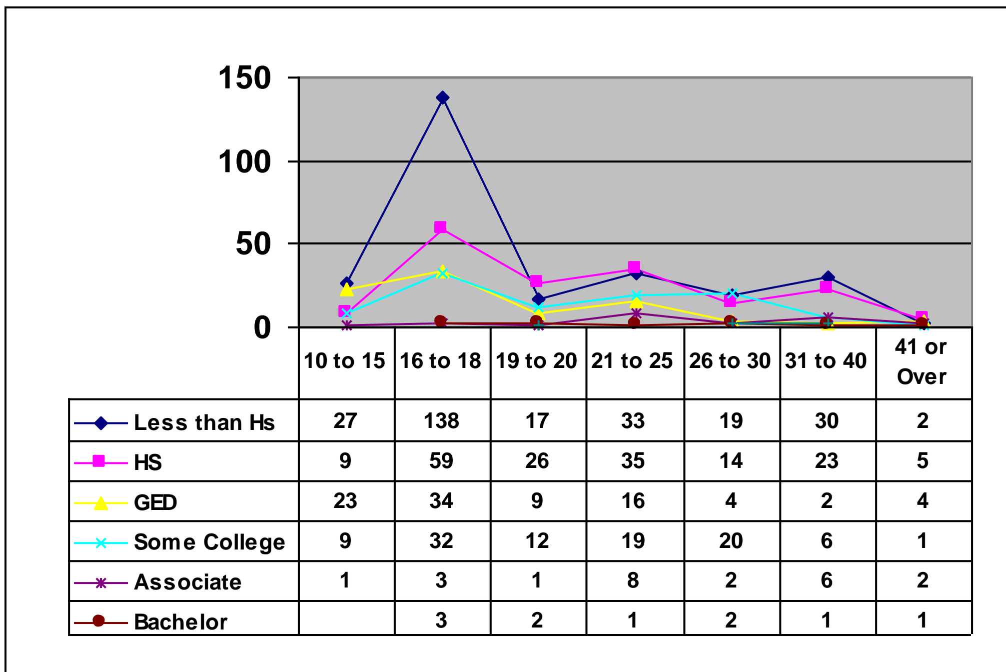
Arrest-Usage-educational Comparisons



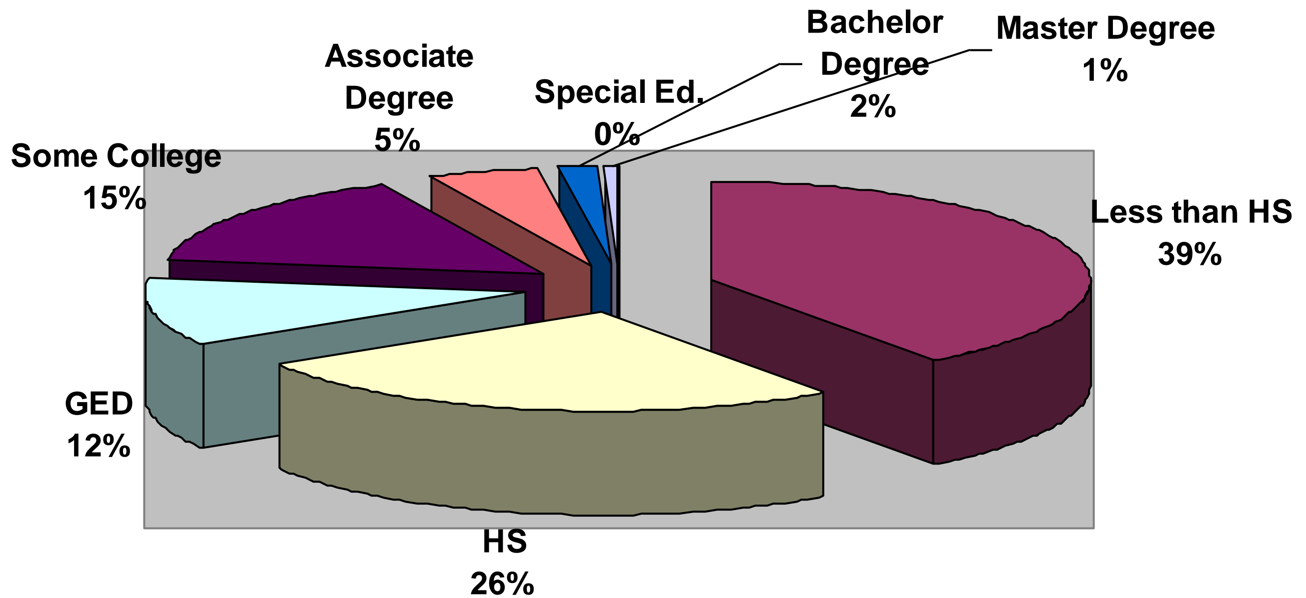


239 (51%) participants who reported first arrest between the ages of 16-18 had less than a high school education. 6 (2%) participants who reported first arrest between the ages of 16-18 had greater than a high school degree. Our findings indicate age of first arrest correlates with age of first use. Forty-one (41%) of BCDC offenders were charged with their first crime between the ages of 16 to 19. Thirty-six (36%) of the BCDC population started using at the age of sixteen or before. Inferential analysis would suggest a significant majority of the enrolled population were adolescents with antisocial behaviors. For some this may have been episodic, but one would speculate knowing the history of addiction that, once again, most addicted individuals started drinking/using at earlier ages and experienced consequences soon after abusive behavior started. It is also likely these findings support the premise that more and more clients are children of addiction and experience impaired object relations. The using behavior replaces the object constancy not available through other family, social or environmental sources. In the case of Drug Courts, the Judge becomes the Object Relator for the client. His role of parent, disciplinarian, nurturer, and mentor speaks for itself. These offender clients are desperately seeking connectedness to a safety net system that rewards responsible behavior and teaches through support and encouragement.

Cross Tab age of first arrest and educational level

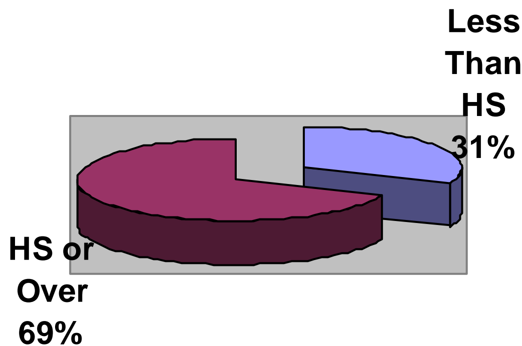


EDUCATION LEVEL for all DRUG COURT CLIENTS

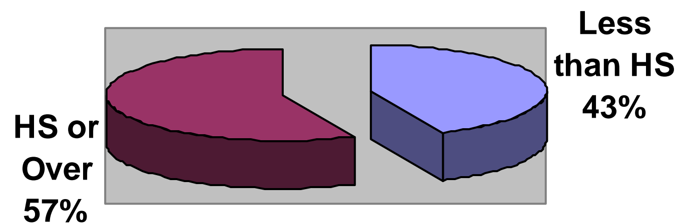


Clients with less than High School Diplomas are more likely to drop out of the program. This is not surprising, as the failure to achieve belief systems of these individuals have been re-reinforced for many years. 266 had less than HS diploma, with the age cohort of 16 to 18 the highest experience first arrest. This is also the group with earlier first use experience. Overall, the BCDC population lacks a high school diploma, 39%. This correlates with the national findings that approximately 45% of addicted clients do not have a high school diploma. These individuals have remedial deficits in reading, writing, critical thinking, abstraction and conceptualization. It is hypothesized, and confirms by some literature that these clients have attention deficit disorders and learning disabilities. Often, these deficits are not diagnosed and result in client failure to follow through, judging them as resistant and lacking motivation.

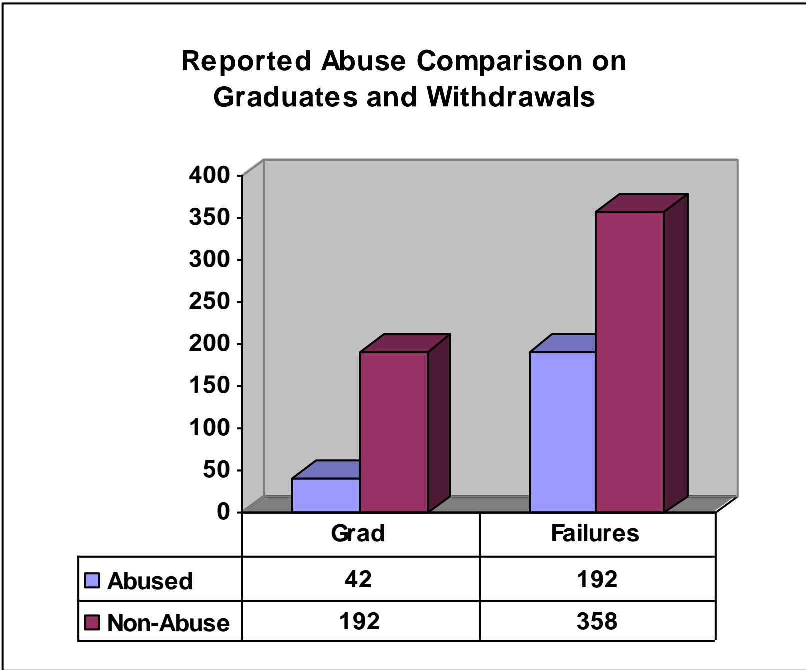
Graduates/Education Level

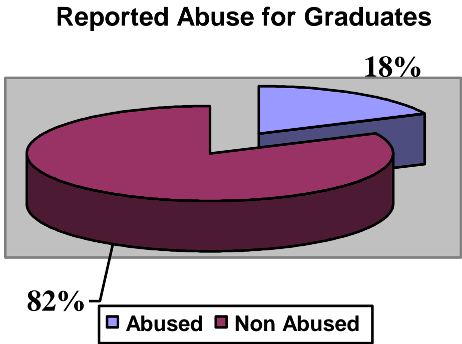


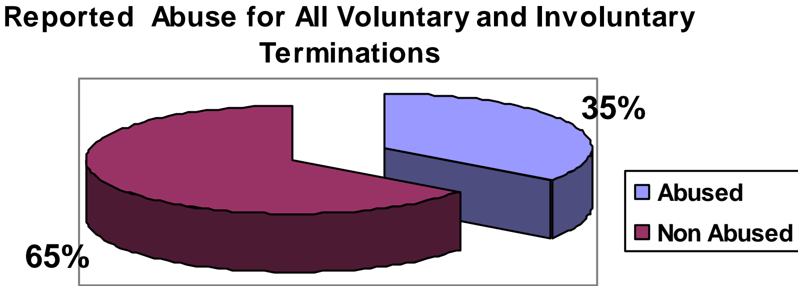
Withdrawals Education Level



Abuse Comparisons

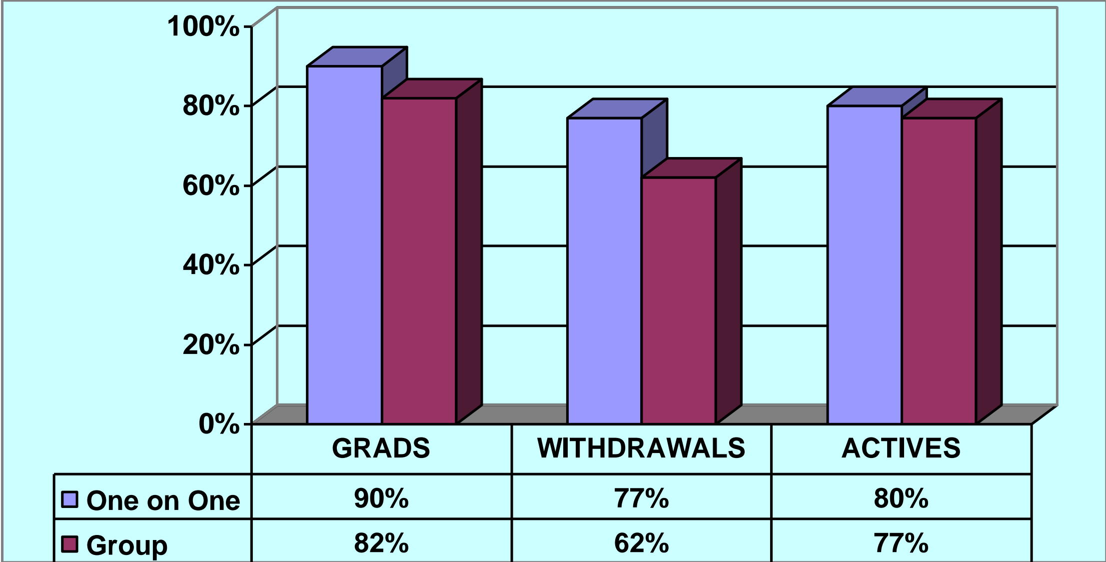






Childhood sexual abuse was associated with increased likelihood of withdrawal from the program. Withdrawals from the BDTC were twice as likely to have experienced childhood physical or sexual abuse than those who successfully completed the BDTC. More than 90% of participants who reported abuse were poly-substance users and 78% reported prior treatment attempts.

1:1 and Group sessions for: Grads, Withdrawals, and Actives



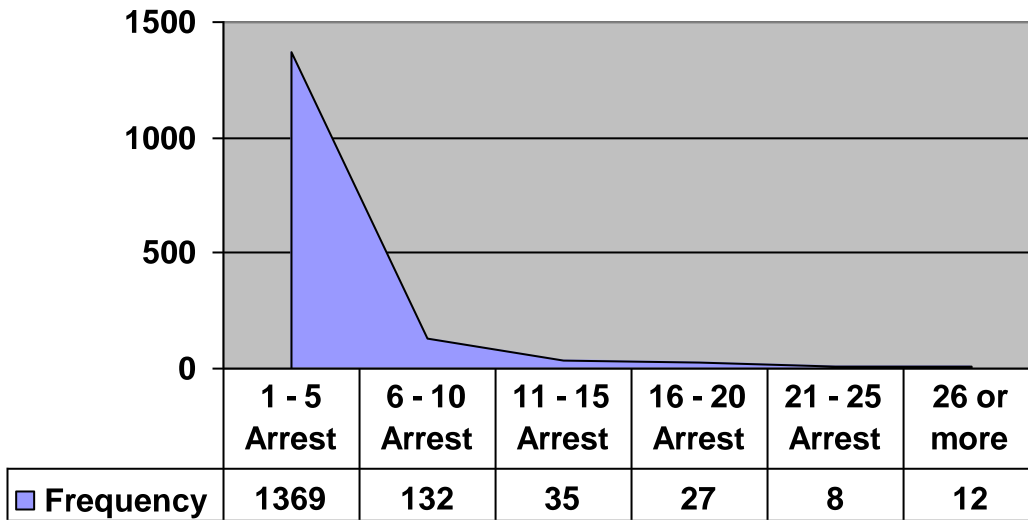
	GRADS	WITHDRAWALS	ACTIVES
One on One	90%	77%	80%
Group	82%	62%	77%

Scheduled 1:1 appointments for listed categories	**n = 2248**
Scheduled group appointments for listed categories	**n = 3082**

Research continues to show that the more frequent the contact the more likelihood of success. The BDTC graduate attended 90% of all schedule appointments with the Primary Therapist and more than 80% of all group appointments. Withdrawals from the program maintained 77% of scheduled appointments with the Primary Therapist and 62% of group appointments. BDTC participants who participated actively in treatment had a higher response rate to treatment sessions and were less likely to drop out. It appears that the key remains the ability of the partnership between BDTC and the treatment staff to engage clients in treatment and recovery. Clearly, the BDTC rates of treatment compliance and engagement are significantly higher than other referral sources to treatment. The mentoring and suggestion of the Judge is a powerful motivator to follow through with treatment intervention recommendations.

It should be noted that it is also significant that even the withdrawals did respond to participation in treatment at higher rates than other clients with different referral source mandates.

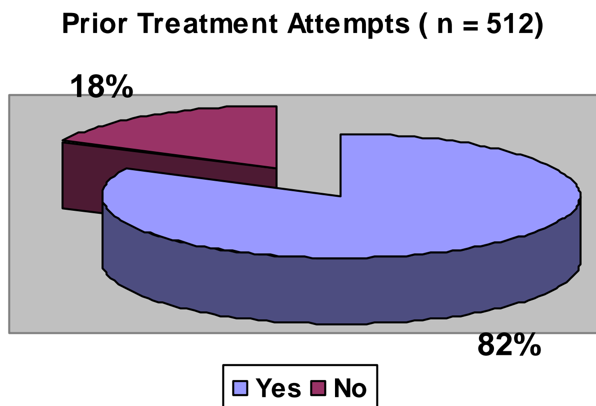
Reported number of arrests over a period of 24 months prior to admission to BDTC



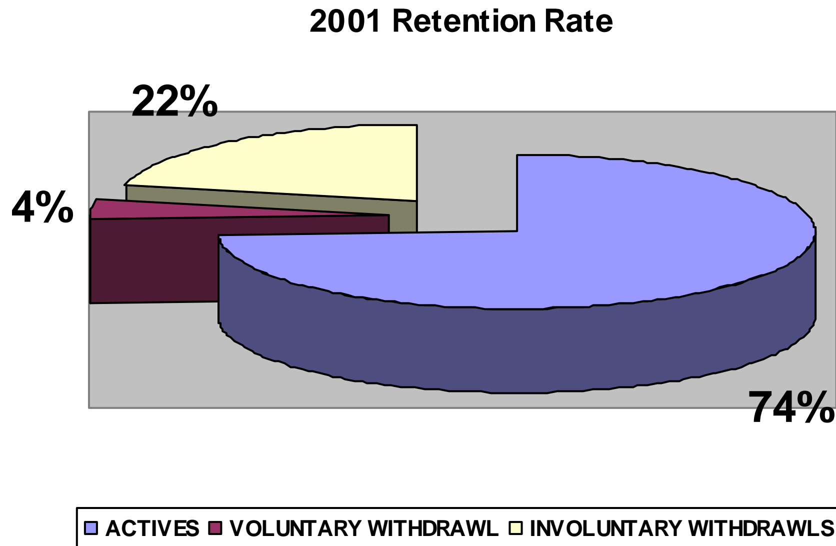
N =1740

BDTC participants reported that they were arrested 5,561 times over a 24-month period prior to admission to the program. 84 % reported being arrested at least once, however, the majority of participants (1,369) reported within a range of 1-5 arrests and on average a BDTC participants was arrested 3.5 times thru same period of time. 82% (421) of the 512 participants who were questioned reported prior treatment attempts. It appears that the pre- Drug Court system of treatment has not been structured to provide specialized services to this offender population as evidenced by the number of prior treatment attempts prior to arrest. It suggests that treatment works when systems of case management are integrated with ongoing intervention and monitoring systems.

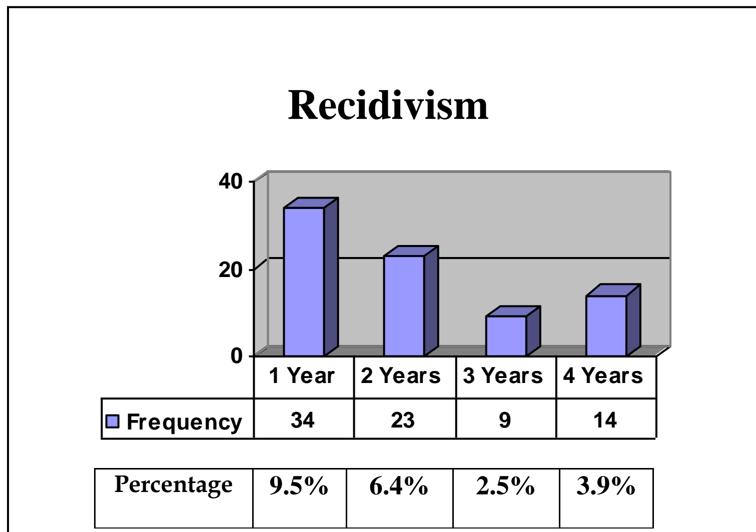
Prior Treatment Attempts (n = 512)



The 74% retention rate is consistent with the method suggested by the GAO (U.S. GAO, 1997) to calculate retention and graduation rates. This method defines retention as equaling the number of graduates plus the number still active divided by the number of total participants. The shortcoming of this method is that it does not control for time in the program: active participants who have been in the program for one month or 12 months are counted as the same.

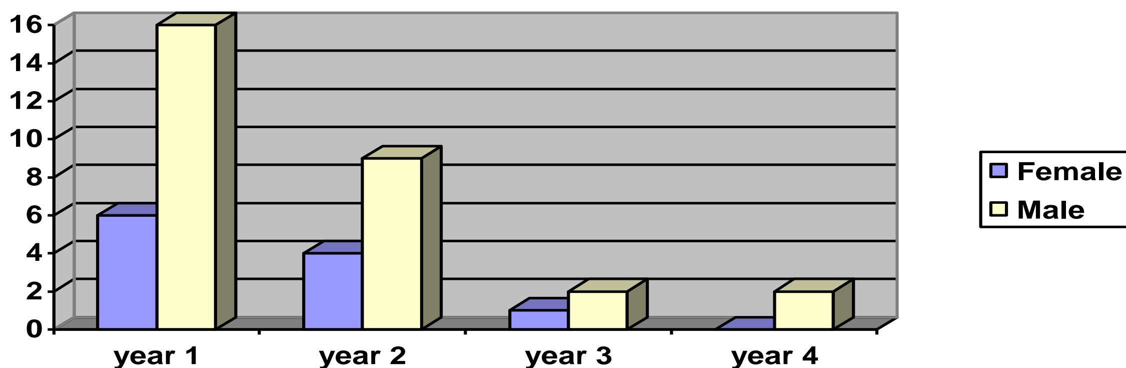


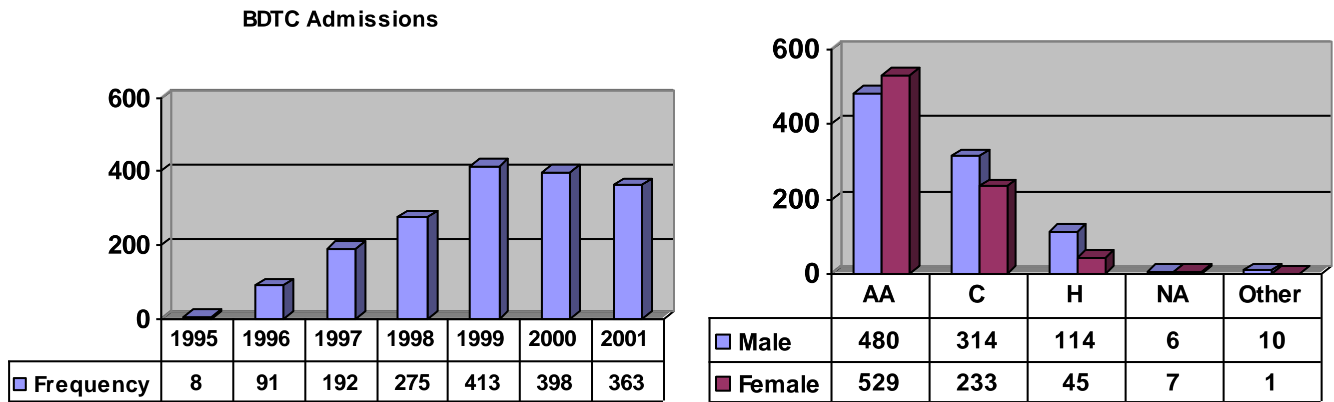
Research continues to affirm the importance of the length of time in treatment for addicts, with better results usually occurring from longer participation in treatment programs. Many short-term residential and outpatient treatment programs are four months or less in duration (Etheridge, et al., 1997); few long-term residential programs (greater than six months) exist. Simpson et al., (1997) and Taxman (1998) illustrate how a treatment process can assist in increasing the length of time in treatment by providing a treatment process of several different programmatic components—more intensive services followed by less intensive traditional outpatient services. The goal is to engage the offender in treatment for longer periods of time by combining intensive and less intensive services. Graduates of the BDTC average 478 days in the program (Contact to graduation date). The average participant prior to graduation averages 20 one on one contacts with their primary therapist (individual sessions) and 60 group sessions. In addition the average participant has 24 scheduled court sessions prior to graduation.



(n = 355)

Most criminal justice system professionals estimate that at least 45 percent of defendants convicted of drug possession will recidivate with a similar offense within 2 to 3 years. The more frequently a defendant has been arrested for a drug offense, the more likely he or she is to recidivate. **Recidivism** is defined as any contact with the criminal justice system that generates an accusatory instrument. **Attrition** is defined as the length of time from graduation to re-arrest. Post program completion recidivism data was limited to local criminal justice reports. Of the 355 graduates, 80 (22.5%) recidivated over a 4-year Span. 58 (73%) of the arrests were not drug specific charges. 13 (59%) of the 22 drugs specific arrests occurred within the first year after graduation. Males were three times more likely to recidivate with drug specific charges than females and were more than twice as likely to recidivate in the first year. Attrition means for first year recidivist is 169.5 days. Second year 616.6 days, third year 880 days and year 4 is 1354 days.



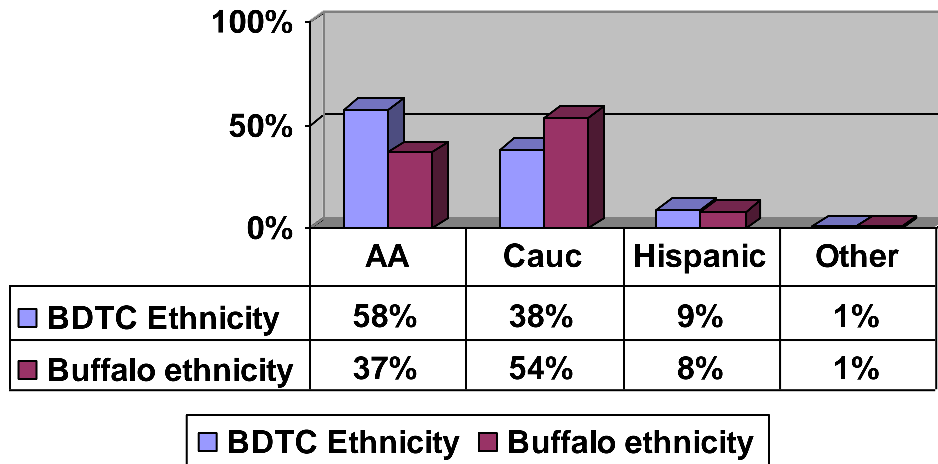


(n =1740)

Culture and Ethnicity

BDTC participants are most likely to be young males, primarily members of cultural and ethnic minority groups. The racial and ethnic data showed that 69% of the participants were members of minority groups (58% percent African American, (9% percent Hispanic, 1% Native American and 1% other). The BDTC cultural and ethnic findings are similar to findings on the National level, for example, African American males are now involved in the criminal justice system at a higher rate than Caucasian and Hispanic males. While many of the reasons for this disparity in racial incarceration rates are due to factors outside the criminal justice system, evidence suggest that criminal justice practices and policies contribute to the differences. Mejer (1992) reported that while rates of drug use among Caucasian and African Americans vary only slightly (10.8 percent for Caucasian versus 9.3 percent for African Americans), African Americans are arrested for drug at far higher rates than Caucasians (1,440 per 100,000 per African Americans versus 302 per 100,000 Caucasians), and the rate of drug-related arrests for African Americans increased at five times the rate for Caucasians between 1972 and 1989. (The rate for Caucasians increased 54 percent during that time versus 272 percent for African Americans.)

Ethnicity	Frequency	Percentage	Male	Female
African American	1009	58%	480 (47%)	529 (53%)
Caucasian	547	31%	314 (57%)	233 (43%)
Hispanic	159	9%	114 (72%)	45 (28%)
Native American	13	1%	6 (46%)	7 (54%)
Other	10	1%	9 (90%)	1 (10%)



Conclusions

There is no "representative or typical" offender. However, it is more likely that the offender is male, a member or a cultural or minority group, less than 35 years old, and has low educational attainment, low employability, and poor health. Major health problems for this population include substance abuse, consequences of injecting drugs, and HIV/AIDS, TB, and other infectious diseases many have psychiatric disorders in addition to substance abuse disorders. Additional problems are faced by female offenders, particularly those who are pregnant or have children, because the women need childcare assistance and have problems related to pregnancy, health, and victimization, often involving violence.

Cost Effectiveness

The Director of Medicaid for Erie County has estimated the average cost for the treatment component per BDTC participant ranges between $1,200 and $3,000 per participant, depending upon the range of services provided. Savings in jail bed days alone have been estimated to be at least $5,000 per defendant—which does not factor in the value of the added capability to incarcerate the more serious offenders. Similarly, The Buffalo City Court District Attorneys Bureau Chief has indicated that it appears that the BDTC has reduced police overtime, witness costs, as well as grand jury expenses that would otherwise be required is these cases proceeded in the traditional manner. The BDTC also reports that a substantial percentage of the participants

who came into the program unemployed and on public assistance have become employed while in the program and are now self-supporting. In addition, 344 participants (19%) who were employed at the time of program entry were able to maintain their employment, despite their arrest, because of their program participation.

Benefit for Families and Children

Approximately two-thirds of the BDTC participants are parents of minor children. Many of these parents have lost or are in danger of losing custody of their children because of their drug use. Drug court has resulted in many of these participants/litigants retaining or regaining custody upon completing the drug court. Forty five (45) drug-free babies have been born to participants while enrolled in the BDTC, thus obviating the substantial medical and social service cost (estimated at a t minimum of $250,000 per baby) required to care for a drug-addicted infant, let alone the resultant societal impact.

Cost Avoidance

A recent study of 236 graduates of the Buffalo Drug Court, conducted by the Buffalo Drug Court and the Erie Count Division of Social Services determined that out of 156 participants who had open social service cases (Medicaid, food Stamps, and or Public assistance) when they enrolled in Drug Court, 75 (involving 61 individuals) had such cases closed: 68 children who were in foster care were returned to their homes; 47 crack free babies were born; 38 Child protective Service cases were closed; 81 children involved with Child protective Service were allowed to remain in their homes; 9 children were removed from social service rolls due to increased child support from parent/graduate; and more than forty eight thousand ($48,000) was collected in back child support payments.

The gross costs Erie County will avoid over the next five years are estimated at over five million dollars ($5,000,000). This study has recently been extended to include all drug courts within Erie County and preliminary data indicates the potential savings to exceed twelve million dollars ($12,000,000). While savings in secondary social service benefits may be difficult to quantify with precision, these are the kinds of benefits that can reasonably be anticipated to results from successful program completion.

Benefits to Prosecutors and Police

Interviews of prosecutors and police have revealed that the BDTC has significantly enhanced the efficacy of the law enforcement functions, by providing their agencies with expanded and more effective response to substance abuse. This is a significant answer to the "revolving door" syndrome that existed within the traditional experience of the City Court prior to the BDTC. Defendants are no longer returned to the community soon after their arrest but, rather, placed in a rigorous, court-supervised treatment program that intervenes in the cycle of addiction, obviously by impacting on their consumption of drugs.

CHAPTER 9: Recommendations

- Length of stay in treatment and in aftercare are identified factors associated with positive outcomes and, in particular, with the cessation of drug use, reduction in recidivism rates, and improvement in educational and employment status and family relationships. It is recommended that the BDTC continue to be the catalyst of change for the types of treatment services offered to offenders. To be effective, these services must be intensive and occur over a long period of time. It appears that the BDTC must go beyond the nomenclature of the existing treatment system to define a level and type of treatment service that is appropriate for the target population. This will require the BDTC focusing on the types of services provided within the context of the drug court, not merely linking into existing services. It is suggested that the BDTC look at a core concentration of recovery services and then have modules for the individual with mental health issues, those with abuse issues, those with educational limitations. This approach would look closely at functional improvements.
- It is recommended that the BDTC develop and implement on-site orientation for new Drug Court transfers. This may include treatment groups/treatment readiness groups to improve the engagement and retention. They could also provide soft skills training in Success Skills in the World and Recovery - peer/alumni driven support groups.
- One of the greatest challenges faced by both the criminal justice and AOD treatment system is to understand the variations among offenders. With limited resources, the criminal justice and AOD systems are faced with serving increasing numbers of individuals while using program models developed to treat a Caucasian, male population—these models are not directly transferable to treatment models which are gender and culturally sensitive and effective. Thus, new techniques and methods are needed to meet these requirements. It is recommended that the BDTC develop a focus group through its oversight committee to address this issue.
- Levels of care distribution and having consistent criteria has been a relatively new trend to the operations level of both the treatment system and the BDTC, even though the information has been in publication for over ten years. The reasons for this lack of implementation have centered on two primary issues: 1) acceptance of standard criteria and 2) trained clinicians to follow them. BDTC personnel are trained in treatment decision- making criteria, along with Judges, Prosecutors and Defense Attorneys. However, the training needs to continue and court clinical case conferencing with trained staff needs to be implemented. WHY? The literature continues to confirm that treatment matching makes some impact on client follow through and short term positive recovery outcomes. It is recommended that the BDTC continue and expand its educational series with Erie Community College.

- The BDTC has long recognized that enhancements in physical, intellectual, vocational and emotional skills are needed to complement the participant's recovery and reintegration into the community. Vocational placement and job retention are a requirement for completion of the program and the judge monitors this requirement in a manner similar to the monitoring required to ensure abstinence from alcohol and drugs. To meet this requirement it is recommended that the BDTC continue and expand the collaborative effort with The New York State Department of Labor, The State University of New York (SUNY), Erie Community College and the Erie County Department of Social Services. The Vocational Life Enhancement and Action Program (LEAP) developed to serve BDTC participants primary focus is to reduce the time it takes for these individuals to become employed (self-sufficient). The program goal is to provide individuals disabled by substance abuse alcoholism and/or mental health problems with academic/vocational skills improvement while actively participating in residential, outpatient and/or transitional services.
- The Court needs to improve its coordination with local law enforcement. The effectiveness of the Drug Court is in part contingent on the perception of defendants that the sanctions for failure to comply with the program are credible and significant. This requires that defendants perceive that non-compliance will result in the sure and swift application of the sanctions applied by the Judge, including incarceration. The instances of long delay in the apprehension of defendants for whom a bench warrant has been issued by the Judge serves to undermine the Court's effectiveness with those specific defendants. Additionally, the potential development of a perception by defendants and others that Court sanctions are not credible might threaten the overall effectiveness of the Court. It should be noted that the Drug Court Judge has initiated discussions with the new local police chief to ensure that all reasonable efforts are made to enforce Court bench warrants expeditiously and effectively.
- We recommend increased coordination among the BDTC stakeholders. We recommend that the advisory and oversight committee continue to meet on a regular basis (quarterly). Partners and stakeholders have indicated that quarterly meetings are beneficial for keeping community partners informed by sharing in its continued growth and development.
- The Buffalo MIS system has evolved with the growth of the BDTC. As the program grew so did the need for information. The initial database (1995) had 87 fields; the current database has almost 300 fields. What we found is that the information collected today is more entailed than in the past. Much of the data that was not collected from the initial cohort is not

retrievable. In addition, the BDTC modified original program definitions, for example: in the pilot stage "Active participant" was defined as any case that was transferred to the Drug Court, However, when program moved to full implementation, "Active participant" was defined as an individual who (pre-adjudicated) has signed a BDTC contract or who has been sentenced to the BDTC (post-adjudicated). Another area of concern was found in cases were warrants have been issued and are still outstanding. The majority of these cases are pre-adjudicated with no signed contract; by definition they are not BDTC participants. We recommend that the BDTC support staff continue to update the database and retrieve as much data as possible within their limited resources.

APPENDIX A: Criminal Justice Task Force

Buffalo City Court Criminal Justice Task Force

NAME	TITLE	ORGANIZATION	CONTACT INFORMATION
Hon. Thomas P. Amodeo	Chief Judge	Buffalo City Court 8th Judicial District, New York State	Buffalo City Court 50 Delaware Avenue, Ste 750 Buffalo, NY 14202
Hon. Robert T. Russell	Judge, Buffalo City Court	Buffalo City Court 8th Judicial District, New York State	Buffalo City Court 50 Delaware Avenue, Ste 200 Buffalo, NY 14202
Henry G. Pirowski	C.O.U.R.T.S. Program, Director/Drug Court	Buffalo City Court 8th Judicial District, New York State	Buffalo City Court 50 Delaware Avenue, Ste 400 Buffalo, NY 14202

APPENDIX B : Treatment

Agency Name	Address	Telephone	Intake Hours	Operating Hours	License
ALCOHOL & DRUG DEPENDENCY	291 ELM ST	854-2997	24X7	24X7	ALCOHOL REHAB
ALCOHOL & DRUG DEPENDENCY	STATLER TOWER, 107 DELAWARE	855-0163	M,TH 8:30-8,	M,TH 8:30-8, TU-9,	ALC & SA CLINIC
ALCOHOL COUNSEL OF NIAGARA	800 MAIN ST	282-1228	M-TH 9-8:30, F	M-TH 9-8:30, F 9-5	ALC OUTPT CLINIC
ALCOHOL COUNSEL OF NIAGARA	41 MAIN ST	433-3846	M-TH 9-8:30, F	M-TH 9-8:30, F 9-5	ALC & SA CLINIC
BEACON CENTER	ELLICOT SQ. 295 MAIN ST SUITE	853-0243	M-F 9-8	M-F 9-8, SA 9-12	ALC & SA CLINIC
BEACON CENTER	2440 SHERIDAN DR	831-1937	M-F 9-9	M-F 9-9, SA 9-12	ALC & SA CLINIC
BEACON CENTER	36 EAST AVE	439-6815	M-F 9-8	M-F 9-8	ALC & SA CLINIC
BEACON CENTER	473 3RD ST	282-4480	M-F 9-8	M-F 9-8	ALC & SA CLINIC
BGH/80 GOODRICH	80 GOODRICH	(716) 859-1576	M-F 9-8	M-F 9-8	ALC & SA CLINIC
BGH/DEACONESS	1001 HUMBOLT PKWY	(716) 887-8105	M-F 9-8	M-F 9-8	ALC & SA CLINIC
BGH/LANCASTER	11 WEST MAIN ST	(716) 681-4957	M-F 9-8	M-F 9-8	ALC & SA CLINIC
BRYLIN	1263 DELAWARE AVE	886-8200 EXT	24X7	24X7	ALCOHOL & SUBSTANCE
BRYLIN	11438 GENESEE ST	937-4484	24X7	24X7	ALC & SA REHAB
BRYLIN	2625 DELAWARE AVE	874-2222	M-F 9-6	M-F 9-8	ALC & SA CLINIC
BRYLIN	5225 SHERIDANDR	633-1927	M,TU,TH 8:30-	M,TU,TH 8:30-7,	ALC & SA CLINIC
CAO-DART	1237 MAIN ST	884-9101	M-F 7-4	M-F 7-4, Sa,Su 7-	METHADONE TX
CITY VIEW TREATMENT CENTER	SHEEHAN HOSPITAL, 425	848-2078 OR 1-	M-F 8:30-7, ER	24X7	ALCOHOL & SUBSTANCE
CLEARVIEW-MT. ST. MARY'S	5200 MILITARY RD	298-2115	M-F 8:30-4:30	24X7	ALC & SA REHAB
CLEARVIEW-MT. ST. MARY'S	66 MEAD ST	694-3214	M-TH 8:30-9, F	M-TH 8:30-9,F 8-4	ALC OUTPT CLINIC
CLINICAL RESEARCH CENTER	RESEARCH INST. ON	887-2387	M,Tu,F 8:30-	M,W,Th 8-8,Tu,F8-	ALC OUTPT CLINIC
DSAS-ELLICOTT-MASTEN	@ SHEEHAN 425 MICHIGAN	851-5556	M-F 8-4	M-F 8-4	MED SUPV SA
DSAS-ELMWOOD CENTER	656 ELMWOOD AVE	851-5556	M-F 8:30-4:30	M-F 8:30-4:30	MED SUPV SA
DSAS-FILLMORE-LEROY	2225 FILLMORE AVE	834-3272	M-F 9-5	M-F 9-5	MED SUPV SA
DSAS-GENESSEE-MOSELLE	1532 GENESEE	891-8337	M-F 8:30-4:30	M-F 8:30-4:30	MED SUPV SA
DSAS-RIVERSDIDE CENTER	255 LAWN AVE	873-9650	M-F 8:30-4:30	M-F 8:30-4:30	MED SUPV SA
ECMC-DOWNTOWN CLINIC	1280 MAIN ST	883-4517	M-Th 8-8,F 8-	M-Th 8-8,F 8-5,Sa	ALC OUTPT CLINIC
ECMC-NORTHERN ERIE	2283 ELMWOOD AVE	874-5536	M-Th 8:30-9, F	M-Th 8:30-9, F	ALC OUTPT CLINIC
ECMC-SOUTHERN ERIE	4390 QUINBY	648-7584	M-Th 8-8, F 8-5	M-Th 8-8, F 8-5	ALC OUTPT CLINIC
ECMC-WEST EAGLE	134 WEST EAGLE ST	858-2921	M-F @ 12:30	M-F 9-5	ALC OUTPT CLINIC
ERIE COUNTY MEDICAL CENTER	462 GRIDER ST	898-3000 ASK	24X7	24X7	ALCOHOL & SUBSTANCE
FIRST STEP CENTER	ALCOHOL COUNCIL OF NIG. CO.	285-3421	24X7	24X7	CHEMICAL
HORIZON - BAILEY-LASALLE	3297 BAILEY AVE	833-3622	M-Th 8:30-7, F	M-Th 8:30-8, F	ALC & SA CLINIC

HORIZON-BLACK ROCK	699 HERTEL AVE	831-1977	M-Th 9-7, F 9-4	M-Th 9-8, F 9-5	ALC & SA CLINIC
HORIZON-BOULEVARD	1370 NIAGARA FALLS BOULVARD	833-3708	M-Th 9-8, F 9-4	M-Th 9-9, F 9-5	ALC & SA CLINIC
HORIZON-CENTRAL PARK	60 EAST AMHERST ST	834-6401	M-W 9-8, Th -	M-W 9-9, Th - 8, F -	ALC & SA CLINIC
HORIZON-LOCKPORT	14 MARKET ST. SUITE 225	433-2484	M,Th 9-7 Tu -6,	M,Th 9-8, Tu -7, W	ALC OUTPT CLINIC
HORIZON-NIAGARA CENTER	6520 NIAGARA FALLS	283-	M,W 9-7, Tu-6,	M,W 9-8, Tu-7, Th -	ALC & SA CLINIC
KALEIDA - BGH-CHMC	80 GOODRICH	859-1576	M-Th @ 1PM	M,W,Th 9-7:30, F 9-	ALC OUTPT CLINIC
KALEIDA – DEACONESS	1001 HUMBOLT PARKWAY	859-1576	M-F 9-5	M-F 9-5	ALC OUTPT CLINIC
KALEIDA – LANCASTER	11 WEST MAIN ST	681-4957	M-Th 9-8, F 9-5	M-Th 9-8, F 9-5	ALC OUTPT CLINIC
LAKESHORE BEHAV. HEALTH	951 NIAGARA ST 2 ND FLOOR	883-5344 EXT	M,W 9-7,	M,W 9-8, Tu,Th,F	MED SUPV SA
LAKESHORE BEHAV. HEALTH	2600 SOUTH PARK	822-2117	M,W 9-7 Tu,	M 9-8,W 9-	MED SUPV SA
LAKESHORE BEHAV. HEALTH-EL	951 NIAGARA ST 1 ST FLOOR	883-5344 EXT	M 9-5:30, Tu-F	M 9-6, Tu-F 9-5	ALC OUTPT CLINIC
MID-ERIE COUNSELING &	1131 BROADWAY - 2ND FLOOR	896-7712	M 9-6, Tu,Th 9-	M 9-6, Tu,Th 9-	ALC & SA CLINIC
MID-ERIE COUNSELING &	1520 WALDEN AVE	8956700	M-Th 9-8, F 9-5	M-Th 9-9, F 9-5	ALC & SA CLINIC
MONSIGNOR CARR INST.	75 WEST HUMBOLT PARKWAY	835-9745	M,Tu,Th 8:45-	M,Tu,Th 8:45-8:45,	MED SUPV SA
NIAGARA CO DEPT OF MENTAL	TROTT ACCESS CENTER-1001	862-1330	M-F 9-12N	M-F 6AM-9PM, Sa	METHADONE TX
NIAGARA COUNTY DRUG ABUSE	TROTT ACCESS CENTER, 1001	278-8110	M,W,F 9-	M,W,F 9-5,Tu,Th 9-	ALC & SA CLINIC
PATHWAYS – SISTER'S HOSPITAL	2157 MAIN ST	862-1330	M-F 7-2	M-F 6:30-2:30,	METHADONE TX
PATHWAYS - ST. LOUISE PROGRAM	209 NIAGARA ST	856-8411	W, Th 7:30-	M-F 6:30-	METHADONE TX
REFLECTIONS-LOCKPORT	521 EAST AVE	439-8713 OR	M-F 8:30-5:30	24X7	ALC & SA REHAB
RENAISSANCE HOUSE	920 HARLEM RD	821-0391	ASSES: M-F,	24X7	CD FOR YOUTH
SPECTRUM HUMAN SERVICES	NEW ALTERNAATIVES, 1235 MAIN	884-5797	M-F 8:30-4	M-F 8:30-4	SA DRUG FREE OUTPT
SPECTRUM HUMAN SERVICES	2040 SENECA ST	828-0560	M, Tu,Th 9-8,	M, Tu,Th 9-8, W,F	ALC & SA CLINIC
SPECTRUM HUMAN SERVICES	227 THORN AVE	662-6618	M 12-8, F 10-3,	M-W 9-8, Th 9-5, F	ALC & SA CLINIC
SPECTRUM HUMAN SERVICES	27 FRANKLIN ST	592-9301	M-Th 8:30-5, F	M-Th 8:30-5, F	ALC & SA CLINIC
STAR	1500 UNION RD	674-8354	M-F 8:30-5	M-F 8:30-9	ALC & SA CLINIC
STAR	1595 BAILEY AVE	893-9350	M-F 8:30-4:30	M,W,F 8:30-4:30,	ALC OUTPT CLINIC
STAR	4949 HARLEM RD	839-8060	M-F 8-5	M-F 8-9	ALC & SA CLINIC
STUTZMAN ATC	360 FOREST AVE	882-4900	M-F 9-5	24X7	ALC REHAB
UNIVERA HEALTH CARE	130 EMPIRE DR	878-2700	M-Th 8-9,F 8-5	M-Th 8-9,F 8-5	ALC OUTPT CLINIC
UNIVERA HEALTH CARE	MOSHER CENTER, 899 MAIN ST	878-2700	M,Tu,Th 8:30-	M,Tu,Th 8:30-7:30,	ALC OUTPT CLINIC

APPENDIX C: Drug Court Contract

DRUG COURT CONTRACT

STATE OF NEW YORK : COUNTY OF ERIE
: CITY OF BUFFALO

THE PEOPLE OF THE STATE OF NEW YORK
VS.

File No. __________________

____
Defendant
____

I, ____, the defendant in the above-captioned case do hereby agree to enter into the Drug Court Program and agree to the following conditions:

1. I hereby knowingly, intelligently, and voluntarily waive my constitutional and statutory rights to a speedy trial and to a preliminary hearing so long as I am enrolled in the Drug Court Program. I make this waiver after consulting with my attorney. I understand that if I fail to complete the program my case will be remanded to Buffalo City Court for a preliminary hearing and/or further proceedings.

2. I understand that my right to file pre-trial motions will be reserved. Should I be terminated from this program, I will have forty-five (45) days from the termination date to make such motions.

3. I agree to fully cooperate with all evaluation and all treatments as required by the court and by my case manager.

4. I agree to random urine testing and random breathalyzer testing.

5. I agree to return to the Drug Court as ordered by the Court for progress reports from my case manager. I understand that if I miss any court dates, a bench warrant will be issued, and if the warrant is outstanding for more than one month, then I will be released from the diversion program and the original charges will be reinstated for prosecution. I further understand that if I have plead guilty to a criminal charges that I can then be sentenced should I miss any court dates.

6. I understand that if I violate any terms of this contract and / or fail to work diligently toward the goals of the treatment program, my case will be return to buffalo City Court for prosecution of the original charge(s).

7. I agree to keep all treatment providers and the Court advised of my current address at all times during my participation in the program.

8. I understand that any new arrest while I am in the Drug Court Program must be reported to my case manager and will be grounds for immediate termination from the program.

9. I understand and agree that the Drug court Judge alone will determine whether or not I have complied with or failed any of the terms of this agreement.

10. I understand that if I successfully complete the Drug Court Program the Court will:

a. Grant me an adjournment in contemplation of dismissal if my pending charge is a misdemeanor;

b. The District Attorney will reduce my charge to a class "B" misdemeanor if my present pending charge is a felony.

Dated: Buffalo, New York

DATE ________________

____

Signature of Defendant

____

Name Printed

____

____

Signature of Defense Attorney

____

Name Printed

I. Non-Compliance

The following are example of non-compliance that may result in Court ordered sanction:

a) Failure of defendant/client to keep mandated treatment appointment date(s) with the service provider;

b) Failure of defendant/client to keep ALL SCHEDULED court appearance dates;

c) Failure of defendant/client to consistently remain drug free as evidenced by repeated positive lab results demonstrating drug usage:

d) Failure of defendant/client to lead a law abiding life a s a result of re-arrest/conviction.

II. SANCTIONS

The following is a list of Court ordered sanctions that may be imposed as a result of non-compliance:

a) In-court admonishment;
b) Requiring defendant/client to attend additional days for treatment with the service provider;
c) Requiring defendant/client to attend additional court appearance;
d) Extending defendant/client treatment period or period under the Drug Court Program;
e) Punitive period of incarceration to encourage compliance with Drug Court mandates;
f) Termination for the Drug Court Program.

I have read, understood and received a copy of the conditions of non-compliance and resulting sanctions.

__________________________ ____________ ____________________

Signature of Defendant/Client | Date | Judge

APPENDIX D: Progress Report

APPENDIX E: Release

CITY OF BUFFALO C.O.U.R.T.S. PROGRAM/ BUFFALO CITY COURT/ BUFFALO DRUG COURT

****
CRIMINAL JUSTICE CONSENT TO RELEASE INFORMATION
****

I, ____ hereby consent to
(Name of Defendant/Client)
communication between The City Of Buffalo C.O.U.R.T.S. Program (Court Outreach Unit Referral and Treatment Services) Buffalo City Court and: ____
____
____
____
____

(Name all Persons and Agencies to which disclosure is to be made- i.e., Court/Prosecuting Agency/ Probation Agency)

The purpose of the disclosure and need for the disclosure is to inform the above named Criminal Justice Agency(ies)/ Person (s) of my attendance at, progress in and attitude toward my evaluation and treatment, results of urine toxicology and participation/cooperations________________________________
____
____

The extend of information to be disclosed is my diagnosis, information about my attendance or lack of attendance at treatment sessions, my cooperation with the treatment program, my prognosis and current status with the agency (ies)____
____
____

I understand that my participation in treatment is a condition of (check all that apply):

________ My release from confinement.
________ The execution of a sentence imposed upon me.
________ The disposition of a criminal justice proceeding against me.
________ The suspension of a sentence imposed upon me.
________ Other action (specify): Condition of continued release

I understand that, unless otherwise specified, this consent will remain in effect and may not be revoked by me revocation of my release from confinement and/or action Duration of consent (if different):
____
____

Condition(s) of revocation of consent (if different): ____
____

I also understand that any disclosure made is bound by Part 2 of Title 42 of the Code of Federal Regulations governing confidentiality of alcohol and drug abuse patient records and that recipients of this information may redisclose it only in connection with their official duties.

______________________________ ___________________
(Signature of Defendant/Client) (Date)

____
(Parent/Legal Guardian)

Appendix F: References

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