A DIAGNOSTIC STUDY OF THE ADDICTION TREATMENT COURT IN GUADALUPE, NUEVO LEÓN, MÉXICO

Findings and Recommendations

Agosto 2014

Organization of American States

Inter-American Drug Abuse Control Commission

CENTER FOR COURT INNOVATION

SCHOOL of PUBLIC AFFAIRS
AMERICAN UNIVERSITY • WASHINGTON, DC

OAS Cataloging-in-Publication Data

Inter-American Drug Abuse Control Commission.
A Diagnostic study of the Addiction Treatment Court in Guadalupe, Nuevo León, Mexico : Findings and Recommendations / [Drafted by the Inter-American Drug Abuse Control Commission and the Center for Court Innovation, in cooperation with the Department of Justice, Law and Criminology at the School of Public Affairs at American University].
v.; cm. (OAS. Official records ; OEA/Ser.L/XIV.6.43).
ISBN 978-0-8270-6424-9
1. Drug courts. 2. Drug addiction--Treatment--Law and legislation. 3. Substance abuse--Treatment--Law and legislation. I. Title. II. Center for Court Innovation.
III. Rempel, Michael. IV. Lomba Maurandi, Antonio. V. Raine, Valerie. VI. American University (Washington, D.C.). School of Public Affairs.
VII. Organization of American States. Secretariat for Multidimensional Security. VIII. Drug Treatment Court Program for the Americas. IX. Series.
X. Cooper, Caroline S. XI. Spadafore, Joseph. XII. Lambson, Suvi H.

OEA/ Ser.L/XIV.6.43

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ISBN 978-0-8270-6424-9

A Diagnostic Study of the Addiction Treatment Court in Guadalupe, Nuevo León, Mexico

Findings and Recommendations

This Diagnostic Study has been drafted by the Inter-American Drug Abuse Control Commission (CICAD), Secretariat of Multidimensional Security of the Organization of American States (OAS), and the Center for Court Innovation (CCI), in cooperation with the Department of Justice, Law and Criminology at the School of Public Affairs at American University (AU).

- August 2014 -

Report written and presented by:

Organización de los Estados Américanos

Comisión Interamericana para el Control del Abuso de Drogas

CENTER FOR COURT INNOVATION

A Project of the Fund for the City of New York

In cooperation with:

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Important: When this project was granted, the Organization of American States, the Center for Court Innovation, and American University, committed (1) to conduct a diagnostic evaluation of the drug court program in Nuevo León; and (2) to develop recommendations for drug court expansion in Mexico.

This report was presented as a draft prior to meetings that the authors of this diagnostic evaluation had with the Secretariat of Prevention and Citizen Participation of the Ministry of the Interior (SEGOB) and the National Commission Against Addiction of the Ministry of Health (CONADIC) on July 23rd, 2014 and then on July 24th, 2014 with authorities and professionals from the State of Nuevo León, as well as other entities and institutions that collaborated in this process from Mexico, such as National Center for Disease Prevention and Control of Addictions (CENADIC), and the National Institute of Psychiatry. The product of the discussions that were held over the course of those two days are likewise included in Chapter 6 as final recommendations from this study. This final document was officially launched on August 11, 2014 in Nuevo León with officials and authorities from the State of Nuevo León (Supreme Court, Governor's Office, and Ministry of Health).

The project is entirely intended for the benefit of Mexico and will target a number of specific actors:

1. The drug treatment court in Nuevo León, Mexico, in addition to other Federal Entities exploring the viability of this model;

2. State level policymakers, State Supreme Courts, and treatment professionals, especially from the Mexican states that have implemented some of the 2008 constitutional reforms and therefore have the capacity to establish the complete drug court model in other Federal Entities.

3. National policymakers and professionals from the Federal Government (SEGOB), Attorney General´s Office (PGR), Federal Secretary of Health (CONADIC), the Supreme Court of Mexico, National Institute of Psychiatry, and other non-governmental organizations (NGOs).

4. Drug-dependent offenders who will benefit from the evidence-based treatment practices that will be advanced in the drug treatment courts in Nuevo León and across Mexico.

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Acknowledgements

This study was supported by a grant from the Bureau of International Narcotics and Law Enforcement Affairs (INL) of the U.S. Department of State (contract #INL13GR001WHPMEXICO-10262012). The authors are deeply grateful to Jeffrey Zinsmeister, Nohemi Líra, and Alejandro Juárez of the U.S. Embassy in Mexico, U.S. Department of State, for their support, assistance, and insight during the project. We also thank Joseph M. Pomper, U.S. Consul General in Monterrey, Mexico, for his interest in the project and for meeting with the research team during a site visit to Guadalupe in September of 2013.

The Government of Mexico, through the *Subsecretaría de Prevención y Participación Ciudadana de la Secretaría de Gobernación (SEGOB)* and the *Comisión Nacional contra las Adicciones de la Secretaría de Salud (CONADIC),* together with the Government of the State of Nuevo León, and the Addiction Treatment Court (ATC) managing body at the State level, made this initiative possible. The will of the Government of Mexico to pause and evaluate what has been done in a new model such as the ATC is not only remarkable but also sets up a reference of quality assurance for many other OAS member states. The leadership of the Government of Mexico in doing so is something we applaud and admire. We hope that through this experience, the expansion of the ATC model to other Mexico states will find a reference of lessons learned and practical recommendations. Thanks to the Subsecretario Roberto Campa, Commissioner Fernando Cano Valle from CONADIC and their teams, with a special thank you to Berenice Santamaría (CONADIC) and Xiuh Tenorio and Ariadna Camacho (SEGOB), as well as Honorable Graciela Guadalupe Buchanan, former Chief Justice of Nuevo León, Honorable Gustavo Adolfo Guerrero Gutiérrez, Chief Justice of Nuevo León, Judge Jesus Cadena Montoya, and their team in Nuevo León.

This initiative was made possible thanks to the leadership of Ambassador Paul Simons, Executive Secretary of CICAD, whose support in promoting Drug Treatment Courts in the Americas has made the ES-CICAD a reference in the Hemisphere. As a result of his support, ES-CICAD has become a platform for all OAS member states to promote alternatives to incarceration for drug dependent offenders, including the Drug Treatment Court model.

We are also grateful to Dr. María Elena Medina Mora, Director of the National Institute of Psychiatry in Mexico, a partner of this study. We also thank Jorge Galván Reyes, a research scientist at the National Institute of Psychiatry, for joining the project team and kindly moderating one of the participant focus groups held during the September 2013 site visit. We thank Efren Esquivel-Obregon, who served as interpreter for Center for Court Innovation staff during the site visit. His work was truly outstanding and much appreciated.

We thank all of the individuals who graciously gave their time to participate in research interviews or to help coordinate the September site visit in Nuevo León: from the Judiciary of the State of Nuevo León (Honorable Graciela Guadalupe Buchanan, former Chief Justice of

Nuevo León; Honorable Gustavo Adolfo Guerrero Gutiérrez, Chief Justice of Nuevo León; Honorable Sonia Alejandrina Martínez Mirales, St. Nicholas Addiction Treatment Court; Mauro Zacarías, Director Director of Cultural Disemmination of Judicial Power of the State; Jaime Guerrero Rodríguez, Clerk for Judge Jesus Demetrio Cadena Montoya); from the Office of the Attorney General (Adrián Emilio de la Garza Santos, Attorney General of the State of Nuevo León; Etna Mata García, Guadalupe ATC Prosecutor); from the State Institute of Public Defense (David Peña González, Director General, Rubén Martínez Otera, Director of Criminal Investigations and Proceedings, Fabián Darío Acosta Cisneros, Chief of Microtrafficking and ATC Defense Attorneys); from the Department of Public Security (Rolando Almanza, ATC Probation Coordinator); and from the Ministry of Health (Dr. Juan José Roque Segovia, Director of Mental Health and Addiction at Nuevo León Ministry of Health; and ATC Treatment Team: Dr. Jorge Luis Mancera Maldonado, Director and Psychiatrist, José Luis García Guillen, Psychologist, Ramón Antonio Lara López, Psychologist, David Israel Sánchez Montemayor, Psychologist, and Claudia Mónica López Moran Social Worker).

Our gratitude also to Martin del Campo Raul Sanchez, Director General of the National Center for the Prevention and Control of Addictions (CENADIC) for his comments in the document review phase.

We also thank 14 current and former program participants of the Addiction Treatment Court in Guadalupe for offering their perspectives during confidential research focus groups.

Executive Summary

While drug dependence is considered a chronic and recurring disease,[1] many offenders who present criminal behavior associated with drug use are imprisoned instead of receiving treatment from the health system. However, it is increasingly clear that imprisonment does not deter recidivism and may even be harmful for offenders, their families, and in the long term, the community (see, for example, Cullen et al., 2011; Listwan et al., 2013; Loeffler, 2013; Spohn, 2007). In response to this state of affairs, **drug (addiction) treatment courts[2]** were created as an alternative to incarceration, combining treatment with intensive judicial oversight of the treatment process. Judicial oversight typically involves ongoing status hearings before a drug treatment court judge; individualized interaction between the judge and participant; interim sanctions and incentives to motivate compliance; drug testing; community supervision; legal incentives for graduating; and in some cases incarceration for unsuccessful termination. The intended beneficiaries of the drug treatment court model are drug dependent defendants who would otherwise be handled in the regular criminal justice system and, in some cases, would face imprisonment for criminal offenses.

Since the first drug treatment court opened in the United States in 1989, a growing number of countries have implemented this model. Canada, Bermuda, the Cayman Islands, Chile, and Jamaica followed the U.S. after 2000. In 2009, Mexico joined this list of countries. In 2010, the Organization of American States (OAS) through the Inter-American Drug Abuse Control Commission (CICAD) launched the OAS Drug Treatment Court Program for the Americas to support the expansion of the model to other member states. By 2014, they existed in Argentina, Barbados, Bermuda, Canada, Cayman Islands, Chile, Costa Rica, the Dominican Republic, Jamaica, Mexico, Panama, the United States of America, and Trinidad and Tobago; and in many other countries around the globe, including Australia, Belgium, Ireland, New Zealand, Norway, and the United Kingdom (England and Scotland). However, besides the U.S. and to some extent Canada, Drug Treatment Courts in OAS member states do not have a Monitoring and Evaluation mechanism in place that could show concrete, measurable outcomes. With this in mind, a growing number of countries are working closely with the Organization of American States (through CICAD) and its partners worldwide to install a greater research and evaluation capacity. Based on previous research primarily conducted in the United States (which had more than 1,400 drug treatment courts for adult offenders in 2014), most drug treatment courts for adults have produced reductions in recidivism and drug use and cost savings for taxpayers and for potential victims of future crimes. Therefore, although not the

[1] The Hemispheric Drug Strategy (adopted by the General Assembly of the OAS in June 2010) recognizes that drug dependence is a chronic, recurring disease that should be treated as a central element of public health policy. The strategy calls on member states to "explore the means of offering treatment, rehabilitation and recovery support services to drug-dependent criminal offenders as an alternative to criminal prosecution or imprisonment."

[2] In this document the term Drug Treatment Court will be used generically when referring to the model in general and Addiction Treatment Court when referring in particular to the model in Mexico.

only solution, drug treatment courts are a promising model, suitable for adaptation and evaluation in other local and national settings.

Addiction Treatment Courts in Mexico

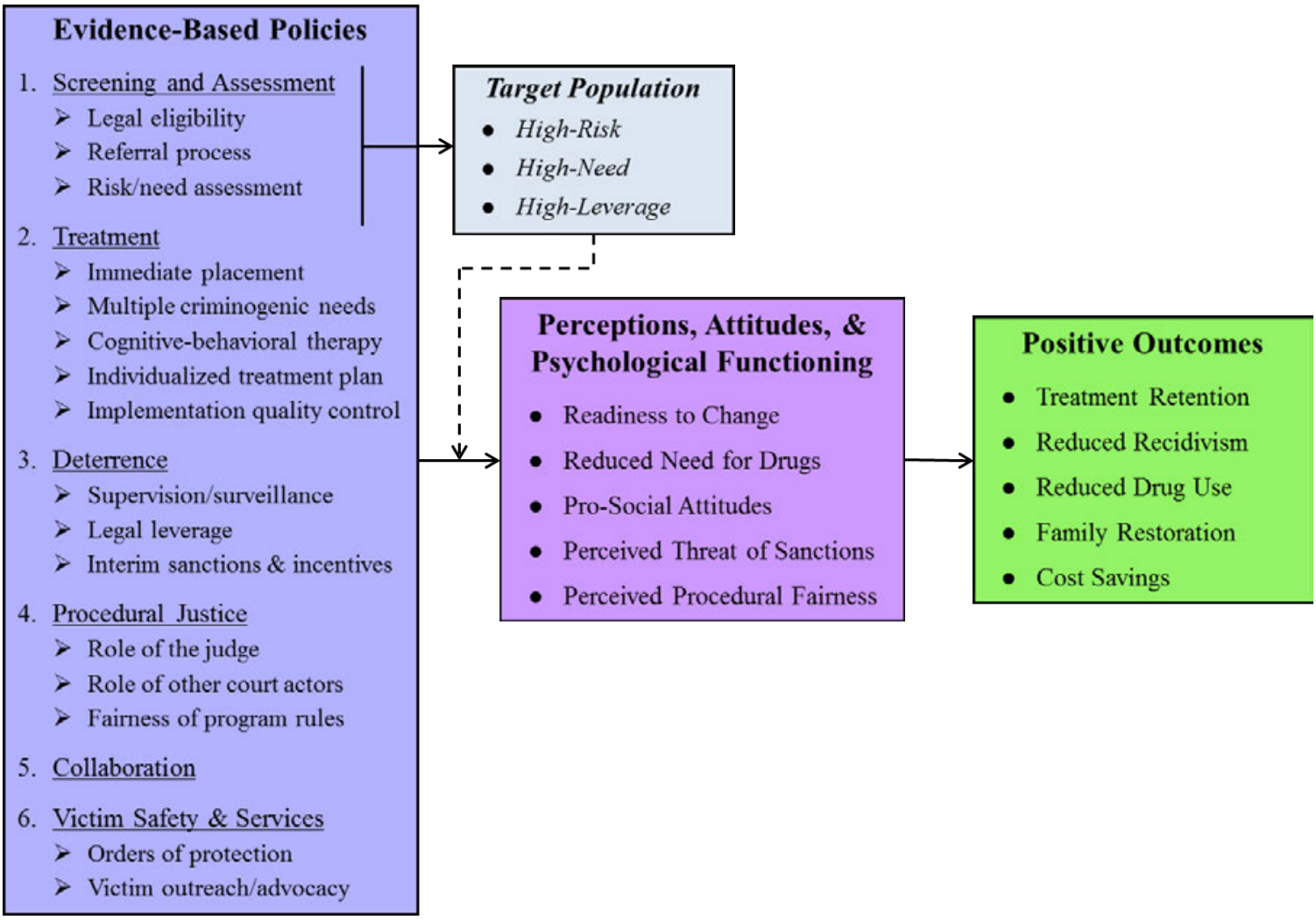
In September 2009, the Addiction Treatment Court in Guadalupe, Nuevo León was established in an effort to adapt the drug treatment court model to the unique legal, cultural, and political context in the state of Nuevo León, and Mexico in general. In 2013, a second drug treatment court opened in St. Nicholas, Nuevo León; and federal officials as well as officials in several states, including Baja California, Chihuahua, Durango, Guanajuato, Hidalgo, Morelos, Nuevo León, Puebla, Sonora, the State of Mexico, and the Federal District (Mexico City) have expressed an interest in opening more addiction treatment courts as part of a national and federal policy.

Mexico is the first country to request an external diagnostic study—of its Nuevo León (Guadalupe) drug treatment court after its implementation as a pilot project. By requesting this diagnostic study, the State of Nuevo León, together with the Federal Government of Mexico, through the S*ecretaría de Gobernación (SEGOB)* and the *Comisión Nacional contra las Adicciones de la Secretaría de Salud (CONADIC),* and with the support of the U.S. Government, sets a precedent for a culture of evaluation that will benefit not only the expansion of the model in the rest of the Mexican Federal Entities, but the entire Hemisphere.

To inform these efforts, and with funding from the U.S. Department of State, the Organization of American States and the Center for Court Innovation performed a diagnostic evaluation of the original pilot program in Guadalupe. Specifically, thepolicies and practices of the Guadalupe Addiction Treatment Court (*Tribunales de Tratamiento de Adicciones*) were assessed according to an evaluation framework (see next page) that is based on past research concerning "what works" in adult drug treatment courts. First and perhaps most important is the practice of enrolling a target population that is medium or high risk. Research has repeatedly confirmed that people with a higher risk of reoffending receive the greatest benefit from the intensive drug treatment court model. The four main risk factors are history of criminal behavior, antisocial personality, criminal thinking and anti-social associates. Additional proven evidence-based practices include treating multiple criminogenic needs (not limited to substance abuse); applying sanctions and incentives consistently in response to recent behavior; identifying clear consequences that will be imposed for failing the drug treatment court program; providing clear information on program rules and responsibilities; and promoting a fair process—especially during judicial status hearings—that leads participants to feel that they are treated with respect and their needs are taken into account.

Research methods included document review; interviews with Addiction Treatment Court team members and state-level stakeholders who hold key policymaking positions in Nuevo León; structured observations of team staffing meetings and court sessions; focus groups with current and previous program participants; and an analysis of available participant data as of August 2013.

Figure E1. Diagnostic Evaluation Framework



This unique diagnostic evaluation study is comprised of two phases: observations (phase 1) and recommendations (phase 2). In phase 1, the research team included the authors of this report, assisted by a larger group of international experts respectively affiliated with the Center for Court Innovation, the Organization of American States, the judiciary in Chile, and the National Institute of Psychiatry in Mexico. In phase 2, this effort also received the support of the Office of Justice Programs of the School of Public Affairs at American University.

Main Strengths of the Addiction Treatment Court in Guadalupe

The Addiction Treatment Court is an innovative pilot program designed to test the feasibility of the drug court model in Mexico and to provide lessons for other Mexican states, as well as other OAS member states, who also want to implement drug treatment courts. The program incorporates most of the elements that are commonly associated with well-implemented drug

treatment courts, including high-quality treatment services; frequent judicial status hearings that effectively engage the participants; well-run pre-court staffing meetings; interim sanctions and incentives; drug testing; community supervision; and case dismissal for those who graduate. The most notable strengths are:

- Clinical assessment: Clinical staff conduct a comprehensive evaluation prior to participation in the program, including comprehensive assessments of the individual by a psychologist, a social worker and a psychiatrist at the designated Treatment Center.

- Treatment of multiple needs: Psychologists use cognitive-behavioral methods to address multiple needs (often including substance dependence as well as anger and aggression). The social worker addresses employment and vocational needs and engages family members so as to promote safe and effective family restoration. Participants expressed high levels of satisfaction with the quality of treatment.

- Judicial status hearings: In the program frequent judicial status hearings are conducted in which the judge demonstrates a high level of procedural justice, achieved through fair, respectful and committed interactions that invite participants to reflect on their experiences. Participants praised the role of the judge of the Addiction Treatment Court.

- Collaboration: The program demonstrates a high level of professional collaboration both between high-level stakeholders in Nuevo Leon as well as between members of the Treatment Court (judge, lawyers, supervisory officers and treatment providers).

Summary of the Results of the Evaluation

The Addiction Treatment Court is a classic example of the drug treatment court model. However, the program also reflects the distinctive legal, cultural, and political context specific to Mexico. In this legal context, the program participants in Guadalupe enroll through a preexisting suspension of proceedings -"stay of trial on probation"- which is a legal mechanism that precedes case adjudication. Notably, this mechanism is restricted to defendants with select charges and criminal histories, posing a unique challenge to broad availability of the drug treatment court option. Furthermore, in the case of Nuevo León nearly all participants to date have been charged with domestic violence, encompassing intimate partner violence and violence towards children, parents, siblings, or other family members. This focus on domestic violence matters reflects both their legal eligibility for the aforementioned suspension of proceedings mechanism and the cultural appeal—in Mexico—of a novel, innovative model that holds the prospect of supporting, strengthening, and reintegrating families that have recently been harmed by anti-social behavior. Similarly, the goal of family rehabilitation is a distinctive element that is seen as a particularly high priority in the model implemented in Nuevo Leon.

Many OAS member states have decided to start implementing this model. Once the model is implemented and has shown that the system succeeds in each jurisdiction (in terms of internal

procedures and interagency cooperation), eligibility criteria could be expanded. Indeed, other Mexican states are already considering the possibility of adopting different legal eligibility criteria. As it stands, since not all criminal cases in Mexico can legally be granted a stay of proceedings, the requirement for a suspension of proceedings prior to a conviction limits the cases that can be assigned to the Mexican Addiction Treatment Courts. In Mexico, the gradual process of including more cases in the new accusatory system also influences the evolution and feasibility of different eligibility criteria.

Over its first four years of operations, the Addiction Treatment Court enrolled close to 130 participants (averaging 30-35 new participants per year). Most have a primary drug of alcohol, with about one in five having a primary drug of marijuana, and a smaller percentage abusing other illegal drugs, including cocaine or inhalants. Major evaluation findings are as follows:

Screening and Assessment

Current eligibility, referral, and screening policies yield a relatively narrow target population, consisting mostly of first-time domestic violence defendants who abuse alcohol or marijuana.

- Legal Eligibility: Both the drug treatment court team and the victim must agree that the offender can be admitted to the program. The defendant cannot have links to organized crime; cannot have another pending case; cannot have any other pending cases; and must be eligible for a suspension of proceedings. The suspension of proceedings criterion excludes defendants with a prior conviction; excludes most property cases (that are investigated and charged by the police); and excludes cases with a maximum prison sentence of more than eight years. Cases are also nearly always excluded if a weapon was involved or if the victim experienced serious physical injuries. With rare exceptions, these restrictions have effectively limited eligibility to first-time domestic violence defendants.

- Drug Cases: In 2009, the Mexican Congress approved the reform of the General Health Law, the Federal Penal Code, and the National Code of Criminal Procedure. These reforms aim, among other elements, at allowing state and local security forces to share the prosecution of minor drug sales with the federal government and to differentiate between criminal and victims or addicts. As the possession of "small drug amounts" for personal consumption usually is not punishable, the reforms established a maximum dosage for eight frequently used drugs that would be considered "for personal use". Although some drug cases are now prosecuted in state courts, they remain ineligible for the Guadalupe program, with team members and stakeholders expressing a range of opinions on the appropriateness and feasibility of admitting drug cases in the future. Excluding these cases leaves out a pool of defendants who may be drug-addicted and who comprise a central target population in many other drug treatment courts around the globe.[3]

[3] The Drug Treatment Courts Program for the Americas which promotes OAS does not recommend including cases of use and possession as eligibility criteria for these models, but those whose crimes have been something other

- Screening and Referral Process: The drug treatment court employs a case-by-case referral process, with most referrals initiated by the defense attorney. Of those who are referred, the vast majority enroll (about 30-35 people per year).

- Clinical Assessment: Participants are assessed at a state-funded Treatment Center for all drug treatment courts in Nuevo León. The assessment includes multiple structured tools, covering drug and alcohol use, depression, anxiety, and mental well-being; and also includes semi-structured interviews with a psychologist, social worker, and psychiatrist. The assessment does not incorporate validated actuarial tools to classify recidivism risk (low, medium, or high risk).

- Target Population: Reflecting the above policies, only three participants to date are not charged with domestic violence. The participants have a wide range of drug use histories, with many participants consuming multiple drugs. The consumption of illegal drugs includes marijuana, and/or cocaine, and a significant number of participants are also addicted to alcohol. The primary drug of choice is alcohol (71%), marijuana (18%), both marijuana and alcohol (2%), or other drugs (less than 10%). The highest degree attained is mainly junior high school (61%) or less (24%). Given the exclusion of cases with a prior conviction, it may be inferred (although data is not available to confirm) that the target population averages a relatively low-risk of re-offending.

Treatment

Nearly all participants receive an immediate outpatient placement. The typical regimen incorporates evidence-based cognitive-behavioral approaches, combined with comprehensive social work services and significant efforts to engage the victim and other family members.

- Time to Treatment Placement: Most participants are assessed and enrolled within two weeks of case filing and receive an immediate placement at the Treatment Center.

- Treatment Plan: Nearly all participants receive a standardized outpatient regimen at the Treatment Center, although referrals for residential drug or mental health treatment are available when needed. In Phase One (lasting a minimum of three months), treatment includes two group and two individual counseling sessions per week—with social work or psychiatric consultations, family counseling, and attendance at life skills workshops, optional at all times and sometimes mandated based on individual need. Attendance requirements are progressively downgraded in advanced phases. Participants must also attend three AA sessions per week throughout their participation.

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than consumption itself, but where drug dependence has been diagnosed as the trigger or cause for the commission of the offense. Cases in which the individual would definitely have gone to prison for the crime committed (e.g. property crimes), and where once the dependence is diagnosed, treatment is determined as an alternative to imprisonment. However, each country ultimately must make the decision that corresponds in respect to the eligibility criteria of the applicable model.

- Cognitive-Behavioral Therapy (CBT): Treatment employs proven CBT methods that are designed to address alcohol/drug abuse and other criminogenic needs. Most of the participants have co-occurring problems related to self-control, anger, and aggression—specifically towards family and household members. Accordingly, counselors lead participants to identify and express their feelings; recognize triggers to drug use and violence; and develop the necessary communication and other skills for responding in pro-social ways. In focus groups, participants expressed great satisfaction with treatment and described how treatment helped them in ways reflecting the intended cognitive-behavioral focus.

- Social Work Services: The social worker at the Treatment Center assists with employment, educational, vocational, and housing needs, as well as providing weekly groups and individualized information and assistance to family members of participants.

- Implementation Fidelity: All Treatment Center staff hold advanced degrees. While the three psychologists and one social worker do not receive regular supervision from the director/psychiatrist, they appear to be highly experienced and skilled in working with the target population. Notably, the clinical staff has undergone little turnover to date. Currently, the Treatment Center does not use a manualized treatment curriculum.

- Logistics: Mandated treatment services take place weekday mornings, beginning at 9:00 a.m. As this schedule can represent a barrier to employment, the participants should prioritize treatment over employment during the period of compulsory treatment imposed by the court.

Deterrence

Legal leverage is limited, since enrollment is pre-plea, and most of those who fail have the case dismissed when the victim drops the charges. The court still seeks to promote compliance through judicial status hearings, drug testing, and community supervision—as well as interim sanctions and incentives, selected case-by-case in response to recent behavior.

- Supervision: In Phases One and Two, participants attend weekly judicial status hearings, with the required frequency decreasing in subsequent phases. Participants are also drug-tested when appearing at the Treatment Center and monitored through home visits by a supervision officer (weekly at first and less often thereafter).

- Legal Leverage: Enrollment is via a pre-plea suspension of proceedings. If participants fail, the case is adjudicated from scratch, making it impossible to establish definite jail or prison consequences in advance. In fact, most victims drop the charges when participants fail, resulting in the same case dismissal outcome as that received by program graduates.

- Interim Sanctions and Incentives: The program does not employ a written schedule linking specific classes of infractions to possible sanctions. On a case-by-case basis, the program uses several sanctions (e.g., verbal admonishment, Phase One demotion, increased treatment, supervision, or AA meetings, or 36 hours in jail) and incentives (judicial praise, courtroom applause, or monthly groceries from the Treatment Center).

Procedural Justice

The program generally excels in procedural justice, primarily as a result of the fair, respectful, and consistent demeanor that the current judge appears to display in judicial status hearings. Procedural justice is perceived fairness of the judicial proceedings and interpersonal treatment during the handling of the case.

- Transparency of Program Rules: Prior to enrollment, treatment staff hand participants written information on program rules and participant responsibilities. However, focus group findings suggest that many participants do not adequately absorb this information. When they enrolled, participants expressed that they were unaware of the weekly time, the logistic demands of required treatment and court attendance, and were unaware of the overall length of the program.

- Judicial Status Hearings: Participants directly converse with the judge in judicial status hearings. Across two observed sessions, it was registered that this conversation lasted an average of 3.71 minutes (above the three minutes that is recommended by research). The judge usually asked probing questions, and participants spoke openly of their recent experiences. The judge often added instructions, advice, or reminders of the potential consequences of future compliance and noncompliance. On a semi-structured observation protocol, the judge was classified as "5" (highest score on a 1-5 scale) on being respectful, fair, attentive, and consistent/predictable.

Collaboration

A wide array of federal and state stakeholders collaborated in planning the Addiction Treatment Court. In general, the drug treatment court team exemplifies effective communication and collaboration.

- Communication: Treatment and supervision provide the full team (including the judge and attorneys) with a weekly written report on participants scheduled to appear in court.

- Staffing Meetings: Weekly staffing meetings include oral reports on each participant from treatment and supervision and an orderly discussion that nearly always ends in a consensus recommendation (92% of cases observed) when responding to noncompliance.

Victim Safety and Services

The court imposes an order of protection in many, but not all, domestic violence cases, based on an assessment of victim safety. The Treatment Center provides services to the victim and other family members. As a group, the drug treatment court team has not received domestic violence training.

- Orders of Protection: Many, but not all, domestic violence cases have an order of protection imposed, based on an initial assessment by an in-house psychologist in the prosecutor's office, and on subsequent deliberations among drug treatment court team members on whether existing orders should be continued. In the observed judicial status hearings, the judge did not remind any participant of requirements related to an order or protection.

- Victim Services: Beyond an initial consultation with a psychologist in the prosecutor's office, victims are not linked to an independent victim advocate, who could provide ongoing legal assistance, safety planning, or other services. However, victims and other family members of drug treatment court participants may attend a weekly group session for family members at the Treatment Center; individualized social work or counseling services; or—when deemed safe and appropriate by clinical staff at the Treatment Center—family therapy with the participant present.

Other Policies and Practices

- Graduation Requirements: The minimum time to graduation is 18 months, and the actual average time to graduate (allowing for relapses and other setbacks) exceeds two years—which outstrips the average of 15 to 18 months in the United States. The current graduation rate is close to 50%, which is comparable to the average U.S. drug treatment court.

- Training: The original drug treatment court team participated in extensive training opportunities in the United States, Chile, and Mexico. However, training protocols for new staff have not been formalized, and the team has not received domestic violence training.

- Performance Monitoring: The program collects basic data on participant background characteristics, court dates, and program status (e.g., open, graduated, or terminated). The program can produce summary statistics on request but does not issue a routine report (e.g., annual). The court has not sought feedback from participants.

Chapter 1
Introduction

The Mexican Federal Government, through the Ministry of the Interior and the National Commission Against Addictions, promotes the benefits of alternative models of justice for people with addictions as an effective strategy to reduce drug demand, decreased rates of recidivism, and as a mechanism of social reintegration for people with addictions who are in conflict with the law. Among these models of justice, the Addiction Treatment Court (ATC) and the pioneering project in Guadalupe, Nuevo León stand out.

One of the primary means of dissemination and implementation of these models is through technical assistance to states, which by their procedural conditions, under the adversarial criminal justice system, and given an adequate treatment infrastructure, can feasibly operate these programs. In this context and as part of the Mérida Initiative (a broader initiative that includes efforts to reduce the demand for drugs throughout Mexico), a 2009 letter of agreement highlighted the importance of promoting the implementation and expansion of Addiction Treatment Courts (ATCs) in Mexico. Following up on that letter, the Mexican government became interested in completing a specialized diagnostic study on the operation of its first ATC in the state of Nuevo León.

Additionally, the Work Plan for Assistance of the Organization of American States for ATC Expansion Model in Mexico by the Executive Secretariat of the Inter-American Commission for Drug Abuse Control (SE-CICAD) was developed in collaboration with the National Commission Against Addictions (CONADIC) and the Secretariat for Prevention and Citizen Participation (SEGOB). This document describes the collaboration and assistance provided by CICAD to the Mexican government in opening ATCs in different Mexican states.

Thus, the development of the current diagnostic study is of crucial importance as a mechanism for assessing progress in implementing the ATCs in Mexico and strengthens the actions that CONADIC and SEGOB currently perform in the management of these alternative justice programs in different states. The results thereof will provide guidance for improved planning and design of a work plan in candidate states to include a model similar to that of Nuevo Leon.

Moreover, information generated through research on ATCs adopted in other North and South American countries besides the "Drug Courts" in the United States is essential in order to meet the pertinent requirements for adaptation and impact of these alternative justice mechanisms in the countries and populations with different legal requirements and cultural contexts.

Drug treatment courts combine court-ordered treatment with ongoing judicial oversight of the treatment process.[4] The first drug treatment court (DTC) opened in Miami, Florida in 1989. By April of 2013, more than 1,400 drug treatment courts were serving adult criminal defendants throughout the United States (American University 2013). Drug treatment courts were also launched in Canada, Chile, Jamaica, Bermuda, and the Cayman Islands in the beginning of this Century. Mexico joined the group of countries implementing drug treatment courts in 2009, after attending a meeting of the Inter-American Drug Abuse Control Commission (CICAD) of the Organization of American States (OAS) in Santo Domingo (Dominican Republic), and after visiting DTCs in the United States, Chile, and Belgium. After Mexico launched this initiative, and since the Executive Secretary of CICAD launched the Drug Treatment Court Program for the Americas in 2010, other countries have also adopted this model, making necessary adaptations to their own realities and legal landscape. Indeed, as DTCs have spread internationally, observers have drawn attention to the role of legal, cultural, and political context in producing different national adaptations (Nolan 2009; Lomba 2012). Whereas an extensive evaluation literature demonstrates that most adult criminal drug treatment courts in the United States reduce recidivism and drug use (Mitchell, Wilson, Eggers, and MacKenzie 2012), relatively little research has examined the many models that have now emerged elsewhere. The OAS, through the Drug Treatment Courts Program in the Americas, is working together with participating member states to develop their own system of monitoring and evaluation of DTCs. As part of this process, the OAS is conducting regional training workshops to assist member states to develop their own systems of monitoring and evaluation. The OAS works with leading experts in monitoring and evaluation and drafted the first manual on Monitoring and Evaluation for DTCs with a Hemispheric Approach. This Manual will be reviewed by member states in 2014 and 2015 and will be published in late 2014.

In exploring the prospects for international expansion, Mexico is an ideal country for study. The first Mexican drug treatment court, the Addiction Treatment Court in Guadalupe, Nuevo León, has been operating since September of 2009. A second Mexican drug treatment court opened in the summer of 2013 in St. Nicholas, and two more are in the planning stages, all employing an identical program model within different municipalities of the State of Nuevo León.

With the support and leadership of those responsible for the federal policies, discussions are now underway concerning the expansion of drug treatment courts to other states throughout Mexico. The U.S. Department of State is supporting these discussions, which represents one facet of the larger Mérida Initiative, a wide-ranging public safety strategy implemented in collaboration with the Government of Mexico. The Organization of American States (OAS) has also lent assistance through its Drug Treatment Court Program for the Americas. This initiative has provided training and technical assistance to a growing number of OAS member states. In July 2013, OAS organized training week in Washington D.C., where seven OAS member states, including Mexico, had the opportunity to share questions and find common solutions to global

[4] The program in Guadalupe, Nuevo León is known as an "Addiction Treatment Court" and is referred to as such in this report. However, when describing the model overall, the authors have adopted the generic and widely used term "Drug Treatment Court" (Drug Court in the United States).

problems. Among other training events, in November 2013, OAS convened a training conference in the State of Mexico with the explicit aim of promoting sound practices in other drug treatment courts that are currently in planning throughout Mexico.

With national expansion discussions accelerating, the moment is timely for an independent assessment. With funding from the U.S. Department of State, the Organization of American States and the Center for Court Innovation are collaborating on a two-phase project. The first phase involves a *diagnostic evaluation* of the Addiction Treatment Court in Guadalupe. Partly informed by the findings of this phase, the second phase included the addition of another partner in this project, the Office of Justice Programs, Department of Justice, Law and Society, Faculty of Public Affairs, at American University. This second phase involves the development of *national recommendations* concerning whether and how to expand drug treatment courts or other demand reduction policies elsewhere and how to do it.

This introductory chapter outlines the drug treatment court model in general terms; summarizes the research literature; and reviews the legal context in which the Guadalupe program arose. Chapter 2 presents an evidence-based conceptual framework that was used to inform the evaluation process and describes specific evaluation methods. Chapter 3 describes the Guadalupe program in full—and includes specific findings regarding the strengths and limitations of the program. Chapter 4 provides the perspective of program participants, synthesizing themes and findings from two participant focus groups held in September 2013. Chapter 5 provides some conclusions. Chapter 6 provides recommendations for the Guadalupe program and identifies an initial set of recommendations when contemplating a national addiction treatment court model for Mexico. development of this model is a living process, constantly considering and incorporating new variables as applied to different jurisdictions. Therefore, it is important to view this as an initial recommendation list, capable of being expanded as the model extends in the whole country.

The Drug Treatment Court Model

Although policies and practices vary from site to site, certain core elements of the drug treatment court model are close to universal. In the late 1990s, ten of these elements were memorialized in *Defining Drug Treatment Courts: The Key Components* (OJP/NADCP 1997). Around the same time, an international working group established an overlapping set of 13 drug treatment court principles (United Nations 1999). Much more recently, two parallel efforts have drawn attention to those particular drug treatment court policies that are supported by evidence—the *Seven Program Design Features* (BJA/NIJ 2013) and *Adult Drug Treatment Court Best Practice Standards* (NADCP 2013).

In general, drug treatment courts combine the idea that criminal behavior and drug use can be reduced through community-based treatment with the idea that only through intensive judicial oversight are participants likely to remain engaged in treatment for long enough to benefit (see overview of the model in Rempel 2014). The main beneficiaries of the drug treatment court model are those drug dependent offenders who would otherwise be subject to the traditional

criminal justice system and face potential imprisonment for crimes (crimes against property, for example), but whose dependence drugs is the underlying reason why they committed the offense in the first place.

Indeed, a longstanding body of research confirms that treatment can reduce crime and drug use when participants are retained for at least 90 days and preferably up to one year (Anglin, Brecht and Maddahian 1989; DeLeon 1988; Taxman 1998; Taxman, Kubu, and Destefano 1999). However, treatment retention rates are generally poor, with more than three-quarters of those who begin treatment dropping out prior to 90 days (Condelli and DeLeon 1993; Lewis and Ross 1994). The drug treatment court model presumes that judicial oversight can incentivize participants to be retained for longer periods. Prior research confirms that legal pressure, whether applied by judges or other criminal justice agents, can increase treatment retention rates (Anglin et al. 1989; DeLeon 1988; Hiller, Knight, and Simpson 1998; Rempel and DeStefano 2001; Young and Belenko, 2002). Drug treatment courts in the United States appear to average relatively high one-year retention rates of at least 60 percent, representing a vast improvement over "treatment as usual" programs (Belenko 1998; Cissner et al. 2013; Rempel et al. 2003; Rossman et al. 2011).

Drug treatment courts employ judicial oversight through several mechanisms. Once the participants are accepted (meet the legal and clinical eligibility criteria and are clinically tested for a drug dependence), participants must attend regular judicial status hearings, often weekly or biweekly at the outset of participation, before a specially assigned judge. At these hearings, the judge engages in a motivating, conversational interaction with each participant; administers interim sanctions in response to noncompliance; and provides praise, gift certificates, or other tangible incentives in response to progress. Participants are also regularly drug-tested and, in most programs, must meet with case managers or probation officers, who monitor compliance and assist participants with any problems they may have. Further incentivizing compliance, program graduates can expect to receive a dismissal or reduction of the criminal charges against them, whereas those who fail can expect to receive a conviction along with a jail or prison sentence.

Another important feature of the drug treatment court model is the high level of cross-system collaboration fostered amongst justice and treatment professionals. In this model, various agencies and institutions work together for the sole purpose of helping participants. Many drug treatment courts hold weekly staffing meetings, in which the judge, prosecutor, defense attorney, case managers, probation officers, and treatment providers discuss how various participants are doing and arrive at recommendations regarding treatment needs and judicial responses. The judge is the one who ultimately makes the final decision in court. The use of these staffing meetings to facilitate treatment planning decisions and, at times, to air opposing points of view allows the traditional adversarial process to be relaxed during the actual court session that follows. By minimizing the adversarial process during the court session, the judge is able to engage in a more unmediated, constructive, and motivating interaction with the participant.

The Impact of Adult Criminal Drug Treatment Courts

Research indicates that most drug treatment courts for adult criminal offenders reduce recidivism.[5] Across more than 90 evaluations, average differences in drug treatment court and comparison group re-arrest or re-conviction rates have ranged from eight to 12 percentage points (Gutierrez and Bourgon 2009; Mitchell et al. 2012; Shaffer 2011). Most evaluations have tracked defendants for one or two years, but several extended the follow-up period to three years or longer and still reported positive results (e.g., Carey, Crumpton, Finigan, and Waller 2005; Finigan, Carey, and Cox 2007; Gottfredson, Najaka, Kearley, and Rocha 2006; Rempel et al. 2003). Nearly all of the completed evaluations focused on drug treatment courts in the United States, but one randomized controlled trial of a New South Wales (Australia) drug treatment court reported significant recidivism reductions over 18 months (Shanahan et al. 2004).

Few studies have directly examined whether drug treatment courts reduce drug use, but their results are also mostly positive (Deschenes, Turner, and Greenwood 1995; Gottfredson, Kearley, Najaka, and Rocha 2005; Harrell, Roman, and Sack 2001; Rossman et al. 2011; Turner, Greenwood, Fain, and Deschenes 1999). In particular, *NIJ's Multi-Site Adult Drug Treatment Court Evaluation*, a five-year study of 23 drug treatment courts and six comparison jurisdictions across the United States, found that drug treatment court participants were significantly less likely than comparison offenders to report using any drug (56% v. 76%) or to report using serious drugs (41% v. 58%) in the year prior to an 18-month follow-up interview (Rossman et al. 2011).[6]

Finally, an array of cost-benefit studies in the United States (e.g., Barnoski and Aos 2003; Carey et al. 2005; Waller, Carey, Farley, and Rempel 2013; Rossman et al. 2011), and one in Australia (Shanahan et al. 2004), indicate that drug treatment courts consistently produce resource savings. These savings largely stem from reducing recidivism, which avoids costs to taxpayers and crime victims that would otherwise have resulted had drug treatment courts not prevented new crimes. The greatest source of these savings lies in treating "high-risk" individuals (those most likely to re-offend) who, had they not enrolled in drug treatment court, would have committed serious property or violent crimes (Roman 2013).

Despite the positive average effects of drug treatment courts, research also makes clear that they are not all equally effective. The impact ranges from cutting the re-arrest rate in half to reducing re-arrests by modest levels to, in a small number of drug treatment courts, increasing

[5] Research literatures on juvenile, family, reentry, and tribal drug treatment courts are less extensive than the research literature on the original adult criminal model. Since national expansion discussions in Mexico have largely focused on adult criminal drug treatment courts, this report will not address research concerning other closely related models.

[6] Serious drug use omitted both marijuana and "light" alcohol use, with the latter defined as less than four drinks per day for women and less than five drinks per day for men. Besides demonstrating positive results on self-report measures, the same study also detected positive effects on drug use when examining the results of oral swab drug tests that were conducted at the time of the 18-month follow-up interview.

re-arrests (see especially Mitchell et al. 2012). Moreover, recent research has drawn a clear link between the rigorous application of evidence-based principles and practices and more positive drug treatment court impacts (see especially Carey, Macklin, and Finigan 2012; Cissner et al. 2013; Gutierrez and Bourgon 2009; Rossman et al. 2011). The realization that evidence-based practices truly matter has led the National Association of Drug treatment Court Professionals and major funding agencies in the United States to define and promote such practices (described below) to a dramatically greater extent than during the first 20 years of the drug treatment court experiment (NADCP 2013; BJA/NIJ 2013).

The Legal Context of Drug Treatment Courts in Mexico

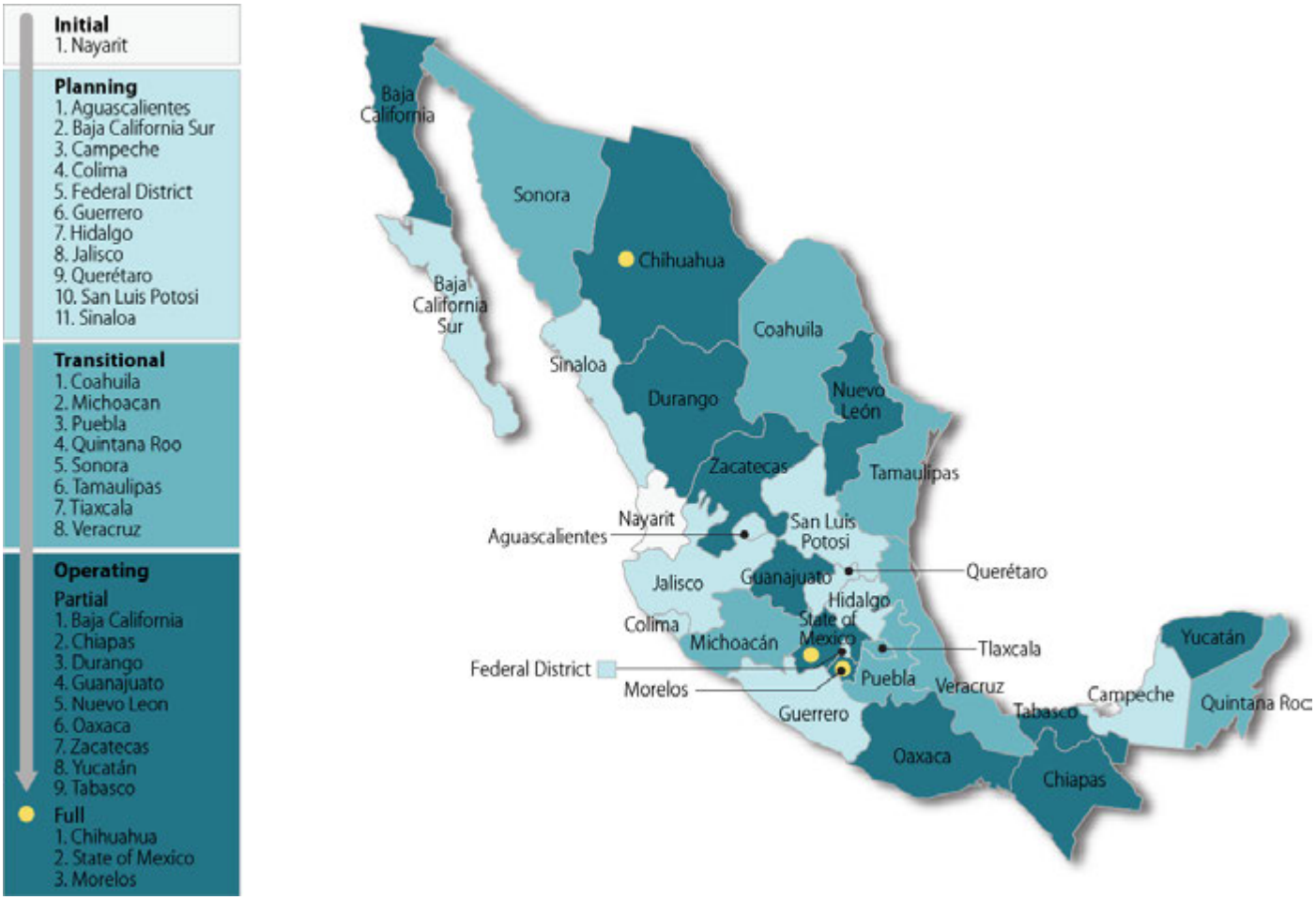
Since the passage of sweeping legislative and constitutional reforms in 2008, Mexico has been transforming its criminal justice system in an effort to reduce corruption, reduce pretrial detention, and increase fairness, due process, and case processing efficiency (Seelke 2013; Shirk 2010). The 2008 constitutional reforms extended to the federal system, Mexico's 31 state-based criminal justice systems, and the Federal District (Mexico City). Five states actually began their reform process slightly earlier, prior to federal legislation (Chihuahua, Morelos, Nuevo León, Oaxaca, and Zacatecas). The 2008 legislation allowed each state to control the process and to set its own timeline, with a final deadline of 2016 to complete the transition. As shown in Figure 1.1, nine states achieved partial implementation and three (Chihuahua, Morelos, and the State of Mexico) had fully implemented the required reforms by the end of 2012 (Seelke 2013).

For drug treatment courts, the most relevant elements of the 2008 reforms involved new procedures that, for the first time, allowed plea bargaining, alternative dispute resolution, and oral trials, whereby judge, attorneys, and defendants could directly interact during court hearings. Previously, prosecutors would submit written arguments to the judge, who would then issue written decisions—all without the benefit of oral arguments involving both the prosecution and defense. Such a written process precludes the drug treatment court practice of holding in-person judicial status hearings, during which the judge and participant directly converse. Research has consistently shown that the judicial interaction during these status hearings, as well as the judge's capacity to apply interim sanctions for noncompliance, are highly effective elements of the drug treatment court model (e.g., Carey et al. 2012; Cissner et al. 2013; Farole and Cissner 2005; Goldkamp, White, and Robinson 2002; Marlowe, Festinger, and Lee 2004; Rossman et al. 2011). Accordingly, drug treatment courts are now feasible, in at most, the 12 states that have completed partial implementation of the 2008 reforms.

An analysis by Mexico's National Center for Analysis, Planning, and Information for the Fight against Crime of the Attorney General's Office advanced one further legal requirement: that drug treatment court admission must occur pursuant to a judicial order for a suspension of proceedings, also known as a "stay of trial on probation" (Montoya, González, and Rivas 2013). Such a suspension is ordered prior to case adjudication and has the effect of halting the dispositional process. The identification of this legal requirement implies that, although most

drug treatment courts in the United States follow a "post-plea" model, whereby participants plead guilty to some offense at the time of enrollment (Rossman et al. 2011), a post-plea framework was not considered for Mexico. Instead, national planners presumed that drug treatment court participants would have to enroll before entering a guilty plea. Part of the rationale for adopting a pre-plea framework is that, were a post-plea model followed, it would be legally impossible to reward program graduates by vacating their plea and dismissing the charges. (In the United States, the legal system provides for vacating the plea of program graduates "in the interest of justice.") In turn, since not all criminal cases in Mexico are legally able to receive a suspension of proceedings, the necessity of a pre-plea framework restricts which cases may be considered for Mexican drug treatment courts.

Figure 1.1. Judicial Reform Implementation in Mexico's States (November 2012)



Source: Figure reproduced from Seelke 2013, based on classifications obtained from the Government of Mexico, Ministry of the Interior, Technical Secretariat of the Coordinating Council for the Implementation of the Criminal Justice System (SETEC), November 2012.

Selection of Guadalupe, Nuevo León for the First Mexican Addiction Treatment Court

The outcome of the aforementioned feasibility analysis (see Montoya et al. 2013) was the selection of Guadalupe, Nuevo León as the site for the country's first drug treatment court. In 2004, Nuevo León had become the first Mexican state to initiate judicial reforms (Seelke 2013), affording the state substantial prior experience with an oral hearing process. Furthermore, a wide array of stakeholders, representing the Nuevo León Supreme Court, the District Attorney's Office, State Institute of Public Defense, Public Security, Ministry of Health, and state government, all strongly supported the establishment of a drug treatment court; and the Ministry of Health was able to fund a dedicated Treatment Center where all treatment and social work services could be delivered.[7]

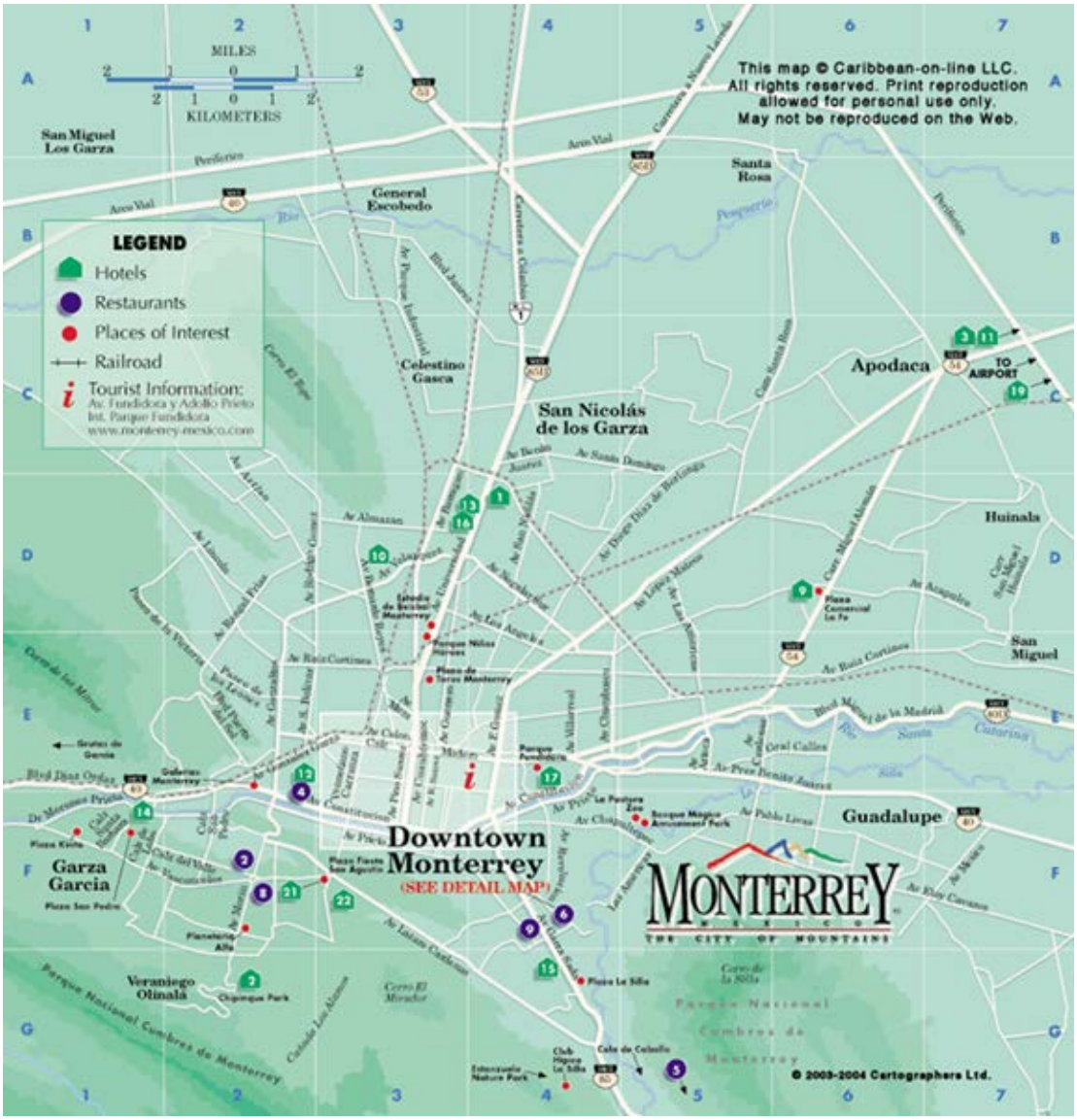
Guadalupe is a densely populated municipality within Nuevo León, located just east of Monterrey (see map of the greater Monterrey metropolitan area in Figure 1.2). The Guadalupe population was just under 700,000 as of the 2005 census, representing about 15 percent of Nuevo León's state population of 4.3 million. In 2012, Guadalupe was the site of 17% of all state crimes, with 129 homicides (6% of the state total), 5,026 robberies (19% of the state total), 853 assaults/injuries (15% of the state total), 1,617 family violence offenses (16% of the state total), and 200 sex crimes (15% of the state total). Drug possession and sales offenses were federally prosecuted in 2012 and, therefore, are not reflected in these state crime statistics. In 2009, Mexico's Congress approved the reform of the General Health Law, the Federal Penal Code and the Federal Code of Criminal Procedure. These reforms aim, among other things, to enable state and local security forces to share the prosecution of retail drug sales with the federal government and differentiate between criminals and victims or addicts. As the possession of "small amounts of drugs" for personal consumption usually is not punishable, reforms established a specific maximum dosage for eight frequently used drugs that can be considered "for personal use." Although this legislation was enacted in 2009, Nuevo León did not begin the processing of drug offenses until 2013. Consequently, they were not eligible for the drug treatment court when it opened in 2009. Since early 2013, a new law led some drug offenses to be prosecuted in state courts (see below), but the drug treatment court has yet to change its original eligibility criteria.

Concerning drug use and addiction, research indicates that 5.22% of the Nuevo León population reported ever using illegal drugs, with 0.97% reporting illegal drug use in the previous month. The primary illegal drugs of choice are cocaine, marijuana, and inhalants, with far smaller percentages (less than 6% of those who report illegal drug use) involved with amphetamines/methamphetamine, LSD, or illegal use of prescription drugs; and less than 2% involves with opiates. Approximately half of those reporting illegal drug use indicated that they first used such drugs by the age of 14 years, and almost 45% of users are ages 15-19 years (original sources for the above statistics are cited in Segovia and Maldonado 2012). The

[7] The strong support of these stakeholders for establishing a drug treatment court was determined through the extensive stakeholder interviews that were conducted for the current diagnostic evaluation study (see below).

aforementioned statistics do not include alcohol use, although it proved to be a particularly significant problem amongst those who enrolled in the Guadalupe Addiction Treatment Court.

Figure 1.2. Map of the Greater Monterrey Metropolitan Area



Source: Map of Monterrey (http://mexico-on-line.com/monterrey/monterrey-maps/monterrey-map.html), copyright and courtesy of Mexico-On-Line.com (http://mexico-on-line.com).

In planning the addiction treatment court, stakeholders agreed that family violence offenses, robberies, and minor harassment/molestation cases would be eligible. As a practical matter, Mexican legal practice only involves allowing a suspension of proceedings in cases brought by the victim, where the victim does not object to the suspension (Shirk 2010). Conversely, when law enforcement investigates a crime or initiates the charging process, suspensions are not customary. Since robberies are nearly always investigated and charged by law enforcement, robberies would rarely be eligible for the drug treatment court in practice—and indeed, only one robbery case has enrolled to date.

Over its first four years of operation, the Guadalupe Addiction Treatment Court admitted close to 130 participants. Of these participants, all except three were charged with family violence, two were charged with molestation/harassment, and one was charged with robbery.

Candidate States (and Federal Entities) for Future Addiction Treatment Court Expansion

At this time, at least ten other states are actively exploring the feasibility of drug treatment courts: Baja California, Chihuahua, Durango, Guanajuato, Hidalgo, Morelos, Nuevo León, Puebla, Sonora, and the State of Mexico. The Federal District (Mexico City) is also considering a drug treatment court and, with a population of almost nine million, Mexico City would obviously have the potential to yield a high-volume drug treatment court program.

Chapter 2
Evaluation Framework and Methods

This chapter describes the conceptual framework as well as specific data sources and methods for the evaluation. Importantly, the current evaluation did not test the *impact* of the Guadalupe program on recidivism or other outcomes. Since the drug treatment court has admitted fewer than 140 participants, some in only the past year, sample size remains insufficient for a rigorous impact analysis involving a standard one-year or two-year follow-up period. In addition, when planning this study, it was not clear whether the data necessary for an impact analysis would be available. (Such data would need to include recidivism records both for drug treatment court participants and a matched comparison group consisting of non-participating defendants.) In lieu of an impact analysis, a *diagnostic evaluation* describes and assesses a program in light of other previous research on which policies and practices have, in general, proven to be effective in analogous program settings. Such an evaluation depends on understanding the prior research literature and on gaining accurate information about how, precisely, the program under study operates.

Diagnostic Evaluation Framework

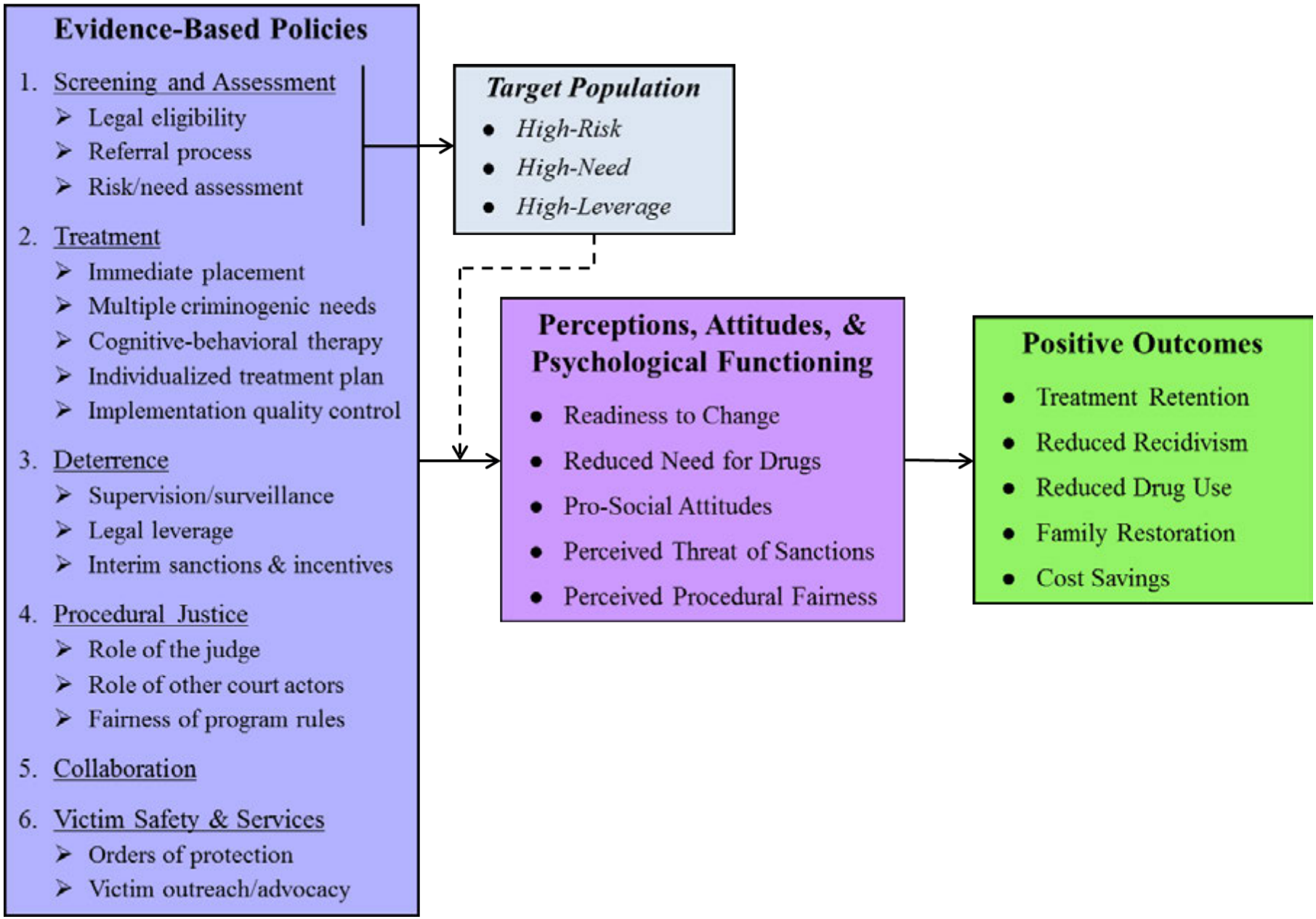
Figure 2.1 displays the evaluation framework, dividing drug treatment court policies into six core areas (left column). In theory, by implementing effective policies in these areas, a drug treatment court can reach an appropriate target population and produce positive changes in participant perceptions, attitudes, and cognitions (middle column). In turn, these changes can precipitate reductions in recidivism and drug use as well as cost savings for taxpayers and for crime victims (right column). The research that informs this framework is summarized below.

Screening and Assessment

A drug treatment court's legal eligibility criteria, combined with its protocols for referring cases, determine who can participate. Many drug treatment courts rely on informal, case-by-case referral procedures that cause many eligible defendants to "slip through the cracks" without receiving an assessment (Rempel et al. 2003; Rossman et al. 2011). Evidence indicates that more systematic protocols, such as having drug treatment court staff automatically screen all defendants meeting certain legal criteria, can identify more drug treatment court candidates, increasing enrollment (Fritsche 2010).

Once cases are referred, a standard best practice is to conduct a *risk-need assessment*. More than 25 years of research suggests that the content of such an assessment should be guided by the Risk-Needs-Responsivity (RNR) principles of offender intervention (Andrews and Bonta 2010).

Figure 2.1. Diagnostic Evaluation Framework



- The *Risk Principle* holds that treatment interventions are most effective with *high-risk* offenders—those who are especially predisposed to re-offend. The Risk Principle also implies that interventions may have unintended deleterious effects with low-risk offenders, for instance interfering with their ability to attend school or work or placing them in group sessions alongside high-risk offenders, who may then exert a negative influence (Lowenkamp and Latessa 2004; Lowenkamp, Latessa, and Holsinger 2006).

- The *Need Principle* holds that treatment is most effective when it targets an offender's criminogenic needs. Criminogenic needs are simply those problems that, if untreated, will contribute to ongoing recidivism. Such needs are not limited to drug involvement but can include a range of other problems, such as criminal thinking, anti-social peers, family dysfunction, and employment deficits (Andrews et al. 1990; Gendreau, Little, and Goggin 1996).[8]

- The *Responsivity Principle* holds that the treatment should employ cognitive-behavioral approaches but should *not* apply those approaches in the same fashion with everyone. Instead, treatment should be tailored to different offender attributes and learning styles. For instance, some research indicates that specialized approaches should be used with key sub-populations, such as women, young adults, or those with a trauma history (Lipsey, Landenberger, and Wilson 2007; Wilson, Bouffard, and MacKenzie 2005).

In totality, the Risk-Needs-Responsivity principles imply that an effective assessment should: (1) classify defendants by risk level; (2) assess for multiple criminogenic needs (not merely drug involvement); and (3) assess for other clinical impairments, such as trauma or other mental disorders, which may interfere with responsivity if they are not also addressed in treatment.

Target Population

A given program's target population results from the general characteristics of the offender population in the community, as well as the drug treatment court's specific legal eligibility criteria, referral protocols, and assessment process. As previously noted, the Risk Principle indicates that intensive interventions, such as drug treatment courts, should focus on high-risk offenders. However, with domestic violence offenders specifically, some research qualifies the Risk Principle in finding that a significant subset of high-risk domestic violence offenders may have severe personality disorders that may be resistant to treatment (see Gondolf 2002). A second qualification is that measuring risk may be particularly difficult with domestic violence offenders, since a substantial quantity of domestic abuse goes unreported to law enforcement.

[8] The "Central Eight" risk/need factors that meta-analytic research has linked to re-offending are as follows: (1) prior criminal history, (2) antisocial personality, (3) criminal thinking (antisocial beliefs and attitudes), (4) antisocial peers, (5) family or marital problems, (6) school or work problems, (7) lack of pro-social leisure/recreational activities, and (8) substance abuse. Of these factors, criminal history is static, meaning that it cannot be changed or undone. Antisocial personality is largely static, since it is a personality disorder for which a proven effective treatment has not been established. The six remaining risk/need factors are all dynamic—i.e., changeable—and are therefore appropriate needs for treatment interventions to target (Andrews and Bonta, 2010; Gendreau et al. 1996).

(Hence a given defendant's true prior criminal history, which would in turn be used to predict risk, may be largely unknown.) Accordingly, the applicability of the Risk Principle to domestic violence offenders is not as clear or well-researched as with other offender populations (see also Klein et al. 2005).

When treating those who are addicted to drugs, some propose that intensive programs should focus on those who are both "high-risk" and possess a "high-need" for drug treatment (Marlowe 2012a, 2012b). Little research has explicitly tested the importance of a "high-need" focus; however, providing some initial support for it, *NIJ's Multi-Site Adult Drug Treament Court Evaluation* found that drug treatment courts were more effective in reducing drug use among those who, at baseline, used drugs more often or had a serious primary drug, such as cocaine, heroin, or methamphetamine (Rossman et al. 2011; and see similar findings in Deschenes et al. 1995).

Besides the characteristics of the offender, some research indicates that the characteristics of the criminal case matter as well. Research, both in and outside of drug treatment courts, indicates that interventions work better when the severity of the criminal charges provide the court with more *legal leverage* to penalize noncompliance (DeLeon 1998; Hiller et al. 1998; Rossman et al. 2011; Young and Belenko 2002). For instance, in the United States, drug treatment court participants charged with felony offenses tend to face more severe legal consequences for failing than those charged with misdemeanors; as a result, felony defendants have a greater legal incentive to comply and, indeed, average better drug treatment court outcomes (Cissner et al. 2013; Rempel and DeStefano 2001).

Treatment

The Responsivity Principle indicates that, in general, cognitive-behavioral approaches are particularly effective in reducing recidivism (Lipsey et al. 2007). Research suggests that with domestic violence offenders specifically, cognitive-behavioral approaches may work better than educational programs that merely impart information (Miller, Drake, and Nafziger 2013).

In general, cognitive-behavioral approaches are present-focused (as contrasted with psychodynamic treatment). They seek to restructure the conscious and unconscious thoughts and feelings that trigger uncontrollable anger, hopelessness, impulsivity, and anti-social behavior. In treatment, participants are led to recognize their triggers to anti-social behavior and to develop decision-making strategies that will yield less impulsive and more pro-social responses. As noted above, cognitive-behavioral approaches are not supposed to be "one size fits all" but work best when they are tailored to the attributes, needs, and learning style of individuals or key subgroups. A history of domestic violence in itself comprises an important attribute that a sound cognitive-behavioral approach should take into account; accordingly, an evidence-based adaptation of the Responsivity Principle to a domestic violence population would presumably involve incorporating curricular topics and decision-making strategies designed specifically to counter this population's tendency to respond with violence to family and household members.

Even when treatment programs seek to follow the Responsivity Principle in theory, research also underlines the importance of high-quality *implementation* in practice. Key elements of effective implementation include: (1) having and disseminating to all treatment staff an explicit, coherent treatment philosophy; (2) using manualized (written) curricula with specific lesson plans; (3) maintaining low staff turnover; (4) holding regular staff training and retraining activities; and (5) closely supervising treatment staff, monitoring their fidelity to the official curriculum (Taxman and Bouffard 2003; Lipsey et al. 2007). Research also suggests that beginning treatment for court-ordered participants soon after the precipitating arrest—preferably within 30 days—can help to engage participants at a receptive moment in time (Leigh, Ogborne, and Cleland 1984; Maddux 1983; and Mundell 1994; Rempel and DeStefano 2001; Rempel et al. 2003).

Deterrence

In lieu of producing internalized changes in the offender's cognitive and attitudinal states, deterrence strategies seek to manipulate the rational costs and benefits of continued anti-social behavior. Drug treatment courts employ three basic types of deterrence strategies: (1) surveillance, (2) interim sanctions, and (3) threat of consequences for program failure.

- *Surveillance* involves regular monitoring through frequent judicial status hearings, random drug testing, and mandatory case manager/probation officer meetings. The research literature suggests that surveillance methods are ineffective by themselves but can be a helpful tool when employed in tandem with sound treatment strategies and consistent sanctions for noncompliance (Petersilia 1999; Taxman 2002).

- *Interim sanctions* involve penalties for noncompliance that fall short of program failure—participants are penalized but then allowed to continue in a program. The general offender supervision literature indicates that interim sanctions can be effective when they involve *certainty* (each infraction elicits a sanction), *celerity* (imposed soon after the infraction), and *severity* (sufficiently severe to deter misbehavior but not so severe as to preclude more serious sanctions in the future) (Marlowe and Kirby 1999; Paternoster and Piquero 1995). Some studies indicate that sanction certainty is more important than severity (Nagin and Pogarsky 2001; Wright, 2010); and this conclusion was recently confirmed in a multi-site study of 86 drug treatment courts in New York State (Cissner et al. 2013).

- *The consequence for program failure* consists of the promised jail or prison sentence that participants will receive if they fail the drug treatment court program entirely. Research indicates that establishing a certain, severe, and undesirable outcome for failing the program can, in turn, make program failure significantly less likely (Cissner et al. 2013; Rempel and DeStefano 2001; Rossman et al. 2011; Young and Belenko 2002).

Moreover, research indicates repeated oral and written reminders play a critical role in making participants consciously *aware* of the consequences that noncompliance will trigger (Young and Belenko 2002). For instance, a recent study found that handing to participants a written

schedule linking specific noncompliant behaviors to a specific range of sanctions can be an important tool for creating clear expectations and, in turn, for increasing compliance and reducing recidivism (Cissner et al. 2013). Another study found that the more criminal justice agents who reminded participants of their responsibilities, and the more times that participants verbalized a commitment to comply, the higher were their retention rates (Young and Belenko 2002).

Procedural Justice

Procedural justice involves the perceived fairness of court procedures and interpersonal treatment during the pendency of a case. Key dimensions include *voice* (defendants can express their views); *respect* (defendants believe they are treated respectfully); *neutrality* (decision-makers seem trustworthy and unbiased); *understanding* (decisions are clearly understood); and *helpfulness* (decision-makers seem interested in defendants' needs) (Farley, Jensen, and Rempel 2014; Tyler and Huo 2002). When defendants or other litigants have more favorable perceptions of procedural justice, they are more likely to comply with court orders and to follow the law in the future (Paternoster et al. 1997; Tyler and Huo 2002). Within adult drug treatment courts, some studies have found that the fairness embodied in the demeanor and conduct of the judge can exert a particularly strong influence over subsequent behavior (Carey et al. 2012; Rossman et al. 2011).

Collaboration

Drug treatment courts were founded on the idea that addicted offenders are best served when justice system and community-based treatment stakeholders work together to promote each participant's recovery (OJP/NADCP 1997). Two recent studies confirm that drug treatment courts produce more positive outcomes when team members in a variety of roles, including prosecution, defense, and treatment, communicate regularly and collaborate (Carey et al. 2012; Cissner et al. 2013). In previous studies of domestic violence courts, researchers have also drawn specific attention to the benefits of collaborating with domestic violence victim advocacy community (Cissner 2005; Gover 2007; Harrell, Newmark, and Visher 2007; Henning and Klesges 1999; Moore 2009; Newmark et al. 2001).

Victim Safety and Services

Unlike most drug treatment courts, the Addiction Treatment Court in Guadalupe almost exclusively enrolls domestic violence defendants. These defendants know their victims and, in some cases, may pose an ongoing threat to victim safety. Given this target population, the Guadalupe program operates, in effect, as a hybrid "drug/domestic violence court" for domestic violence offenders with an overlapping drug problem (for a general description of the domestic violence court model, see Keilitz 2001; Labriola et al. 2009; Mazur and Aldrich 2003).

Interestingly, whereas there is an extensive body of research on the high rate of overlap between domestic violence and substance abuse (e.g., Bennett, Tolman, Rogalski, and Srinivasaraghavan 1994; Brookoff et al. 1997), there is little research on integrated programs for these co-occurring problems. One exception is a study of an integrated program in Miami, Florida. The results found that the integrated drug treatment/batterer program model

produced a higher retention rate and less future violence than a traditional batterer program-only model (Goldkamp, Weiland, Collins, and White 1996).

Besides providing treatment, existing domestic violence courts generally provide legal and social services to the victim (Henning and Klesges 1999; Newmark, Rempel, Diffily, and Kane 2001; Visher, Harrell, Newmark, and Yahner 2008). A common practice is to identify the victim at the outset of the court case and to assign a *victim advocate*, who assists the victim with safety planning, social services, legal information, and escorts in and around the courthouse (see also Moore 2009). A recent study found that domestic violence courts that implemented more of these victim safety and service measures reduced recidivism by greater magnitudes than other types of domestic violence courts (Cissner, Labriola, and Rempel 2013).

A standard practice in nearly all domestic violence courts is to impose a temporary order of protection that prohibits contact with the victim while a case is underway; and a final order when cases end in a conviction (Mazur and Aldrich 2003). Domestic violence court judges typically make clear to the defendant that such protection orders were issued by the court, not the victim; hence, contact is prohibited even if it is sought by the victim, and only the court has the authority to modify the order. Although the evidence is somewhat mixed, more studies than not have found that protection orders reduce future threats and abuse (e.g., Carlson, Harris, and Holden 1999; Holt, Kernic, Wolf, and Rivara 2003; Logan and Walker 2010).

In effect, the focus on Guadalupe incorporates features that would be, in other countries, known as domestic violence courts. In a potentially innovative approach, the Addiction Treatment Court in Guadalupe has combined features that in other places are typical of domestic violence courts with elements of a classic drug treatment court model. With respect to the objective of providing treatment to the dual problems of substance dependence and domestic violence, there is abundant research material about the high rate of co-occurrence of substance abuse and domestic violence (e.g., Bennett, Tolman, Rogalski and Srinivasaraghavan 1994; Brookoff et al, 1997). However, there is not much previous research on integrated programs that seek to reduce these concurrent problems. One exception is a study of an integrated program in Miami, Florida. The results showed that the program model of abuse/integrated drug treatment resulted in greater retention rate and less future violence than a traditional program model only addressing abuse (Goldkamp, Weiland, Collins and White, 1996). Future research on the model of Guadalupe could have a potential international importance due to the limited material available on the subject.

Evaluation Methods

The policies and practices of the Guadalupe Addiction Treatment Court were assessed within each category and sub-category of the evaluation framework (see Figure 2.1). Information for this assessment was gathered through a mix of document review; phone and in-person interviews; structured observations; participant focus groups; and original data analysis.

Document Review

With the assistance of drug treatment court team members at the Guadalupe court and project funders at the U.S. Department of State, we were able to obtain the following key documents:

- Background publications concerning legislative and constitutional reforms to the Mexican legal system passed in 2008;
- Original documents providing updated criminal procedures in Nuevo León as of 2013 (after partial implementation of the 2008 reforms);
- A publication (Montoya et al. 2013) providing the results of a national feasibility analysis, which led to the selection of Guadalupe as the site of Mexico's first drug treatment court;
- A powerpoint presentation (by Fábian Darío Acosta Cisneros) providing background information on drug-related problems in Nuevo León and describing the socio-demographic characteristics of the first 33 program participants;
- A handout, *Court for Addiction Treatment*, which provides an overview of program policies and the characteristics of the first 48 program participants;
- A detailed powerpoint presentation created after the Guadalupe program had been operating for six months, *Innovations in the Criminal Justice System: Experiment on Drug Treatment Courts Projects in the State of Nuevo León, Mexico* (by Jesús Salazar Villegas), concerning the court's planning process, current policies, and future needs.
- An Organization of American States report on the results of a comprehensive survey of drug treatment courts in 13 countries, including Mexico (Cooper, Franklin, and Mease 2010).
- Statistical information concerning the number of crimes in the municipality of Guadalupe as well as in all of Nuevo León in 2011, 2012, and the first several months of 2013, with breakdowns by crime type (homicide, assault/injury, property crime, sex crime, family violence offense, and corruption of minors).
- Standardized intake and clinical assessment tools and forms currently used by Treatment Center staff when evaluating new drug treatment court candidates and developing treatment plans.
- Written information on program policies and participant responsibilities that is provided to all new participants by Treatment Center staff.

Team Member and Stakeholder Interviews

A total of 17 drug treatment court team members and stakeholders were interviewed in-person, either during an international drug treatment court workshop held in Washington, D.C. on July 11-13, 2013 or during a four-day site visit to the Guadalupe program on September 23-26, 2013. In addition, select phone interviews were conducted with team members throughout the summer of 2013.[9]

[9] The interviews in Washington, D.C., as well as all phone interviews, were conducted in Spanish by Suvi Hynynen Lambson of the Center for Court Innovation. The agenda for the September site visit was developed by Joseph Spadafore of the Organization of American States. The actual interviews in the September site visit were conducted in English (where necessary with the aid of an interpreter) by Michael Rempel or Valerie Raine of the Center for Court Innovation, in collaboration with an international team composed of Antonio Lomba, José Vázquez, the Honorable Alberto Amiot Rodríguez, Francisco Cumsille, and Joseph Spadafore of the Organization of the American States, as well as Dr. Jorge Galván Reyes of the National Institute of Psychiatry in Mexico.

Team members who participated in interviews included the original presiding judge of the Guadalupe program (from inception to September 2013); the original court secretary (from inception to September 2013); the dedicated prosecutor; one of the dedicated public defenders (who has recently assumed a supervisory role over several different programs); one of the dedicated supervision officers; and all five clinical staff members at the Treatment Center (the director, social worker, and the three psychologists/treatment counselors).

Unlike team members, stakeholders are individuals who are in a policymaking position and who were involved in the program's planning process or who supervise current drug treatment court staff, but are not involved in everyday operations. Stakeholders who participated in interviews included both the current and former Chief Justices in Nuevo León,[10] the Attorney General in Nuevo León; the supervising area prosecutor who directly oversees prosecutorial policy in the drug treatment court; a deputy public defender for Nuevo León; and the Director of the Ministry of Health in Nuevo León. An interview was also conducted with the presiding judge in the St. Nicholas Addiction Treatment Court, the second drug treatment court to open in Nuevo León during the summer of 2013.

The primary interview protocol was a lengthy program assessment document designed to cover policies and practices spanning all aspects of the evaluation framework (see Appendix A). This document was mostly covered in a phone interview with the Honorable Jesús Demetrio Cadena Montoya, the presiding judge of the drug treatment court from inception to September 2013. However, portions of the protocol were covered with other team members as well, and all sections concerning assessment and treatment were reviewed during a group interview held during the September site visit with the three psychologists and social worker at the Treatment Center. Additional role-specific protocols were written for the interviews with other team members and stakeholders (e.g., judge, prosecutor, defense attorney, supervision officer, and treatment staff) to ensure that each individual's expertise would be probed sufficiently. In addition, all interview subjects were asked to describe their particular roles and responsibilities.

Structured Observations

Separate structured observation protocols were utilized to document practice in two staffing meetings and two court sessions (held respectively on September 17, 2013 and September 24, 2013).[11] These protocols were adapted from ones previously developed by Center for Court Innovation staff for *NIJ's Multi-Site Adult Drug Treatment Court Evaluation* (Rossman et al. 2011). An additional protocol was written for the observation of supervision officer home visits

[10] The current Chief Justice also served as Chief Justice in a prior rotation, which spanned the period of time when the Addiction Treatment Court in Guadalupe was first planned in 2009.

[11] One member of the project team, Joseph Spadafore, implemented the staffing, court, and probation observations on September 17, 2013 (during an advance trip to the court prior to the full team site visit on September 23-26). Two members of the project team, Joseph Spadafore and Michael Rempel, implemented the staffing and court observations on September 24, 2013. Any differences in their respective observations for that second date (of which there were relatively few) were resolved to produce a single set of final observations.

and was used to document a single visit on September 17, 2013. (These protocols are in Appendices B-F.)

Drug Treatment Court Participant Focus Groups

Two 90-minute focus groups were held with a total of 14 current and former participants. The first group, held on September 24, 2013, included seven current participants. The second group, held on September 25, 2013, included four graduates and three participants who failed the program. The protocol (see Appendix G) covered how and why participants enrolled; knowledge of drug treatment court rules and expectations; perceptions of specific team members (the judge, supervision officer, Treatment Center staff, public defender, and prosecutor); perceptions of sanctions and incentives; and general suggestions or feelings about the program. Recruitment and informed consent protocols were approved by the Center for Court Innovation's Institutional Review Board. Participants were paid $230 Mexican pesos (equivalent to $10 U.S. dollars) for their time and assistance; this amount was judged to be appropriate but not unduly coercive.

The focus group sessions were held in Spanish, audio-recorded, and transcribed and translated into English for analysis.[12] Qualitative analyses were used to extract major themes and findings under each section of the protocol. NVivo qualitative analysis software was also utilized to confirm researcher impressions of key themes and to provide quantitative information on the frequency with which select concepts and keywords were mentioned during the two sessions.

Drug Treatment Court Participant Data Analysis

Staff of the Guadalupe Addiction Treatment Court provided an excel database with the program status (active, graduated, or terminated), criminal charges, drug use, educational background, and relationship to the victim of all participants enrolled by the end of August 2013. (It is unclear whether data was updated as of exactly August 31, 2013.) Data on participant volume, background characteristics, and outcomes draw on information in this database. In interviews, staff reported that 138 participants had enrolled as of mid-September 2013, but since the August database included information on 127 cases, that is the total N for all data presented therein. (Due to the uncertainty created regarding the precise number of program participants, elsewhere in this report, we reference the issues by stating "about 130 participants until August 2013.")

[12] The focus group on September 24 was moderated by Antonio Lomba of the Organization of American States, and the group on September 25 was moderated Dr. Jorge Galván Reyes, a research scientist with the National Institute of Psychiatry in Mexico, in both cases following the same IRB-approved protocol.

Chapter 3
The Guadalupe Addiction Treatment Court Model

The Addiction Treatment Court in Guadalupe opened September 2009 and enrolled approximately 130 participants in its first four years (as of approximately the end of August 2013). This chapter reviews the program model in each of the six policy domains from the evaluation framework.

Screening and Assessment

Legal Eligibility

Cases are legally eligible if the defendant meets the following criteria:

- The defendant is an adult (ages 18 or older).
- The charges fall under the new accusatory/oral trials system. (As of 2013, the 2008 judicial reforms had not been implemented for all charges in Nuevo León).
- The charges allow for a suspension of proceedings (stay of trial on probation) at the pre-plea stage, which implies:
    - The charges must involve a maximum prison sentence of eight years or less;
    - The defendant does not have a prior criminal conviction; and
    - The charges do not involve a link to organized crime.
- The defendant does not have another open (pending) criminal case (although if the open case involves a minor offense, the case might still be considered).
- All parties consent to drug treatment court participation, including the defendant/defense attorney, judge, prosecutor, law enforcement, and the crime victim.

In practice, cases are generally excluded if they involve a weapon or serious injuries to the victim. In domestic violence cases, the victim must agree to drug treatment court participation, while also agreeing not to drop the charges entirely.[13]

As discussed in Chapter 1, customary procedure involves the use of a suspension of proceedings only in cases initiated by the crime victim, not in cases where law enforcement initiates the observation, investigation, or charging of the crime. Since robbery cases are usually brought by law enforcement, they can rarely be considered for drug treatment court, even when they are charge-eligible.[14] Based on several stakeholder interviews, it remains possible that eligibility or enrollment practices might be changed in the future to enable more property cases to enroll.

[13] In the United States, some prosecutors file and pursue domestic violence cases even when the victim wishes to drop the charges, but this is not the practice in Nuevo León.

[14] Charge-eligible robberies based on other legal eligibility criteria would involve stolen amounts of less than $45,322 Mexican pesos, which represents about $3,500 U.S. dollars.

Findings: *Federal and state laws and customary procedures limit the types of cases for which a suspension of proceedings is permissible—sharply limiting the pool of eligible cases. As long as the suspension of proceedings mechanism is the only one used to enroll drug treatment court participants, eligibility may continue to be limited primarily to defendants who both: (1) face domestic violence charges; and (2) tend to be low-risk (since a suspension of proceedings is not allowable for defendants with a prior conviction). Some stakeholders nonetheless expressed an interest in finding a legal mechanism to expand the eligible pool in the future.*

Eligibility of Drug Offenses

One avenue for expanding eligibility could be admitting cases that involve drug possession or sales. Until 2013, drug cases were federally prosecuted in Mexico, precluding participation in programs run by state court systems. (The Guadalupe Municipal Court is part of the Nuevo León state court system.) However, beginning in 2013, a new law allowed cases involving more than certain minimum quantities of illegal drugs to be prosecuted in state courts. The minimum quantities are: Opium (2 grams), heroin (50 milligrams), marijuana (5 grams), cocaine (500 milligrams), LSD (0.015 milligrams), and MDA/MDMA ("ecstasy") (50 milligrams powder or 200 milligram tablet). In effect, the new law created a three-tier system for drug offenses:

1. Less than the Minimum Quantities: These "simple possession" cases are not classified as crimes and are merely subject to administrative penalties. They may be referred to treatment but cannot be court-monitored. In effect, treatment is optional.

2. Above the Minimum Quantities by a Factor of Less than 1,000: These cases can now be prosecuted in the state court systems. They sub-divide into: (a) possession of drugs for personal use; (b) possession of drugs with intent to sell; and (c) drug sales.

3. Above the Minimum Quantities by a Factor of 1,000 or More: These cases are defined as narcotics trafficking and are still federally prosecuted. They sub-divide into: (a) growing illegal drugs; and (b) transporting illegal drugs.

Based on stakeholder interviews, it appears that cases involving possession of drugs for personal use—i.e., sub-category 2a of those specified just above—are currently under consideration for drug treatment court eligibility. Moreover, current laws already enable these cases to be handled with the suspension of proceedings mechanism. According to one stakeholder, as many as 200 such cases were prosecuted in the first nine months of 2013.

While expanding the pool of eligible offenders would serve more people who need the focus of a drug treatment court, jurisdictions that are developing these courts should also be aware of their political environments. A conservative approach could initially generate a more inclusive approach in the end, as confidence grows in the model.

Findings: *The exclusion of drug offenses from the drug treatment court leaves out a significant number of individuals who may be drug-addicted. Although the matter is now*

under consideration, the inclusion of drug offenses in the Nuevo León treatment court may be politically unfeasible in the foreseeable future.

The Screening and Referral Process

The drug treatment court employs a case-by-case screening and referral process, whereby referrals can be initiated by the defense attorney, judge, or prosecutor. In practice, the defense attorney nearly always initiates the process after first consulting with the defendant. The drug treatment court judge has also reportedly initiated a small number of referrals.

The process typically begins within 72 hours after criminal charges are filed—i.e., prior to the preliminary hearing that would otherwise set discovery and other dispositional processes into motion. In advance of the preliminary hearing, the defense attorney typically e-mails the judge and prosecutor that the defendant is interested in the drug treatment court. At the hearing itself, the judge confirms that the prosecutor agrees to have the case considered (the prosecutor rarely objects) and orders an assessment at the Treatment Center. Simultaneously, one of the two supervision officers on the drug treatment court team conducts an assessment of the defendant's criminal background and known criminal associates (if any). The recommendations resulting from these assessments are discussed amongst the entire drug treatment court team, consisting of the judge, prosecutor, defense attorney, supervision officers, and Treatment Center representatives. Any team member may object, and the victim's agreement must also be confirmed, but reportedly, objections are rare at this stage, so long as the Treatment Center found the defendant to be eligible. Moreover, team members all reported high levels of support for the program and indicated that the victim usually wants the defendant to receive help for the drug problem. Defendants who are involved in a gang or who live in a dangerous area may occasionally be ruled out, although in the latter scenario, the defendant may also receive an opportunity to change residences in order to participate.

Once the team reaches agreement, the judge informs the defendant at the next court date—which is scheduled outside the Tuesday morning drug treatment court session. If the defendant agrees to enroll (refusals at this stage are rare), the judge orders the requisite suspension of proceedings. Enrollment is typically formalized within two weeks of the prior order to conduct an assessment.

The referral process establishes a particularly critical role for the defense attorney, who sets the process in motion in nearly all cases. Accordingly, attorneys from the state public defender's office—with just under ten attorneys sharing the criminal caseload for Guadalupe—have received more than four informational presentations about the drug treatment court option. Reportedly, these attorneys support the program, although some have raised two concerns: (1) the existence of a single outpatient Treatment Center makes for an excessively long commute for some defendants; and (2) the requirement that participants receive treatment only in the morning (afternoon or evening sessions are not available) could pose a barrier to employment. However, until additional staff resources and treatment arise, the Treatment Center remains the only source, albeit a high-quality source, of treatment

Available information does not fully illuminate why many defendants do not participate; but the current average of 32 enrolled drug treatment court participants per year (out of only slightly more initial referrals) represents less than 3% of the family violence caseload in Guadalupe, suggesting that the aforementioned problems by the defense attorneys contribute to gaps in the assessment and referral process.

> **Findings:** *Referrals usually originate with the defense attorney. Provided that the Treatment Center recommends enrollment, other drug* treatment *court team members rarely object. To date, it nonetheless appears that a relatively small percentage of legally eligible cases in Guadalupe are referred, raising unanswered questions about whether changes to the process might be necessary or feasible in order to yield a greater volume of program participants.*

Clinical Assessment

The clinical assessment that is conducted at the Treatment Center proceeds as follows:[15]

1. Intake: At reception, the drug treatment court candidates complete several forms and assessment inventories before meeting with clinical staff:
    - *General Patient Information:* A one-page form covering contact information, demographics (age, sex, occupation, and current employment/school status), drugs consumed in the past, and current primary drug of choice.
    - *Alcohol Dependence Scale (ADS):* A 25-question scored and validated inventory that divides participants into one of five categories representing progressively more severe levels of alcohol dependence and treatment need.
    - *Drug Use Questionnaire (DAST-20):* A 20-question scored and validated inventory for drug use other than alcohol that divides participants into one of five categories of drug problems: none, low, intermediate, substantial, and severe.
    - *Brief Situational Confidence Questionnaire (BSCQ):* An eight-question inventory that asks participants to assess their confidence (0-100%) that they could resist the urge to use their primary drug in eight different situations—resulting in a profile of the participant's high-risk situations.
    - *Beck Depression Inventory (BDI) and Beck Anxiety Inventory (BAI):* Two validated inventories that respectively classify participants by level of depression (six categories) and anxiety (three categories).
    - *Satisfaction with Life Scale:* An 80-item inventory, not to be confused with the five-item Satisfaction with Life (SWL) Scale, that asks participants to assess their satisfaction (very, normally, or not satisfied) with 80 aspects of their life.

[15] Each of the intake or assessment forms utilized by the Treatment Center, as well as the participant contract, participant handbook, and document on Treatment Center rules, is available from the authors of this report upon request. The original forms are available in Spanish, and the authors have performed an approximate translation into English. In addition, the ADS, DAST-20, BSCQ, BDI, and BAI are readily available online in both languages.

2. Psychological Evaluation: One of the three psychologists conducts a semi-structured interview, intended to explore psychological history, alcohol/drug history, anger/violence, family problems, work/school performance, prior treatment episodes, and psychological diagnoses and treatment needs.

3. Family Interview (optional): Only if a family member is with the potential drug treatment court participant at the assessment, the same psychologist will separately interview the family member concerning the potential participant's drug/alcohol use and other behavioral problems, difficulties, and needs.

4. Social Worker Assessment: The social worker conducts a semi-structured assessment, covering housing, educational and employment needs, and family structure. This assessment utilizes a genogram technique that asks participants to review and describe their relationships with each individual in their extended family.

5. Psychiatric Evaluation: The psychiatrist (who also serves as Director of the Treatment Center) conducts a semi-structured interview exploring psychiatric problems or symptoms, family history of psychiatric problems, drug use, possible suicide risk, prior hospitalizations or other treatment, life history, educational history, violent history, diagnosis(es), treatment needs, and medical history, symptoms, and needs.

As the preceding account should make clear, the assessment process is remarkably thorough. Notably, the Treatment Center does not utilize a validated tool to assess several important criminogenic needs—including criminal thinking, anti-social peers, and employment problems—nor does the Treatment Center utilize an actuarial tool to measure risk of re-offense, risk of future domestic violence, or risk of future domestic violence-related homicide. Although they are not covered with an actuarial tool, most of these issues are covered qualitatively in the course of the aforementioned semi-structured interview protocols.

In addition, during the psychological evaluation (#2 above), the psychologist explains the rules of the Treatment Center, dress code, and other program rules. The psychologist also provides copies of the participant contract, participant handbook, and rules of the Treatment Center. Finally, the psychologist provides a card proving that the assessment took place, which ensures that the individual will not be detained by any authorities.

Following the assessment, the entire treatment team (psychiatrist, three psychologists, and social worker) discuss the case together. If the potential participant is linked to organized crime or is deemed to pose a risk to Treatment Center staff, they will not recommend admission. Otherwise, the team will recommend admission, so long as the individual engages in problematic alcohol or drug use that contributes to criminal behavior. Reaching the threshold of a formal clinical diagnosis of a substance disorder is not necessary for a case to be eligible, but at least some impairment of functioning must be in evidence. Cases with a co-occurring mental health problem will sometimes, but not always, be found eligible, depending on the

severity of the problem and whether treatment can realistically be provided. For those who are recommended, the team also formulates a treatment plan (see below).

> **Findings:** *The Treatment Center conducts a comprehensive assessment. It includes the use of multiple validated tools, covering drug and alcohol use, depression, anxiety, and mental well-being, as well as separate semi-structured interviews with a psychologist, psychiatrist, and social worker. The assessment does not include a validated actuarial tool to measure risk of recidivism or risk of future violence, nor are certain key criminogenic needs (e.g., criminal thinking) covered with an actuarial tool—but the scope of the Treatment Center's semi-structured assessment process extends to all of these areas.*

Target Population

As discussed previously, all except three program participants to date were charged with crimes of domestic violence, signifying some history of anger and violence. At the same time, because defendants with a prior criminal conviction are legally ineligible, the program's target population may still be at relatively low-risk for future recidivism. Since risk is not measured with an actuarial tool, any conclusion on this point is necessarily speculative.

As shown in Table 3.1, all program participants to date were male;[16] their ages ranged widely (with an average age of 36.7 years); and their highest level of educational attainment was most often junior high school (61%), which in Mexico typically runs through ninth-grade. The data also shows that exactly three-quarters of participants had an intimate partner relationship with the victim (49% were married and 26% were domestic partners). In the remaining cases, the victim was a parent, child, sibling, or cousin.

More than two-thirds of participants had a primary drug of alcohol (71%), 18% had a primary drug of marijuana, 2% listed both, and only 9% had some other primary drug or combination of drugs besides alcohol or marijuana. Although available data cannot confirm as much, it is likely that the target population includes a wide range of addiction severities (low to medium to high), given that eligible defendants must exhibit problematic consumption but need not, in all cases, reach the threshold of a formally diagnosable substance disorder.

> **Findings:** *Program eligibility, screening, and assessment policies produce a target population that mainly consists of first-time domestic violence offenders, whose primary drug of choice is alcohol (most often) or marijuana. Available information suggests that the population skews relatively low-risk (given the exclusion of cases with a prior conviction) and has a wide range of addiction severities. The population is presumably dealing with anger/violence problems as well as drug use/abuse. The hybrid approach to drugs / domestic violence, compared to the perspective of other countries like the United States, Canada and the UK where separate courts were created for domestic violence and drugs, is potentially*

[16] In research interviews, team members reported that all participants to date have been male. Other data in Table 3.1 is based on the excel database provided by the Addiction Treatment Court as of the end of August 2013.

innovative. If the model is found successful, it might be interesting to replicate outside of Mexico.

Table 3.1. Drug Treatment Court Participant Characteristics

Program Status	Total
Number of Cases	127
Sex	
Male	100%
Age	
Ages 18-25	15%
Ages 26-35	38%
Ages 36-45	24%
Ages 46-55	18%
Ages 56-65	5%
Average Age	36.7
Educational Attainment	
Elementary/primary school	24%
Junior high school (through grade 9)	61%
Technical/vocational school	8%
High school	5%
Professional degree	2%
Relationship with the Victim	
Spouse	49%
Domestic partner	26%
Former spouse or domestic partner	5%
Mother/father	11%
Daughter/son	5%
Brother/sister or brother/sister-in-law	3%
Cousin	1%
Primary Drug(s) of Choice	
Alcohol	71%
Marijuana	18%
Alcohol and marijuana (both)	2%
Cocaine	7%
Cocaine and marijuana (both)	2%
Inhalants	1%
Alcohol (alone or with other drug)	*73%*
Marijuana (alone or with other drug)	*22%*

Treatment

Nearly all participants receive a free-of-charge, standardized outpatient treatment regimen at the Treatment Center. The Treatment Center is located in dedicated space within a state psychiatric hospital.[17] At the time of the September 2013 site visit conducted by the research team, the Center was staffed by a director (who is both a psychiatrist and lawyer); three psychologists (one holds a master's degree and two have baccalaureates in psychology); a social worker (who has a baccalaureate in social work); and an administrative assistant. The Center recently added a fourth psychologist (who has a baccalaureate in psychology).

The treatment approach is not manualized (does not employ a formal written curriculum with detailed topics and lesson plans), but it generally follows a cognitive-behavioral approach. Importantly, the program has not experienced any recent staff turnover. (While recently adding new psychologist, all preexisting staff have been with the Center for an extended period of time.) The unanimous impression of the research team was that the treatment staff is highly skilled and knowledgeable.

Immediate Placement

Stakeholders reported that the initial referral to the drug treatment court typically takes place within 10 days of case filing, with formal enrollment taking place within two additional weeks. The existence of a dedicated Treatment Center means that, except where severe co-occurring disorders or residential treatment needs apply (which is rare), participants receive an immediate placement upon enrolling, avoiding the kinds of placement delays sometimes seen elsewhere.

> **Findings:** *Cases are efficiently processed from the time of case filing, with rarely any delay in locating a slot at the dedicated Treatment Center. Nearly all participants begin treatment within 30 days—with most beginning their treatment after significantly less time.*

Treatment Plan

The standardized regimen at the Treatment Center is as follows:

[17] The Treatment Center receives dedicated funded from the state Ministry of Health in Nuevo León. It is intended to serve all drug courts in Nuevo León, including the Guadalupe program, the newly opened Addiction Treatment Court in St. Nicholas, and several other drug courts in the state that are now in planning. The Treatment Center also serves voluntary law enforcement referrals charged with simple possession (which is not a crime); reportedly, less than 10% of these referrals show-up for treatment, and less than 25% of those are subsequently retained. These voluntary referrals attend separate group sessions from those attended by participants in the state's drug courts.

- Drug Treatment Court Phases: Program participants move through five phases of participation, with the first four lasting a minimum of 12 weeks each, and the final phase lasting six months.

- Outpatient Treatment Regimen by Phase: For any day when they are receiving outpatient treatment, participants must report to the Treatment Center by 8:00 a.m. for a group session, which concludes at about 9:30 a.m.; a drug test follows; and (where assigned) individual sessions, social work appointments, and/or psycho-educational groups follow.
    - *Phase One:* Participants are assigned to two group sessions (90 minutes each), and two individual sessions (60 minutes each) per week, as well as occasional psycho-educational workshops and an appointment with the psychiatrist if there is a possible need for medication. For the purpose of the individual sessions, each psychologist/counselor has a maximum caseload of 30 participants; but the program is currently under-capacity and the actual caseload closer to 15.
    - *Phase Two:* Same as Phase One, except individual sessions are one per week.
    - *Phase Three:* Same as Phase Two, except group sessions are one per week.
    - *Phase Four:* One group and one individual session biweekly.
    - *Phase Five:* One group and one individual session monthly.

- Additional Treatment Center Requirements: Participants are drug-tested whenever they come to the Treatment Center (twice weekly in Phases One and Two, once weekly in Phase Three, once biweekly in Phase Four, and once monthly in Phase Five). In addition, throughout their participation, three AA sessions per week are required.

- Content of Group Treatment Sessions: Each group currently has a maximum of 14 participants. The groups follow a cognitive-behavioral approach, focusing on the "here and now." Participants will often be invited to discuss their problems and situations. The psychologists/counselors will, in turn, seek to relate the comments to drug use, anger, or other behavior problems, inviting participants themselves to make these connections, then others in the group, then with the psychologists offering their own insight. In research interviews, the psychologists reported that when they begin treatment, participants often deny their problems or avoid discussing their feelings. The psychologists will seek to address this barrier by focusing on feelings, asking for example, "What kind of feeling did you have when you woke up today?" Participants may often express feelings in the third person but are guided to own them (moving, for example, from "It feels kind of sad" to "I feel sad"). Participants are also guided to identify their triggers for any negative feelings, particularly if they report feeling angry—since anger is a presenting problem for many participants. In this way, through a group processing format, the psychologists guide participants to recognize their feelings; identify those particular feelings that have triggered anti-social behavior in the past; and develop the necessary self-control for engaging in more pro-social behaviors in analogous situations in the future. In short, the approach is classic CBT. Individual

sessions adopt a broadly similar approach but are highly focused on the individual participant's needs and situation.

- Social Work Services: The social worker identifies employment, educational, housing, or other needs during the social work assessment. As needed, the social worker can place participants in two-week or four-week job training programs, often with a 100% scholarship. The social worker can also address employment readiness (e.g., how to apply for jobs, interview, dress for work, etc.) and can send the participants to job interviews based on their skills. Finally, the social worker can help participants obtain required documents (e.g., a voter's card or national registration number).

- Family Outreach: The social worker contacts relatives and encourages them to attend separate sessions (individual or group) at the Treatment Center. Eventually, family therapy with victim and participant in the same sessions may be provided, but only if the participant's risk level makes contact with the victim safe. As discussed previously, risk is identified through semi-structured assessment methods, not through a validated tool that is designed to quantify risk of re-offense or lethality. Family members also receive a manual covering treatment issues such as co-dependency, self-esteem, addiction as a disease, and the role of family members in the treatment and recovery process.

- Life Skills: The Treatment Center runs a series of psycho-educational workshops, covering topics such as addiction as a disease; the recovery process; self-esteem; relapse prevention; and psychodrama. Attendance is usually optional but may sometimes be required, based on the participant's needs and progress. More generally, clinical staff at the Treatment Center reported that they attempt to cultivate in participants a culture of respect for others, self-respect, and professionalism. For example, the Treatment Center enforces a dress code that prohibits references to violence or inappropriate language on clothing; does not allow spitting inside or outside the Treatment Center; and seeks to promote courtesies such as arriving on time and saying "good morning."

- Additional Treatment Modalities: The small proportion of participants who require residential treatment may be sent to one of several nationally licensed residential programs in Nuevo León, generally for up to three months (or up to six months in rare cases). Participants with co-occurring mental health disorders can often be treated (inpatient if necessary) within the same psychiatric hospital in which the dedicated Treatment Center is housed.

To ensure an integrated approach, cases are discussed in a weekly staffing meeting amongst all Treatment Center staff. It is at the staffing meeting when the treatment team might make decisions such as mandating a psycho-educational group; refocusing attention on employment or other social work needs; or determining whether a psychiatric assessment or treatment for co-occurring disorders is needed. The three psychologists and one social worker do not receive

regular, individual supervision meetings from the Center director. However, supervision reportedly takes place informally, and team meetings are an opportunity for a general discussion of treatment strategies.

Findings: *The treatment plan involves a relatively standardized outpatient regimen for all participants—with residential drug or mental health treatment also available when necessary. Although it is not manualized, the treatment curriculum involves a cognitive-behavioral approach that, from all indications, is implemented with high fidelity. Through group and individual sessions, and appointments with the staff social worker, multiple criminogenic needs of the participants are addressed, including drug use; anger/criminal thinking; family relationships; and employment, educational, or vocational training needs.*

Deterrence

Supervision/Surveillance

In general, drug treatment courts monitor participants through judicial status hearings, drug testing, and case management and/or probation supervision, and the Guadalupe program is no exception.

- Judicial Status Hearings: Required status hearings are weekly in Phases One and Two; biweekly in Phase Three; and monthly in Phases Four and Five. The 46 graduates who completed as of August 2013 averaged 44.5 judicial status hearings during their participation, with a range of 34 to 70.

- Drug Testing: Participants are drug-tested whenever they report to the Treatment Center (see above). Most participants have a primary drug of alcohol, however, and the Center is unable to administer a breathalyzer test. To the extent that use can be determined, participants must total at least 50 drug-free days before advancing to Phase Two; 100 drug-free days (cumulative) before advancing to Phase Three; and 300 drug-free days before graduating. (Advancing to Phases Four or Five does not require a certain number of drug-free days. Stakeholders also indicated that some participants can graduate with somewhat less than 300 total drug-free days if other program requirements are fulfilled.)

- Community Supervision: Two dedicated supervision officers from the state police agency (the Department of Public Security) make regular unannounced home visits, averaging about one per week in Phase One and less often thereafter. During these visits, the officer checks for alcohol use (looking for alcoholic drinks or discarded beer containers in the refrigerator, under the bed, or in front of the house) and talks to family members and neighbors, especially regarding any observed alcohol or drug use. If drinking is suspected, the supervision officers are also able to administer a breathalyzer test. A member of the research team participated in one "ride along" with one of the officers. In this case, the officer observed the victim visiting the participant at his home.

Although the participant was not home at the time, the circumstances suggested that the participant and victim were having regular contact that was proscribed by an existing order of protection. The supervision officer found the participant later on at his job and respectfully reminded him that an order of protection was in effect and that the court would have to be notified of what was observed.

Findings: *Participants report to court for judicial status hearings at a frequency that is typical of many drug treatment courts; participants are also drug-tested and receive community supervision (including home visits) from two dedicated officers from the state police agency.*

Legal Leverage

All participants enroll pre-plea via a suspension of proceedings (see above). In the event of program termination, the case returns to the regular court process. Conceivably, the case could conclude with a sentence of up to several years of prison or probation, but stakeholders agreed that in most cases, the victim drops the charges, at which point the case is closed. Of 51 terminated cases through August 2013, 40 (78%) voluntarily withdrew from the program, perhaps reflecting an awareness among many participants that withdrawal may not lead to a real legal penalty. Program graduates receive the benefit of having the case dismissed—although this outcome is no different than that of terminated participants when the victim drops the charges.

Findings: *Given the use of a pre-plea model, lack of a predetermined jail/prison alternative for unsuccessful termination, and the practical reality that many terminated cases are ultimately dismissed when the victim drops the charges, legal leverage is relatively minimal.*

Interim Sanctions and Incentives

The Addiction Treatment Court does not employ a formal sanctions schedule linking specific classes of infractions to a corresponding list of possible sanctions. However, a number of interim sanctions are used depending on the case, including verbal admonishment; loss of credit for drug-free days; demotion to Phase One of the program (for participants in an advanced phase); increased supervision or AA meetings; required psycho-educational workshop attendance at the Treatment Center; or up to 36 hours in detention. Normally, sanctions are imposed at the next scheduled court date, but for a new violent arrest or other noncompliance that is deemed particularly serious (e.g., by the supervision officer or staff at the Treatment Center), a new court date will be set for just one to two days later. Based on structured courtroom observations (see below), it appears that most noncompliance is met with a sanction; however, it appears to be the case that tangible sanctions other than verbal admonishment are often not used.

Participants are positively recognized for their accumulated drug-free days at each judicial status hearing. Other possible incentives include courtroom applause, phase promotions, and routine incentives distributed to compliant participants by the Treatment Center's social worker, who provides monthly groceries and occasional tickets to museums or cultural parks.

Findings: *In response to participant behavior, the Addiction Treatment Court selects from several interim sanctions or incentives. The Court does not use a formal schedule linking specific classes of infractions to a corresponding list of possible sanctions. It appears that verbal admonishment by the judge is often the only sanction imposed for noncompliance. As discussed in the next section, researchers have found that the way in which the judge communicates can have a positive impact on compliance. A respectful and attentive tone of voice, eye contact and dialogue directly addressing the participant promote a sense of fairness. The Treatment Court judge showed all these positive communication characteristics.*

Procedural Justice

The realization of procedural justice largely depends on what participants themselves perceive, based on their own experience of program rules, procedures, and interactions with program staff. Thus, the next chapter (in reporting on participant focus groups) will provide many findings that are germane to procedural justice. This section focuses on what the research team learned through other quasi-objective data collection efforts.

Fairness and Transparency of Program Rules

The Treatment Center counselor who conducts the psychological evaluation hands to each drug treatment court candidate three documents describing rules and responsibilities: (1) a nine-page Addiction Treatment Court Participant Handbook; (2) a three-page contract; and (3) a list of rules at the Treatment Center. These documents cover the length of the program (18 months); legal ramifications of graduation; possible legal ramifications of termination; and rules related to drug abstinence, judicial status hearings, supervision, and conduct at the Treatment Center (including attendance, lateness, attitude, and dress code). The psychologist also reviews some of these rules orally during the clinical assessment. Reportedly, the defense attorney and judge also review some of these requirements prior to formalizing enrollment. Despite these efforts, as the next chapter will discuss, many participants expressed that at the time they enrolled they were not fully cognizant of the time and effort that the program would require.

Findings: *During the initial assessment process, participants receive extensive and clear written information, supplemented by oral summaries, regarding rules and responsibilities. It is, however, unclear to what extent participants read or absorb this information, and focus group findings (next chapter) point to notable limitations in participant understanding.*

Procedural Justice in Judicial Status Hearings

Structured observations were conducted of two drug treatment court sessions, respectively on September 17 and September 24, 2013. The sessions were held in a well-lit courtroom with excellent acoustics (nearly all statements were audible to the audience).

The courtroom was divided into roughly equal-sized front and back areas. The front area included the judge (front/center); the prosecutor, public defender, supervision officer, and Treatment Center liaison (all arrayed to the audience's left); and the participant (to the audience's right, standing about 10-12 feet from the judge). The back area included four rows of seats, with an aisle down the middle. Participants remained in the courtroom for the entire court session (both before and after their hearing). In interviews, staff indicated that if a participant asked to leave immediately after his hearing, for instance in order to be on time to an appointment, it would be allowed if the participant was in compliance.

Cases were called in an intentional order, from those who had been in the program the longest to the most recent entrants (i.e., beginning with those who were eligible for graduation and working backwards to those in each phase, starting with Phase Five). The hearings followed a consistent general structure. The judge began by asking the participant how long he had been drug-free (all participants were male). The judge would acknowledge the participant's achievement and, if necessary, gently correct the participant if court records showed a different number. At the judge's cue, the audience generally offered applause at this point. The judge then asked several open-ended (and some closed-ended) questions intended to encourage the participant to verbalize their experiences in treatment, how they believed they were doing in their recovery process, and what if any barriers or problems they were facing. As a group and relative to other drug treatment courts, the participants exhibited a high level of comfort in sharing their thoughts. Whereas the judge's questions did not tend to probe participants for specifics regarding lessons learned in treatment, the judge's own comments made clear that he was fully up to date on objective aspects of treatment participation, such as attendance, drug test results, and compliance with Treatment Center rules. The comments made by various participants spanned multiple areas, from treatment experiences to relationships with family members to other developments in their lives.

Research has consistently found that the judge is the most pivotal figure in promoting procedural justice. Moreover, the particular structure of judicial status hearings in Guadalupe provided the judge ample opportunities to have a positive impact. Specifically, by positioning the participant in the front area and to the audience's far right—away from all other team members or intervening furniture—the courtroom layout facilitated an unmediated exchange between judge and participant. In addition, other team members did not routinely interject during the status hearings, except to add their own words of congratulations whenever a participant was promoted to the next phase. For instance, other than to congratulate participants for phase promotions, the attorneys, supervision officer, and treatment liaison spoke during only two of 17 hearings observed on September 24, 2013. Findings from the participant focus groups (next chapter) seem to confirm that participants had a generally positive impression of the judge who was observed by the research team. (At the beginning of September 2013, a new judge replaced the one who had formerly presided since September 2009, when the Addiction Treatment Court opened.)

A total of 28 judicial status hearings were observed across two court sessions. The hearings averaged 3.71 minutes, significantly surpassing the recommended minimum average of three minutes identified by NPC Research (see Carey et al. 2012). As shown in Table 3.2, several participants received much longer hearings (six received hearings ranging from 5-10 minutes), based on their needs and the flow of the judicial interaction.

Across the 28 hearings, there were 17 compliant and 11 noncompliant cases. (A "noncompliant" case involved at least some noncompliance, regardless of its nature or severity.)

- Compliant Cases: Sixteen of the 17 compliant cases (94%) received an incentive, generally a combination of praise from the judge and courtroom applause, with several participants also recognized by multiple team members for phase advancement.

- Noncompliant Cases: Seven of the 11 noncompliant cases (64%) received a sanction, with verbal admonishment used in five cases and additional meeting attendance assigned in two. Of the noncompliant cases that were not sanctioned, two involved ambiguous circumstances, leading the judge to stipulate that more information would be sought before taking any action. Nonetheless, the observation results generally suggest that tangible sanctions other than verbal admonishment are often not employed.

Several details concerning the judge's communication and demeanor were also observed. The results (in Table 3.2) indicate that the judge nearly always made regular eye contact (89% of hearings); talked directly to the participant rather than to the attorneys or others in the courtroom (89%); and asked probing questions (82%). The judge frequently asked non-probing questions as well (likely to elicit one-word or one-sentence answers, 64%); imparted instructions or advice (43%); explained the ramifications (e.g., phase promotion and/or graduation) of future compliance (43%); and explained the ramifications (e.g., sanctions or jail) of future noncompliance (32%). Notably, although many participants had an order of protection prohibiting contact with the victim, the judge did not ever remind such participants of this order and its requirements, and only one hearing elicited any discussion at all that referenced the order. In this one case, in advance of the hearing, the participant had conveyed through his attorney an interest in having the order lifted, but based on the Treatment Center's recommendation, the court did not agree to do so until the Treatment Center had completed further assessment and treatment work with both the participant and the victim.

After the court session, the judge was classified from 1-5 on several general aspects of judicial demeanor, shown in *NIJ's Multi-Site Adult Drug Treatment Court Evaluation* to correspond with increased procedural justice and reduced recidivism and drug use (Rossman et al. 2011). Across both court sessions observed, the judge was respectively classified as "5" (highest possible) for respectful, fair, attentive, and consistent/predictable; "4" for caring and knowledgeable; and "1" for intimidating. (The judge did not raise his voice, exhibit anger, or seek to intimidate any participant; the judge's controlled demeanor was particularly evident in one 10-minute hearing,

during which the participant vocally disagreed with a sanction, and the judge responded with repeated firm but highly respectful explanations of why a sanction was necessary.)

Findings: *Based on structured observations of two court sessions, the Addiction Treatment Court excels in nearly all previously researched dimensions of procedural justice. The judge conducts an unmediated, direct interaction with each participant; conveys a high level of interest, fairness, respect, and predictability; and provides nearly all participants with an opportunity to express themselves in the course of the status hearing ("voice").*

Table 3.2. Courtroom Observation Results: Drug Court Sessions on September 17 and September 24, 2013 (Cumulative)

Number of Judicial Status Hearings	Number (N = 28)	Percent
Minutes per Judicial Status Hearing[1]		
One (1) minute	1	4%
Two (2) minutes	7	25%
Three (3) minutes	8	39%
Four (4) minutes	6	21%
Five (5) minutes	2	7%
Six (6) minutes)	1	4%
Seven (7) minutes	1	4%
Eight (8) minutes	1	4%
Nine (9) minutes	0	0%
Ten (10) minutes	1	4%
Average Length	3.71 minutes	
Compliance		
Compliant Cases	17	61%
Incentive Provided (of compliant cases)	16	94%
Praise from the judge	15	88%
Praise from other team members in court	3	18%
Phase promotion recognition	3	18%
Coutroom applause	14	82%
Noncompliant Cases	11	39%
Sanction imposed (of noncompliant cases)	7	64%
Verbal admonishment	5	45%
Re-do missed AA meeting	1	9%
Attend 10 required meetings	1	9%
Judicial Interaction		
Regular eye contact	25	89%
Talked directly to participant	25	89%
Non-probing questions	18	64%
Probing questions	4	82%
Explained consequences of future compliance	12	43%
Explained consequences of future noncompliance	9	32%
Imparted instructions or advice	12	43%
Reminded of order of protection requirements	0	0%
Participant asked questions or made statements	20	71%
Judicial Demeanor (1-5 Scale, 5 = highest)[2]		
Respectful	5	
Fair	5	
Attentive	5	
Consistent/Predictable	5	
Caring	4	
Knowledgeable	4	
Intimidating	1	

[1] Status hearings were timed and recorded by rounding to the nearest minute.

[2] Judicial demeanor is evaluated for the entire court session, not for individual status hearings.

Collaboration

The Addiction Treatment Court was established with the support of officials at the highest levels of the federal government, including the Attorney General of Mexico (PGR) and the National Council Against Addictions (CONADIC) of the federal Ministry of Health, which provided critical funding for the construction and start-up of the Treatment Center.

Within Nuevo León, the Addiction Treatment Court received universal support from the state court system, Attorney General, State Institute of the Public Defender, Department of Public Security, Ministry of Health, and the Governor. In April 2013, all of the Nuevo León stakeholders signed a state Memorandum of Understanding (MOU) that memorialized each agency's support for the project, including an ongoing commitment to provide necessary funding.

The core Addiction Treatment Court team includes a dedicated judge (and his court secretary); dedicated prosecutor; two dedicated public defenders (one of whom was recently promoted to a supervisory role over all drug-related cases); two dedicated supervision officers; and the Treatment Center's five clinical staff. Weekly staffing meetings and court sessions include at least one staff member from each role (e.g., one supervision officer and one clinical staff member, with the latter consisting of one of the three psychologists or the social worker).

The day before the Tuesday morning court session, the court is e-mailed two standardized progress reports on each participant (submitted as MS-Word attachments). One is from the Treatment Center. It includes the participant's primary drug of choice; latest drug test results; employment status or participation in educational or training programs; indications of whether the participant possesses required documents (e.g., birth certificate, army service, population registration number, and previous educational diplomas); treatment attendance; and general observations and comments. The second report is from the supervision officers. It also reviews whether the participant possesses necessary documents and includes a narrative report on recent home visits or meetings. The report also indicates whether the supervision officers consider the participant to be a "high priority" case. Key information from these reports is synthesized in an excel spreadsheet that all team members receive prior to the Tuesday staffing.

During weekly staffing meetings, team members provide further oral updates, ask questions, and discuss the issues presented by different participants. The judge convenes these meetings, and researcher-led observations confirm that the judge acts effectively to ensure an orderly discussion, with each team member providing input as needed. The discussion of each participant begins with two oral reports, respectively by the supervision officer and Treatment Center liaison. The judge, prosecutor, and public defender then add information, questions, comments, or recommendations, as they deem necessary. As suggested by the data in Table 3.3, the prosecutor offers input on somewhat fewer than half of the cases discussed, and in the staffing sessions that were observed, the public defender spoke less often, in only a few cases. In interviews, team members universally expressed that they always have an opportunity to

provide input when they wish to do so and that others are attentive to their views and concerns.

Across the two observed staffing sessions, 36 cases were observed, with discussions on each one averaging 3.11 minutes. Compliant cases tended to take less time (one or two minutes), whereas qualitative observations make clear that the team was willing to take as long as necessary to explore the issues presented by noncompliant cases. The team generally did not conclude a discussion of a noncompliant case until reaching a consensus recommendation. (A consensus recommendation was reached in 92% of noncompliant cases observed.) In addition, the team often discussed and recommended how the judge might interact with the participant (done in 46% of noncompliant cases). Court observations confirmed that the judge typically proceeded in harmony with the consensus recommendation at the staffing meeting.

> **Findings:** *A wide array of federal and state stakeholders collaborated in planning the Addiction Treatment Court. The core Addiction Treatment Court team includes representatives from the court, prosecution, defense, police (supervision), and treatment. Treatment and supervision submit weekly written progress reports via e-mail, and additional oral reports are provided at weekly staffing meetings. The staffing meetings themselves are effectively moderated; convey a collegial tone; and involve discussions of each case that almost always do not conclude until the team has reached a consensus recommendation.*

Victim Safety and Services

In interviews, team members emphasized that the health and well-being of the participant's family in general, and the safety of the victim in particular, are of the utmost importance. In promoting victim safety, the prosecutor's office plays a central role early in the case—and especially at the case screening stage—whereas the Treatment Center seeks to engage the victim and other family members once the treatment process begins.

When a court case is filed, an in-house psychologist/counselor at the prosecutor's office will talk to the victim, assess the danger that the defendant poses, and make a recommendation regarding an order of protection—whether the defendant should be prohibited from contact with the victim and what no-contact terms should be imposed. If the victim requests an order of protection, the prosecutor's office will always seek one; but even if the victim does not make such a request, the prosecutor's office may still request one if the in-house psychologist observes serious physical or emotional injuries or a risk of such injuries in the future. According to one prosecutor, "We have an institutional policy that if our investigation indicates that the victim is in a risky situation, even though she doesn't want the order, we get the order for a certain period, and we continue to monitor the case … If we don't have this order, statistics say that the victim is going to be re-victimized." An initial order is for 30 days, and someone from the prosecutor's office will check up on the victim within that initial 30-day period—and usually within 15 days. (This check-in takes place even if an initial order of protection is not imposed.)

The prosecutor may continue to request that the order be extended for 30-day increments throughout the life of a case.

Table 3.3. Observation Results: Staffing Session (December 11, 2013)

Number of Cases Discussed	Number (N = 36)	Percent
Minutes per Case[1]		
One (1) minute	8	22%
Two (2) minutes	16	44%
Three (3) minutes	6	17%
Four (4) minutes	1	3%
Five (5) minutes	1	3%
Eight (8) minutes	1	3%
Nine (9) minutes	1	3%
Ten (10) minutes	1	3%
Eighteen (18) minutes	1	3%
Average Length	3.11	
Average Length (minus 18-minute outlier)	2.69	
Compliance		
Compliant Cases	23	64%
Noncompliant Cases	13	36%
Actions in Noncompliant Cases (N = 13)		
Specific action recommended	12	92%
Type of judicial interaction recommended	6	46%
Team Participation in Staffing (1-5 Scale, 1 = did not participate, 5 = participated throughout)[2]		
Judge	5	
Treatment Center liaison	5	
Dedicated prosecutor	3	
Dedicated public defender	2	
Dedicated supervision officer	5	

[1] Discussions were timed and recorded by rounding to the nearest minute.

[2] Participation by each team member is evaluated overall, after taking into account participation while each case was discussed.

The prosecutor's office does not link the victim with other follow-up services, but once a case is admitted to the drug treatment court, the victim and other family members are encouraged to participate in services at the Treatment Center. In this regard, the Treatment Center's social worker runs family group sessions—for family members only—every Thursday at 8:00 a.m. (scheduled early in the day to enable family members to go to work afterwards). Both the victim and other family members may attend these sessions. Family members may also meet individually with the social worker, who may sometimes make a referral to one of the psychologists for individual therapy (for the family member) or family therapy (for the family member and participant—where deemed safe and appropriate). The social worker may also assist family members with concrete needs, such as health services or child support. When the participant or victim requests to lift an order of protection, clinical staff at the Treatment Center will usually provide input and, at their discretion, may assess the situation by speaking with the parties individually or together.

Particularly when an order of protection has been imposed, the supervision officers will also monitor compliance and report evidence of prohibited contact to the entire drug treatment court team. The drug treatment court team does not, however, collaborate with a victim advocacy agency that could comprise an additional source of information regarding order of protection compliance.

As noted previously, issues related to domestic violence—including order of protection requirements—appear to receive little attention during judicial status hearings. Moreover, although clinical staff members at the Treatment Center are trained in relevant family dynamics, some stakeholders expressed an interest in extending formal domestic violence training to all members of the drug treatment court. (Such training has not been provided to date.) One stakeholder also expressed an interest in exploring ways to integrate domestic violence treatment (e.g., recognizing and avoiding triggers to domestic violence or, when those triggers arise, using nonviolent communication strategies) more explicitly into the Treatment Center's curriculum. As described above, whereas the Treatment Center focuses extensively on anger, violence, and related family dynamics, the Center does not incorporate a formal domestic violence-specific curriculum into its programming.

> **Findings:** *The court imposes an order of protection in many, but not all, domestic violence cases. A psychologist from the prosecutor's office speaks with the victim and, based on this assessment and other evidence, the prosecutor will seek an order either if the victim desires it or if the victim is deemed to be at risk of future violence. The prosecutor's office does not generally link victims with further services, but in drug* treatment *court cases, the Treatment Center provides therapeutic, child, family, and medical services for both the victim and other family members—and can provide family therapy where deemed appropriate. Beyond Treatment Center staff, the drug treatment court team has not received formal domestic violence training.*

Other Policy and Practice Areas

The following sub-sections cover a number of topics that do not fit neatly into the evaluation framework (Figure 2.1) but remain relevant to an assessment of the Guadalupe program.

Graduation Requirements

As discussed above, the Addiction Treatment Court is divided into five program phases. Apart from phase-specific promotion requirements (see above), graduation requires:

- A minimum of 18 months of program participation;
- Completion of treatment program requirements (as determined by the Treatment Center);
- At least 150 drug-free days (sometimes slightly less if the team approves);
- Obtaining necessary documents (e.g., related to legal identification and military service);
- Obtaining employment or basic education (e.g., employment, high school diploma, or some evidence of participation in training or education programming).

At this time, it is too early to compute an accurate average time to graduation, but two different team members agreed that the figure likely exceeds two years, which is relatively high compared to other drug treatment courts (e.g., see Rempel et al. 2003; Rossman et al. 2011).

> **Findings:** *The drug treatment court program is rigorous and lengthy, with average time to graduation exceeding two years (compared to a 15- to 18-month average for drug treatment courts in the United States and the anticipated time to graduation of 12-18 months in other countries).*

Graduation Rate

As of the August 2013 data received by the research team, 46 participants had graduated, and 51 had failed. Although it is premature to compute a "graduation rate" for the program, because it is common for drug treatment court participants to fail sooner after enrolling than to graduate, one may infer that among those who have enrolled to date, the eventual graduation rate will be about or slightly higher than 50%, which is close to the average for drug treatment courts in the United States.

> **Findings:** *Among participants enrolling to date, the drug treatment court graduation rate appears to be in the vicinity of 50%, which is comparable to the average drug treatment court in the U.S.*

Training for Drug Treatment Court Team Members

In April 2008, CICAD/OAS organized a Training Conference in Santo Domingo (Dominican Republic) including specific training about drug treatment courts. Officials and professionals from Nuevo Leon, Mexico attended. As a follow up, the OAS organized a study visit to a drug treatment court model in Chile. In June 2009, several members of the future drug treatment court team (the court opened in September of that year) attended the annual conference of

the National Association of Drug Court Professionals (NADCP) in Anaheim, California. At least some team members have attended all subsequent NADCP annual conferences. (Beginning in 2010, the NADCP annual conference began including at least some sessions in Spanish.) In addition, in August 2009, NADCP brought a technical assistance team to Nuevo León to train the team in drug treatment court principles and practices. During the planning stages, the team also observed the existing drug treatment court programs in San Diego (California), San Antonio (Texas), and, through OAS, Santiago (Chile). Select team members also participated in various meetings or trainings organized respectively by the Organization of American States, Narcotics Control Board in Chile (CONACE), U.S. Department of State, and the U.S. Office of National Drug Control Policy (ONDCP). In recent years (2013 and 2014), the Nuevo León team has been exposed to the other OAS member states implement the model, through participation in cross training activities organized in cooperation with other countries in the Hemisphere.

However, the Addiction Treatment Court has begun to experience turnover (e.g., recently in the dedicated judge, prosecutor, and public defender), and a protocol has not been established to train new team members, beyond informal training and guidance from their colleagues. Moreover, as several stakeholders observed, the team has not ever participated in a formal training on the unique legal, social, and interpersonal issues posed by domestic violence cases.

> **Findings:** *The original drug treatment court team participated in extensive formal training opportunities. However, training protocols for new staff have not been formalized. Additionally, the drug treatment court team has not received domestic violence-specific training.*

Federal and State Law

Whereas current federal- and state-level stakeholders strongly support the drug treatment court model, several stakeholders echoed a common sentiment that the model would be more sustainable if justified in the law, rather than merely in the April 2013 Memorandum of Understanding that was signed by current office holders. Ideally, stakeholders believed that a new law should formalize that it is legal for the criminal justice system to involve itself in addiction—to assess and treat for drug abuse. One stakeholder proposed that the law should make it mandatory, not voluntary, to consider cases for court-ordered treatment and that a wide range of crimes should have access to drug treatment courts. Based on the research team's only observations, it is clear that a new law could play a role in addressing several limitations of the current program in Guadalupe—for example, the current limited legal eligibility criteria; gaps in the referral process that have led to relatively low program volume; inability to use the suspension of proceedings mechanism except for comparatively low-risk cases; and current unfeasibility of a post-plea enrollment mechanism that can still enable dismissing the charges of successful program graduates.

> **Findings:** *Independent observations of several stakeholders, as well as the research team, suggest that the current absence of a federal or state law that formalizes and legalizes key aspects of the drug treatment court model may limit the scope and sustainability of the model.*

Performance Monitoring

The Addiction Treatment Court maintains an MS-Excel workbook with basic information on each participant, including name, marital status, highest educational degree attained, crime charged, drug(s) of choice, relationship to victim, and number of court appearances to date. (The workbook includes one sheet each for active, graduated, terminated, and non-admitted cases.) The Court also maintains an MS-Word document that includes all active participants, number of days in the program, number of drug-free days, and next court appearance date.

The court does not maintain an array of drug treatment court participant information in a computerized database, including arrest or court filing date; psychosocial assessment information; drug test results; program compliance (infractions, achievements, sanctions, and incentives); and Treatment Center attendance or dates and/or outcomes of supervision meetings.

The court also does not produce a regular performance report of any kind, which might include quarterly, semi-annual, or annual case volume numbers; cumulative numbers of active, graduated, and terminated cases; participation by phase of treatment; retention rates; or participant background characteristics (e.g., charges, drug of choice, and relationship to victim). However, the drug treatment court has the ability to produce most of these kinds of numbers upon request, and the research team reviewed several articles and MS-Powerpoint presentations that clearly presented key data about program participants to date.

Prior to this evaluation, the Addiction Treatment Court had not formally sought the feedback of program participants, whether through exit surveys, confidential interviews, or focus groups.

> **Findings:** *The Addiction Treatment Court has a limited database capacity, facilitating the collection of basic data on program participants. The Court uses this capacity to provide clear and accurate information when necessary but does not produce for team members or stakeholders a routine (e.g., quarterly, semi-annual, or annual) performance report.*

Chapter 4
Participant Perspectives on the Addiction Treatment Court

During the weeklong site visit to the Guadalupe Addiction Treatment Court in September 2013, the research team conducted two focus groups with current and former participants (graduates and non-graduates). The goal was to establish the participants' view of Addiction Treatment Court rules and procedures and their implementation. Each group was made up of seven participants, and groups were divided so that current participants (Focus Group 1) would be separate from graduates and non-graduates (Focus Group 2). A moderator posed a series of questions to the participants (see Appendix G), who responded with comments and opinions.

Background Characteristics of the Focus Group Participants

The research team decided to blindly select the participants who would be invited to the focus group sessions, based on data including name, age, number of hearings, crime, level of education, drug of choice, and number of days in detention.[18] The main selection criterion was the number of days in the program, with the ideal focus group participant being a current participant, graduate, or non-graduate who had enough experience in the program to be able to opine about interactions, sanctions and incentives, court staff, and treatment staff. Graduates and non-graduates were also selected based on having exited the program recently enough to recall their in-program experiences and opinions. Out of 72 participants who were invited, 14 arrived at the Treatment Center to join the focus group. It is unknown to what extent the views expressed at the focus groups precisely represented the views of all Addiction Treatment Court participants, although those who appeared conveyed a fairly high level of consensus on most points.

While identities of the participants who arrived at the focus groups were not disclosed to researchers, their program status (current, graduate, non-graduate) was confirmed. The first group consisted of seven active participants, and the second consisted of four graduates and three non-graduates. Participants in the groups (and the program in general) were 100% male. The crime committed by 100% of participants was domestic violence, with some participants having other charges as well. The following sections detail themes and findings.

[18] The selection was blind in that the Director of the Treatment Center knew the names of all of those who were invited, whereas the members of the research team knew who attended but did not know their names. As required by the Center for Court Innovation's Institutional Review Board (IRB), an oral informed consent process was devised that did not require those attending to print or sign their names on any document. (Participants were read a consent form, and each participant was asked to indicate their understanding, whether they had questions, and whether they consented, with one of the researchers then recording the fact that all of those present in fact consented.)

Motivation/Decision to Participate

Participants enter the Guadalupe Addiction Treatment Court (ATC) by choice, although as evidenced by the focus group responses, this choice can be influenced by the presentation of information and a desire to avoid a bail fee or prison. Focus group participants stated that their participation came as a result of their decision, based on meetings with the defense attorney, judge, or both, where they were told that they could either join the program or go to jail. While a bail fee could have been paid to avoid jail and the program, participants generally stated that they were unable to meet that cost. Some participants also expressed that their decision to enroll was based on a desire to improve their lives.

> *That's what was explained to us. Either pay bail or join this program, or you'd go to prison. I mean, through the defense attorney to us. And we came in to avoid paying bail and to avoid going to prison.*

Concerning the implications of enrollment, as discussed in Chapter 3, the treatment staff provides the participants with extensive written information about the rules of the program and participant's obligations during initial clinical evaluation. However, participants continually mentioned confusion with the requirements and length of the program until after enrollment. When they enrolled in the program, the participants expressed that they did not understand the duration of the program or the time required for treatment and court attendance. . They stated that after they enrolled, the Treatment Center staff clarified their obligations.

> *Not until we got here [did we receive information] … Until we went to the doctor, and he explained to us what this program was, what it was about, what it was for, and what the objective was.*

> *I expected the same that it would be a short time, because I also didn't know about that program. But once the situation was explained clearly, I said, 'Oh well, I'm here, I have to comply.'*

In response to one participant's comments, the moderator probed, "Is there anyone else in this group who thinks that—as our friend here just said--that you're not given all the information?"

> *Yes, it's true.*

> *Yes, me too. I mean, sometimes they were giving us the information little by little, as the treatment went on.*

It is an established expectation that drug treatment courts provide clear written information to the participants, but the perception that they did not receive adequate information about the program requirements was common among participants. It may reflect the impact of drug

dependence and other problems that affect the capacity of the participants to receive information. For this reason, drug treatment court research, and research in general on criminal offender populations, emphasize the importance of repeated oral reminders made early and often by various members of the treatment team of the program rules, obligation of the participants, benefits of program completion and the consequences of failure (for example, see Tyler and Huo, 2002; Young and Belenko, 2002).

Role of the Judge

Beginning with the court session on September 17, 2013, a new judge presided over the ATC, replacing the original judge who had presided since the program opened in 2009. The participants, in general, perceived that both judges had contributed to their rehabilitation.

The research team also conducted structured observations of the court sessions presided over by the new judge (see the previous chapter). In fact, he made frequent reminders and offered advice to participants and appeared to have a fair but firm action and "willingness" in their interactions with participants. Furthermore, in the semi-structured observation protocol observation, the judge was rated with a "5" (the highest score on a scale of 1 to 5) for being respectful, fair, caring and consistent/predictable. These participants often referred to the positive feedback and constructive reminders they received from the judge. Also. a summary analysis points to a largely positive gestalt. The most common words used to describe the judge all involved positive responses: like (49), useful (15), good (14), fair (10), and help (10). (The word count during the discussion of the judge is in parentheses, with related synonyms included.) Several words/synonyms pointing to some of the less positive attributes that participants attached to the status hearings were also mentioned multiple times—yet not as often as the positives: strict (9), waiting (for their case to be heard, 8), intimidate (7), scold (7), and threaten (6). None of these latter characterizations were ever made in reference to the new judge.

The Treatment Team

Participants felt positively toward the clinical team at the Treatment Center. This topic covered a significant portion of the discussion in Focus Group 1. Participants roundly expressed satisfaction with their treatment and offered differing opinions regarding which facet of treatment worked the best for them. The participants felt that they could be open and honest with the treatment staff and that the treatment had helped them to reconnect with their families and, to varying degrees, overcome their addiction. A quantitative analysis of the focus group transcripts revealed an almost exclusive predominance of positive words (and synonyms) in describing treatment generally and the psychologists in particular—with like (39), help (30), good (13), and useful (12) all used by participants throughout the discussion of treatment.

Participants were asked to distinguish between their group and individual counseling sessions:

...The individual ones are more confidential, like more personal, it's more about you. What you have on your mind, you talk to him about, and he tells you what to do, or where to go, like that.

And in listening to other peoples' experiences [in group therapy], sometimes you identify with that person, or you talk about your feelings, your concerns, your way of thinking, and that's why—I like the group one better, but the individual therapy is good too, because there, they give us tips on how to improve your behavior with your family … [The counselors] had me do many activities with my family, 'Sit at the table, talk to your children and ask them what they like about you, what they don't like.' Give them a sheet of paper and ask them, 'What do you not like about your father, what don't you like?' And then, 'What do you like?' And then you: 'What do you not like about her?' What don't you like about him? What don't you like about your husband?' You make a list so you can improve your family.

As demonstrated in these quotations, participants expressed an understanding of key treatment principles and believed that the treatment had benefitted them. Interestingly, the comments of the participants confirmed what the psychologists had articulated when interviewed by the research team—that the treatment was designed to address not only substance abuse, but also the anger and communication problems that the participants often faced in their family relationships.

[My psychologist] helped me express myself and let my feelings out more than anything.

In my personal situation, the therapies helped me a lot because I would hang out a lot—here in Monterrey there are groups of people who drink under the bridges. They sleep there and they sell you anything there, or they get you little flasks of cheap wine. And they're there. So I was getting to that level, of staying at houses under construction, drinking there … I did work, but I would charge it and go and pay and I would be left with very little to eat and all that, and I would put it on a tab again. So [treatment] helped me a lot because—the therapies helped me a lot because currently I don't drink, I don't drink alcohol. I never did drugs, I've never done drugs, but alcohol brought me many problems.

What a person's treatment consisted of was to know how to deal with other people. To learn how to talk to other people, and, well yes, it was a group session to start learning how to interact with other people, to know how to talk to them. So that you don't—well, to make you talk better, isn't that right? To make you learn to talk to people better, that was what the group therapies were for.

As far as one's character, behavior and drinking … you do improve a lot. And the therapies the psychologists give us, and the rehabilitation they're giving us, how to get along with people, or family above all, how to value yourself; to be with them [your family] and value them too. The program has worked for me, quite a bit.

Further analysis of the focus group transcripts confirmed some of the main treatment content, as conveyed by the participants themselves: problems (28), alcohol or drinking (22), feelings (17), family (12), feedback (that counselors provided after participants described their situation, 7), advice (5), wife (5), and drugs (4). (Interestingly, consistent with the focus of the Addiction Treatment Court on a target population that largely abuses alcohol, participants referenced "alcohol" or "drinking" far more often than "drugs" in the focus group discussions.)

Whereas the majority of the conversation regarding treatment was positive, there was also a general sense that the treatment—and the program in general—was too long and at times obstructed other needs, especially the ability to maintain employment.

> *Wherever you go to ask for work … I've gone and I explain to them, 'No, it's just that I have to attend Tuesday, Wednesday and Friday.' [They say] "We'll call you later, we'll call you later." And that … means they didn't hire you. And I have technical degree. I'm sure for those who have middle school education, it's harder.*
>
> *And in my case as well, that's the part I don't agree with, that it be so much time, because I've been in the program for almost two years, so I have struggled with work. So if they cut it down to one year, it would be better.*
>
> *I don't think any of us here thought it was going to take so much of our time, because—we started off uncomfortable with the program. It did help us. It did help many of us. But yes, a great discomfort with the time it took from us. Because most of us are low-income and practically from the beginning of the program, we didn't work to support our families and it was uncomfortable for us in that aspect.*
>
> *Me, what I'm saying, I'm not trying to say it wasn't useful for me. It was useful for me, but it was very inconvenient for me … You would work less because you had to show up here [at the Treatment Center].*
>
> A related concern had to do with employers and their willingness to offer a job that suited the scheduling requirement of the ATC.

Other participants agreed, but also gave examples of situations where, although the social worker had been helpful, employers were not offering support to the program.

> *Yes, there's a social worker here who helps us find options for work, but once you're there, the bosses tell you the same thing … It's just, 'You can't miss work because of scheduling.'*

Participants, therefore, felt caught in a bind, because they universally believed that the treatment was beneficial; yet, the length of the treatment process and its scheduling during daytime hours prevented them from supporting their families through employment.

Perceptions of Other ATC Staff and Court Procedures

Supervision Officers

Supervision officers are an important part of Addiction Treatment Court, filling the supervision gap between judicial status hearings and treatment. Based on researcher observations of the pre-court staffing sessions, the judge trusted the opinion of the supervision officer for a report on the progress of every participant.

However, participants raised several issues regarding supervision. In particular, they felt they had little leverage to speak or defend themselves in situations where the supervision officer may have found contraband on their property or spoken with neighbors or with their spouse regarding a disagreement. Participants specifically objected to the practice of seeking information from neighbors or making assumptions (that may be incorrect) regarding whether evidence of empty beer cans indicates that the participant was drinking:

> *… there are certain neighbors I talk to … I don't talk to the rest. But it's wrong that they ask your neighbors, because the neighbors, just imagine, if they don't like you and [then they] ask [the neighbors if you were where you said you would be] they're going to say no, I don't know. He could say a lot of things.*
>
> *And then I went into the program, but it didn't seem fair to me that the overseeing officer said he talked to all of my neighbors. That they said I was a drunk, this and that.*

It must be noted that, in part, the participants commonly cite the supervision officers for negative comments due to the nature of the supervision role—and the reality that individuals do not generally like to be watched over. The research team observed one of the supervision officers advocating on behalf of several participants at the pre-court staffing sessions; yet, participants are not present there to see the supervision officers playing this supportive role.

Sanctions and Incentives

Participants expressed that sanctions seemed reliable and predictable. Participants in both focus groups highlighted both positive and negative effects of sanctions, with some participants citing stiff sanctions for relapse as demotivating factors and another citing the fear of those sanctions as a positive motivator of his change.

> *… one of things that have made me change here is fear of penalties.*

The most serious offense, according to participants, was lying to the judge about a failed drug test. Sanctions for a failed drug test included jail time (12-36 hours), 100 consecutive days of treatment, and a return to Phase One of the program. Various participants commented that the general parameter for expulsion was after two or three relapses, depending upon the circumstances. The return to Phase One prompted the most negative reaction of the entire focus group from the participants. The following are some sample responses:

In the case of the relapses, they make you come 100 days…once you comply with a penalty, after you tell them, you still have to complete the 18 months.

They put you back to the first stage. And that's not fair. What's fair would be to leave you in that stage [the beginning of the current phase] if you complete the [first] 100 days.

Another participant mentioned that after his second relapse, the thought of returning to Phase One again was too difficult to bear, and he decided to drop out of the program.

Participants only cited three incentives given by the court. The first two were positive comments from the judge and applause for number of days sober. The third was a basic food package (one pound of rice, beans, half a liter of oil, and crackers) given once a month to participants who had demonstrated good behavior in the previous month. (These reports of incentives correspond with what the research team had learned independently from interviewing team members.)

The Role of the Defense Attorney and Prosecutor

Not all participants appeared to understand the role of the defense attorney. In one focus group, several participants initially agreed that they had little contact with their attorney and did not perceive their attorney to be a strong advocate for them.

I was going to mention that the defense attorney, sometimes he does help you, but sometimes he doesn't. He says, 'It's just that it's four against me.'

In my case, when it was necessary, he was there helping me out. And it wasn't one, it was many. Both of them—there were two who were just there supporting me, and they did help me a lot and everything. But there were some who didn't take you into consideration.

However, opinions changed after one participant pointed out the unique nature of the defense attorney's role as a member of an ATC team that is supposed to be non-adversarial:

I don't know if it's the reality or not. I saw it as that it's a group where everyone's going through the same thing … trying to make us finish the treatment. Like a mutual agreement; the defense attorney, the prosecutor, the judge. I saw it like the circle was completed; everyone was focused on the same thing. I mean, the defense attorney wasn't there to get you out of trouble, to do you a favor or whatever …

At this point, the moderator probed the other focus group participants, "So we could say in conclusion that you guys feel that the job the defense attorney does is helpful?"

Yes.

Yes, he is very helpful.

… he was able to get me to get out [of prison]. Right now, I'm going to another program, and I'm also still going to therapy, but thanks to him. If he hadn't intervened, I would be in prison right now…

Opinions and comments regarding the prosecutor were minimal, with most participants stating that there was little interaction. Some participants recounted instances where the prosecutor had intervened to either request their expulsion from the program or to advocate against paying bail in place of participating in the program. In the example below, the participant expressed that neither he nor his family had been well informed of program details by the prosecutor, with an incorrect impression created that in exchange for not paying bail, program requirements would be far less onerous than what would actually prove to be the case.

… But when I had that problem, they asked me for an $8,000 peso bail. And my parents had it in their hand and I was going to get out, and the prosecutor went and got involved with my parents and my wife, that why were they going to spend that money. That they needed it, that I was going to get out without paying anything, just for my wife to say she forgave me and everything. And they told them that I was just going to go for one treatment and just once a week. The same thing they told me …

In most other responses, there was little opinion regarding the prosecutor and little mention of the role in court. The following statement captures the overall feeling regarding the prosecutor.

Well, he followed the law, that's it. I think he did his job well. And he was strict. I mean, whether it was a male or female prosecutor, he [or] she just did his [or] her job.

Participant Recommendations

Throughout the focus groups, participants contributed their ideas for improving the program and were asked to summarize their recommendations towards the end. To recap, the most troubling aspect of the program was the barrier posed to employment by the scheduling of treatment sessions and court appearances. In many instances, participants cited having lost jobs or not having been able to find a job even after the social worker(s) at the Treatment Center had communicated with the employer. They also highlighted the stress this placed on their family relationships, with two participants citing this conflict as the main reason why they decided to leave the program. Participants also mentioned long wait times (up to three hours) for court hearings to begin and stated that because they had to abide by very specific timeframes for both treatment and court appearances, the ATC team should also abide more closely to the determined start and end times of court sessions. This was also mentioned as a major factor affecting the ability of participants to find and maintain work.

In a related topic, participants expressed that information about the length and intensity of the program was not always clearly presented prior to enrollment. While the Treatment Center provides standard written information at the initial assessment, participants noted that their mental state at this time could be affected by drug and alcohol use. Therefore, additional

efforts would assist participants in gaining an accurate up front understanding of their obligations.

Finally, participants in both focus groups frequently stated that one of the sanctions—specifically that of returning to Phase One—was demotivating and in some cases too difficult to bear. They felt that after the required 100 consecutive days of treatment (for completion of Phase One), the participant should be able to return to the beginning of the advanced phase that they had reached prior to the relapse, rather than having to complete the initial 100 days a second time.

Conclusion

Feedback from focus group participants lends an important perspective regarding formal procedures and the execution of ATC operations. The focus group sessions underlined many areas for improvement, including communication, scheduling, application of incentives, and the roles of different ATC team members. Participants also highlighted several areas, especially treatment, cooperation amongst ATC team members, and the role of the judge, as positive examples of a properly operating a drug treatment court. All focus group participants (current participants, graduates and non-graduates) stated that the program was helpful to them and, in every case, stated, regardless of their graduation status, that their family situations had improved as a result.

Chapter 5
Conclusions

The justice and treatment systems in Nuevo León have collaborated to establish the first drug treatment court in Mexico. The Addiction Treatment Court in Guadalupe largely follows the model that evolved in the United States—after adapting it to the unique legal and cultural context in Nuevo León (and in Mexico generally). The most noteworthy adaptation is a primary focus on domestic violence cases—including cases that involve intimate partner violence as well as violence towards children, parents, siblings, and other family members. The result is, in effect, a novel drug/domestic violence court hybrid model. The focus on domestic violence was made necessary by a combination of legal, cultural, and practical circumstances that made it largely unfeasible, when the Guadalupe program was established, to enroll drug possession, sales, and property cases, which in combination comprise the preponderance of cases enrolled in other drug treatment courts in existence today. (Drug possession cases are primarily eligible in the United States but not necessarily in other OAS member states). A strong cultural emphasis upon building, supporting, and valuing the family in Mexico has made it particularly appealing to design a program where those who have harmed family members and who have a drug problem can receive the treatment they need. A genuine desire to help victims, defendants, and their families lies at the heart of the Guadalupe approach.

Whereas the focus on domestic violence follows logically from the local context, the restriction to domestic violence cases nonetheless represents a limitation that should be highlighted. The target population may also currently be restricted to comparatively "low-risk" cases that lack a prior conviction and relatively "low-leverage" cases that do not often face serious legal ramifications (e.g., conviction or incarceration) if they fail the program. Most often, when a participant is terminated unsuccessfully, the victim drops the charges, and the case is dismissed. Moreover, restrictions on legal eligibility, combined with potential gaps in the referral process, have led the program to serve a relatively low volume of cases so far (30-35 new participants per year). Most participants have a primary drug of alcohol, where alcohol consumption is seen as a trigger for domestic violence.

Its limited target population notwithstanding, the Guadalupe program has an exceptionally well-implemented operational model. The core strengths of the program are its effective inter-agency collaboration and its classic array of policies, including drug testing, supervision, sanctions, high-quality treatment, and judicial status hearings that excel in procedural justice. The team includes a highly skilled and collegial group of professionals, who would likely be effective in training future drug treatment court professionals throughout Mexico.

The Addiction Treatment Court in Guadalupe is not only an ambitious and pioneering program as the first drug treatment court throughout Mexico, but it is also a successful example of the drug treatment court model, implementing an operation that represents a commitment to

teamwork. As a pioneer, the Guadalupe program had to incorporate the policies and principles of drug treatment courts exported from other places while at the same time navigating the unique legal, cultural and political situation in Mexico. The program has made progress and overcome barriers, and there will be more opportunities to expand and improve, as long as Nuevo Leon, and Mexico in general, move towards the creation of an improved Mexican drug treatment court model.

Drawing on the findings reported in previous chapters, the next chapter offers recommendations in several key areas, including: legal reform; target population; operational model; and victim services and safety. These recommendations were completed during an exchange of drafts with Mexican officials that took place between July 23 and 24, 2014.

Chapter 6
Initial Recommendations

A. Legal Reform

In the years ahead, some legal reforms are inevitable, as Nuevo León (and all of Mexico) completes the transformation of its legal procedures under the 2008 constitutional reforms. However, this study identified other areas where changes to laws and customary legal procedures may facilitate the expansion of the drug treatment court model. We acknowledge that it is unclear whether political, cultural, and practical conditions are yet ripe for any of these changes to be viable.

1. ***Legalize the Drug Treatment Court Process:*** In research interviews, several stakeholders expressed that a new law explicitly referencing and making the drug treatment court process "legal" was critical to the sustainability of the model and to building support in both the criminal justice system and the community at large. These stakeholders believed that a new law could provide explicit legal support for key drug treatment court practices, such as conducting clinical assessments; using treatment as an alternative to conventional case processing; holding ongoing judicial status hearings; and using community supervision, sanctions, and incentives to promote the recovery process. Some U.S. states have followed a similar path through the enactment of a "legitimizing law" for drug treatment courts, believed to legitimize the courts and promote wider acceptance of the model.

2. ***Consider Making More Cases Legally Eligible for a Suspension of Proceedings:*** Currently, the suspension of proceedings ("stay of trial on probation") mechanism is available to only a small fraction of the criminal caseload, mainly domestic violence cases that are brought by the victim and involve defendants who do not have a prior conviction. Expanding this mechanism could enable the Addiction Treatment Court to reach a higher-risk target population—by opening the program to defendants with a prior conviction—and could enable the court to serve a greater diversity of case types, including those property cases that are investigated and charged by the police.

3. ***Consider Legalizing a Post-Plea Enrollment Mechanism:*** Most drug treatment courts in the United States require participants to plead guilty to some charge when they enroll and then allow for dismissing the charges—or at least reducing them—upon graduation. In a domestic violence court context, a similar mechanism is known as a "conditional plea," whereby a defendant pleads guilty to a particular charge, with the understanding that—conditional on compliance with the court's orders—the charge will later be reduced. Based on research interviews, current laws in Nuevo León do not allow for conditional pleas or for dismissing or reducing the charges once a normal plea is taken.

If post-plea enrollment was legally feasible, it could obviate the necessity for all cases to enroll under a suspension of proceedings mechanism and could provide the court with more leverage to threaten adverse legal consequences in the event of failing the program. Elsewhere, some drug treatment courts use a hybrid model, allowing less serious cases to enroll pre-plea while requiring higher-risk cases, or cases whose charges are more serious, to enroll post-plea. Having both mechanisms available would increase the options for stakeholders when refining program policies in the future.

B. Target Population

Most, but not all, of the following recommended changes to the target population hinge on making at least some of the legal changes noted above. It may be helpful to view the recommendations related to target population in light of the historical development of drug treatment courts in the United States. When drug treatment courts first began in the United States, the creators and stakeholders tended to proceed cautiously not only for political reasons but also because they did not fully understand what types of offenders would be best suited to the model. In recent years, research studies have revealed what offenders and what practices generate the most positive results. To the extent that Mexico expands the drug court model, the research results could be used to respond to at least some of the policy issues related to the expansion of eligibility criteria.

1. ***Expand Legal Eligibility:*** To the extent that it is legally, culturally, and practically feasible, program scope and effectiveness could be increased by expanding eligibility to drug-addicted defendants who: (1) have a prior conviction; (2) face property charges; and (3) face more certain legal consequences if they fail the program. Also of no small importance, by expanding legal eligibility, the court may be able to diversify the *clinical* characteristics of the target population, for instance bringing in more participants whose primary drug is an addictive or illegal drug other than alcohol and marijuana.

2. ***Resolve the Eligibility of Drug Possession Cases:*** Based on interviews with stakeholders and team members, there is currently disagreement concerning whether it is culturally and politically feasible (or appropriate at this time) to admit drug possession cases. The research team is mindful that a recent history of drug market-related violence in Nuevo León may make the provision of treatment unpalatable for anyone whose alleged crimes involve illegal drugs. Yet, it is clear that multiple team members and stakeholders would prefer for certain types of drug possession cases to be legally eligible at this time. Stakeholders and team members should meet, discuss, and resolve the matter. From a strictly social scientific standpoint, admitting at least some drug cases would bring in a target population that has historically performed well in other drug treatment courts.

3. ***Investigate the Referral Process:*** Among those domestic violence cases that are now legally eligible for the Addiction Treatment Court, it appears that a small proportion is in fact referred for an assessment. Since defense attorneys are the primary referral source, and all relevant attorneys have been made aware of the drug treatment court option, it

is not clear why referral volume still remains relatively low. The drug treatment court team should investigate the matter and, if possible, seek to increase the number of referrals.

C. Operational Model

The Addiction Treatment Court in Guadalupe has established a classic operational model that is faithful to all ten "key components" promulgated in the United States and all thirteen "principles" established by a United Nations working group. Accordingly, the recommendations that follow are meant to build upon the strong operational foundation that already exists.

1. ***Improve Participant Understanding Prior to Enrollment:*** The Treatment Center provides participants with clear written materials about the program prior to enrollment. Yet, the focus group discussions made clear that many participants did not adequately digest these materials. Participants reported that they did not realize how long it would take to complete the program or what would be required (e.g., frequent court hearings and treatment sessions that would pose a barrier to employment). Accordingly, the drug treatment court team should discuss ways to improve participant understanding. At a minimum, the team should consider a standardized script for the judge to follow on the court date when a participant signals an interest in enrolling. The script could involve explanations of key rules, responsibilities, and graduation requirements, especially the potential time commitment; and a series of (test) questions that the judge asks to verify each potential participant's level of understanding and to verify that, in light of this understanding, the participant is truly interested and willing to enroll.

2. ***Make Treatment Available at Different Times of Day:*** Focus group participants made clear that the need to attend treatment sessions during weekday mornings was often an insurmountable barrier to employment. Particularly with participants who are already employed or are relatively "low-risk" at baseline, treatment policies should avoid the unintended consequence of increasing socioeconomic distress. Specifically, the Treatment Center should consider alternative scheduling of staff hours and treatment sessions to make treatment attendance possible in the afternoons or evenings.

3. ***Add Treatment Locations:*** With only one Treatment Center available for drug treatment court participants in all of Nuevo León—including participants in the new St. Nicholas and Monterrey Addiction Treatment Courts—the high commuting times for some defendants may prevent them from participating or, if they do participate, may pose a barrier to their recovery. To the extent logistically and financially feasible, stakeholders should contemplate establishing a second Treatment Center in a different location or establishing partnerships with an array of community-based providers located elsewhere in the state.

4. ***Shorten the Program:*** Research indicates that the length of the average drug treatment court program is about 15 months (Rossman et al. 2011). Programs that are much longer risk diminishing returns, whereby participants have recovered from their drug problem but can become increasingly noncompliant due to the prolonged effects on their life routines of regular, required program attendance. Accordingly, it would make sense to shorten the Guadalupe program below its current minimum of 18 months and practical average of more than two years (given relapses and other setbacks). Participants in the two focus groups universally expressed that the program was longer than they expected or desired. Two easy changes might be to eliminate one or two of the required five phases (most existing drug treatment courts have only three phases); and to eliminate the sanction of requiring participants in an advanced phase to start over again at the beginning of Phase One.

5. ***Institute Additional Risk/Need Assessment Tools:*** The Treatment Center utilizes a remarkably thorough assessment protocol, combining an array of structured and semi-structured screening and assessment tools. However, these tools do not include proven actuarial methods to classify drug treatment court candidates on *risk of re-offense* (low, medium, or high) or several other criminogenic domains, including criminal thinking, anti-social peers, and family relationships (although these areas are covered qualitatively). The Treatment Center should consider incorporating validated actuarial tools on these and other topics. If time is limited, the Treatment Center may consider omitting the currently used Brief Situational Confidence Questionnaire or Satisfaction with Life Scale. Since the clinicians at the Treatment Center are highly skilled—and clearly capable of eliciting valuable details during their in-depth interviews—any changes are best made to the self-administered intake forms completed at reception, not to the semi-structured psychological, social work, and psychiatric evaluation protocols that follow.

6. ***Consider New Treatment Fidelity Protocols*:** Because there has been little turnover at the Treatment Center and current staff are highly proficient, classic quality control protocols have not been implemented and are arguably not essential at this time. Such protocols include manualized (written) treatment curricula; regular supervision meetings between each psychologist and the program director; and regular observation of treatment sessions by the program director (followed by feedback sessions). Related, the development of a written curriculum might provide an important opportunity to institutionalize domestic violence-specific topics as a critical part of the treatment curriculum. To guard against future staff turnover, or for the benefit of new psychologists who might need to be hired as drug treatment courts expand throughout Nuevo León, such protocols should be considered.

7. ***Impose Certain Sanctions for Noncompliance:*** Research shows that a sanction—or at least an appropriate clinical response—should be imposed in response to each and every noncompliant act. Yet, it appears that the Addiction Treatment Court sometimes eschews a tangible sanction, often utilizing verbal admonishment alone. The Court

should consider more consistent use of tangible, graduated sanctions, including more frequent court attendance, more treatment sessions, required psycho-educational group attendance, community service, jail stays (up to 36 hours), or other sanctions that are already feasible.

8. ***Consider Developing a Sanctions Schedule:*** Research also shows that a formal (written) schedule linking particular classes (e.g., severities) of infractions to particular types of sanctions can increase participant understanding of the likely and certain consequences of noncompliance—thereby increasing their tendency to comply. The drug treatment court team should consider developing a formal schedule of this nature.

9. ***Increase Available Incentives:*** Both the focus group participants and several of the team members observed that the Addiction Treatment Court currently uses few tangible incentives other than verbal praise and applause in court; and monthly groceries and occasional coupons from the Treatment Center. One method for increasing the use of incentives would be to have a "fishbowl" (literally, a big bowl) in the courtroom with an assortment of monetary prizes, gift certificates, and tokens—and to enable participants to dip into the bowl and withdraw an incentive when reaching important milestones (key numbers of drug-free days, phase promotion, educational degree, new employment, etc.).

10. ***Consider Revisions to Supervision Officer Responsibilities:*** Supervision officers traditionally perform a monitoring role. In the Guadalupe program, while not calling this role fundamentally into question, feedback obtained during the focus group sessions suggested that certain supervision practices were adversely affecting participants' perceptions of procedural justice. Accordingly, the drug treatment court team may wish to consider several refinements, such as ending the practice of supervision officers talking to neighbors and exerting care before inferring that evidence of alcohol near, but not inside, the home of a participant (on the lawn) signals that the participant was drinking.

11. ***Develop a Routine Statistical Report:*** Particularly since the Addiction Treatment Court is a pilot program—the first of its kind in Mexico—it may be useful for team members and stakeholders to receive a semi-annual or annual report displaying key program performance indicators. These indicators could include volume (e.g., number of referrals and participants by month, quarter, and year); participant characteristics (e.g., number and percent with each criminal charge and primary drug of choice); services (e.g., number and percent assigned to the Treatment Center, residential treatment, or other services); and status (e.g., number and percent active, graduated, and terminated; and of those active, percent in each program phase). To the extent possible, such a report should include a one-year retention rate, representing the percent of participants enrolling at least one year prior to the computation who had either graduated or are still active.

12. ***Strengthen What Currently Exists***, without excluding the possibility that the some or any of the levels of Mexican government could create a specialized service exclusively dedicated to this model. A specialized health/treatment service is ideal due to the specific characteristics of the patients and the time requirements of the program in which they participate.

13. ***Implement Monitoring and Evaluation (M&E) Mechanisms***: Design, establish, and implement mechanisms that facilitate long-term monitoring and evaluation (six months to three years) of DTC cases.

14. ***Adhere to Established National Medical Standards***: Ensure that the treatment professionals working in the DTC program deliver treatment services and record treatment progress of DTC cases on the participant´s clinical/medical record in accordance with the Mexican Official Standard NOM-168-SSA1-1998.

D. Victim Safety and Services

Since the Addiction Treatment Court focuses largely on domestic violence matters, which can involve serious harm to victims, children, and other family members, providing for victim safety and services is critical. Moreover, in research interviews, drug treatment court team members and stakeholders themselves voiced several of the recommendations listed below.

1. ***Hold Domestic Violence Training:*** Although Treatment Center staff are already well-versed on the unique issues posed by domestic violence, it will benefit the program if all team members and stakeholders share a common understanding of domestic violence dynamics; how perpetrators sometimes seek to manipulate both their victim and the legal system; the role of orders of protection; and common safety and service needs of victims and their children. Accordingly, the team should seek out opportunities for comprehensive in-person and/or online domestic violence training.

2. ***Consider Expanded Victim Advocacy Services:*** The Treatment Center provides a wealth of counseling and other services for victims and their families. Yet, at the start of a court case, victims are not routinely linked with "victim advocates," who could provide the victims with early, independent guidance concerning the court process; legal options; safety planning; and services. To the extent that resources are available, the drug treatment court team and its stakeholders might endeavor seek to learn more about the possible role of victim advocates; and explore whether expanding advocacy services are feasible.

3. ***Incorporate Domestic Violence-Specific Assessment and Treatment Tools:*** In the course of implementing validated risk/need assessment tools (see above), the drug treatment court team should specifically consider tools that can measure risk of domestic violence—including, most importantly, a *lethality assessment* for measuring risk of domestic violence homicide. The Treatment Center might also consider institutionalizing

domestic violence-specific content as part of its group treatment curriculum. Notably, the Treatment Center psychologists already address thoughts, feelings, and behaviors that are commonly associated with domestic violence as part of their standard approach; these strategies, however, have not been integrated and manualized in a formal curriculum.

4. ***Define Orders of Protection as Court-Imposed:*** Based upon research interviews, it is clear that orders of protection are sometimes imposed against the victim's wishes to ensure the victim's safety; and that orders are not always removed at the victim's request. Yet, some of those interviewed conveyed that the victim plays a significant role in these decisions. Providing the victim with a real voice in the matter is not problematic, but a clear message needs to be conveyed to the participants: Specifically, to discourage participants from seeking to coerce or manipulate their victims, it is important for team members to convey that orders of protection are imposed and enforced by the court, not by the victim, and that the court's independent judgment is paramount.

5. ***Remind Participants of Order of Protection Requirements:*** In the observed court sessions, the judge did not remind any participants of the existence of an order of protection or its requirements. To promote participant understanding, and to convey to participants that the court takes such orders seriously, the judge should consider adding reminders related to orders of protection to at least some of the judicial interactions that take place in the course of any given drug treatment court session. Related, the drug treatment court team should consider whether sufficient compliance monitoring protocols exist to detect domestic violence during program participation, and, specifically, to detect order of protection violations, where such orders have been imposed.

Other Considerations and Recommendations for Expanding the Treatment Court Model to other Mexican states

The program developed by the Addiction Treatment Court in Nuevo León provides a solid basis for adapting the program model in other jurisdictions in Mexico. The adaptation process can (1) build on the framework developed for the Nuevo León program, along with lessons learned over the course of implementation; and (2) take into account the priorities and unique issues in the local Mexican state or jurisdiction adopting the model. Therefore, although the essential concept of the Addiction Treatment Court model would remain the same regardless of where it is applied, it is likely that the services and the specific operational design must be tailored to address the priorities and specific problems of the local jurisdiction and the local context. Moreover, the Addiction Treatment Court model consists of many "moving parts" reflected in the operational practices and relationships of the various stakeholders and requires ongoing judicial leadership to ensure that all work is in sync. Bringing organizations that do not traditionally work together into a collaboration has proven to be a major challenge faced by

every community that has tried to implement a drug court program. Adding the periodic rotation of key stakeholders at all levels involved in the program underlines the challenge of maintaining an effective addiction treatment court.

Regarding the expansion of the model to other states, and based on observed experiences of other countries where this model has been launched, the following more general recommendations are included for consideration and must conform to the context of the jurisdiction of the federal entity where applicable:

1. **Development of a Common Vision**

   Before addressing the operational elements of the drug court concept, it is important to identify the overall mission of the drug court model that forms the basis of the major operational components.

   At the operational level, the implementation of this "vision" consists of:
   - Integrating the criminal justice process with public health services for people who have been involved in the justice system primarily as a result of substance use disorder; and
   - Using the law as a therapeutic tool to promote treatment and recovery while preserving public safety (e.g. the concept of therapeutic jurisprudence)

2. **Observing the Major Policy Components**

   In addition to the essential judicial supervision role of the drug treatment court judge, the key components of the drug treatment court model that make it effective are:

   - The use of a public health approach to treating addiction, based on a medical model that is applied to the treatment of other chronic diseases and includes (a) intensive treatment, (b) supported rehabilitation, and (c) continuing care and aftercare;
   - Recognition that addictions are chronic illnesses[19] that require continuous care and services throughout the life of the person, like other chronic diseases;

[19] See the definition of addiction published by the American Society of Addiction Medicine: “Addiction is a primary, chronic disease of brain reward, motivation, memory and related circuitry. Dysfunction in these circuits leads to characteristic biological, psychological, social and spiritual manifestations. This is reflected in an individual pathologically pursuing reward and/or relief by substance use and other behaviors. Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one’s behaviors and interpersonal relationships, and a dysfunctional emotional response. Like other chronic diseases, addiction often involves cycles of relapse and remission. Without treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death”. http://www.asam.org/for-the-public/definition-of-addiction

- Importance of "immediacy" in the treatment of the disease, both in terms of providing immediate services after the diagnosis and as a prompt response to continued use or consumption that might occur again and is often experienced by people dependent on drugs; and thus,
- The essential need to monitor the progress of participants as they participate, including participation in treatment under the direct supervision of the judge and the treatment team using various treatment practices and tools, including drug tests, where the results of drug tests are used to determine if the current treatment is effective or if modifications are necessary; and
- Recognition that drug use is a multifaceted disease, where rehabilitation requires many additional services besides drug treatment per se to help people to address the underlying and complex causes of consumption, so it is necessary to provide services that address a wide range of psychological, emotional, socio-economic and other needs and incorporate them into the treatment and rehabilitation plans of every person.

3. Program Planning

Planning a drug treatment court should be well thought out, including thinking about the essential stakeholders, their functions, and available resources. However, the planning process should also be continuous, with periodic adjustments made to the program after its initial implementation, as dictated by the experience.

Included below are essential initial considerations intended to highlight key issues to be considered during the planning process. While this is by no means an exhaustive list of all the tasks involved in the planning and implementation of a drug treatment court, it certainly provides a planning framework that will identify other tasks and key issues that should be addressed.

a. Initial Planning Tasks

One of the first tasks when developing a drug treatment court is to bring together a multidisciplinary planning team composed of representatives from the key groups and/or organizations who will be involved with the program and that must understand- and help tailor the "vision of the program."

This process should include the following:

- Determining which agencies and stakeholders should be part of the multidisciplinary team that will be created;
- Creating consensus on program objectives, problems to be addressed, the results to be achieved, and the target crimes and populations;

- Gathering essential information in order to develop a baseline documenting the problem or problems to be treated and then measuring the program's effectiveness in treating these problems (including a criminogenic factors profile); and
- Determining the nature and availability of services required to serve the target population and to achieve program objectives; and identifying any gaps.

b. Development of the Program Operating Design

Once the overall program objectives are agreed upon, including the target population, the program operating design may be developed. This process will include:

- Determining who should be involved in program design, delivery of services and extend the planning team, if necessary; and to the extent possible;
- Agreeing on criteria for determining eligibility: legal and clinical;
- Agreeing on the referral process to ensure that all eligible participants are identified as soon as possible, screened for program eligibility, and evaluated to determine the nature of the services they need;
- Agreeing on how the program should operate: developing a "flow chart" for program operation.

The current transition taking place in Mexico from an inquisitorial judicial process to an adversarial one adds a level of complexity to the planning process. To develop a drug treatment court program, the planning may be divided into phases where the initial focus is on the crimes initially provided for processing in the drug courts, with the addition of other crimes as the program evolves. The operating design and "flowchart" should also reflect an approach that is divided into stages.

c. Identification of services and resources needed to implement the program, its availability and the way in which the service gaps will be addressed.

The fourth “Key Component" of drug courts requires that "a continuum of services" is provided to participants. Over time, this "continuity" has been constantly expanding. In terms of treating substance abuse per se, the drug court model is based on intensive outpatient programs (IOP), augmented by inpatient short-term detoxification and, where appropriate, to address the needs of participants who cannot be treated in an outpatient setting. In addition to treatment services for substance abuse, it is also invariably necessary to provide services for associated mental disorders, including trauma.

To complement treatment and mental health services, other types of services are also necessary—housing, medical, family, vocational, and services for other criminogenic needs—to provide the support that most people need to truly "rehabilitate." Program support services for post-treatment rehabilitation, along with these services, must also be incorporated as soon as possible so that people can develop plans for rehabilitation and links to community rehabilitation in their respective jurisdictions.

As the nature of the resources and necessary services to assist the target population are identified, it is likely that additional stakeholders to join the planning team will be identified as well as those who can provide housing services, vocational, educational, family, and other services that participants in drug courts need.

d. Planning Program Implementation

- **Key Areas of Focus**

The implementation of the planning process generally focuses on achieving three main objectives:

- Ensure that planners have the necessary resources to operate the program;
- Document all written policies and procedures for the operation of the program, the services to be provided by the participating agencies, functions and duties of the members of the "team" and all that has been agreed during the course of the planning; and
- Provide the necessary training to all who will be involved in the program.

The implementation of the planning process then focuses on documenting all agreements that have been reached during the planning process, including the operational design and referral program, so that the tasks, duties, obligations, information and decision-making, etc. are articulated and clearly documented for both current program officials and future ones.

We have determined that it is particularly important:

- To develop a Memorandum of Understanding in writing with participating agencies to define the nature of the services provided and to document existing oral agreements or understandings reached during the planning process and lay the foundation for sustainability of the program when the key leaders of participating organizations and agency priorities could change.
- To clearly articulate the program's procedures for key functions (e.g., screening, referral, etc.) and applicable deadlines;
- To develop policies and procedures manuals-and update them constantly to reflect the experience of the program, as appropriate, and ensure that all members of the drug court "team" work from a common understanding of how the program operates;

- To develop information and guidance for participants that is concise, versatile, and clearly describes the program requirements, the obligations of participants, and other relevant information, taking into account the different levels of education, cognitive function and that the influence of drugs and alcohol that may affect the ability of participants to understand the implication of their participation in the program; and
- To develop a solid plan to involve the wider community, both in terms of advice and guidance (e.g., Policy Committee) and in terms of providing additional resources the program may need (employment, housing, education, doctors, etc.).
- To ensure a functional structure adequate for program operations

An essential element of implementation of the planning process is to ensure that the program has an operational structure that is appropriate for program operations, including the ability to perform supervision duties, service delivery, coordination, data collection, monitoring and management as needed.

This operational structure is necessary for the development and sustainability of a drug treatment court program, as it is usually an evolving process, beginning with core issues and constructed further as the program develops and lessons are learned. The undertaking is hampered by the complexity of the services to be provided, the tasks to be completed and the variety of agencies involved in providing services and operating the program, making it a challenge to ensure adequate supervision and monitoring, as is required of strong “systems” and interagency working relationships.

Regarding the "core issues" that are necessary for a functioning drug treatment court program structure, cited below are those that are particularly essential:

- The use of valid and appropriate assessment tools that can be relied on by the program to identify a series of substance use needs, public health and other needs presented by participants and the nature and types of services needed to treat the diagnosis. With the publication of the DSM-V diagnostic criteria and the recently published criteria for the allocation of the ASAM, it is particularly important to use diagnostic tools and evaluation that take into account these developments;
- A variety of modalities to provide substance use treatment that meets the individual needs of the participant;
- Drug testing resources that provide an observed and random test and rapid communication of test results to the drug court team and judge;
- Comprehensive case management services to ensure that participants receive the holistic services they need and that developing problems are immediately identified and treated;
- The development of systematic procedures and policies to respond to the progress and/or lack of progress of participants, with a schedule for the typical program responses applicable to the various signs of progress or lack of progress of the participant (e.g., "incentives" and "sanctions "), providing certainty and discretion

and that conform to the recovery stage of the participants involved (e.g., objectives "proximal" and" distal ");[20]

- A Management Information System (MIS) capable of capturing the information necessary to track the progress (or lack of progress) of participants, manage the program, provide regular information to stakeholders and the community at large about the services provided and the populations served, and lay the foundation for evaluating the program from the different perspectives that may be required; and
- Mechanisms for ensuring the quality of treatment services and other functions to ensure that all scheduled services are actually rendered in accordance with evidence-based practices.

- **Training: Initial and Continuous**

  We have found that training is a key element to successful implementation and to the continuity of the operation of a program and should include orientation (initial and ongoing) and continuing education, taking into account that there is probably a regular rotation among team members and within the organizations they represent. The training component of the program should address key issues such as training on:

  - The drug treatment court program model and objectives of the local program (and how they differ from the traditional treatment process/justice system);
  - The policies and procedures of the local program and how to apply it;
  - The neurobiology of addiction, its effect on cognitive functions, the rehabilitation process and the implications of these scientific results for drug court services and expectations in terms of the demands that can reasonably be expected of participants at baseline and as they progress; and
  - Cross training the team, so that each team member understands the standards and operating principles applicable to the disciplines represented by each member of the team.

e. Announcement of the program to the community

Once the plan for the drug treatment court program is developed—even if it is a pilot program—the announcement should be made to the community, both to stakeholders as well as the wider community, describing the program, the purpose for which it was designed, the services to be provided, the resources it will demand, and the various bodies which are depended on for the success of the program.

4. Launch and Program Implementation

- **Continuous monitoring to ensure that the program works as intended and to address implementation issues as they arise**

[20] See Douglas B. Marlowe. *Practical Guide to Incentives and Sanctions*. National Drug Court Institute.

Once the program is launched, it is extremely important to monitor its operations—the different processes, services, reports and deadlines—and continuously measure those against the expectations and protocols established during the planning process. The discrepancies and problems should be addressed and resolved immediately. Many drug treatment courts observe "disparities" between program expectations and actual practice during the early stages of implementation with issues such as the number of enrollees in the program and/or the actual retention much lower than expected.

Beyond simply observing the disparity as it relates to the number of people who enter/remain in the program or within other areas of the operation that do not meet the expected measurements, monitoring provides a useful opportunity for stakeholders and team members to review the program design and practices and determine how they can better respond to guide the program.

- **Dissemination, development and community involvement**

  Once the program is running, it will be important to ensure that multiple mechanisms are in place to involve the community—through participation in the program advisory committee and/or a special committee on community resources to provide links to services such as housing, vocational, medical and other services necessary for the programming - and through continuously providing information to a wide range of community groups about program services, demographic information of those it serves (e.g. length of drugs or alcohol consumption, links to the community, numbers of parents, educational status, employment, etc.) so that the community becomes aware of community problems that the program addresses and benefits offered by the program in order to obtain the support necessary to sustain the program over the long term.

5. **Program Evaluation: What is expected? Sources of information to harness? How to use the results of the evaluation?**

- **What is expected?**

  In general, any new initiative should be evaluated to determine if it "works"—that is, if it reaches the intended target and if it has produced any unexpected results or consequences. The evaluation of a drug treatment program's operation experience is particularly important from several perspectives, including include the following:
  - Does the program work as expected? If not, what problems have arisen and why?
  - Do processes and program services comply with evidence-based practices? If not, what aspects of the program should be improved and what impact might failure of the program have?
  - Does the program achieve its stated objectives?

- What impact has the program had on problems originally identified as problems to address?
- What has been the cost of operating the program? Have there been any costs/benefits?

- **What sources of information should be used?**

  While program evaluations are necessarily based on statistical data—such as data likely to be stored in management information systems that track programmatic information on participants—program evaluations of drug treatment courts are also based on perceptions and comments from a broad range of stakeholders who are involved in the program and others whose comments are also important. It is therefore important to maintain a quantitative as well as qualitative approach in the process of monitoring and evaluating a model. The focus of the information that a drug treatment court program may wish to evaluate must be identified during the planning stages of the program, to ensure that the necessary information is actually compiled and made available by the time the evaluation is performed.

  The wide range of stakeholders involved directly or indirectly with drug court programs can provide a rich variety of evaluation measures that can be used to evaluate the drug court. The diverse entities and perspectives involved in the drug court program can provide an unusually rich resource to access valuable information for evaluation and perspectives that, in addition to statistical data, may include the following:
  - Comments from participants obtained in focus groups and exit interviews;
  - Comments from stakeholder organizations through periodic surveys and/or interviews;
  - Comments from families of participants;
  - Comments from the team regarding the operation of the team through interviews and/or surveys addressing team relationships, understanding of roles, program objectives, etc.
  - Comments from community leaders and others concerning the awareness of the program, its achievements, and suggestions, if applicable, for improvement and expansion.

  In this regard, CICAD/OAS will be holding regional workshops on Monitoring and Evaluation of the Model for all countries in the hemisphere. For these workshops, the SE-CICAD/OAS has developed the first Manual for a Scientific Assessment of Drug Treatment Courts Model with a hemispheric approach. Experts from over 20 countries participated in the development of this manual.

As part of the planning phase, it is recommended that each state identify an academic institution or external researchers apart from the court itself (a university for example) to partner with in this process of monitoring and evaluation.

- **Using the results of the evaluation**

  Regardless of the evaluation approach used, the evaluation process should be considered a continuous process used to inform policymakers about the operations of the program, the impact it achieves, the areas that potentially deserve attention, the midstream corrections that might be necessary, the overall impact that the program has, the degree to which the program is achieving its objectives, and, if applicable, areas for improvement. Ideally, these evaluations are performed incrementally, so that interim results can be applied to the design of the program and relevant policy decisions. Partnerships among drug courts and local universities can strengthen the evaluation process and ensure that the implementation problems or challenges that political stakeholders want to solve are addressed.

The extensive experience in implementing drug treatment court programs that has developed in the last 20 years has clearly shown that drug courts, properly designed, are effective in promoting the rehabilitation of participants, reducing the consumption of drugs and related crimes, saving public funds and promoting a multitude of pro-social benefits, including strengthening family relationships, improving the educational and vocational situations of participants and promoting public safety. Therefore, it is expected that, if properly structured, additional drug court programs that may be implemented in Mexico would achieve the same results.

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Appendices

APPENDIX A

CENTER FOR COURT INNOVATION
Diagnostic Study for the Drug Court in Guadalupe, Nuevo León

Drug Court Policy Survey

Name of Court: _____

Date Opened: _____

Your Name: _____

Your Position: _____

E-mail: _____

Today's Date: _____

Please answer the questions in this survey candidly and to the best of your knowledge. Your responses will be invaluable in producing a basic understanding of your drug court's policies and procedures.

I. TARGET POPULATION

A) LEGAL ELIGIBILITY

1. What is the maximum prison sentence allowed for a case to participate in drug court?

   _____ (# Years)

2. May defendants participate in drug court if they have one or more prior criminal convictions?

   ☐ Yes
   ☐ No
   ☐ Sometimes: Please clarify criminal history criteria: _____

   _____

3. In practice, please list the most common charges of your drug court participants? *Probe for eligibility of different types of robbery (violent, nonviolent, etc.). Clarify whether sex crimes are eligible. Clarify the prevalence of drug sales or possession offenses (not listed in official statistics) and whether they are eligible. Ask for the rationale for focusing on these charges.*

   _____

4. In practice, what is the maximum prison sentence for each of the most common charges and the typical sentence (not the maximum but what is usually imposed in practice) for those charges? *Probe to elicit what commonly happens in practice in addition to the legal maximum.*

   Charge #1: _____

   Charge #2: _____

   Charge #3: _____

   Charge #4: _____

   Charge #5: _____

5. Are there criteria that absolutely disqualify someone from being eligible to participate in the drug treatment court? For example, a violent offense, age, etc.

   _____

   _____

B) LEGAL SCREENING

6. What are all possible referral sources for the drug court? *Check all that apply.*

   ☐ Some types of cases (e.g., based on their charge) are automatically referred to the drug court
   ☐ Referral by judge
   ☐ Referral by prosecutor
   ☐ Referral by defense attorney/defendant
   ☐ Referral by police/law enforcement
   ☐ Referral by probation
   ☐ Other: Please specify: _____

7. Answer only if some cases are automatically referred to the drug court: Which specific types of cases are automatically referred to the drug court?

   ☐ All cases in the court
   ☐ Some cases: Which ones? _____

8. How often does the public prosecutor exclude a potential case from participating?

   ☐ Never or rarely
   ☐ Sometimes (from roughly a few to one-quarter of potentially eligible cases)
   ☐ Often (roughly one-quarter to one-half of potentially eligible cases)
   ☐ Very often (roughly half or more of potentially eligible cases)

9. How often does the police/law enforcement exclude a potential case from participating?

☐ Never or rarely
☐ Sometimes (from roughly a few to one-quarter of potentially eligible cases)
☐ Often (roughly one-quarter to one-half of potentially eligible cases)
☐ Very often (roughly half or more of potentially eligible cases)

10. Why might the public prosecutor or police exclude a potential case from participating?

_____

_____

_____

11. How often does the judge exclude a potential case that other staff have found to be eligible?

☐ Never or rarely
☐ Sometimes (from roughly a few to one-quarter of potentially eligible cases)
☐ Often (roughly one-quarter to one-half of potentially eligible cases)
☐ Very often (roughly half or more of potentially eligible cases)

12. For crimes with victims, how often does victim preference lead a potential case to be excluded?

☐ Never or rarely
☐ Sometimes (from roughly a few to one-quarter of potentially eligible cases)
☐ Often (roughly one-quarter to one-half of potentially eligible cases)
☐ Very often (roughly half or more of potentially eligible cases)

C) CLINICAL ELIGIBILITY

13. To participate, what kinds of drug problems must defendants have? *Check all that apply. Probe to elicit how highly addicted or functionally impaired the defendant must be to participate.*

☐ Addiction to alcohol or illegal drugs
☐ Uses drugs but not clinically addicted or dependent
☐ Uses alcohol only – *no other drugs*
☐ Uses marijuana only – *no other drugs*
☐ Other problems: _____

14. Can defendants with a severe mental illness participate?

☐ Yes (always or almost always eligible)
☐ Sometimes/depends on the nature of the illness
☐ No (rarely or never eligible)

D) DEFENDANT OPT-IN OR REFUSAL

15. When given the chance, about how often do defendants refuse to participate?

☐ Never or rarely
☐ Sometimes (from roughly a few to one-quarter of eligible cases)
☐ Often (from roughly one-quarter to one-half of eligible cases)
☐ Very often (roughly half or more of eligible cases)

16. What do you think is the <u>most common</u> reason why defendants refuse to participate?

☐ Drug court program is too long and intensive
☐ Better legal outcome is likely by not participating
☐ Unmotivated to enter treatment
☐ Other: Please specify: _____

17. Overall, for defendants who are referred and found eligible, what is the <u>most common</u> reason why some do not participate?

_____

_____

II. CLINICAL SCREENING AND ASSESSMENT

18. What is the "Treatment Center"? *Probe for an accurate understanding of the location and role of the Treatment Center, who oversees its staff, and where it is located.*

☐ Office within the court
☐ Office within the Department of Probation
☐ Office within the local police/law enforcement agency
☐ A community-based treatment agency that is affiliated with the court
☐ Other: Explain: _____

19. Does the Treatment Center/court perform a clinical screen (e.g., 10 minutes or less)? *As needed, explain what a brief clinical screen is and how it differs from a full-length assessment.*

☐ Yes
☐ No

20. *If "Yes" to previous question:*

a. Who receives the clinical screen?

☐ All defendants in the courthouse
☐ All defendants who are referred to the drug court
☐ Other subgroup: Please specify: _____

b. At what point in the process is the clinical screen conducted?

_____

c. Can you attach or provide a copy of your screening tool(s)?

☐ Yes (Attached/Provided)
☐ No

21. Does the Treatment Center/court perform a full-length assessment (e.g., 30 minutes or longer)?

☐ Yes
☐ No

22. If "Yes" to previous question:

a. Who receives the assessment? *Probe for when in the intake process it is administered.*

☐ All defendants in the courthouse
☐ All defendants who are referred to the drug court
☐ Only enrolled program participants
☐ Other subgroup: Please specify: _____

b. What issues does your assessment cover? If you are unsure, do not check at this time.

☐ Demographic information
☐ Alcohol use
☐ Use of other illegal drugs
☐ Criminal history
☐ Anti-social personality
☐ Anti-social peer relationships
☐ Criminal thinking (pro-criminal beliefs or attitudes; negative views towards the law)
☐ Current employment status and employment history
☐ Current educational/vocational enrollment and educational/vocational history
☐ Family relationships
☐ Anti-social tendencies among family members (criminal or drug-using behavior)
☐ Leisure activities
☐ Neighborhood conditions where the defendant lives
☐ Past experiences of trauma and/or symptoms of-traumatic stress
☐ Depression and/or bipolar disorder
☐ Other mental health issues
☐ Risk of re-offense
☐ Prior domestic violence perpetration or victimization
☐ Readiness to Change
☐ Other: Please specify: _____

c. Does your assessment produce a summary score for the following? *Check all that apply.*
   - ☐ Risk of re-offense
   - ☐ Lethality (risk of committing murder against a domestic partner or other individual)
   - ☐ Level of drug addiction
   - ☐ Level of alcohol addiction
   - ☐ Criminal history
   - ☐ Criminal thinking or negative attitudes towards the law
   - ☐ Trauma or post-traumatic stress symptoms
   - ☐ Other mental health disorders
   - ☐ Employment problems and needs

d. Do you use the summary scores to assist in treatment or supervision planning?
   - ☐ Yes
   - ☐ No

e. At what point is the full-length assessment conducted with the defendant?

   _____

   _____

f. How do you use your assessment? *Check all that apply. Probe for how the initial treatment plan is determined and write answers in the space below.*
   - ☐ Determine eligibility for the drug court
   - ☐ Determine the treatment plan
   - ☐ Determine frequency of judicial status hearings at outset of program participation
   - ☐ Other: Please specify: _____

   Answer to how initial treatment plan and modality(ies) is determined?_____

   _____

   _____

   _____

   _____

g. If you assess defendants for their risk of re-offending, which of the following risk levels do you seek to enroll in your drug court? *If needed, explain what is meant by risk of re-offending and what factors might indicate if a defendant is high- or low-risk.*
   - ☐ N/A (risk assessment not performed)
   - ☐ Low-risk
   - ☐ Moderate-risk
   - ☐ High-risk

h. Do you routinely re-administer your assessment after a certain period of time?
☐ Yes
☐ No

i. Can you attach or provide a copy of all assessment tool(s) that you use?
☐ Yes (Attached/Provided)
☐ No

III. DETERRENCE AND INCENTIVE STRATEGIES

A) LEGAL LEVERAGE

23. Do all drug court participants receive a "stay of trial on probation"?
☐ Yes
☐ No

24. What is the participant's legal status when they begin drug court participation? *Please check all that apply in at least some cases. Probe to clarify exact legal status at time of enrollment. Try to elicit a clear answer as to whether or not a guilty plea is entered prior to enrollment.*
☐ Proceedings are suspended and participant has not yet been convicted of a crime
☐ Proceedings are suspended after a conviction but before imposition of a sentence
☐ Proceedings and sentence are suspended after a sentence to probation is first imposed
☐ Other: Please specify: _____

_____

25. What happens to the court case at graduation? *Please check all that apply in at least some cases. Probe to clarify exact legal outcome and legal status at graduation. If the answer involves a hearing or court process of some kind, document this in the space provided.*
☐ Case dismissed (there will not be a conviction on the participant's record)
☐ Case closed without dismissal of charges
☐ Other: Please specify: _____

Additional Clarification: _____

_____

_____

_____

26. Are participants told at the beginning of their drug court participation exactly what will happen if they graduate? *For example, participants might be told in advance that if they graduate, the charges against them will be dismissed. Or they might be told that if they graduate, they will still be convicted of a crime but will avoid going to prison. Please answer "no" if participant is merely told of one or more possible outcomes. As needed, probe to clarify whether participant is merely told what may happen or is given an exact graduation promise up front.*
☐ Yes
☐ No

27. If "Yes" to previous question: Who tells participants what will happen if they graduate? *Check all that apply, but check only if the given role conveys this information routinely in all cases.*
☐ Specified in the drug court contract
☐ Judge
☐ Prosecutor
☐ Defense attorney
☐ Drug court coordinator or case manager
☐ Probation officer
☐ Police/law enforcement officer
☐ Other: Please specify: _____

28. What happens to the court case when a participant fails the drug court? *Please check all that apply in at least some cases. Probe to clarify any legal process that must take place at this stage, and document answers in the space provided.*
☐ Sentenced immediately to jail or prison
☐ Sentenced immediately to probation
☐ Subject to further court hearing(s) before the drug court judge
☐ Subject to further court hearing(s) before a different judge
☐ Other: Please specify: _____

Additional Clarification: _____

_____

_____

_____

29. Are participants told at the beginning of their drug court participation exactly how much jail or prison time, if any, they will serve if they fail the program? *As needed, make clear that a "yes" answer means participants receive a specific promise of the exact length of the sentence to be imposed if they fail—not a possible upper limit or range, but the exact terms of sentence.*
☐ Yes
☐ No

30. If "Yes" to previous question:

    a. Upon failing, will participants always in fact receive the exact sentence length (e.g., same number of days/months/years) that was specified at the time of drug court entry?
    ☐ Yes (always or virtually always)
    ☐ No

    b. Who tells participants in advance of the exact legal consequences of failing? *Check all that apply, but check only if the given role conveys routinely in all cases.*
    ☐ Specified in the drug court contract
    ☐ Judge
    ☐ Prosecutor
    ☐ Defense attorney
    ☐ Drug court coordinator or case manager
    ☐ Probation officer
    ☐ Police/law enforcement officer
    ☐ Other: Please specify:_____

31. What is roughly the *most common* or *average* length of the jail or prison sentence that is actually imposed on participants who fail? *If the answer varies by participant charges or other factors use the space provided to explain your answer.*
    _____ Days / Months / Years *(Enter length and circle a unit of time)*
    _____
    _____
    _____

32. Prior to drug court entry, who provides the participant with an overview of drug court policies and procedures? *Check all that apply.*

    ☐ Specified in the drug courtcontract
    ☐ Judge
    ☐ Prosecutor
    ☐ Defense attorney
    ☐ Drug court coordinator or case manager
    ☐ Probation Officer
    ☐ Other: Please specify: _____

B) COURT SUPERVISION

33. On average, about how many times per month are judicial status hearings during the first three months of drug court participation?
    _____ (#) times per month

34. Does the drug court conduct random drug tests?

☐ Yes
☐ Not

35. On average, about many times per month are participants drug tested over the first three months of participation?

_____ (#) times per month

36. Who administers the regularly scheduled drug tests? *Check all that may apply. As needed, revisit the role of Treatment Center staff, their agency affiliation, and to whom they report.*

☐ Court-employed case management staff
☐ Probation officers
☐ Police/law enforcement officers
☐ Treatment Center staff
☐ Staff of the community-based treatment program to which participant is assigned

37. Who provides case management for the drug court? *Check all that apply.*
☐ Court-employed case management staff
☐ Probation officers
☐ Police/law enforcement officers
☐ Treatment Center staff
☐ Staff of the community-based treatment program to which participant is assigned

38. What is the average caseload per case manager/supervision officer?
_____ (#) cases per full-time case manager/supervision officer

39. On average, about how many times per month must participants meet with a case manager or supervision officer over the first three months of participation?
_____ (#) required meetings per month

40. Do the case managers/supervision officers conduct random home visits?
☐ Yes
☐ No

C) INTERIM SANCTIONS AND INCENTIVES

41. What interim rewards or incentives does your drug court commonly use? *Check all that apply.*

☐ Judicial praise
☐ Courtroom applause
☐ Journal
☐ Phase advancement recognition
☐ Other token or certificate of achievement
☐ Gift certificate
☐ Decrease in judicial status hearing frequency
☐ Others: Please List: _____

_____

42. Which actions commonly receive either judicial praise or a tangible incentive?

☐ Compliant since last status hearing
☐ Drug-free since last status hearing
☐ 30 additional days of drug-free time
☐ 90 additional days of drug-free time
☐ Phase promotion
☐ Completed community-based treatment program
☐ GED or completed vocational training
☐ Obtained work
☐ Other achievements: Please List: _____

_____

43. For drug court participants who are <u>compliant</u> with all program rules, about how often do they receive a positive reward or incentive?

☐ Each judicial status hearing
☐ Monthly
☐ Once every two months
☐ Once every three months
☐ Less than once every three months

44. When you receive a report of noncompliance, how soon must participants appear in court?

☐ Within 1-2 days, regardless of the judicial status hearing schedule
☐ Within one week, regardless of the judicial status hearing schedule
☐ Within two weeks, regardless of the judicial status hearing schedule
☐ At the next scheduled judicial status hearing
☐ Other: Please specify: _____

45. What interim sanctions does your drug court commonly use? *Check all that apply.*

☐ Judicial admonishment
☐ Formal "zero tolerance" warning (specific automatic consequence for next noncompliance)
☐ Jail (3 days or less)
☐ Jail (4-7 days)
☐ Jail (more than 7 days)
☐ Jury box/observe court
☐ Essay/letter
☐ Increased frequency of judicial status hearings
☐ Increased frequency/intensity of treatment modality
☐ Assignment to new service (e.g., criminal thinking, anger management, employment, etc.)
☐ Curfew
☐ Electronic monitoring
☐ Community service
☐ Return to beginning of current phase
☐ Demotion to prior phase of treatment
☐ Demotion to Phase 1 (start of program)
☐ Loss of drug-free days/increased length of participation
☐ Others: Please List and Explain:

_____

_____

_____

_____

46. How often are interim sanctions imposed in response to the following infractions?

	Always	**Usually**	**Some-times**	**Rarely**	**Never**
Positive drug test					
Missed drug test					
Tampered drug test					
Single treatment absence					
Multiple treatment absences					
Reports of noncompliance with rules at treatment program					
Missed judicial status hearing					
Late for judicial status hearing					
Missed case manager appt.					
Absconding (broke contact with treatment and court)					
New arrest (nonviolent)					
New arrest (violent)					
Poor attitude in treatment					
Poor attitude in court					
Other :					
Other:					

47. Does the court have a formal (written) sanction schedule defining which sanctions to impose in response to different infractions or combinations of infractions?

☐ Yes
☐ No

48. *If yes to previous question:*

a. Do participants receive a written copy of the sanction schedule at time of enrollment?
☐ Yes
☐ No

b. If yes, how often is the sanction schedule followed in practice?
☐ Never
☐ Rarely
☐ Sometimes
☐ Usually
☐ Always

49. On a scale from 1 (Least Important) to 5 (Most Important), how important are the following factors in determining which sanction a defendant will receive? *(Please circle your answer.)*

	Least Important				**Most Important**
Formal sanction schedule	1	2	3	4	5
Severity of the infraction	1	2	3	4	5
Number of prior infractions	1	2	3	4	5
Knowledge of case-specifics	1	2	3	4	5

IV. TREATMENT STRATEGIES

50. About how often are participants sent to inpatient treatment as their <u>first drug treatment modality</u>?
    - ☐ Never orrarely
    - ☐ Sometimes (from roughly a few to one-quarter of participants)
    - ☐ Often (from one-quarter to one-half of participants)
    - ☐ Very often (roughly half or more of participants)

51. In practice, when participants are sent to inpatient treatment, about how long do they generally stay at the inpatient treatment program? *Probe for whether the drug court uses different inpatient modalities, such as short-term rehabilitation (e.g., for 30 days), three-month inpatient programs, six-month programs, or one-year programs.*
    _____ (# Months)

52. In practice, when participants are sent to an <u>outpatient treatment program</u>, about how long do they generally stay at the outpatient program? *Probe for whether there are separate intensive outpatient and regular outpatient modalities that involve different lengths of stay.*
    _____ (# Months)

53. In practice, when participants are sent to an outpatient treatment program, about how many days per week do they tend to spend at the program and how many hours per day? *If easier, please provide a brief narrative summary regarding selection of outpatient treatment programs and possible frequency of outpatient services (days per week and hours per day). Again, probe for possible variations between intensive and regular outpatient programs.*
    _____ # Days per week of outpatient treatment
    _____ # Hours/per day of outpatient treatment (on the days when treatment is attended
    Additional information about frequency of outpatient treatment: _____
    _____
    _____

54. Does your drug court link any participants to Medication Assisted Treatment, such as methadone or buprenorphine?
☐ No
☐ Yes, for heroin dependence
☐ Yes, for alcohol dependence
☐ Yes, for other drug addictions: Please list: _____

55. Please indicate how many drug treatment providers used by your drug court provides each of the following treatment modalities.
Outpatient treatment _____ (# providers)
Inpatient Treatment _____ (# providers)
Medication-Assisted Treatment _____ (# providers)

56. Does your drug court link any of its participants to a Cognitive Behavioral Therapy (CBT) treatment that is designed to reduce criminal thinking (pro-criminal attitudes, beliefs, and behaviors)? *Illustrate the meaning of criminal thinking as negative attitudes towards the law; negative attitudes towards the police, prosecutors, or courts; or a view that their criminal behavior is not really harmful. If there is any doubt, record the answer as "no."*

☐ No
☐ Yes: What is the treatment called? _____

57. If yes to the previous question: Does your drug court choose to assign or not assign participants to a criminal thinking treatment based on the results of an assessment?

☐ No
☐ Yes

58. Does your drug court link any of its participants to a batterer program intended for domestic violence offenders?

☐ No
☐ Yes: What is the program called? _____

59. Does your drug court link any of its participants to an anger management program?

☐ No
☐ Yes: What is the program called? _____

60. Does your drug court conduct a formal assessment for trauma and/or post-traumatic stress?
☐ No
☐ Yes

61. Does your drug court link any of its participants to a special treatment for trauma and/or post-traumatic stress syndrome?
    ☐ No
    ☐ Yes: What is the program called? _____

62. Does your drug court link any of its participants to the following additional treatment modalities or services? *Ask if any of the categories are confusing and offer brief explanations as needed. But in general, establish that there answer may be "no" to most of these services and that the list can be read and covered quickly if that is the case.*

    ☐ Motivation Enhancement Therapy (e.g., motivational interviewing)
    ☐ Specialized "young adult" treatment (for example, treatment for ages 18 to 24)
    ☐ Specialized gender-specific treatment
    ☐ Specialized alcohol treatment (targeting issues unique to the use of alcohol)
    ☐ Treatment for co-occurring mental health disorders other than trauma
    ☐ Contingency management (a set schedule of frequent rewards for compliant behavior))
    ☐ Relapse prevention—with cognitive behavioral focus, not education
    ☐ Housing assistance
    ☐ Vocational services
    ☐ Job placement services
    ☐ GED or adult education classes
    ☐ Parenting classes
    ☐ Other: Please specify: _____
    ☐ Other: Please specify: _____

63. Based on the information you have received, do <u>most</u> of the treatment programs your drug court uses have the following characteristics? *Please answer "not sure" if there is any doubt.*

	Yes	**No**	**Not Sure**
Coherent treatment philosophy			
Treatment manual created in-house			
Research-based treatment manual (adapted from outside, evidence-based curricular materials)			
Extensive use of cognitive behavioral therapy			
Availability of treatments for special populations (e.g., young adults, women, trauma victims, etc.)			
Frequent supervision meetings between line treatment staff and their clinical supervisors			
Clinical supervisors frequently sit in on groups that line staff facilitates—after which supervisor provides feedback in a meeting with the line staff member			
Regular formal training offered for line treatment staff			
Line treatment staff are held accountable for following a treatment manual with fidelity			

64. How do treatment providers communicate about participant compliance with the court? *Check all that apply.*

☐ In person (at staffing meetings or court sessions)
☐ Fax
☐ Phone
☐ E-mail
☐ Hard copy/snail-mail

65. About how often do you believe treatment provider reports are both complete and accurate?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely or never

66. About how often do you believe treatment provider reports are timely (i.e., always prior to staffing meetings and court sessions, with immediate updates in cases of noncompliance)?

☐ Always ☐ Usually ☐ Sometimes ☐ Rarely or never

67. Do drug court participants ever remain active in the drug court program, although they have completed all treatment requirements? If so, are they required to participate in community-based aftercare services?
    - ☐ Participants never complete treatment prior to completing drug court program
    - ☐ Participants may complete treatment and are not ordered to community-based aftercare
    - ☐ Participants may complete treatment and are ordered to community-based aftercare

68. How easy is it to get compliance information from treatment providers?
    - ☐ Very easy, most service providers give us compliance information in a timely manner
    - ☐ Somewhat easy, most service providers give us compliance information when we ask for it
    - ☐ Somewhat difficult, we often need to request compliance information multiple times
    - ☐ Very difficult, we have trouble getting compliance information from most service providers

V. PROGRAM OVERSIGHT

69. What is the name of the drug court judge?

    _____

70. For how many years has the judge presided in the drug court?

    _____ (# Years)

71. What is the name of the program coordinator (if different from the judge)?

    _____

72. What advanced training or educational credentials does the program coordinator possess (e.g., JD, MSW, LSW, CASAC)?

    _____

73. For how many years has the program coordinator worked in the drug court?

    _____ (# Years)

74. For how many years has the program coordinator worked as a clinician or clinical supervisor *(enter "0" if the program coordinator has a legal or other non-clinical background)?*

    _____ (# Years)

75. Please indicate whether the current judge or coordinator helped to plan the drug court.

☐ Neither
☐ Yes, judge
☐ Yes, coordinator
☐ Yes, both judge and coordinator

76. Please indicate whether the judge or coordinator (if different from the judge) have ever attended a training covering each of the following topics by checking the appropriate boxes.

Training Topic	**Judge**	**Coordinator**
Pharmacology of addiction		
Co-occurring mental health disorders		
Best practices in legal sanctions and incentives		
Best practices in communicating with offenders		
The "Risk-Needs-Responsivity" principles		
Trauma assessment and/or trauma-informed therapy		
Treatment for special populations (e.g., young adults or women with children)		

77. For each of the roles listed below, please indicate whether either the judge or coordinator is completely responsible for hiring or assigning new staff, is able to advise on the selection of new staff, or plays no role at all in the assignment or hiring of new staff.

Position	**Completely Responsible for Assigning**	**Advises on Assigning new Staff**	**Plays No Role in Assigning New Staff**
Dedicated prosecutor			
Dedicated defense attorney			
Case managers			
Supervision Officers			
Other			

78. How many drug court staff (including the judge, coordinator, case managers, supervision officers, and dedicated attorneys) attends a training or conference at least once per year?

_____ (# drug court staff that attends a training or conference once/year)

79. What do you believe are the most important training needs for the staff of your drug court?

_____

_____

_____

VI. TEAM COLLABORATION

80. Does your drug court hold regular staffing meetings to discuss individual cases?

☐ No
☐ Yes, weekly
☐ Yes, biweekly
☐ Yes, less often than biweekly

81. Does your drug court hold regular policy-level stakeholder meetings to discuss court policies and practices or to review quantitative performance data?

☐ No
☐ Yes, quarterly or more frequent
☐ Yes, two or three times per year
☐ Yes, annually
☐ Yes, less than annually

82. For each position listed in the chart below, please indicate how many staff members fill that position, attend staffing meetings, attend policy meetings, and attend court sessions.

Position	**# Assigned Staff**	**# at Staffing Meetings**	**# at Policy Meetings**	**# at Court Sessions**
Coordinator				
Dedicated judge				
Dedicated prosecutor				
Dedicated defense attorney				
Resource coordinator				
Case manager				
Probation				
Police/law enforcement				
Treatment provider (list only those who attend meetings or court sessions)				
Mental health agency (list only those who attend meetings or court sessions)				
Other:				
Other:				

VI. ADDITIONAL POLICIES AND REQUIREMENTS

A) PARTICIPATION TIMELINE

83. On average, about how many days or weeks pass between an arrest and a referral to the drug court?

    _____ (#) Days / Weeks / Months *(circle time unit that applies)*

84. On average, about how many days or weeks pass between a referral to the drug court and officially becoming a drug court participant?

    _____ (#) Days / Weeks / Months *(circle time unit that applies)*

85. On average, about how many days or weeks pass between becoming a drug court participant and a first appointment at a community-based substance abuse treatment program?

    _____ (#) Days / Weeks / Months *(circle time unit that applies)*

86. What is the minimum number of months from becoming a participant to drug court graduation?

    _____ (# Months)

87. In practice, about how long does the average drug court graduate spend in the program (after considering extra accumulated time due to noncompliance or other reasons)?

    _____ (# Months)

B) OTHER COURT POLICIES AND PROCEDURES

88. Does the drug court have an official policies and procedures manual?

    ☐ Yes
    ☐ No

89. If yes to the previous question, can you please provide a copy of the manual?

    ☐ Yes/Attached
    ☐ No

90. Do all participants receive a handbook detailing all program policies and requirements?

    ☐ Yes
    ☐ No

91. If yes to the previous question, can you please provide a copy of the handbook?

☐ Yes/Attached
☐ No

92. In order to graduate, please check which, if any, of the following requirements apply?

☐ High school diploma, GED, and/or employed
☐ Community Service: # days? _____ (# Days)
☐ Minimum time in the program: # months? _____ (# Months)
☐ Consecutive drug-free time just prior to graduation: # months? _____ (# Months)
☐ Fees: What is the cost? _____ ($$$)

93. Do drug court participants receive a copy of these requirements in writing?

☐ No
☐ Yes

94. Does the drug court judge regularly rotate?

☐ No (or very infrequently)
☐ Yes, every 1 year or less
☐ Yes, every 1-2 years
☐ Yes, every 2-3 years

95. Does the court maintain a specialized database tracking participant characteristics and performance?

☐ No
☐ Yes, simple spreadsheet (Excel, Lotus, etc.)
☐ Yes, Access database
☐ Yes, Relational database
☐ Yes, other

96. Do you routinely survey your drug court participants to obtain their feedback on the program? *(Please check all that apply.)*

☐ No
☐ Yes, through surveys that participants fill-out
☐ Yes, through focus groups or discussions in which participants are invited to offer feedback
☐ Yes, through other means: _____

VII. COURT DATA

97. How many defendants were referred to the drug court in 2012?

_____ (# defendants)

98. How many defendants in fact became drug court participants in 2012?
_____ (# participants enrolled in 2012)

99. As of right now, how many drug court participants have enrolled since the program opened?
_____ (# participants since program opened)

100. As of right now, of those who enrolled since the program opened, how many participants?

Have open cases	_____ (# open cases)
Have graduated from the program	_____ (# graduates)
Have involuntarily failed the program	_____ (# failed involuntarily)
Failed due to dropping-out voluntarily	_____ (# failed due to dropping-out)
Enrolled and have some other status	_____ (# enrolled with some other status)

101. Please rank the five most prevalent primary drugs of choice in your court. Place a "1" by the primary drug that is most prevalent, 1 "2" by the second most prevalent, and up to "5."
_____ Alcohol
_____ Cocaine: Crack
_____ Cocaine: Powder
_____ Heroin
_____ Marijuana
_____ Other: Please specify: _____
_____ Other: Please specify: _____

APPENDIX B

NUEVO LEON ADDICTION TREATMENT COURT EVALUATION
Court Observation Protocol I. Court Session

Complete one form for each day of court observation. Try to observe all cases heard on that day or, at minimum, all cases heard during one complete session (morning or afternoon).

Court: _____ Date: _____

Judge: _____ Observer: _____

Total Court Time Observed *(morning plus afternoon)*: ____ Hours ____ Minutes

Total Number of Court Appearances Observed *(count from court appearance protocol)*: _____

Type of court appearance

Tally up the number of each type of appearance and total once finished.

Regular Judicial Status Hearing	Pre-participation/potential new participant	Other *(briefly explain in space below)*
Total= ***(this number is the denominator for the %'s in the next question)***	*Total=*	*Total=*

******Record the remaining items only for drug court participant regular judicial status hearings, <u>not</u> for pre-participation candidates or non-drug court appearances.******

Tally the number of hearings that each role participated in and calculate the percentage when court observation is complete.

Participant	# participated in	% participated in (*denominator is total status hearings*)
Judge		
Dedicated prosecutor		
Dedicated defense attorney		
Project / resource coordinator		
Case manager		
Probation officer		
Treatment Agency officer (works for Treatment Center)		
Other Describe: _____		

Did drug court participants appear with counsel in the cases that were observed?

□ Always □ Sometimes □ Never

Notes/Clarification *(especially if answer was "sometimes")*: _____

_____

When participants appeared with counsel, did they stand right next to counsel? *(Answer "no" if participant stands at center, while counsel remains symbolically apart, behind the middle of the defense table for example, even if the distance is only several feet.)*

_____

Did the attorneys present opposing positions to the court?

□ Always □ Sometimes □ Never □ N/A (neither attorneys are in court)

Notes/Clarification *(especially if answer was "sometimes")*: _____

_____

_____

Were cases called in an intentional order (e.g., sanctions first)?

□ Yes □ No

Notes/Clarification *(mandatory to add notes if answer was "yes")*: _____

_____

Was the court session open to the public?

□ Yes □ No

Was the court session open to participants other than when their case was called?

□ Yes □ No

If the observed court session was open, were "on record" comments audible to the audience?

□ Entirely □ Mostly □ Barely (e.g., front row or loud remarks only)

□ Not at all

Notes/Clarification:

_____

_____

_____

Were treatment progress reports conveyed orally (e.g., by the coordinator, case manager, or treatment liaison)?

☐ Always ☐ Sometimes ☐ Never

Notes/Clarification *(especially if answer was "sometimes")*: _____

_____

Did the judge possess written treatment progress reports?

☐ Always ☐ Sometimes ☐ Never

Did drug court participants have to stay for the entire court session, or were they allowed to exit after their appearance? *(Answer "stay" if only a small number of participants are allowed to leave due to employment-related or other special circumstances)*

☐ Must Stay ☐ Allowed to Exit ☐ Depends on Phase

Notes/Clarification: _____

_____

_____

Approximately how many feet were participants from the bench during appearances? (circle one)

Less than 5 feet 5-10 feet More than 10 feet

Did the judge frequently hold bench conferences during court appearances or frequently ask participants to approach the bench to speak to them off the record?

☐ Yes ☐ No

Please describe this practice: _____

_____

_____

Circle the number that best represents the observer's impression based upon the court sessions that were observed: 1 = strongly disagree and 5 = strongly agree.

Concerning the actions and demeanor of the judge towards the participants, was the judge:

Respectful	1	2	3	4	5
Fair	1	2	3	4	5
Attentive	1	2	3	4	5
Consistent/Predictable	1	2	3	4	5
Caring	1	2	3	4	5
Intimidating	1	2	3	4	5
Knowledgeable	1	2	3	4	5

Did the judge frequently elicit questions or statements from the participants?

☐ Yes ☐ No

Describe the manner in which treatment issues tended to be discussed during court appearances.

_____

_____

_____

_____

Describe the manner of any discussions that alluded to specific drug histories or drug-related problems of the defendant (e.g., alcohol, heroin, cocaine, or other drug-related problems)?

_____

_____

_____

_____

Describe the manner of any discussions that alluded to specific domestic violence histories or problems of the defendant and/or that alluded to appropriate conduct in a relationship and/or that alluded to any protection orders that were in effect and the need to comply with them.

_____

_____

_____

_____

Describe the physical layout of the courtroom (e.g., dimensions, lighting, number of rows in the gallery, size of audience, and audibility of the proceedings).

_____

_____

_____

Thinking back to the staffing, did the Judge's decisions in cases agree with what was decided by the staffing recommendations?

Most of the time agreed Most of the time conflicted

Provide other salient observations about the court session.

_____

_____

_____

_____

APPENDIX C

NUEVO LEON ADDICTION TREATMENT COURT EVALUATION
Court Observation Protocol II. Court Appearances

Complete one form for each court appearance.

Court: _____ Date: _____

Observer Initials: _____

Length of Appearance *(round to nearest minute)*: _____

Type of Appearance:

- ☐ Drug court – judicial status hearing
- ☐ Drug court – pre-participation *(count if defendant becomes participant during the appearance)*
- ☐ Drug court—not a regularly scheduled appearance. Describe: _____
  _____
- ☐ No-show/non-appearance

Defendant Sex: Male Female

Compliance Status *(circle only one – check "bad report" if any noncompliance was noted)*:
Good report Bad report

If "bad report," answer the following:

1. Noncompliance was *(circle all that apply)*:
   Treatment absence(s) Missed court date(s) Positive drug test(s)
   Re-Arrest Returned on warrant Violated rules at treatment
   Poor attitude Protection order violation: Explain: _____
   Other: Specify: _____

2. What was the court's response? *(circle all that apply.)*
   None Admonishment from judge Admonishment from other staff: Who? _____
   Other sanction(s) imposed: List all sanctions: _____
   _____
   Participant failed drug court: Indicate consequences: _____

3. Did judge raise his/her voice while responding? Yes No

Achievements: Were any of the following recognized? (*circle all that apply)*
Drug-free days: How many? _____ Phase advancement Job/school event
Eligible for graduation Other: specify: _____

Rewards: Were any of the following administered? (*circle all that apply)*

Courtroom applause Shook hands with judge Praise from judge

Praise from other staff: Who? _____

Other reward: Specify: _____

Judicial Interaction *(check box if the given type of interaction occurred)*:

- ☐ Judge made regular eye contact with defendant (for most of the appearance)
- ☐ Judge talked directly to defendant (as opposed to through attorney)
- ☐ Judge asked non-probing questions (e.g., "yes/no" or others eliciting one-word answers)
- ☐ Judge asked probing questions
- ☐ Judge imparted instructions or advice
- ☐ Judge explained consequences of future compliance (e.g., phase advancement, graduation, etc.)
- ☐ Judge explained consequences of future noncompliance (e.g., jail or other legal consequences)
- ☐ Judge directed comments to the audience (e.g., using the current case as an example)
- ☐ Judge reminded defendant of the requirements of an order of protection that is in effect
- ☐ Judge spoke off-record to the defendant (i.e., not transcribed)
- ☐ Defendant asked questions or made statements

Other notes/impressions of the judicial interaction: _____

_____

_____

Was an individual who appeared to be the victim if the case involved family violence present in the courtroom?

Yes/Silent Yes/Participated No

Notes/impressions related to the presence of the victim (if "yes"):

_____

Did the defendant's presentation or demeanor seem? *(circle all that apply.)*

Forthcoming Intimidated Satisfied

Angry Upset Resentful

Other notes/impressions: _____

_____

_____

APPENDIX D

NUEVO LEON ADDICTION TREATMENT COURT EVALUATION
Staffing Observation Protocol I. Staffing Session

********Complete one form for each drug court, whether or not a staffing was observed.********

Court: _____ Date: _____

Observer: _____

Was staffing observed? □ Yes □ No: not logistically feasible. □ No: regular staffings not held.

How frequently do staffings occur? _____

********Complete remainder of protocol only if staffing was observed.********

Start time: _____ End time: _____ Total minutes of staffing: ____

Types of Cases Discussed *(count from case protocol)*:

#____ Drug court – pre-participation appearance – potential new participants

#____ Drug court – regular judicial status hearings

Of participant cases (enrolled in drug court/regular judicial status hearing), which types were discussed during the staffing?

□ All open cases

□ All open cases appearing at next drug court session

□ Select cases only *(check all that apply)*:

□ Cases with noncompliance issues □ Cases with treatment program issues

□ Cases with reward or graduation pending □ Other: specify: _____

Were other issues discussed besides individual cases? □ Yes □ No

If yes, describe what other issues were discussed: _____

_____

Roles Present. (G*ive the number of staff in each role that was present during the staffing and rate the level of participation of each role throughout the agenda; if multiple staff belong to the same role, estimate the participation of the role overall rather than of any particular person.)*

		Did not participate in the observed staffing →	→	→	→	→	→	→ Participated throughout
#____	Judge	1	2	3	4	5		
#____	Prosecutor	1	2	3	4	5		
#____	Defense attorney	1	2	3	4	5		
#____	Project/resource coord.	1	2	3	4	5		
#____	Case manager	1	2	3	4	5		
#____	Probation officer	1	2	3	4	5		
#____	Treatment agency liaison (works for Treatment Center)	1	2	3	4	5		
#____	Other: Describe: _____	1	2	3	4	5		

Who ran the staffing (i.e., led the agenda or called the cases)? _____

Notes/clarification: _____

_____

_____

How often were decisions made about how to handle the cases under discussion (versus deferring decisions to the court session)?

1	2	3	4	5
Not Observed	Rarely	Sometimes	Very Often	Always Observed

Who made final decisions (e.g., resolves how to handle sanctions or rewards, what treatment program to use, etc.)? _____

Notes/clarification: _____

_____

Were decisions finalized only after reaching consensus during the observed staffing?

☐ Always ☐ Sometimes ☐ Never

Notes/clarification *(especially if answer was "sometimes"):*_____

_____

_____

Did decisions related to rewards and sanctions appear to draw upon a fixed schedule in the observed staffing?

☐ Always/usually ☐ In between ☐ Never/rarely ☐ N/A (insufficient observation)

Describe how cases tended to be discussed, any types of issues that tended to come up frequently (e.g., treatment attendance, attitude, or domestic violence-specific issues), and any other impressions of the staffing:

_____

_____

_____

_____

_____

_____

APPENDIX E

NUEVO LEON ADDICTION TREATMENT COURT EVALUATION
Staffing Observation Protocol II. Cases Discussed

Complete one form for each individual case discussed

Court: _____ Date: _____ Observer Initials: _____

****

Length of Discussion *(round to nearest minute)*: _____

Type of Case:

- □ Drug court – regular judicial status hearing
- □ Drug court – pre-participation appearance/potential new participant
- □ Non-drug court: Describe: _____

Compliance Status: Was anything negative brought up about the participant □ Yes □ No

If anything negative was brought up, answer the following:

Did the team decide on a response (*not* waiting to the court session)? □ Yes □ No

Did the team recommend the kind of judicial interaction for the next court appearance (e.g., ask particular questions, offer praise, warn the participant not to continue certain behaviors, etc.) □ Yes □ No

Other notes/impressions: _____

_____

_____

****

Length of Discussion *(round to nearest minute)*: _____

Type of Case:

- □ Drug court – regular judicial status hearing
- □ Drug court – pre-participation appearance/potential new participant
- □ Non-drug court: Describe: _____

Compliance Status: Was anything negative brought up about the participant □ Yes □ No

If anything negative was brought up, answer the following:

Did the team decide on a response (*not* waiting to the court session)? □ Yes □ No

Did the team recommend the kind of judicial interaction for the next court appearance (e.g., ask particular questions, offer praise, warn the participant not to continue certain behaviors, etc.) □ Yes □ No

Other notes/impressions: _____

_____

_____

APPENDIX F

NUEVO LEON ADDICTION TREATMENT COURT EVALUATION
Probation Visit Observation Protocol

Complete one form for each day of probation visit observations. Try to observe all visits conducted on that day or, at minimum, all visits conducted during the shift (morning or afternoon).

Probation Officer: _____ Date: _____

2nd Probation Officer: _____Observer: _____

Probation Visits Observed (check all that apply):

- ☐ Morning: If checked, start time (leaving for first visit):_____ End Time _____
- ☐ Afternoon: If checked, start time (leaving for first visit):_____ End Time _____

Total Probation Visit Time Observed *(morning plus afternoon)*: ____ Hours ____ Minutes

Total Number of Visits Observed *(count from visit protocols)*: _____

Type of probation visits

Tally up the number of each type of visits and total once finished.

Regular probation visit (scheduled court appearance that week)	Pre-participation/ potential new participant	Non-compliance visit (need to check up on someone due to negative report)
Total= ***(this number is the denominator for the %'s in the next question)***	*Total=*	*Total=*

If drug court participants were at home, how often were they responsive to the probation officer?

☐ Always ☐ Sometimes ☐ Never

Notes/Clarification *(especially if answer was "sometimes")*: _____

_____

For non-compliance visits, were participants informed of the purpose of the visit?

☐ Always ☐ Sometimes ☐ Never

Notes/Clarification *(especially if answer was "sometimes")*: _____

_____

If the probation officer found signs of drug or alcohol use or other non-compliance, what was the nature of the noncompliance, and how and when did the probation officer report it to the court or treatment center?

_____

_____

_____

_____

_____

Circle the number that best represents the observer's impression based upon the probation visits that were observed: 1 = strongly disagree and 5 = strongly agree.

Concerning the actions and demeanor of the probation officer towards the participants, was the probation officer:

Respectful	1	2	3	4	5
Fair	1	2	3	4	5
Attentive	1	2	3	4	5
Consistent/Predictable	1	2	3	4	5
Caring	1	2	3	4	5
Intimidating	1	2	3	4	5
Knowledgeable	1	2	3	4	5

Did the probation officer frequently elicit questions or statements from the participants?

☐ Yes ☐ No

APPENDIX G

Guadalupe TTA Participant
Focus Group Protocol

TO BRING:

- Consent forms
- 2 digital recorders, a flat mic, and extra batteries
- laptop computer for notes
- Blank notecards for comments
- Cash incentives
- Receipt forms
- Food, drinks & paper products (napkins, plates, cups)

Thank you for agreeing to participate in today's *group discussion. My name is …. and this is …. [Facilitator] works at [org name] and [Facilitator] works at [org name]. (Introduce all observers in the room and state that they will just be observing and have signed a confidentiality agreement. We are conducting a study to better understand addiction treatment courts in Mexico. We are holding group discussions to help our research team better understand program participants' experiences with the program. Because your rights as a participant in this research study are important, I will review with you what you are being asked to do as part of this study and ask if you all agree to participate.*

(Read the consent form and clarify any questions the participants might have. The researcher will mark on the consent form if everyone is willing to have the discussion recorded and if everyone agrees to participate and will then sign and date the consent form. There will be one form for each group).

- Finally, there are some ground rules for the discussion group:
    - Be open and honest about your experiences, as the information you provide will help make the program better for everyone.
    - The focus group discussion will be taped but the information will only be used for purposes of transcription and, as always, participants will not be identified (as no names will be used during the group).
    - It is important that everyone gets a chance to participate, so please respect the other participants by letting them talk about their experiences without judging them or making negative comments. That having been said, you may respond to others' comments after they have spoken (this is definitely encouraged!)
    - No interrupting when someone is talking. We'll take turns and make sure everyone gets a chance to talk.

- If you think of something that you don't want to share in the group, but think I should know, you can write it down on one of the comment cards, or you can stay after and tell me before you leave.
- We ask that everything said here "stay in the room." For our part, we will keep everything that is said completely confidential. We encourage you to do the same to help us in having an open and honest conversation about your true experiences in the program. Keep in mind that if a participant repeats what you say here or if you repeat what someone else says, other people outside of this group, including the program staff, could learn what was said here and become upset.
- We ask that everyone stick to the topic of their experience in the drug court and not talk about any plans for the future.
- Does everybody here agree that what is said here stays here? (either get a show of hands or go around the circle asking each person if they agree)

Are there any questions before we get started?

1. First, let's talk about how you started in the addiction treatment court.
   - Why did you choose to participate in addiction treatment court?
     - Who talked to you about the addiction treatment court when you were deciding whether to participate, and what were you told about it?
     - What do you think would have happened to your criminal case had you NOT enrolled in the addiction treatment court? Why do you think that?
     - Did you think the addiction treatment court would be helpful to you? How?

2. Let's talk about the court itself:
   - When you first started in the program, were the rules of the court clearly explained to you? Who explained them? What are the rules of the court?
     - Did you receive any written information about the rules of the court?
     - Did you know what you had to do to graduate?
     - What happens if you fail? How does someone fail in the treatment program?

3. Now, let's talk about some specific parts of the reentry court program… Starting with the judge:

   - What words would you use to describe the judge? In what ways, if any, is he helpful? Why was what he did helpful? In what ways, if any, is he not helpful? Why was this unhelpful?

   - What kinds of things does the judge usually talk to you about at court?
     - How did this make you feel?

- How do you feel about the time you spend in the courtroom for hearings, including sanction hearings and sanction challenge hearings? Do you find that time helpful?
    - *(If participants must stay for the whole court session)* How do you feel about spending time in the court before or after your own case to hear how other participants are doing? Do you find it helpful? Why or why not?

4. Let's talk next about your supervision officer—that is, your probation officer (seguridad) who keeps track of what you're doing in the program.

    - What words would you use to describe him? In what ways, if any, is he helpful? How did he help you? In what ways, if any, was he unhelpful?

    - How, if at all, does supervision differ from what you had expected? In what ways, if any, do you get more help than you expected? In what ways, if any, does your supervision officer keep tabs on your behavior more closely than you expected? In general, how is supervision in the treatment court different?

5. Let's talk next about your case manager at the Treatment center—the person that you meet with most at the Treatment Center for individual counseling sessions.

    - What words would you use to describe him/her? In what ways, if any, is s/he helpful? How did s/he help you? In what ways, if any, was s/he unhelpful?

    - What kinds of issues do you discuss during your individual counseling sessions? (We're not asking you to reveal any personal information. Just in general, what sorts of things does your case manager talk to you about?)

    - What kinds of issues are covered in group sessions at your treatment program? How are the group sessions organized—how do they start, who does most of the talking, or generally, how do they work?

    - How, if at all, does treatment differ from what you had expected? In what ways, if any, do you get more help than you expected? In what ways, if any, does your case worker keep tabs on your behavior more closely than you expected?

    - Of all the treatment you have received, what has been the most helpful? The least helpful? For example, individual counseling sessions versus therapeutic group sessions or Alcoholics Anonymous.

- How do you feel about the rules of the Treatment Center? Are they fair? What about the sanctions for breaking rules?

6. Let's talk about your relationship with the other members of the treatment court staff, for example the prosecutor or your defense attorney. What words would you use to describe them? In what ways, if any, are they helpful? How did this help you? In what ways if any, were they not helpful? Why was this unhelpful?

7. What kind of sanctions have you experienced in this program? Were they meaningful to you?

8. What kind of rewards or incentives have you experienced? What did those mean to you?

9. What is the most helpful part of being in the treatment court program for you?

10. What is the least helpful part of being in treatment court program for you?

11. Do you have any suggestions for ways the program could improve?

12. ***Only for former participants:*** How long ago did you leave the program? Did you graduate or leave the program for some other reason?

    - *If graduates:* How did you feel about completing the program? What kind of difference has it made in your life?
    - *If non-graduates:* Why did you leave the program? Was it your choice to leave or did the program terminate your case? What happened after you left the program with your case? Is there anything that would have helped you stay in the program?

13. Is there anything else you'd like us to know about your treatment court experience? Do you have any questions for me?

Thank you again for your time and sharing your experiences with us. Remember that if you'd like to share something else you can write it down on one of the comment cards right now or talk to me afterwards.

IMMEDIATELY AFTER THE FOCUS GROUPS:

- The site visit team should provide each participant with $120MXN cash. The researcher will write down each incentive given on the incentive distribution log.
- Compile the comment cards, digital recorder, and any other materials.
- Power down the laptop that was used to take electronic notes.
- Restore the furniture to its original location, if necessary.
- The PI (Michael Rempel) will take all notes, recordings and comment cards with him.

THE ORGANIZATION OF AMERICAN STATES

The Organization of American States (OAS) is the world's oldest regional organization, dating back to the First International Conference of American States, held in Washington, D.C., from October 1889 to April 1890. At that meeting the establishment of the International Union of American Republics was approved. The Charter of the OAS was signed in Bogotá in 1948 and entered into force in December 1951. The Charter was subsequently amended by the Protocol of Buenos Aires, signed in 1967, which entered into force in February 1970; by the Protocol of Cartagena de Indias, signed in 1985, which entered into force in November 1988; by the Protocol of Managua, signed in 1993, which entered into force on January 29, 1996; and by the Protocol of Washington, signed in 1992, which entered into force on September 25, 1997. The OAS currently has 35 member states. In addition, the Organization has granted permanent observer status to 63 states, as well as to the European Union.

The essential purposes of the OAS are: to strengthen peace and security in the Hemisphere; to promote and consolidate representative democracy, with due respect for the principle of nonintervention; to prevent possible causes of difficulties and to ensure peaceful settlement of disputes that may arise among the member states; to provide for common action on the part of those states in the event of aggression; to seek the solution of political, juridical, and economic problems that may arise among them; to promote, by cooperative action, their economic, social, and cultural development; and to achieve an effective limitation of conventional weapons that will make it possible to devote the largest amount of resources to the economic and social development of the member states.

The Organization of American States accomplishes its purposes by means of: the General Assembly; the Meeting of Consultation of Ministers of Foreign Affairs; the Councils (the Permanent Council and the Inter-American Council for Integral Development); the Inter-American Juridical Committee; the Inter-American Commission on Human Rights; the General Secretariat; the specialized conferences; the specialized organizations; and other entities established by the General Assembly.

The General Assembly holds a regular session once a year. Under special circumstances it meets in special session. The Meeting of Consultation is convened to consider urgent matters of common interest and to serve as Organ of Consultation under the Inter American Treaty of Reciprocal Assistance (Rio Treaty), the main instrument for joint action in the event of aggression. The Permanent Council takes cognizance of such matters as are entrusted to it by the General Assembly or the Meeting of Consultation and implements the decisions of both organs when their implementation has not been assigned to any other body; it monitors the maintenance of friendly relations among the member states and the observance of the standards governing General Secretariat operations; and it also acts provisionally as Organ of Consultation under the Rio Treaty. The General Secretariat is the central and permanent organ of the OAS. The headquarters of both the Permanent Council and the General Secretariat are in Washington, D.C.

MEMBER STATES: Antigua and Barbuda, Argentina, The Bahamas (Commonwealth of), Barbados, Belize, Bolivia, Brazil, Canada, Chile, Colombia, Costa Rica, Cuba, Dominica (Commonwealth of), Dominican Republic, Ecuador, El Salvador, Grenada, Guatemala, Guyana, Haiti, Honduras, Jamaica, Mexico, Nicaragua, Panama, Paraguay, Peru, Saint Kitts and Nevis, Saint Lucia, Saint Vincent and the Grenadines, Suriname, Trinidad and Tobago, United States, Uruguay, and Venezuela.

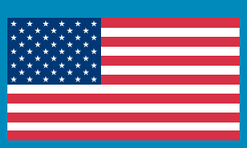
Organization of American States

Inter-American Drug Abuse Control Commission

CENTER FOR COURT INNOVATION

SCHOOL *of* PUBLIC AFFAIRS
AMERICAN UNIVERSITY • WASHINGTON, DC

This document was prepared by the Institutional Strengthening and Policy Coordination Section Of the Inter-American Drug Abuse Control Commission (CICAD), Secretariat for Multidimensional Security of the Organization of American States (OAS); and the Center for Court Innovation (CCI). For the drafting of the second part of this document (future recommendations), this initiative also included the collaboration of the Justice Programs Office, Department of Justice, Law and Society, School of Public Affairs, American University; and the Mexican Institute of Psychiatry. This publication was made possible through the financial contribution of the Government of the United States of America, and the support of CONADIC and SEGOB. The content of this publication does not necessarily reflect the positions or policies of the Government of the United States or the institutions and organizations mentioned above.



Report presented to the United States of America Department of State. August 2014.