

NC Drug treatment Courts

Drug court in Roxboro and Yanceyville



N. C. Drug Treatment Courts Chief District Court Judge Mark Galloway

District 9A
Caswell and Person Counties
Yanceyville and Roxboro, N. C.

**Email: thescoop@esinc.net
www.ncdrugtreatmentcourts.com**

CONTENTS

Section I

Funding and expanding Drug Treatment Courts.....	4
--	---

Section 2

The 12-minute tour of drug courts.....	4
--	---

Section 3

Brain scans.....	5
------------------	---

Section 4

Two Case Studies: Recovery by those who do not seek to recover.....	8
---	---

Section 5

Workings of a Drug Court Team: Effectiveness of “Quick and Certain” reactions.....	13
---	----

Section 6

The hook on the Good Shepherd’s staff.....	18
--	----

Section 7

Knowledge empowering probation officers Team meetings conveying knowledge.....	19
---	----

Section 8

Three ways drug court is different from every other rehab.....	20
--	----

Section 9

The components of a local drug court: All but one already exists.....	20
---	----

Section 10

Graduation and recovery rates.....	21
------------------------------------	----

Section 11

Pregnant addicts and healthy babies: birthing cost of babies addicted in the womb:.....	22
---	----

Section 12

Different types of court-directed rehab modalities.....	22
---	----

Section 13

Cost per participant of operating a drug court.....24

Section 14

Recidivism rates and state-wide cost savings arising from drug courts.....26

Section 15

County and local savings from drug court.....29

Section 16

Conservatives agree that drug courts save taxpayer dollars.....30

Section 17

Neuroscience, brain pharmacology support long-term treatment.....31

Section 18

Recent history of NC drug courts: funding challenges.....32

Section 19

Other online research.....34

Section 20

Q&A on objections & responses.....35

Appendix: Medical costs of Addicted Newborns : Neonatal Abstinence Syndrome, 40
written and researched by Robert Mihaly, and used by permission.

Section 1

Funding and expanding Drug Treatment Courts

This e-book is prepared in the hope that it will serve as a resource for those who are interested in whether criminal justice-oriented drug courts should be re-funded and extended across North Carolina. There are a number of court-directed rehab models that do not arise from the criminal justice system. These problem-solving courts include veterans' treatment courts; juvenile drug courts; mental health courts that deal specifically with mentally ill persons; and family treatment courts that treat the parents of abused, neglected or dependent children. This document is addressed specifically toward court-directed rehab models that arise in the criminal justice context.

As a judge of a small town criminal justice drug court, I have witnessed the effectiveness of these courts. I came to understand how court-directed rehab models resolve substance abuse in ways that were unavailable to voluntary (traditional) drug treatment. I realized that professed and acknowledged conservatives support drug courts as good correction policy and conservative use of tax dollars. Drug court supporters include Republican conservatives from the Tea Party in the U.S. House and Senate, including Republican governors and legislatures in all states contiguous to North Carolina as well its Governor Pat McCrory. It also includes the sitting Republican governors who sought the U.S. Presidency in 2016.

In this document, I will use North Carolina Corrections statistics to explain that it costs less to remove these repeat offenders from the revolving door than to continue to house them in prison facilities at a cost of \$28,000 per year. I will show why the North Carolina Administrative Office of the Courts (NCAOC) chose to cut drug court funding for 23 counties in 2011 rather than cut state-wide programming that increased efficiency for the court system. I will show that the data clearly proves the need for North Carolina conservatives to move away from paying more for less and toward following nationally recognized conservative leadership.

Each section is written to stand alone. This means concepts which are important in several sections will be repeated in each section.

If you contact me at thescoop@esinc.net understand I have a day job

Feel free to copy, utilize, or forward this document.

Section 2

The 12-minute tour of drug courts

This e-book does not read like the great American novel, or even like The Wall Street Journal and may include more information than you might not desire to read even on your most curious day. It was my hope to create a resource that could answer basic questions as well as serve as a guide to further inquiry. Topics are purposefully grouped, but this arrangement does not put most important data first. Some sections may contain information of no interest to you, but hopefully of interest to others.

Rather than plow through this entire document, (guaranteed by some to solve insomnia) the reader might be willing to spend 12 minutes before deciding either that you know enough to “get on board.”

Here is your 12-minute tour guide.

First, view the **brain scans, SECTION 3** to give you an idea how the brains of drug and alcohol addicts have been affected. The **case studies in SECTION 4** show why drug courts succeed with hard core, treatment-resistant addicts when other models don't. Finally, the first 2 paragraphs of Section 16 “**Conservatives agree: drug courts actually do save taxpayer dollars**” should have you pulling into the station at around 11 minutes, 18 seconds.

Thanks for reading this far.

Take your mark.

Get set.

Go!

Section 3

Brain Scans

The damage to addicts' brains shows up on brain scans

What follows are brain scans that register activity on the surface of the brain. These scans are taken from several views. These scans are presented here to suggest or substantiate four points:

First, physical damage has occurred to the brains of these users.

Second, drug users and alcohol users, whose brains are so visibly impaired by substances, have diminished capacity to put their brain to good use to break their addiction.

Third, the visible changes strengthen the argument that recovery from addiction depends on more than will power alone.

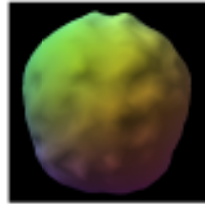
Fourth, treatment needs to be long term. Brains that are so damaged will not heal themselves in a 28-day program.

The images that follow are taken from:

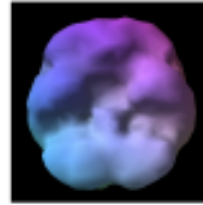
http://www.addictionrecoverycenteroftemecula.com/browse20741/Brain_Scan_Images.html

View images in color if possible.

Normal Brain Scans



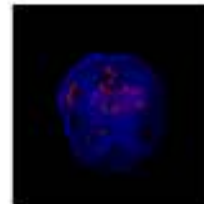
Top Down



Bottom Up

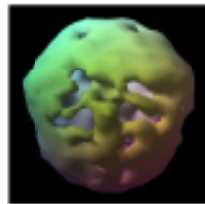


Rotating View



Active View

Effects of Long Term Alcohol Abuse on Brain

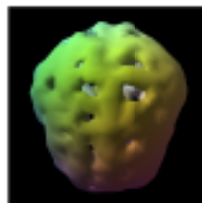


Top View



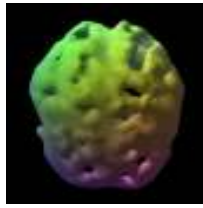
Rotational View

Effects of Cocaine Use on Brain



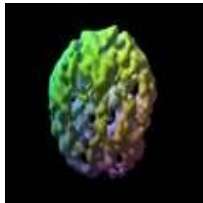
Top View

Effects of Methamphetamine Use on Brain



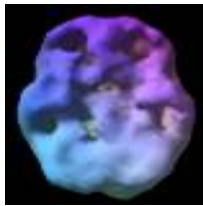
Top View

Effects of Heroin/Opiates on Brain



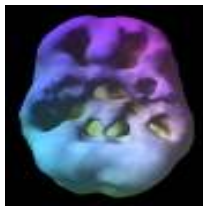
Top View

Effects of Inhalants on Brain



Bottom View

Effects of Marijuana Use on Brain



Bottom View

Normal/Healthy Brain Image Compared to Long Term Alcohol

and Drug Use Brain Images



Normal Brain

Long Term Alcohol Use

An article on brain imaging techniques appears at:

http://archives.drugabuse.gov/NIDA_Notes/NNVol11N5/Basics.html

Do these irregularities diminish after extended sobriety? Articles cited below indicate after extended sobriety, the irregularities diminish.

Doctors at teaching hospitals tell me that the scans do not allow a professional looking at the scan to determine whether the subject is addicted, so its clear brain scans are not **predictive** of addiction. If you Google search “addict brain scan”, you will see that scans of brains with other diseases show irregularities as well.

Persons interested in learning more about brain scans of substance users might go to
http://archives.drugabuse.gov/NIDA_Notes/NNVol11N5/Basics.html

Section 4

Two Case Studies

How Drug Courts Reform Criminal Addicts Who Don't Want to Be Reformed

Drug courts do not wait for addicts to acknowledge they need help before drug courts initiate treatment. Drug courts admit non-violent hard core repeat offenders whose addiction contributes to their criminality. They move addicts from forced compliance to self-directed compliance. Drug courts do not wait for addicts to acknowledge they are using or backsliding before initiating relapse prevention. To prevent relapse, drug courts test frequently and randomly for drug use, monitor for slurring of speech and addiction-friendly behavior, regularly shares such information within the treatment team and react quickly. Sanctions and reactions in drug court are focused on being “quick and certain.”

Al and Baker, real people with fictional names, were multiple offenders who had resisted and failed at all of many attempts at drug and alcohol rehab, who only wanted to be left alone with their drugs and booze. Despite their initial resistance, they (like 75% of similar offenders who finished drug court) recovered themselves, became drug free, exited the revolving door of crime and never went back. Their histories demonstrate how court-directed rehab modalities succeed when traditional voluntary rehab fails. Their histories demonstrate why Tea Party conservatives

and other conservatives across the political spectrum endorse drug courts as a means to save taxpayer money.

“**Al**” was furious that he was being put in drug court as part of his probation. So much so, he wrote a 20- page manifesto to read to his new audience. Al’s document explained why drug court should just leave him alone. His North Carolina record included some 20 assaults, driving while license revoked and multiple DWI’s. Baker was furious that drug court personnel were trying to force him to stay home at night, to have no booze in the refrigerator, to know a drug dog was likely to accompany a probation officer to his house, to stay out of bars and drug houses, to have his movements reported to Judge and Probation by law enforcement, to go to meetings, to test clean and sober and to submit a drug screen on demand. When Al was called on in court, he commenced to read from his multi-page manifesto. After he read a few pages I was able to divert him from his reading, but I was unable to stem the tide of his anger. When he wheeled around to leave court, he tossed this comment over his shoulder as he stormed out: “Frankly, Judge, there is nothing you have to offer me that is in the least bit interesting to me.”

Al did not like the program, but, after a few sanctions and overnights in jail, he concluded that as little as he liked the program, he liked going to jail even less. He concluded that unlike his previous probation, drug court sanctions were likely to be **quick and certain**. It did not take him long to determine that compliance was the lesser of the evils facing him. He grudgingly began to comply, and after a few weeks he was avoiding using, complying with rules and testing clean. At this stage of his recovery, he was not happy, but he was compliant. With time he moved toward self-motivation as will be shown below.

Baker, we will call him, was not as assertive as Al about his misgivings, but, as he told us after drug court graduation, he did not want to be in treatment either. A judge had required drug court as a condition of not going back to prison, but the judge had not even bothered to ask if he wanted to stop drugging. When **Baker** came to drug court, his history of drug abuse and his felony record followed him like a puppy who will not go home. He had been caught yet again for felony larceny, and (since he was a career felon) the Department of Prisons was oiling up the revolving door. Again. At first, Baker seemed to me as if (but for drug court) he was one of those hopeless cases whose life was most likely to be ended by one of those shootings, stabbings, prison homicides, overdoses, accidents or suicides that typically befall the addicted incorrigible.

The first difference between drug court and voluntary drug therapy: The drug court target population seeks (1) multiple failures at rehab; and (2) criminal records should show them to be hard core multiple offenders. When I say we seek “multiple offenders,” I point out that 1,388 crimes were charged and resolved by the 57 graduates of my District 9A between Jan. 1, 2006 and Dec. 31, 2010. They were evaluated in a 2016 report that revealed that these 57 graduates averaged 24 crimes per graduate before the graduates entered drug court.

I counted the number of charges against the graduates in the five-year period from 2006 to 2010 so that I could check for reoffending for five years ending April 2016. The 57 graduates accounted for 1,388 pre-drug court charges per graduate of District 9! Drug court program. That averages out to 24 charges per graduate immediately before entering drug court. I counted 34 non-re-offending graduates. Before they entered drug court. the 34 non-reoffending graduates who did not offend after graduation racked up an average of 18.14 crimes each, totaling 617

jailhouse-worthy crimes charged against them in the courts. In the last three years, the 34 non-reoffending participants who had no convictions after they graduated each averaged 10.02 crimes charged, before they entered drug court, a total of 341 charges.

The second difference between drug court and traditional voluntary rehab is drug court does not wait for addicts to acknowledge they need help before drug courts initiate treatment. Despite Al's and Baker's lifetimes of crime and addiction, the drug treatment court went to work. Baker's recovery was more like a roller coaster than Al's. It took Baker a longer time to start moving toward compliance than with Al. For months Baker believed that the drug court personnel were treating him unfairly, as he told us in his exit interview. Why, he was thinking, was the drug court team checking his curfew, searching his home for alcohol and drugs, making him go to treatment, reporting on him when he was seen by local police in crack houses and bars, testing him for drugs, punishing him quickly when he failed to comply? Since his youth, Baker had never stopped using except when he was behind bars. In his first months in the program, (he told us later) he distrusted everyone in the program from therapists to probation officers to the judge. Drug courts have succeeded with hard core, resistant addicts like Al and Baker and drug courts do not see their resistance as a reason to wait before beginning treatment.

When inpatient treatment was needed but not wanted: Baker was unable to quit using even after months in the program. The treatment team decided he needed an enhanced level of supervision--a residential program (Dart Cherry at Cherry Hospital) which gets him away from his dealers, and gets him off the street. Baker did not want to go, but drug treatment court was able to make sure he went. He was, after all, on probation.

The third difference between drug court and traditional drug therapy: Drug court is unlike traditional therapy in that with drug court, enhanced treatment is provided even if the addict resists. Such a requirement is unavailable to traditional therapists. Consider Whitney Houston, whose therapists, whose family, and the whole world saw she needed treatment. Had she been in court-directed rehab modalities, the enhanced treatment would have occurred. Drug treatment court can require the addict go to residential rehab, go to secure lock up rehab, go to residential detox or go to child-accompanied rehab even if the addict prefers to be left alone. Drug Court addicts are on probation, and can be mandated to the program regardless of what their brain wants them to do.

Drug court moves addicts from forced compliance to self-directed compliance. When Baker returned from 90 days' inpatient residential treatment, he was more clear-headed than before. Still, he was not happy that drug treatment court was forcing compliance by monitoring his behavior, his curfew, his friends, his attendance and participation at treatment, his Narcotics Anonymous (NA) attendance, his drug and alcohol use and his drug screen results. After three or four months in treatment, he still didn't like being forced to change his behavior.

He did not like all of the attention, but he liked trips to jail even less. So he began to comply, and he began testing clean. As Baker tells it, somewhere around the fifth or sixth month of forced sobriety, (not always clean and sober) the fog began to lift, and he acquired some level of mental clarity that came from having been forced to stay clean and sober. As he came out of his drug induced fog, he realized that following the drug court's rules (the same rules that he had so hated so much) made it possible for him to avoid using. He was surprised to realize that his life was better--that his life could be changed if he followed the rules. Baker, like Al, was learning how to avoid his triggers and how to control his urges.

RELAPSE PREVENTION IS ESSENTIAL TO EVENTUAL RECOVERY: Before Baker graduated, he tested dirty again, as did Al and the majority of participants who eventually successfully complete the program. If an addict in recovery starts to use again, it is imperative to intercede immediately. If not, the use tends to spiral down into full blown relapse. I'll say it again: **drug court does not wait for addicts to acknowledge they are using or backsliding before initiating relapse prevention initiatives.** Baker's use was caught quickly, sanctions imposed and Baker was nudged back into compliance. More than half of the graduates in the program test clean for a period of time, only to slide back into using at least once before cleaning up and succeeding.

Relapse prevention: The treatment team must be on constant lookout for signs that a patient is about to backslide or to relapse. Sometimes members of the treatment team sense a participant is in danger of relapsing. Partners on the team and the Judge are all informed. If a particular reason can be identified, (lost job, girlfriend troubles, arguments with family members) the team is informed and additional attention is applied with this information in mind. To Baker, as with most of the people in drug treatment court, the fact that people in authority showed genuine interest in his case was beneficial to his recovery. It seemed he worked out his problem and his outlook and demeanor improved for a matter of weeks. Then with no apparent warning, he tested dirty. He was expecting to be sent to the jail for a short term after testing dirty. He took his jail time as an opportunity to learn from his mistake and to strategize how to avoid similar mistakes in the future. We increased the frequency of testing and the intensity of monitoring. He returned to testing clean. He never had a full blown nosedive. He quickly regained his sobriety and re-entered treatment. He never fully relapsed.

Positive reinforcement is the proven way to encourage recovery-friendly behavior. As Baker's and Al's behavior improved, drug treatment court encouraged and rewarded sobriety-friendly behavior. We praised and congratulated them for clean tests. Positive reinforcement is used in traditional modalities. Participants have their own pro sobriety behavior recognized and enforced, and they watch as others had good behavior and clean tests recognized and encouraged. Here the courts have a chance to make peer pressure work for us. The court recognizes, encourages and congratulates clean drug screens, curfew compliance, attendance at NA/Alcoholics Anonymous and treatment, improved attitude, improved physical appearance and skin tone, positive results in Abuse Neglect Dependency hearings, well written letters to the court about plans to correct past mistakes, and more. The addict must eventually learn to live clean and sober without monitoring from the court. Positive reinforcement of improvements, at first small then greater, moves the participant toward clean and sober living independent of a high level of supervision. Drug testing, however, continues throughout.

The fourth difference between court-directed rehab model and voluntary traditional rehab: Sanctions in drug court are focused on being "Quick and Certain." Both Al and Baker had previously faced threats of punishment for violation of probation rules, but drug treatment court was the first time they realized that punishment for violating the rules would be quick and certain. The courts routinely convey the message that "if you break probation rules, there are consequences." Traditional probation's problem with conveying the notion of "consequences" is that in the mind of the resistant addict "consequences" were weeks--sometime months--in coming. This is because probation violations do not come to trial until the probation officer: (1) observes the violation; (2) writes it up; (3) confers with supervisor and gets permission to file a violation report; (4) gets a judge to sign an order for arrest; (5) the defendant is arrested and

appears at a first hearing: (6) counsel is procured and the case continued until counsel can prepare: (7) a hearing is held before a judge.

To the mind of addicts, consequences that are weeks-months away do little to modify behavior today. If the courts wish to modify behavior of a resistant addict, they must convince the addict that sanctions are **quick and certain**. This is not a criticism of probation. They are doing the best they can with the resources available to them. In drug courts, the violator can be in front of the judge on the day of the rule violation, or (more frequently) the next twice-monthly drug court session. The principle of “**quick and certain**” was applied to Al and Baker so that (like others in the program) they came to believe that, like it or not, if they broke the rules, there was a good chance he would be caught quickly, and it was pretty certain that something unwanted would happen. When evidence appears of dirty drug screens, of curfew violations, of failure to attend meetings, of presence of participants in bars or drug houses, of behavior indicative of use, of statements indicative of weakening of resolve, the team would impose a sanction, would increase drug testing, would send a participant to jail, would send a participant to a residential facility or to a secure facility. This would usually happen at the twice monthly drug court session or occasionally sooner.

Had it not been for Drug Court, Baker would have gone back to prison at \$28,000 per year. There was nothing to lead one to think that his inclinations to break and enter would be changed, for he had been imprisoned so many times before without changing his outlook. He graduated from the program and now, nearly 10 years later, he remains drug free, law abiding, and tax-paying citizen. No longer stealing for a living, he now has a job working for a Piedmont-area factory, has gotten his license back, has a home, has a respectable car, has a wife, is supporting her child and has a life. Al’s drunk driving history predisposed him to tragic death behind the wheel of a car involved in death or serious injury of others, but he found himself. More than six years since his graduation, he is recovering his employability, is a deacon in his church, and is a beacon of light to those who know him.

If an addict is put in a treatment program before his addiction evolves from pursuit of drug-induced ecstasy to avoidance of pain, the likelihood of success is diminished. An addict’s responsiveness to rehab depends in part on whether his primary motive is sheer pleasure, or whether his primary motive is using drugs to keep from feeling like he wants to die. If an addicts’ drug use is all about pleasure and nothing about withdrawal, therapists will have a hard time convincing him to walk away from “the best sensation of his life.” It will be difficult in the extreme to talk an addict away from his drug when he thinks, “That crack was like all the orgasms I ever had all rolled into one.” Or, “I never felt as calm and relaxed as when I was on opiates.” When the addict is pursuing and sometimes achieving ecstasy the therapist can offer the user precious little motivation. On the other hand, if the addict’s motivation is to mitigate his withdrawal symptoms, therapists have something to offer. The therapists has something to offer when the addict’s motivation is that he/she feels like he/she will die of pain and discomfort if he/she does not get another hit. There is little the therapist can offer to the user who wants the sensation of a lifetime, but an addict who has grown “sick and tired of being sick and tired” might be more ready to consider a life without withdrawal pains.

Section 5

Workings of a Drug Court team
*How drug court's "Quick and Certain" reactions
 prevent relapse like no other therapy can do*

With resistant addicts, there will be no meaningful change in behavior unless the addict believes that the drug court team's reaction to dirty tests or addictive behavior will be "quick and certain." Drug courts work better with resistant addicts than do other modalities because drug courts do not wait for the addict to agree to undertake treatment or to return to treatment. Drug treatment courts are designed to observe addictive behavior quickly to correct it in order to prevent full blown skid row relapse. Typically addicts on the way to recovery backslide or use drugs or otherwise regress at times during recovery. Drug courts focus on relapse prevention. They make use of "the hook" on the Good Shepherd's staff to pull the backsliding addict back toward recovery.

Team approach: The treatment team consists of:

1. A judge.
2. A prosecuting attorney, an Assistant District Attorney who seeks to assure that non-compliant addicts are appropriately punished or ejected from the program.
3. A substance abuse therapist who facilitates and directs treatment meetings and reports the addict's progress, or lack thereof, to the Court.
4. A mental health agency representative who coordinates or provides services to addicts with need for treatment for disorders other than addiction.
5. A probation officer who monitors compliance with Court rules and meets with the addict in his home and community.
6. An attorney for defendants.
7. A reporter to grant provider or funding provider.
8. An administrator who assures that information is shared between team members and who monitors whether or not team members are meeting their responsibilities.

On occasion, these responsibilities are assumed by more than one of the team members. Treatment team members conduct most of their duties independent of the other team members, and their interactions with the addict are reported at team meetings. The treatment team meets before every court session, usually every two weeks. Each addict in the program is discussed at every meeting, and the observations of each team member and reports from team members and others are shared. The team confers on whether or not the addict is succeeding in his/her treatment plan, what needs to be done to meet challenges or to encourage compliance. The team's observations are used by the judge in planning for the judge's interaction with the participant in courtroom. The judge should consider the input of all of the team members, but the final decision about what to do is the judge's.

Data collection and transmission using Management Information System (MIS): Drug treatment courts operating in the state must report admissions, completions, removals from the program, drug screening results, sanctions imposed for non-compliance, rewards granted for compliance, hospitalizations, pregnancy, and health of the baby, events creating challenges for addicts, training events undertaken and completed and a variety of events of compliance or non-compliance. Reports go on line via MIS to the Administrative Office of the Courts (AOC) and to

agencies who gave grants to individual programs. Around middle of 2015, MIS experienced technology problems and the contractor responsible for the program was unable to get the system to accept data for a matter of months. The local courts as well as AOC were unable to collate, retrieve and organize data as before. As of this writing, much of the MIS data transmission has been operationalized, but some reporting of some data remains unavailable as of March 2016.

How are addicted offenders sentenced to criminal justice drug courts? In criminal justice drug courts, sentencing judges have a mix of options whereby offenders might end up in drug court. Drug court is usually one of several conditions of probation. Drug court probation frequently follows a term in jail or in prison. In the final analysis, it is always a Judge who initiates referral of an offender to drug treatment court. The process might be started by probation officers, prosecuting attorneys, law enforcement officers, defense lawyers, or judges doing sentencing. The Judge and any persons involved in the referral process should make an initial determination that the offender would qualify for participation in the drug treatment court. The judge's decision to refer the addict to the court means that the addict must undergo an initial intake process to determine whether, in fact, the addict is appropriate for the drug treatment court. Occasionally a defendant is found not appropriate for admission after the intake process, and the offender is referred back for possible resentencing.

Initial intake inquiry is done by trained drug court personnel to determine whether the offender fits the target population of resistant addict and habitual offender. Is this offender appropriate for drug treatment court? Facts learned during intake might demonstrate that the offender would be detrimental to the program or that the program is not appropriate for the offender. If the drug court judge learns from the intake process that the prospect is not a good fit for drug treatment court, the sentencing judge is typically notified by the drug court judge, and the trial judge might countermand the referral to drug court.

Reasons to decline an offender at the intake stage include: Does the offender fit the target population of resistant addict, habitual offender? Will the prospect sell to participants? Is the prospect so violent as to jeopardize participants? Is the prospect a casual user rather than a resistant addict? Is the prospect's sentence of insufficient duration?

(1) If the offender remains active in sale of drugs, he could be expected to victimize other participants in the program. (2) Tendency toward violence would interfere with others in the program. (3) Drug use which is only casual: Drug courts are designed for hard core resistant addicts, not casual users. (4) Short suspended sentence: If the length of the criminal sentence is too short, the prospect would frequently rather take his time rather than undergo the supervision of drug court.

What about the addict who is also mentally ill? The recovery community uses terms like "dual diagnosis" and "co-occurring disorders" to describe the individual with both a mental illness and a drug addiction. What are the special challenges? If a local drug court has limited access to mental health treatment for dual diagnosed addicts, its effectiveness will be diminished.

As a nation we see have strong and natural compassion toward the wounded warrior whose PTSD does not show up on a physical or a scan. As a judge of juvenile abuse, neglect, dependency cases, I see infants who, through no fault of their own, will bedevil teachers, doctors and police officers as long as they live. My awareness of their challenges does not mean I do not hold them accountable for their behavior. It does mean, however, as protectors of the community, we place our neighbors at greater risk if we fail to deal with them as they are, rather than as they should be. We in our neighborhoods and highways will reap the whirlwind if we merely tell them to “get a grip” and get on with living.

Now, about the question: **What are the special challenges?** I would categorize the challenges into treatment and training. I would say we need adequate therapy by persons trained in treating the conditions in question. Locating and interfacing with trained professionals has proven far more difficult than should be the case. I have witnessed this to be true even when I have been trying to secure needed therapy to prevent a needless death or victimization of an innocent person. If the mental health therapist is unavailable, the substance abuse therapy proves to be of minimal benefit. Regarding training, I would say the team members need training in how to avoid making a condition worse. Even the best of intentions can lead to bad results. If the probation officer never got “trauma informed training” the probation officer might never know the PTSD patient is put in a fearful condition when being followed, and the probation officer will not know that the patient’s fearful condition is suddenly and greatly multiplied when the patient is shown into a darkened room before the light is switched on. The Probation officer will mistake a flashback for sudden and undeserved rage.

Relapse prevention requires close monitoring and quick reaction by drug court team: Offenders are monitored closely so that they can be quickly directed back into sobriety and treatment if they show behavior that is averse to recovery. Monitoring is done by probation officers. Addicts are tested at least two times a week for alcohol and drug use. Probation officers search the addict’s premises and persons when appropriate. Curfew is frequently checked. When participants are observed by law enforcement spending time with unsavory individuals or frequenting drug houses, drug court probation officers are informed. In a small town, this is more likely to happen than in a larger town where there are so many participants that law enforcement does not know them all. Probation officers check addicts’ cell phones for indications of a participant’s drug purchase or sale. Drug court monitors attendance at group therapy, individual drug therapy and support groups. Regular staffing meetings share information about participants’ behavior. Provable violation of drug treatment court rules is sanctioned. Second hand reports (sometimes from angry girlfriends or boyfriends, sometimes legitimate) on addicts that do not constitute clear and provable violations are noted, and additional attention, drug testing or monitoring is directed to the addict in question.

When I say we seek “multiple offenders”, I mean participants had long and substantial criminal records. Before the eventual 57 graduates entered drug court, 1,388 crimes were charged and resolved by them.

I counted the number of pre-drug court charges against the graduates in the five-year period from 2006 to 2010. I ended the group of graduates in 2010 so that I could check for reoffending for

five years ending April 2016. There were 57 who graduated, and the 57 graduates accounted for 1,388 charges disposed of before they entered the drug court program. That averages out to 24 pre-drug court charges per graduate in the five-year period. I also calculated prior charges for graduates who did not reoffend. Of the 34 graduates who did not re-offend in the five years between January 1, 2011 and December 31st, this group had 617 crimes charged and resolved before they entered drug court. That's an average of 18.14 crimes for each non re-offender. In the three years before they went in drug court, they averaged 10.02 crimes each. Remember, these are the people who graduated, turned over a new leaf and had no new charges.

Target population excludes casual users. Drug Treatment Courts are not for everyone, and many offenders who are infrequent users should not be placed in them. The target population is offenders who are high risk to re-offend. This Court should not mix high risk confirmed offenders with offenders who do not need such intensive programming as this. One might think that an advocate of the program like I would say every offender needs a dose. Not so. Data indicates that offenders who have not penetrated deeply into criminality might be encouraged to do so if put in a highly regimented program with long-term offenders. Secondly, from a statistical point of view, it is important to be able to point out that the nationwide 75% recovery rate that drug courts boast is the result of the programming, not of "newbies" who have been cherry picked to improve recovery statistics.

Monitoring, enforcing and mandating: Hard core addicts will not recover if their behavior predisposes them to use, so the Court requires recovery-friendly behaviors like: submitting to drug tests when demanded; going home at night and staying there; keeping one's home, pockets, refrigerators and automobiles free of alcohol and substances; attending meetings; arriving on time; participating; and staying until the end of the meeting; meeting with probation officers in the home and office; staying away from people and places that attract alcohol and substances; wearing a GPS transmitter if the addict can't stay home; avoiding communication with addicts and sellers, letting the probation officer check your cell to see if wrongful contact has occurred; getting to court on time; getting and maintain employment. Probation officers check curfews, check attendance at treatment, check appearance in treatment, report failure to meet probation officers, require a drug test three times a week, note whether probationers hang in the bars or hang out with other users. GPS is required as appropriate. Addicts learn that the probation officer might check his room or his pockets for drugs, his refrigerator for alcohol. Probation officers check cell phones for contacts with persons in the drug culture. An addict's behavior, his conversation or his complexion in meetings with probation officers or treatment provider can tip off the treatment team that more attention is required and drug testing should be performed more frequently.

Court proceedings: Sobriety and compliance are rewarded from the bench. Drug court sessions look much like one would expect a court to appear. There is a courtroom, a judge in a robe, a bailiff, clerk, counsel tables and a courtroom with participants. Every participant is recognized, and rewards or sanctions are imposed, usually as was decided in staffing. When situations call for findings of fact or presentation of evidence, matters are presented like one sees on Perry Mason. Data and research confirm that rewarding participants for sobriety and compliance is much more effective than imposing sanctions for non-compliance. Drug courts reinforce positive behavior with congratulations from the bench, tangible rewards (e.g., the

judge's ballpoint pens with his name on them, judge-purchased dollar coins, \$5 gift cards to local groceries) relaxing of curfews, and liberalization of supervision rules. It is surprising and rewarding how much participants come to desire to be recognized for good behavior, and how they will correct me for failing to identify them as "perfect" in meeting all their goals for the past 2 weeks.

As addicts move into increased ability to control addictive behavior, the treatment team gives participants less supervision, and addicts learn to regulate their behavior. While some supervision is relaxed, drug testing never stops. The drug court team seeks to increase a participant's ability to self-regulate by reducing the intensity of supervision as the participant demonstrates recovery-friendly behavior. The speed with which participants move toward independent recovery varies and the team must monitor each addict individually. After months of clean testing and recovery-friendly behavior, the frequency and intensity of curfew checks and house checks is reduced. Curfews and other behavior curbs are relaxed, but drug and alcohol testing never stops. Never. Some addicts are so fearful of relapse that they ask for more supervision-and it is granted. As the brains of addicts recover, addicts who had thought for years that they could not recover come to realize that they can recover, and they become energized with the process-with receiving recognition in court that they had no violations since the last court-that they were "perfect" in meeting all goals since last court session. This recognition of the "perfection" is witnessed by the participants who are not-yet-compliant, who in turn, knowing the "perfection" from the streets and from meeting, come to realize they too might succeed.

Drug Treatment Courts (aka drug courts) are less than 40% "treatment" and are more than 60% monitoring and reaction. The latter 60% is supervision, monitoring, correcting, refocusing, drug testing, information sharing and promptly responding to addictive behavior and applying the hook of the Good Shepherd's staff. The drug court team focuses on determining whether addictive behavior is occurring and correcting it quickly. Addictive behavior includes, among other things hanging out with or communicating with users; communicating with sellers; appearing disoriented or sleepy in public or at meetings; missing required meetings; tardiness or early leaving of required meetings; missing required tests; possessing alcohol or controlled substances in their dwelling, car or person; violating curfew; admitting use; testing positive for prohibited substances. The observations of all team members are shared at team meetings before court sessions and more frequently when necessary. Sanctions or increased scrutiny or other corrections come out of the team meetings. More than 60% of the work of the team revolves around observing the addict, sharing information and making corrections that will modify the addict's behavior

An addict's cost benefit analysis focuses on what is immediate. Therefore, monitoring must be perceived by participants to be quick and certain. Even the resistant addict is capable of making a cost benefit analysis, even if the analysis ignores facts that only an addict would ignore. The addict's analysis is about what will happen right now. To the mind of the resistant addict, the threat of prison months hence is not as meaningful a threat, but the threat of unpleasant consequences right now is powerful. A threat, right here, right now, is substantially more likely to change behavior right now than a threat of a more draconian but delayed consequence. This thought is probably foreign to most folks, but consider the heroin addict who chooses to shoot up in private, not in public. A crack addict determined to steal his parents'

goods will wait to steal from them when no one is around. His addictive-thinking brain doesn't consider the certainty that since he has been caught stealing before his family will figure out it was him. But his addictive-thinking brain does know he might go to jail right now if they see him do it. So he waits. If the threat of an unpleasant consequence is not believed to be quick and certain, the threat is not a meaningful threat to the mind of the resistant addict.

If an addict is put in a treatment program before his addiction evolves from pursuit of drug-induced ecstasy to avoidance of pain, the likelihood of success is diminished. An addict's responsiveness to rehab depends in part on whether his primary motive is sheer pleasure, or whether his primary motive is using drugs to keep from feeling like he wants to die. If an addict's drug use is all about pleasure and nothing about withdrawal, therapists will have a hard time convincing him to walk away from "the best sensation of his life." It will be difficult in the extreme to talk an addict away from his drug when he thinks, "That crack was like all the orgasms I ever had all rolled into one." Or, "I never felt as calm and relaxed as when I was on opiates." When the addict is pursuing and sometimes achieving ecstasy the therapist can offer the user precious little motivation. On the other hand, if the addict's motivation is to mitigate his withdrawal symptoms, therapists have something to offer. The therapist has something to offer when the addict's motivation is that he/she feels like he/she will die of pain and discomfort if he/she does not get another hit. There is little the therapist can offer to the user who wants the sensation of a lifetime, but an addict who has grown "sick and tired of being sick and tired" might be more ready to consider a life without withdrawal pains.

Section 6

The hook on The Good Shepherd's staff

Drug courts have it.

Other rehabs do not.

Anyone who has seen a stained glass window in a church in North Carolina has seen the Good Shepherd with his shepherd's staff. Anyone who asked why does the staff has a hook on the top knows: The hook allows the shepherd immediately to pull the wayward sheep back toward the shepherd. Immediately. Quick and certain. Sheep, like addicts, cannot be relied on to return to the fold. Hence, the shepherd's staff has a hook.

An addict's family cannot force the addict into treatment. The addict who does not want to go into treatment is unlikely to go unless there is a mechanism to say, "You will go, or you will experience consequences you had rather not experience, and quickly." A hook.

An addict who has started treatment, but who is wavering in his sobriety will resist returning to treatment unless there is a mechanism to say, “You must, go or you will experience consequences you had rather not experience, and you will experience them quickly.” A hook. Most addicts who eventually recover will have a failure along the way. The trick is to make sure the failure does not turn into a full blown relapse. An addict who needs to go into residential treatment but who doesn’t want to go will not go unless there is a mechanism to say, “You must, or you will experience consequences you had rather not experience, and you will experience consequences quickly.” A hook.

An addict who is using does not want his probation officer to test him for drugs and will resist being tested it unless there is a mechanism to say, “You will test, or you will experience consequences you had rather not experience, and quickly.” A hook.

An addict who is failing to go to treatment is unlikely to resume treatment unless there is a mechanism to say, “You must, or you will experience consequences you had rather not experience. Quickly.” A hook.

Section 7

Better informed probation officers better protect the community

Team meetings empower probation officers

The drug court team meetings are eye-openers for probation officers. These twice monthly team meetings gather information they would not have otherwise known-information on which they took action they would not have otherwise known to take. They have learned their probationers are high in group therapy, (confidentiality having been waived) were seen by drug cops at crack houses, are calling undercover drug sellers, are skipping treatment, have lost a job, are about to be charged with new offenses. This information helps probation officers direct their attention where it is needed. Information gathered leads to additional searches, additional drug tests, additional checks of cell phones, and additional monitoring. Information gathered in team meetings means that probation officers can take meaningful action to protect the public. Probation officers who do surveillance have only so much time. It is better for them to spend their time where the most good is done rather than to do drive randomly from house to house.

Section 8

Three ways drug courts are different from every other rehab

1. When the substance abuser walks away from sobriety, drug treatment courts don't have to wait until the addict decides to return to treatment. Courts can mandate sobriety in ways that are not available in traditional rehab.
 - (a.) Probation monitors and reports signs of trouble to the treatment team.
 - (b) Drug treatment courts use the legal system (confinement when needed) to intervene quickly when an addict's behavior becomes adverse to recovery.
 - (c) Drug treatment courts promptly order the binging addict into inpatient treatment so as to prevent a binge from becoming a full-blown skid row relapse.
2. Drug treatment courts focus on high risk, hard core offenders rather than low-risk self-correcting offenders.
3. Drug treatment courts insist on long-term treatment for long enough for the brain to recover-at least one year.

Section 9

Components of a local drug court *All but one component is already funded*

The component, which is not currently, state funded is that of the administrator or program manager. This team member works with the addict during intake, meets with defendant regularly, checks drug tests, prods the defendant to achieve compliance. The administrator's work with other team members is collecting and transmitting information and reports between team members, providing testing and other supplies to team members, prodding team members who may be tardy in relaying information to the team, transmitting data from team meetings and other meetings to the computerized MIS at the AOC and planning court events.

Drug courts use corrections-funded inpatient facilities. A local drug court frequently has a defendant who would not improve unless the defendant could first be placed for a time in a residential program. These are not administered by local drug court, but they are essential to recovery of a sizeable minority of drug court defendants. Referrals to these programs are not an expense of the local drug court. They receive their funding independent of drug courts. When an addict continues to test dirty, the court has the option to send the addict to one of these facilities even if Defendant does not want to go. The Baker case study above involved sending him to an inpatient facility despite his desire not to go. Referrals to inpatient facilities occur when it is believed that the defendant is unable to become drug free while still living in the community. Corrections operates facilities for men and for women which are available to defendants on probation. Other inpatient facilities are otherwise available depending on insurance, grants or charitable organization.

Section 10

Recovery rates

Three out of four drug court graduates do not re-offend, according to nationwide statistics. Drug courts' graduation rates are nearly double completion rates for traditional voluntary rehab.

Bureau of Justice statistics and National Association of Drug Court Professionals www.allrise.org report 75% of graduates do not re-offend. A 2011 analysis of my District 9A drug court showed 74% of our graduates had no criminal charges for five years after graduation. A 2016 analysis of 9A drug court finds six out of 10 graduates had no criminal convictions for five to nine years after graduation. The 2016 study's cohort of graduates is the same group of graduates who had an average of 24 charges each before they entered drug court.

Rates of completion of rehab programs: Person County was in line with the national averages for completion rates. Drug court graduation rates at 35% (as reported in national studies) are 75% higher than the 20% completion rate of addicts in traditional voluntary treatment models. The rate at which alcoholics maintain sobriety after they enter voluntary treatment is in the range of 5% according to Drinking: A Love Story. Both national and Person county survey data from 2011 District 9A data indicate that 35% of those who enter the program will actually graduate from drug court.

If an addict is put in a treatment program before his addiction evolves from pursuit of drug-induced ecstasy to avoidance of pain, the likelihood of success is diminished. An addict's responsiveness to rehab depends in part on whether his primary motive is sheer pleasure, or whether his primary motive is using drugs to keep from feeling like he wants to die. If an addicts' drug use is all about pleasure and nothing about withdrawal, therapists will have a hard time convincing him to walk away from "the best sensation of his life." It will be difficult in the extreme talk an addict away from his drug when he thinks, "That crack was like all the orgasms I ever had all rolled into one." Or, "I never felt as calm and relaxed as when I was on opiates." When the addict is pursuing and sometimes achieving ecstasy the therapist can offer the user precious little motivation. On the other hand, if the addict's motivation is to mitigate his withdrawal symptoms, therapists have something to offer. The therapists has something to offer when the addict's motivation is that he/she feels like he/she will die of pain and discomfort if he/she does not get another hit. There is little the therapist can offer to the user who wants the sensation of a lifetime, but an addict who has grown "sick and tired of being sick and tired" might be more ready to consider a life without withdrawal pains.

Section 11

**Pregnant addicts and healthy babies
If momma is using and baby is still in the womb,
Baby will likely have a difficult start**

**Unless
Momma is in drug court.
If not, baby is likely on her own.**

From pregnant crack addicts--healthy babies. From pregnant heroin addicts--healthy babies. Drug courts make such miracles happen. As of May 2016, all but one of the 11 babies born to an addict while she was in my small-town drug court was born healthy--born a **miracle baby**.

Miracle babies in counties with drug courts: In 2010, the last year before the NC drug court funding cuts, 25 drug-free babies were born to addicted mothers in the 23 counties with drug courts as reported on the State drug court's Management Information System (MIS). During my 16-year tenure as a drug court judge, all but one of 11 babies delivered to an addicted mother in my court was born healthy. One Cumberland County drug court delivered 10 **miracle babies** during its first five years of existence. Mecklenburg County drug courts reported 43 healthy babies born to addicts in their court. (After privatization and failure of the statewide MIS that recorded and organized drug court data, efforts to resurrect it have failed to allow access to pregnancy data.

Drug treatment courts have powers which are unavailable to traditional rehab. Drug treatment courts do not wait for addicts or alcoholics to acknowledge they need treatment before putting addicts in treatment. When the addict in drug court walks away from sobriety, drug courts don't have to wait until the addict agrees to return to treatment. Like the Good Shepherd's staff, drug courts pull addicts back into treatment using tools that are unavailable in traditional rehab. Drug courts monitor constantly and react quickly to drug use and other behaviors that are averse to recovery. Drug treatment courts promptly order the binging addict into enforced sobriety, so as to prevent a use from becoming a full-blown skid row relapse. A treatment plan for addicts which fails to provide a method to return the wayward addict into treatment is like a shepherd's staff without a hook.

MEDICAL COST OF ADDICTED NEWBORNS: Neonatal Abstinence Syndrome is researched and developed in appendix by that title. prepared by Robert Mihaley.....

Section 12

Different types of court-directed rehab

Drug treatment courts, drug courts, DWI courts, family drug treatment courts, juvenile drug treatment courts, veterans drug treatment courts, and veteran's courts all follow a "mandated compliance" model: the "court-directed rehab modality." They all share the model of team effort at mandating compliance-a quick response team that continues to nudge the addict toward substance abstinence for at least 12 months. Deferred Prosecution in criminal justice drug court proceedings are rarely used and allow for dismissal of all charges after graduation.

Drug treatment court and drug court: The term “**drug treatment court**” was initiated to distinguish courts using treatment in its operations as distinguished from a court dealing with drug sellers, growers, manufacturers muscle men and smugglers. The purpose of the latter courts focused on prison, not rehab. These days, “**drug court**” and “**drug treatment court**” are used essentially interchangeably. I use the 2 terms essentially interchangeably herein except where my text is focused on treatment.

DWI Courts exist in many larger NC counties now. They are much like a “**drug treatment court**” except they accept only DWI clients--the vast majority of whom consider alcohol as their drug of choice. The literature indicates repeat DWI offenders function better if they are separated out from controlled substances addicts. It seems alcoholics and “hard drug” users tend to look down on one another, so separating them seems to have a therapeutic benefit.

My judicial district is too small to have separate courts for repeat DWI offenders and controlled substances abusers, so they DWIs and controlled substance users are combined in one court in my district. My opinion (devoid of statistics) is that we do better to combine DWI and controlled substance addicts than to fail to treat DWI. I have no reason to doubt the analysts when they report a DWI court that separates alcoholics from controlled substance users has should have a higher success record than a combined court. My combined court, however, has good results with repeat DWIs. Many DWI offenders are also frequently controlled substance users. Do you remember Al? He shot up on heroin before he drove drunk. We did not know about the heron until he spoke at a drug court graduation. So when the population is too small to separate DWI from controlled substance courts, I say, “Combine and conquer.”

Veterans Treatment Courts are criminal justice-focused drug treatment courts that accept only veterans. Lectures and testimonials at National Association of Drug Court Professionals (NADCP) as well as North Carolina press coverage indicate that addicted veterans who are put in treatment groups with vets only have much better results than when vets are mixed with civilians in treatment. (See NADCP website, www.allrise.org.) Veterans court utilize veterans to serve as mentors for the probationers in the court.

Mental Health Courts are comprised of persons who get in trouble due to mental health problems. These offenders are like drug treatment court clients in that both moved into the criminal justice system by violating some law. The difference is that mental health court clients fail to take their pills, whereas traditional drug treatment court clients can’t seem to stop taking pills.

Juvenile drug treatment courts are very much like traditional drug treatment courts only for juveniles. It was a violation of the law that brought both juvenile drug treatment court clients and traditional drug treatment court clients into the treatment court. Parents of the juvenile are brought into the juvenile drug treatment court process and are put under court order.

Family treatment courts are courts that apply the lessons learned in the “mandated compliance” model or “court-directed rehab model.” to parents of children in foster care. Foster care usually starts with a court proceeding where children are alleged to be “abused, neglected and dependent” children. “Abused, neglected and dependent” cases are brought by Department of

Social Services (DSS) on behalf of children who were determined to be abused, neglected or dependent. The objective is to get the “abused neglected and dependent” children in a permanent stable environment. The law of “abused neglected and dependent” children defines what it means to be “abused neglected and dependent.” A family treatment court team has no district attorney prosecuting and no probation officer supervising. There is no sentence of months or years hanging over the head of the parent. The judge has the power to punish for contempt to incarcerate a non-compliant parent. Family treatment court has a treatment team much like drug treatment court, except that the District Attorney and Probation are replaced by Department of Social Services (DSS) attorney and DSS investigators.

What about earning a dismissal in drug courts? At one time, about 10% of the participants in the Judicial District 9A drug treatment court would be able to earn a dismissal of their pending charges by completing drug court. Different counties and different DA’s approach these courts differently. These cases are so-called “deferred prosecution” cases or “pre plea” cases. (We have reduced our use of this mechanism at my suggestion because national data and the experience of the treatment team indicates this group is less likely to succeed than those who are on probation when they enter the program.) These cases must be approved by the elected District Attorney before they are entered in drug court in hope of eventual dismissal of the charges. With almost all of these cases, the defendant does not have a significant criminal record. These cases are closely evaluated and reviewed by the elected District Attorney and the drug court judge before the defendant is referred to drug court. In the larger districts, drug court participants in an “deferred prosecution” or a “pre-plea” are separated from probationers who have experienced a conviction.

Section 13

Cost per participant of operating a drug court

Costs described in this section do not consider savings generated by drug courts. There are some analysts who compute cost differently. I suggest \$2,500 per participant is a fair (and easily remembered) figure. The cost figures stated are independent of savings generated by drug court. Indeed, the data below establishes that for every dollar spent on drug court, the savings to the Corrections is \$2.2 dollars per dollar spent, and \$3.3 dollars saved where the drug court focuses on high risk offenders. When savings outside corrections are considered, (such as Medicaid, foster care, institutional care, schools and other public costs), the savings are determined to be between \$2 and \$27 for every dollar spent. The difference between \$2 and \$27 arises from the costliness of the matter eliminated by drug court and studied by the economist. The more expensive it is, (2 months in ICU or 3 month of foster care) the greater the savings.

How much do local drug courts cost per participant? National Association of Drug Court Professionals has conducted many research projects on cost per participant at www.allrise.org and by National Drug Court Institute, at www.ndci.org. The methodology of calculating varies. The figure of \$2,500 per participant continues to appear from the drug court research projects.

Some calculate the cost of each component even if the component (probation, jail facilities for violators, local outpatient treatment, inpatient treatment, mental health assessment programming, indigent defense, district attorney, judge) is available for every probationer who ends up in drug court even if the probationer were not in drug court. The Virginia cost benefit analysis that follows does such an analysis. The Virginia analysis is more fully explained below, and that study found a cost of \$2160 per participant.

I did an analysis of the cost per participant in 9A drug court by considering how much was needed to be raised. My analysis was: what if any money is raised to operate the drug court program from local taxpayer money, state taxpayer money, local mental health agency grant money, United Way or local charity money, or local ABC money. During fiscal 2011-2012, the year that state funding was cut, my drug court raised no outside funds and still managed to operate. We did so without salaried administrator, salaried case manager, or training budget. Contrast \$0 spent in one year in Judicial District 9A Drug Court with press reports that indicated that \$18,000 would be the cost per participant in a contiguous drug court in Danville, Virginia area. How to explain a swing from \$18,000 to \$0?

Drug treatment courts are like an “add on” to probation. In North Carolina, all of the components except for local administrator (information, collection and exchange of information within the treatment team) are already funded. Drug treatment courts utilize services which are utilized in other probation cases, and add the services peculiar to drug court. Every state provides or mandates a number of services for probationers. Supervision, curfew monitoring, substance abuse treatment services, jail, detox, Alcoholics Anonymous, Narcotics Anonymous, inpatient drug treatment, inpatient detox, training for service providers, probation violation hearings, attorneys for indigent defendants in hearings involving probation violations and other re-incarceration threats, judges to try violations, state attorneys to prosecute violations, and other services are among services which are provided to persons on probation in North Carolina. Drug treatment courts simply utilize the universe of services which are, and have been provided to probationers for decades.

Coordination of all of the services makes the services more powerful and muscular. Coordination is typically performed by an administrator, case manager or both. The administrator and case manager meet the probationer, assure that appropriate screenings are provided, direct and “nudge” the probationer to enroll in and complete meetings and services that are required, follow up when probationers are out of compliance or when additional services are needed. Incentives need to be obtained, and the administrator or case manager usually does this. Compliance and non-compliance with program requirements needs to be reported to some state-wide agency which can collect and report to state authorities and to funding agencies. Theoretically, many services of the administrator and case manager could be performed by a well-trained probation officer, but these responsibilities are outside of the job description of the usual probation officer. In fiscal year 2011 – 2012, my Judicial District 9A drug court had one grant employee who was able to share the “add on” responsibilities of the administrator in order to keep the court in operation. In fiscal year 2012 - 2013, the grant employee became unavailable, and a retired probation officer was hired part-time to perform some of the “add on” responsibilities. It must be admitted that from 2011 until 2015 the judicial District 9A drug treatment court operated without any training other than that provided in staffing sessions. The trial judge continued to take

training at his own expense during this period, and to relay some of the training he gained to the other team members. The District 9A drug treatment court was fortunate in that almost all of its team members had received substantial training before the budget cuts of 2011.

I would never suggest that a Wake County or Mecklenburg County or Guilford County or other larger County drug treatment court could operate as inexpensively as the District 9A court. District 9A is a small population with caseloads dramatically lower than that in most districts. Further, the operation of the 9A drug treatment court required the team members to perform in ways that they had not performed previously.

The Virginia cost benefit analysis addresses “cost per participant” in Section 20, Question 3, of this document. question three, starting on page 37. The total cost of all supervision, assessment, drug testing, probation supervision and treatment was \$17,900.82 when computed according to “transactional and institutional cost analysis” or TICA analysis. Drug court supervision was stated at \$2,160, this being the largest component. (See table 8, page 38 of the analysis.) Recalling that all of the local components are already funded except for drug court supervision, **The Virginia study sets this figure at \$2,160.**

www.courts.state.va.us/courtadmin/aoc/djs/programs/dtc/resources/virginiadtccostbenefit.pdf.

Section 14

State-wide cost savings from drug courts and cost of re-offenders

The Virginia Cost Benefit Analysis discussed here concluded “Virginia Drug Courts save \$19,234 per person as compared to traditional case processing. In 2011, there were 937 drug court participants served in Virginia’s adult drug courts, so that 937 program participation saved taxpayers \$18,022,258 compared to cost of business as usual for the same group of offenders.” Other researchers compute savings to the state in dollars saved per dollar invested at \$2.21, (Urban Institute) to \$3.36 where courts focus on higher-risk offenders (Urban Institute); to between \$2 and \$27 depending on degree of consideration of healthcare services, foster care costs and other benefits.

Other Scholarly studies on cost savings for every dollar spent: Urban Institute found \$2.21 benefits to the criminal justice system for every \$1 invested. (*Bhati, AS, Roman, J.K. and Chalfin A (2008) To Treat or Not to Treat: Evidence on the Prospects of Expanding Treatment to Drug-Involved Offenders. Washington D. C. The Urban Institute*) When drug courts targeted their services to the more serious higher-risk drug offenders, the average return on investment was determined to be higher \$ 3.36 for every \$1 invested. These savings reflected direct and measurable cost-offsets to the criminal justice system resulting from reduced re-arrests, law enforcement contacts, court hearings and the use of jail or prison beds.

When costs outside the criminal justice system are considered such as treating children born fetal alcohol syndrome, born premature, born addicted and in withdrawal, needing lengthy

institutionalization, needing foster care services, born needing extended treatment after their release from hospital, the cost captured by the study depends on the nature of the medical problem being quantified and the depth to which the analyst is able to pursue the data. Cost savings estimates go between \$2 and \$27.

How account for such a difference? The literature says it depends on the nature of the cost being studied and the depth of the study undertaken. My efforts to determine some average cost for medical treatment to treat children poisoned in the womb is instructive of why cost figures would vary so much. Social Services investigators tell me the newborn's length of stay in intensive care is between one and two months, and I get at least one every couple of months. So I would suspect there is some data providing average cost for such children. Certainly, I would like to be able to present the savings, because I suspect the three babies Person County kept out of intensive care could have saved enough Medicaid money to fund drug court statewide. But I have yet to find it.

Carey, Finigan, Crumpton & Waller (2006) California Drug Courts: Outcomes, costs and promising practices: an overview of phase II in a statewide study. Journal of Psychactive Drugs SARC Supplement 3 345-356.

Finigan, Carey & Cox (2007) The "Impact of a Drug Court over 10 Years of Operation: Recidivism and Costs Portland, OR available at www.npcresearch.com. Barnoski, R. & Aos, S. (2003) Washington State's Drug Courts for Adult Defendants: Outcome Evaluation and Cost-Benefits Analysis. Olympia WA. Washington State Institute for Public Policy.)

What is the cost and impact of re-incarceration under current practice? Re-arrest rates in North Carolina for robbers was 70%, for burglars 74%, for larceny 64.6%, for motor vehicle larceny 78.8%. The cost of imprisoning convicts in North Carolina varies with the seriousness of the crime from \$26,000 per year to \$28,000 per year. (See N.C. Department of Corrections web sites.) Costs vary from year to year depending on population, pay down for new construction, and budget modifications. I suspect reported costs may have changed since I began this publication. Over 60% of prisoners return within three years to the prison for another all-expense paid stay. See <http://sentencingproject.org/doc/publications/inc>

In North Carolina, returnees cost taxpayers another \$26,000 to \$28,000 per year. The cost of putting an addict in Drug Court (\$1,760 per addict in my court) is less than the cost of imprisoning him two months.

The Virginia Adult Treatment Courts Cost-Benefit Analysis determines that Virginia saves \$19,234 per person in drug courts as opposed to traditional case processing. This included cost like victimization and additional incarcerations. This study gave me a look inside the mind of a PhD economist that, after only two courses in economics, I had never seen before. I merely summarize its findings in this section, but I call it to the attention of any reader who might be interested in how at least one writer prepares a cost benefit analysis.

The re-offense rate for the study in the preceding paragraph looks at reoffending in a three-year period, meaning if the offender waited four years before getting caught, the reoffender is not

considered for statistical purposes in these foregoing surveys. I can recall seeing no studies of re-offense rates that do not use a three-year look back period except for two surveys from my home county that used five years. I have not read or heard an explanation for why three years is used. To view the Virginia Adult Treatment Courts Cost-Benefit Analysis as of October 2012, go to: www.courts.state.va.us/courtadmin/aoc/djs/programs/dtc/resources/viriniadtccostbenefit.pdf.

Funding I hope to raise for operating a drug court where I preside is \$44,000 budgeted for local operations. I do not raise funds for counsel fees but \$1,400 yearly cost for indigent counsel, paid by Indigent Defendant Services (the state agency that facilitates and pays for counsel fees for indigents charged with crimes). The sum is \$45,400 as the overall cost. The cost per participant fluctuates with the number of participants. Assuming a current number of 25 participants, we arrive at a per participant cost of \$1,816. Daily cost of least expensive State prisoner is \$26,000- for 365 days at \$71 per day. The current cost per addict in our program (\$1,816) is just less than the cost of 26 days in prison at \$71 per day at \$1,846. (Logan, K. T. Hoyt. W. Mc Collister, K. E. French, M. T. Leukefeld, C., & Minton, I., (2004) *Economic evaluation of Drug Court: Methodology, Results and Policy Implications. Evaluation & Program Planning*, 27 381-396)

Other Scholarly studies on cost savings for every dollar spent: Urban Institute found \$2.21 benefits to the criminal justice system for every \$1 invested. (Bhati, AS, Roman, J.K. and Chalfin A (2008) *To Treat or Not to Treat: Evidence on the Prospects of Expanding Treatment to Drug-Involved Offenders*. Washington D. C. The Urban Institute. When drug courts targeted their services to the more serious higher-risk drug offenders, the average return on investment was determined to be higher \$ 3.36 for every \$1 invested. These savings reflected direct and measurable cost-offsets to the criminal justice system resulting from reduced re-arrests, law enforcement contacts, court hearings and the use of jail or prison beds.

See Carey, Finigan, Crumpton & Waller (2006) *California Drug Courts: Outcomes, costs and promising practices an overview of phase II in a statewide study. Journal of Psychoactive Drugs SARC Supplement 3* 345-356. See also Finigan, Carey & Cox (2007) *The "Impact of a: Drug Court over 10 Years of Operation: Recidivism and Costs Portland, OR* available at www.npcresearch.com. Barnoski, R. & Aos, S. (2003) *"Washington State's Drug Courts for Adult Defendants: Outcome Evaluation and Cost-Benefits Analysis*. Olympia WA. Washington State Institute for Public Policy.

Here is a compendium of other resource organizations and their web sites:

Center for Court Innovation (www.problem-solvingcourts.org)
 Council of State Governments (www.consensusproject.org)
 Children and Family Futures (www.cffutures.org)
 Justice Management Institute (www.jmijustice.org)
 Justice Programs Office of the School of Public Affairs at American University (www.spa.american.edu/justice)
 Justice for Vets (WWW.justiceforvets.org)
 National Association of Drug Court Professionals (www.allrise.org)
 National Center for DWI Courts (www.DWIsystems.org)
 National Center for State Courts (www.ncsconline.org)

National Council of Juvenile and Family Court Judges (www.ncjfcj.org)
 National Drug Court Institute (www.ndci.org)

Section 15

Reduction in County jail cost from drug court

A five-year cohort of local drug court 9A graduates would have cost Person county \$99,450 to hold them in jail, pending trial, had the participants continued offending as before drug court. Had each been charged only once in the five years after their graduation, the cost of holding them in jail awaiting trial would total \$99,450 for the five-year period at \$19,890 per year.

The proof is derived by my actual count of crimes committed by graduates. The number of non-reoffenders stated here is based on my count of actual criminal charges. The \$99,450 figure is based on: (1) Local drug court's computer list of graduates of drug court participants between January 1, 2006 and Dec 31, 2010; (2) criminal record check of all graduates from their birth until the check was completed in April 2016; (3) North Carolina State wide jail cost per day that sheriffs charge other sheriffs to hold one another's prisoners waiting trial; (4) District 9A District Attorney's analysis that the average length of stay in the Person County jail for prisoners awaiting trial other than those awaiting trial for murder is 65 days. The \$99,450.00 savings is obtained by computing the average cost per prisoner held awaiting trial (\$2,925 per prisoner awaiting trial) multiplied by the number of drug court participants, 34, who ceased to reoffend after graduating (the non-reoffenders).

Here is how the \$2,925 average cost per arrest is computed. Each of these 34 prior offenders would have cost the county--not the state but the county--\$2,925 with every new arrest. To arrive at \$2,925, multiply the two factors together: (1) The District Attorney's calculation of average stay in jail awaiting trial as 65 days and (2) \$45 jail cost per day being the amount sheriffs charge each other to hold one another's prisoners. **Multiply 65 by 45 and get \$2,925.** In times past, the number of days awaiting trial (before District Attorney Wallace Bradsher's HALO policy was put in place) was higher-between 120 days and 150 days, and the cost per arrest was higher. The District Attorney's HALO initiative was a project to reduce the number of days spent in jail spent awaiting trial.

The pre drug court criminal record of the 34 non-reoffending graduates shows they were on track to reoffend. Before they were in drug court, 617 jailhouse-worthy crimes were charged against these 34 graduates who ceased offending after drug court. They racked up an average of 18.14 crimes each before they got in drug court. During the last three years before they were ordered to drug court, each of them averaged 10.02 crimes charged and resolved in the courts--341 for the group. After they graduated from drug court, these same 34 non-reoffenders were never convicted of a crime. The cost of an arrest for each the 34 non-reoffenders would have cost the county 34 x \$2,925 or \$99,450 during the 5fiveyears of the study.

More about my methodology: To determine who was a “non-reoffender” I actually personally checked the record of each graduate for crimes committed before and after graduation. The violations I counted as “crimes” in my calculations were all offenses that would subject the offender to incarceration. No traffic infractions, no civil violations, and no offenses punishable only by fine were counted as “crimes.” The group whose cost I calculate was jailed Person County prisoners awaiting trial who don’t make bond within five days of arrest.

Section 16

Conservatives agree: drug courts save taxpayer dollars

Drug Courts are supported and funded by professed conservatives: Tea Party in Congress; all Republican Governors who ran for President in 2016; every Republican Governor and Republican legislature in every state that borders North Carolina; each Republican Governor who resides in the Governor’s mansion in Raleigh, North Carolina. Proof is as close as your nearest Google search.

Every year going back to the year of the North Carolina drug court cuts, the Republican-controlled US House and Senate have permitted increases in drug court funding. This includes years after ascendancy of the Tea Party. The U.S. House permitted passage of \$78 million for drug courts for Fiscal Year 2012. See nadcp-info@nadcp.org for Dec. 19, 2011. Google “drug court funding” every year since. Or search National Association of Drug Court Professionals sites nadcp-info@nadcp.org and www.allrise.org.) For five years since 2011, the National Association of Drug Court Professionals is emailing me asking me to write my congressman to approve the increase in drug court funding. Then they write me and the membership celebrating an increase in drug court funding and thanking members for their support.

North Carolina’s 2011 new majority should not be blamed for being skeptical of supporters of drug courts who stated that drug courts save money. When advocates for programming say, as drug court advocates said, “spend money and save money,” it sounded like everyone’s 13-year-old daughter or granddaughter who might say, “If you give me \$200 to shop the sales, I will save you \$400.”

When there were 17 Republican candidates for President, a number were governors, and each governor had drug courts in the state. Several had remarkable press releases about the savings of drug courts. Governor Rick Perry of Texas received special recognitions for his expansion funding for drug courts in a number of press reports that show up on Google searches. The state of New Jersey faced crippling budget shortfalls resulting in layoffs of approximately 600 police officers. (105 in Trenton, 165 in Camden, 51 in Princeton, 167 in Newark) In 2011-2012, while cities were pleading for funding, Governor Chris Christie chose instead to funnel money into drug court expansion. “Expanding” is Gov. Christie’s word, used in his press releases. Every state that borders NC was Republican controlled when drug courts were initiated or when they were expanded and all are expanding drug courts because drug courts save money. Don’t take

my word for it. **Google** “police layoffs, New Jersey,” “expanding drug courts, New Jersey,” and “expanding drug courts” for all of the candidates.

Finally, don’t forget to research NC Governor Pat McCrory whose support for refunding drug courts goes back to his first State of the State speech.

Section 17

Neuroscience explains need for long-term treatment

Neuroscience offers insight into the physical brain changes depicted by the scans. The “high” experienced on alcohol or drugs results not from coke, or pot, or opiates interacting with brain cells, but from chemicals generated in the brain interacting with brain cells. The way drugs alter brain function is by stimulating the glands in the brain to change the chemical make-up of the brain. The “high” comes when glands in the brain overproduce or under recover naturally occurring brain chemicals after the glands are tricked into doing so by the chemicals from the street or bottle. Normally, glands in the brain produce chemicals that regulate sense of well-being, fight-or-flight mechanism, need for sleep, arousal, anxiety, etc. When enough of the chemical has been produced, a healthy brain removes or “uptakes” the chemical to maintain a balanced brain chemistry. Some drugs interact with brain cells by inhibiting the uptake of brain chemicals and leaving the brain awash in the chemicals, which should have otherwise been removed under usual circumstances.

Drugs and alcohol “trick” the brain into over producing the chemical, or into blocking the uptake, or both, depending on the substance. This trick on the brain produces a heightened and extend sense of wellbeing, arousal, sleepiness, etc. Following repeated over-use, however, the user’s brain becomes deficient in these brain chemicals. The glands are over worked and need time to recover. Furthermore, when there is no uptake, the chemicals remain in the brain too long and adversely affect brain chemistry.

The diseased brain needs time to recover. Before the addict’s brain recovers, he is impeded in his recovery by his own sick and ineffective mind. If the addict wanders out of treatment or falls out of sobriety while the brain is recovering, there is a strong likelihood of a complete fall-down skid row relapse. Drug courts focus on preventing relapse by observing any behavior which is averse to recovery and pushing the addict back into treatment. Quickly. The drug court does not wait for the backslider to bring himself back to treatment. The court mandates that the addict be placed in a drug-free environment for long enough to get back on track. Like the hook on the Good Shepherd’s staff pulls sheep back toward the foal, drug courts nudge addicts back into recovery. Unlike drug court participants, addicts in traditional therapy stay in therapy only as long as they chose to do so. Drug courts, on the other hand continue to nudge addicts back in therapy for as long as they remain in the drug court.

Links to scholarly and professional articles on pharmacology of addiction and recovery:

Wilkie Wilson, a Duke Professor of pharmacology wrote a 10-page layperson friendly article for a scholarly journal. See: "How Addiction Hijacks our Reward System."

<http://www.whps.org/schools/hall/projects/CoC/documents/WilkinsAddiction.pdf>

Another Duke Medical Center study is summarized in one-page article titled "Duke Medical Center Study Shows Alcohol Damages Learning more in Young Brains." See:

http://www.eurekalert.org/pub_releases/1996-04/DU-DMCS-290496.php

A National Institute of Drug Abuse publication of 5 pages (with pictures and brain scans) titled "Drugs, Brains and Behavior: The Science of Addiction" appears at:

<http://www.drugabuse.gov/publications/science-addiction>

An MD's article titled "Addiction and the Brain's Pleasure Pathway: Beyond Willpower" appears at:

http://www.hbo.com/addiction/understanding_addiction/12_pleasure_pathway.html.

The National Association of Drug Court Professionals web sites are www.allrise.org and www.nadcp.org. National Institute of Drug Abuse, NIDA, publishes research as well

Section 18

Recent History of NC Drug Courts & Funding Challenges

In the 1990s The N.C. General Assembly created a statutory platform on which the courts would operate. The legislation provided funding for the Administrative Office of the Courts (AOC) which assisted local drug courts with training, monitoring and review of local court effectiveness and operations, a computer system to receive data from local courts and funding local drug court administration. The legislation funded local administrators. Local organizational setup was mandated by statute, which required a supervisory board containing a local judge, sheriff, District Attorney, clerk, probation and mental health providers. The platform essentially mandated that the local court must have the approval of the local judicial authorities to form a drug court and local law enforcement authorities. Using AOC platforms and funding, local court districts were able to set up local drug courts. Some counties set up multiple treatment courts so that criminal justice focused drug court might co-exist with DWI court, mental health court, veterans court or family treatment courts in the same county.

Since it was up to each judicial district to determine whether to set up a drug court, many opted not to do so. The larger cities had drug courts, but most rural districts did not. A multi-county rural district had an extra challenge of transportation between small towns where there was perceived to be insufficient population to justify a fully operational court in each town. Drug courts are novel and present a judicial district with new challenges or unfamiliar paradigms. So that many districts might be reluctant to accept a drug court. I am grateful, as the drug court judge and the Chief District Court Judge of a small district, that in the mid-90s my predecessor, Judge Pattie S. Harrison, took the initiative to set up a drug court in Judicial District 9A. In 9A, the Caswell County drug court population is rarely over four, so the sessions with the Caswell drug court population are dependent on when the drug court judge is holding criminal court in

Caswell. I am not always in Caswell for criminal court, but individual participants in Caswell get more individual attention than the Person County participants.

In 2011, the Legislature was cutting allocations throughout the budget. The AOC was told the amount of the cut, and AOC was allowed to recommend where the cuts would come. The AOC decided to recommend the cuts come from drug courts rather than elsewhere in AOC's budget, and the Legislature accepted the recommendation. The legislature cut funding but did not eliminate the statutory foundation for drug courts. Drug courts could operate, but they had to find the money somewhere other than State government. Drug courts do not save money for the courts, though they do save money for other agencies. Had the AOC preserved funding for the drug courts, they would have had to suffer loss elsewhere like custody mediation, loss of equitable distribution property mediation, loss of trial court administrators, or loss of additional personnel in clerk's offices, in district attorneys' offices, and in the AOC services in order to pay for drug courts.

I AGREE WITH THE CHOICE AOC MADE to save system-wide programming rather than to maintain full funding of drug courts in 23 counties. The choice presented to AOC was balancing programs which increased the functionality and efficiency throughout the courts against dramatically reducing drug court funding. Love drug courts though I do, I must concede the truth is that drug courts do precious little to increase efficiency of the courts. The vast majority of efficiencies initiated by drug courts are experienced outside the court system. Drug courts were reducing cost to Medicaid, schools, foster care, and corrections without significantly increasing efficiency of the courts.

I am confident that the argument was made in 2011 that "drug courts save money," but in 2011, nobody in the new majority was buying that argument at a time of such financial emergency. There was also a fairness argument that if other divisions of state government were sustaining cuts, the courts should do the same. The AOC could well lose funding for drug courts without decreasing its functionality and without losing essential services. The defunding of drug courts would have had a bearing on that one program, but no impact across the AOC and no impact across the courts.

In 2016, North Carolina legislators can have confidence they are making streets safer and freeing money for school in so doing. Rock-ribbed conservatives elsewhere assure their people that they are doing so. If the research did not justify the expenditures, the staffers for these conservatives would step in and say "No."

North Carolina will continue to get less for more, however, as long as legislators fail to realize the benefits generated by drug courts are not experienced in the courts. Funding should be considered by looking at the benefits across government. The Virginia Cost Benefit analysis puts the benefit at \$19,234 per person. Other researchers state benefits as a factor of 17 times expenditure when all benefits--hospital, Medicaid, school, institutionalization, foster care costs, DSS attorney fee costs--are taken into consideration. But as long as budgeting is conceived in terms of how much can we cut at AOC, these savings will not be fully recognized.

Why, today, should the legislature fund drug courts when the 21 counties that wish to do are continuing to operate without state funding? FIRST, it is a heavy lift for a judicial district to start a drug court **and** take on the responsibility of funding it. A drug court is a time-consuming operation. Time in drug court administration doubles the time in court. Most judges and DAs are close to maximum utilization as it is. SECOND, drug courts should be encouraged not discouraged. When it becomes clear that operating a drug court will not be helped from Raleigh, there will be few volunteers to start new drug court or even to maintain one that is operational. THIRD, drug courts need to be in place in order that the entire state will become a cost savings engine for prisons and jails, for reducing Medicaid costs, and for preventing addicted babies from being born to addicted mothers.

During the 2011 debate, an argument was made that funding for drug court should not be continued because it benefited only a few counties. This misunderstands the operation of the benefits. The drug court programming occurs in the counties where the addicts live, but the savings go to the benefit of the entire state. When (in a single year) three pregnant addicts in Judicial District 9A deliver healthy babies, the savings goes to statewide Medicaid. Reduction of prison population by 21 drug courts does not inure to the benefit of the 21 counties where the drug court operated, but to the statewide corrections budget. Person and Caswell counties received no financial benefit in any meaningful way. When Person and Caswell counties move a habitual drunk driver to a life of sobriety, drivers and passengers on the highways are made safer from Murphy to Manteo.

Section 19

Other online research sources

Let me provide a compendium of resource organizations and their websites.

Center for Court Innovation (www.problem-solvingcourts.org)

Council of State Governments (www.consensusproject.org)

Children and Family Futures (www.cffutures.org)

Justice Management Institute (www.jmijustice.org)

Justice Programs Office of the School of Public Affairs at American University (www.spa.american.edu/justice)

Justice for Vets (WWW.justiceforvets.org)

National Association of Drug Court Professionals (www.allrise.org)

National Center for DWI Courts (www.DWIsCourts.org)

National Center for State Courts (www.ncsconline.org)

National Council of Juvenile and Family Court Judges (www.ncjfcj.org)

National Drug Court Institute (www.ndci.org)

Virginia's cost benefit analysis is easily located and contains info on cites and scholarships.

www.courts.state.va.us/courtadmin/aoc/djs/programs/dtc/resources/virginiadtccostbenefit.pdf.

Section 20

Q&A on objections and responses

Question 1: We never had drug courts when I was younger. Why do we need them now? (I actually was asked this question by a legislator)

Answer: My home county jail has gone from no prisoners on two occasions I recall to building a new jail with capacity for 148, all while I was practicing law. The game changed when crack, meth and opiates hit our streets. Drug courts are succeeding at getting some of these offenders out of our \$29,000/year revolving door.

Question 2: Drug court is a kind of probation. A person who goes on a crime spree deserves prison not probation.

Answer: Deserve? Offenders have done nothing to **deserve** assistance, and I do not advocate for offenders. I advocate for citizens who **deserve** more safety on the highway and who **deserve** freedom from felons at their back doors and windows.

Drug court participants usually get both prison/jail time and drug court. Most of the sentences I see in drug court are multiple terms, where the judge gives a prison/jail term, to start, and then-after prisoners finish the first prison term- they get a second term that carries drug court. It is the second term that has a probation condition of finishing drug court. Get ejected from drug court and face the second prison term. For prisoners who were sentenced for only one crime, judges frequently impose a “split sentence” (also known as “special probation” sentence) whereby the offender gets time behind bars and the rest of the sentence is suspended on condition of completing drug court. Fail in drug court and face more time behind bars. When I am sentencing someone to drug court, I like to be certain the participant has pulled enough time behind bars and away from his/her dealer before drug court begins. I encourage judges visiting to the district to do likewise.

Question 3: Why did Administrative Office of the Courts (AOC) chose to cut funding to drug courts in 2011?

Answer Drug courts do not save money for AOC, and drug courts do not facilitate court operations. In fact, they are time-consuming. Drug courts do, however, save money for prisons, for Medicaid, for schools, for Indigent Defense Services and for Social Services. I know that in 2011 when the legislature came up with a preliminary budget, they informed AOC of the amount that would have to be cut from AOC budget, and AOC was permitted to recommend the cuts. That is good legislative policy, and the legislature deserves to be commended by asking AOC to make the recommendations for the cuts. Possible cuts included a number of AOC initiatives which saved time and increased productivity throughout the courts including custody mediation and equitable distribution financial mediation, two programs which dramatically reduce the number of domestic law trials. A cut in funding for trial court administrators would have reduced the amount of time that judges could try cases by increasing the time required for organizing cases for trial and setting of calendars. Drug courts only operated in 23 counties when AOC was told to choose the cuts. In 2011, AOC chose to save the programs which increased efficiency across the state rather than to save a program which did not as significantly increase statewide court efficiency. I agree with AOC’s decision, given the choice it had to make. That was then and this is now.

Question 4: Why should we coddle predators, rapist, robbers, and drug dealers? They deserve more than just probation.

Answer: Drug court selection doesn't work that way. Rapists, predators, drug dealers are poison to drug court and are not allowed to enter. As violent offenders, they do not qualify for drug court. The program seeks "hard-core" offenders, but "hard core" does not equate to "violent." Recall that I stated in Section 5 that drug courts exclude persons who would be detrimental to the program.

Question 5: Why should we spend taxpayer dollars on felons, thieves, and victimizers even if they are non-violent?

Answer: At this very moment felons and predators are being fed, housed, medically treated, protected from one another and entertained on flat screen televisions at taxpayer expense. At this very moment we are funding programming that keeps the revolving door turning. It works so well that more than 60% go back for another dose at taxpayer expense. We spend roughly \$45 per day on them in jail awaiting trial and roughly \$71 per day on them in prison. We are spending the money hoping to get them off our roads and out of our homes, neighborhoods and businesses. We can do better, and cost less in the process. What-today-do we get for this money? Eighty percent of those imprisoned either have been there before or are going again. We must protect ourselves from predators, but we can do better with those who are going to return to the community.

Question 6: Cheating on drug tests by few can ruin the program for all.

Answer: Cheaters are demoralizing. Jail or ejection from the program are the expectation when cheaters they are caught. The Internet and magazine racks are full of advertisements for vitamins, pills and even devices that carry the promise of fooling the drug tests. There are ways that the drug court can catch would be cheaters. Mouth swabs and hair tests are more expensive and are rarely used, but they do demonstrate when a participant has been cheating on urine screens. Addicts like to talk and to brag to others in treatment, to people on the street, even to confidential informants. (Information from confidential informants is one reason we want to maintain a strong relationship with local law enforcement.) Information about cheating gets back to us with remarkable frequency. When a braggart is caught and incarcerated, it adds credibility to our statements to participants that they are wasting their money on the cheater pills and devices.

Question 7: All of this cheerleading, applause, backslapping, fails to show respect and dignity of the court.

Answer: Positive reinforcement works. The applause in drug court serves a function that is otherwise unattainable. Encouragement and reinforcement of good behavior is the best way to modify behavior. This rule of human nature does not change just because the person at the front of the room wears a black robe. The role of drug court judge is encouraging sobriety. I concede: Using a court for something approaching cheerleading is a paradigm shift. Many judges will never be comfortable in such an environment, and they can be comfortable in the knowledge that nobody is going to force them to do drug court. But one judge's comfort level should not be another judge's model for performance. I must concede I was uncomfortable with the encouragement, cheerleading and reinforcement at first, and there are still aspects this manner of encouragement that go past my comfort level. Still, the objective a drug court judge is to achieve sobriety for an offender, not to keep the judge in his comfort zone.

If I had my preference, every case, every issue would be quiet and dignified. I don't want to see or hear applause and high fives in my court- unless I am swearing in a guardian ad litem, swearing in a lawyer, swearing in a judge, or, perhaps, if I am being sworn in myself. Oh, yes. The "in crowd" is doing applause and high fives even in the "dignified courts."

Question 8: One of the characteristics of addicts is they are very deceptive. How can a judge deal with such lying, deceit and deception? Why would he want to do so?

Answer: I admit I find the constant deception and deceit they hard to deal with. This was probably the most difficult aspect of my first several years in drug court. I find it very difficult to discern whether they are telling me the truth or a lie. Several times my skepticism lead me to believe they were lying to me only later to learn clearly that they were telling me the truth. I put up with deceptiveness because I could see no way to engage with these souls other than to engage with them. I finally accommodated myself to engage with deceivers when I realized that their recovery was more important than my ego.

Question 9: Why don't drug courts eject addicts from the program as soon as they test dirty or fail to comply with pro – sobriety rules? Doesn't it just encourage them to keep them in the program?

Answer: Addicts won't recover if they don't stay in treatment at least a year. Remember the brain scans. It is a rule of the program that a participant's duration in the program can be extended if they fail to comply. (The exception to this is if the failure to comply jeopardizes the program or tempts other participants into relapse.) Drug court judges should make it understood from the outset that the drug court team will continue to nudge the addict into recovery – to apply the Good Shepherd's hook. Drug Court guidelines state the addict needs to stay in treatment at least a year. If this addict gets back on the street the first or second time he tests dirty, without resolving his addiction, he/she will reenter the revolving door and will continue to be a danger on our streets and a menace in our neighborhoods. I am aware of some residential programs that eject a participant with a first dirty test. I do not expect residential programs to adopt the drug court model.

Question 10: Why do only 35% of those put in drug court finish?

Answer: Most of the persons who fail have learned to do jail and prison and they state they had rather go back behind bars than continue with drug court. Drug court's completion rate of 35% is better- almost double-traditional therapy's 20% completion rate.

Question 11: What happens to those who are ejected from drug court?

Answer: The most frequent reason participants fail is they had rather do prison than do drug court. When they are ejected from drug court they face probation violation. The usual response to probation violation involves bars-the iron kind of bars.

Question 12: Other criticisms of drug courts?

“Only a few counties had it. **Answer**” I heard this a lot in 2011. My response is that it would be a heavy lift to start one now without state funding, knowing the legislature is rejecting the request of a Republican Governor.

Drug courts are too expensive.” **Answer** If the data did not support it, we would not see as many rock-ribbed conservatives supporting drug courts. Certainly, there are minds better than mine with the time and resources better to research drug courts and better to research the researchers. But I take confidence this knowledge: Taxpayers can be assured that elected conservatives wish to ferret out waste fraud and abuse in government. These elected conservatives have staffers to help them in discern fact from fiction. Note well that the staffers for conservative congressmen, for conservative candidates for president, for conservative legislatures and for conservative governors roundabout the Old North State have failed to find supply them with waste fraud and abuse evidence sufficient to divert these conservatives away from drug court funding.

If the contrary research and the data were there, these researchers should have found it.

3. Drug courts don’t use state of the art Medically Assisted Treatment or MAT. A recent letter to Huffpost Politics from the mother of a drug court participant who had died while in drug court asserted that the judge in her son’s court failed to use state of the art Medically Assisted Treatment, referred to as MAT. Lectures in the last couple of years at National Association of Drug Court Professionals, NADCP, have stressed that MAT has become the standard of practice in treatment, and courts fail to follow this standard “at their own hazard.” The treatment community has in years past taken the position that a patient who changes from one drug to another drug is not living “drug free.” This outlook completely discredited MAT. The move toward MAT as the standard of practice is a recent development. I have attended NADCP conferences for 10 years or so, and only 3 years ago did I learn of 2 new drugs in the MAT constellation. It was 2 years ago that a lecturer led me to understand the standard had changed. As I was doing a final read through, I recalled seeing on June 16, 2016 an announcement of on-line training for MAT. Using MAT injects another mechanism for defrauding the court, so that it requires co-ordination between the subscribing physician, the team and the therapist. I don’t doubt that some are failing to use best practices in drug courts, just as I don’t doubt that some are failing to use best practices in medicine, engineering, journalism and the other professions._

Question 13: Why can’t all the counties that want drug court get a grant?

Answer: I have spent way too much energy looking into it and I found:

The Federal drug court grants contemplate a request much larger than my court would justify. Most grants assume I will get a similar grant from locals or that locals will match. Most grants go away in three years leaving us where?
I have been able until now to get by with a little dollar here and a little dollar here. It is a lot of lifting, but it’s better than going after a single-pay grant. If you have a friend, call me.

APPENDIX: SEE P. 40 ET SEQ

Medical Costs of Addicted Newborns: Neonatal Abstinence Syndrome
by Robert Mihaly

Contents:

- I. Introduction
- II. Scale
- III. Costs
- IV. Opiate Causation
- V. Prescription Opiate Causation
- VI. Other Drug Causation
- VII. Treatments
- VIII. Conclusion
- IX. References

I. Introduction

Drug use by pregnant mothers can cause babies to be born addicted. This condition of the baby is referred to as Neonatal Abstinence Syndrome (NAS). There is both prenatal and postnatal NAS. Generally, NAS refers to the condition and constellation of drug withdrawal symptoms exhibited by babies born dependent on drugs. (Dutta & Sachdev, 2007). NAS occurs when the newborn is immediately cutoff at birth from opioids and other drugs, sometimes in combination. The frequency and costs of NAS are rapidly increasing, so much so that NAS might be considered an epidemic.

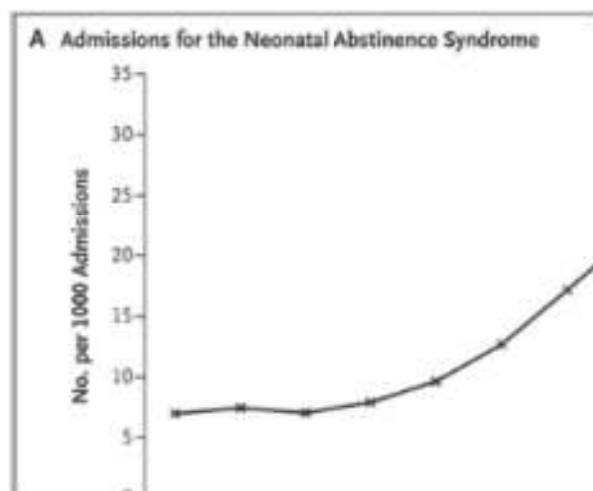
NAS most commonly results from antepartum opiate use, both illegal and prescription. Other drugs have also been implicated (Patrick et al., 2012). Some degree of withdrawal symptoms associated with NAS have been found in 60% to 80% of newborns exposed to heroin or methadone in utero (Doberczak, Kandall, & Wilets, 1991). Newborns born to mothers with opioid disorders have approximately a 50% chance of developing NAS (Petz & Anand, 2015).

Babies with NAS are known to have an increased incidence of an array of symptoms such as seizures, respiratory disorders, feeding difficulties, and low birth weight (Patrick et al., 2012). NAS leads to an ever-increasing period of hospitalization for supportive care and sometimes opioid-replacement therapy averaging 16 days (Petz & Anand, 2015) to 19 days (Tolia et. al., 2013)

Substance abuse and its effects on others are very costly, Medical treatments of babies suffering with NAS regularly reach beyond \$150,000 per child (Petz & Anand, 2015).

II. Scale

It is estimated 400,000 to 440,000 infants, a baby born between every 75 seconds, may be affected to some extent by prenatal alcohol or illicit drug exposure (Verklan & Walden, 2014). But an infant born somewhere between every 39 minutes (Patrick et al., 2012), and every hour (Murphy-Oikonen, 2013) in the United States suffers from NAS.



Between 1979 and 1987, the number of drug-affected newborns increased by >300% (Dutta & Sachdev, 2007). Then the annual rate of NAS-diagnosed newborns in the United States increased another 300% between 2000 and 2009 (Patrick et al., 2012). Then the incidence of NAS then doubled between 2009 and 2012 (Patrick, Davis, Lehman, & Cooper, 2015). Assuming no increase between 1987 and 2000, the increase in babies suffering from NAS from 1979 to 2012 exceeds 1,800%.

In 2009, mothers at time of delivery were diagnosed as dependent on or using opiates at a rate of 5.63 per 1000 hospital births (Patrick et al., 2012). Newborns suffering from NAS were

3.39 per 1000 hospital births (Patrick et al., 2012). Maternal opiate use is increasing at a more rapid rate than the incidence of NAS, likely because not all opiate-exposed newborns exhibit signs of withdrawal (Doberczak et. al., 1991). By 2012, the national NAS incidence had increased to 5.8 per 1000 hospital births (Patrick, Davis et. al., 2015).

The prevalence of maternal opioid drug use at the time of delivery is much higher in some states. For example, in California it is approximately 10 per 1,000 births, or one percent (Peltz & Drover, 2012). Closer to home, in West Virginia, the numbers are staggering. The 2007-2013 WV Health Care Authority, analyzed uniform billing data of 119,605 newborn admissions with 1,974 NAS diagnoses. Between 2007 and 2013, NAS increased from 7.74 to 31.56 per 1,000 live births (Stabler et. al., 2016). In 2013, in the southeastern region of West Virginia, almost 5% of babies were born suffering from NAS, 48.76 per 1,000 live births (Stabler et. al., 2016).

NAS is becoming more common among babies in both developed and developing countries (Kocherlakota, 2014). The incidence of NAS among newborns in Western Australia from 1980 to 2005 increased from 0.097 to a high of 4.2 per 1,000 live births (O'donnell et al., 2009).

III. Costs

Although NAS treatments are of relatively short duration, the treatment is typically very costly. In 2000, mean hospital charges for newborns diagnosed with NAS was \$39,400. By 2009 this had increased to \$53,400. (Patrick et al., 2012) (Verklan & Walden, 2014). Last year, the typical overall cost of care for a newborn child suffering from NAS was found to be \$159,000 to \$238,000 beyond that of a typical newborn (Petz & Anand, 2015).

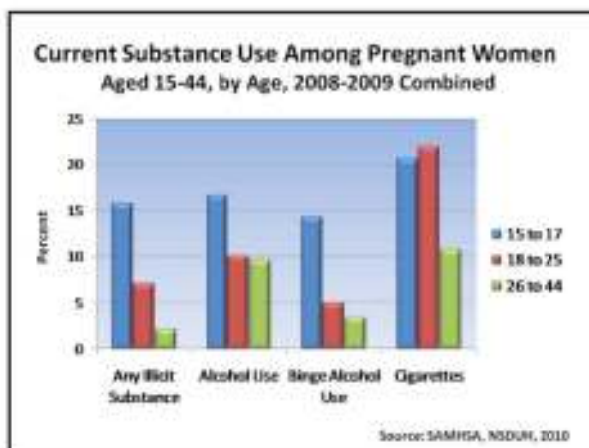
The medical expenses of birthing mothers using opiates are paid by Medicaid 60% of the time. The costs of treating babies suffering from NAS are more often, and increasingly, paid by Medicaid. In 2009, 77.6%-78.1% of charges for NAS sufferers were paid by state Medicaid programs (Patrick et al., 2012). By 2012, 81% of babies suffering from NAS were paid by state Medicaid programs (Patrick, Davis et. al., 2015).

From 2009 to 2012, aggregate hospital charges for NAS increased from \$732 million to \$1.5 billion (Patrick, Davis, Lehman, & Cooper, 2015). (Patrick, Davis et. al., 2015).

IV. Opiate Causation

Prenatal exposure to opiates such as heroin, morphine, methadone, codeine, oxycodone, and buprenorphine, can cause NAS. Opioid use in pregnancy, and NAS, is correlated with increased incidence of low birthweight, third trimester bleeding, toxemia, mortality, irritability, feeding difficulties, hypertonia, emesis, seizures, postnatal growth deficiency, microcephaly, neurobehavioral problems, and sudden infant death syndrome, central nervous system hyperirritability (high-pitched cry, increased muscle tone, tremors, restlessness, convulsions), gastrointestinal dysfunctions (poor feeding, weak suction reflex, regurgitation, vomit, loose or watery stools), fever, sweating, respiratory distress, and apnea (Bersani, 2013) (Forray, 2016) (Patrick et al., 2012).

The consequences of prenatal opium use are confounded by coexisting substance use. For example, cigarettes are smoked by opiate-using pregnant women, in 77% to 95% of cases (Forray, 2016). Moreover, Substance-abusing women frequently experience inadequate prenatal care, poor nutrition, chronic medical problems, poverty, and domestic violence (Forray, 2016).



V. Prescription Opiate Causation

Illicit drug use is unfortunately common among young, pregnant females. In the year prior to pregnancy, 36.5% of teenagers used illegal drugs, typically marijuana. 16.2%-16.5% of pregnant teens use illicit drugs during pregnancy (Chandler, 1997). 7.4% of pregnant women aged 18 to 25 years have been shown to use (Substance Abuse and Mental Health Administration, 2010). As women mature, illicit drug use drops substantially, such that the overall average usage by women aged 15 to 44 years is about 4.4% (Bersani, 2013) to 5.4% (NSDUH, 2014). The NAS epidemic has been described as driven primarily by a nationwide increase in prescription drug use (Patrick, Dudley, Martin, Harrell, Warren, & Hartmann, 2015).

Of 26,314 deliveries studied by Kellogg, et. al., 167 (6.34 per 1,000) women chronically used prescription narcotics during pregnancy. The prevalence of chronic, opium-using pregnant women increased between 1998 and 2009 (Kellogg, Rose, Harms, & Watson, 2011).

Opiate use is increasing across the United States. It is not limited to illicit drugs. The misuse of opioid medications has been called the most rapidly increasing drug problem in the US (Peltz & Drover, 2012). In Florida, opiate pain reliever-related deaths account for 4 times the number of deaths as all illicit drugs (Centers for Disease Control and Prevention, 2011a). The Centers for Disease Control and Prevention found both sales and deaths related to opiate pain relievers quadrupled between 1999 and 2008 in the United States (2011b).

VI. Other Drug Causation

Alcohol use in pregnancy has well-established adverse fetal health effects. Heavy alcohol use in pregnancy is associated with a range of negative birth outcomes such as miscarriage, stillbirth, infant mortality, congenital anomalies, low birthweight, reduced gestational age, preterm delivery, small-for-gestational age, cognitive challenges, adverse neurodevelopmental outcomes, behavioral challenges, psychosocial consequences in adulthood, speech difficulties, and adverse language outcomes (Forray, 2016).

Smoking tobacco during pregnancy causes many negative birth outcomes, such as umbilical cord damage, miscarriage, ectopic pregnancy, low birthweight, placental abruption, preterm birth, increased infant mortality. Moreover, post-birth, second-hand smoke creates higher rates of respiratory and ear infections in newborns, sudden infant death syndrome, behavioral dysfunction and cognitive impairment (Forray, 2016).

Marijuana during pregnancy has been linked to preterm labor, low birthweight, small-for-gestational age, admission to the neonatal intensive care unit, adverse consequences for the growth of fetal brains, adverse adolescent brain growth, reduced attention, reduced executive functioning skills, poorer academic achievement and behavioral problems (Forray, 2016).

In several large, recent studies, cocaine use in pregnancy is associated with negative outcomes such as premature rupture of membranes, placental abruption, preterm birth, low birthweight, and small-for-gestational-age infants (Forray, 2016).

Methamphetamine use is linked with shorter gestational ages, lower birthweight, fetal loss, developmental defects, behavioral problems, preeclampsia, gestational hypertension, and intrauterine fetal death (Forray, 2016).

Other drugs such as benzodiazepines, opioids, mood-stabilizing drugs, and selective serotonin reuptake inhibitors may induce NAS. Such drugs are metabolized by the placenta, and their metabolites cross the placental barrier. These drugs produce prenatal injuries such as NAS and symptoms such as intrauterine growth restriction, preterm birth, low birth weight, gastroschisis, heart defects, cleft lip, sudden infant death syndrome, increased respiratory infections, ear infections, sinus infections, neurological disorders and behavioral disorders (Bersani, 2013).

VII. Treatment

Newborns suffering with NAS may be treated with pharmacotherapies such as morphine, methadone, or phenobarbital (Burns & Mattick, 2007) (Petz & Anand, 2015). From 2004 to 2013, the proportion of infants with NAS who received pharmacotherapy increased from 74% to 87% (Tolia, et. al., 2015). Morphine is the most common medication used to treat infants suffering from NAS, up to 72% in 2013, from 49% in 2004 (Tolia, et. al., 2015). Other medications used to treat NAS include benzodiazepines (clonazepam, diazepam, lorazepam, or midazolam), opioids, mood-stabilizing drugs, selective serotonin reuptake inhibitors, buprenorphine, clonidine, dilute tincture of opium, and nicotine (Bersani, 2013) (Tolia, et. al., 2015).

As always, breastfeeding is recommended. Although the amount of methadone in breast milk is low, breast-fed newborns are characterized by less severe NAS and lower need for

pharmacologic treatment. It is not clear if these effects are secondary to the drug itself or the calming effect of breastfeeding. (Bersani, 2013). However, methadone in breast milk is insufficient to prevent NAS (Henshaw, Cox, & Barton, 2009). In any case, ongoing irritability associated with the syndrome (excessive crying, feeding difficulties and sleep disturbances that may recur over the first 6 months) can hinder the attachment process between the newborn and mother (Burns & Mattick, 2007).

Babies suffering with NAS are frequently cared for in neonatal intensive care units (NICUs). NICUs offer minimization of external stimulation that can exacerbate withdrawal symptoms, but NICUs are costly. Studies suggest that caring for NAS-suffering babies in hospital settings outside NICUs (Saiki, Lee, Hannam, & Greenough, (2009) and outpatient management reduce both length of stay and cost (Backes et. al., 2011). NICU days attributed to NAS increased 7-fold from 0.6% in 2004 to 4% in 2013. Up to 20% of all NICU days in some centers are used by babies suffering from NAS (Petz & Anand, 2015).

However, it has been shown babies fare better rooming with their mothers than being in the NICU or the nursery. This is not typical practice in United States, even for normal babies. But breast-feeding, skin -to-skin contact, and bonding greatly reduce the amount of medication needed (Knopf, 2016). Studies have found rooming-in reduces costs. (Holmes, 2016a) (Holmes, 2016b). On the other hand, substance-using pregnant women can develop an early dysfunctional mother-infant relationship that can exacerbate negative effects of prenatal drug exposure. (Forray, 2016).

Some researchers argue that scientific evidence does not support linking substance use with judicial determinations of maternal unfitness. The argument is that further criminalizing substance use by pregnant women causes pregnant women to refrain from seeking obstetric care and substance use treatment, which can negatively affect the health of both mother and child (Lund, et. al., 2015).

Tolia, et. al. studied 674,845 infants at 299 clinical centers from 2004 through 2013. 10,327 infants, almost 2% met the criteria for NAS. From 2004 to 2013, NICU admissions for NAS increased from 7 cases per 1000 admissions to 27 cases per 1000 admissions (2015). Furthermore, throughout the period of study, the rate of increase accelerated (Tolia, et. al., 2015). Total NICU days attributed to infants with NAS increased from 0.6% in 2004 to 4.0% in 2013 (Tolia, et. al., 2015).

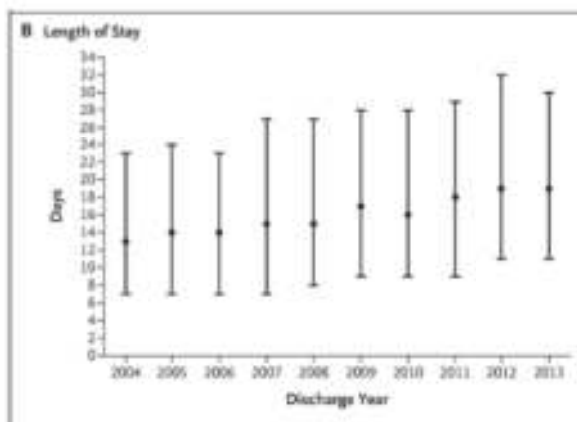
23 of 213 centers reported that more than 10% of their NICU days were attributable to infants suffering from NAS in 2013, as compared with 1 of 157 centers in 2004 (Tolia, et. al., 2015). Moreover, in 2013, more than 20% of NICU days at 8 centers were devoted to NAS babies, and more than 40% of NICU days at 2 centers were devoted to NAS babies. (Figure 2B) (Tolia, et. al., 2015). In 2013, 4% of all NICU hospital days nationwide were used by infants suffering with NAS. This is a 6 to 7 times increase over 2004 (Tolia, et. al., 2015).

The median length of hospital stay for NAS-suffering babies was 13 days in 2004 (Tolia, et. al., 2015). In the intervening years it climbed. Burns and Mattick reported 16 days (2007). Agthe, et al reported 16 days (2009). Patrick et al. reported 15-17 days (2012). By 2015, Tolia et. al. reported the average had been 19 days in 2013. Patient admissions, length of stay, and resource utilization for infants suffering from NAS, and admitted to NICUs, are increasing.

Effective strategies are required for prenatal prevention and postnatal treatment of NAS (Tolia, et. al., 2015).

VIII. Conclusion

NAS incidence and hospital charges have steadily and substantially grown. A typical NAS-suffering newborn's cost has been measured at \$159,000 to \$238,000 *more than* other newborns (Petz & Anand, 2015). We must act to reduce human suffering and to reduce the growing societal costs of in-utero and newly-born opium addicts.



These numbers, however alarming, may understate the costs of this epidemic. Unless a mother is arrested or reports opiate use, *and this is committed to the medical record*, the opiate use is not be included in the newborn baby's file. Thus maternal opiate use is likely underestimated. We must seek to limit the costs created by both illicit drugs and the effects of opioid pain reliever misuse (Patrick, Davis et. al., 2015). North Carolina should seek innovative solutions to decrease the burdens of NAS, because the majority of hospital expenditures for this condition are shouldered by state Medicaid programs.

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Thank you,

Mark Galloway
Chief District Court Judge
Email: thescoop@esinc.net

“Now this is not **THE END**. It is not even the beginning of **THE END**. But it is, perhaps, **THE END** of the beginning.” Winston Churchill, November 1942

