Hon. Stephen Manley's comments from R2P Drug Court Treatment Services Webinar

Thanks Caroline. It's a real pleasure to be joining this discussion. I think it's a very important subject. I've been a drug court judge as you noted for many years. I work with very high needs and high risk offenders, over 2000 of them, and in my view, a judge will not be successful without a clear understanding of how treatment works, how it can work better, and how the judge should interact with treatment and appreciate the critical importance treatment plays in helping us assist substance abusers change their lives.

Q: In terms of the assessment, what information do you find most helpful to receive from the assessment at the time the participant is entering the program and how do you use this information?

Well, at this point it is the first time the offender is before me and I need the basic elements to move towards a treatment plan that I can order or can direct the offender to and engage the offender to participate in. I need to know all of the treatment needs identified for this person –substance abuse, mental health, neurological, medical, and similar needs. I need to know the level of functioning as well as the level of understanding so that I can come up with a good approach for me as a judge to discuss the plan directly with the defendant. Then I need to know the specific initial treatment that is recommended by the assessors. In other words, what modality of substance abuse will the defendant be entering, is there mental health needs, how are they going to be met right now, on down the list of needs. I always need to know where the defendant will be living, who the defendant will be living with and whether or not housing will be an ongoing issue, because this issue must be addressed repeatedly. Based on the high risk needs of the offenders I work with, all assessments also cover the remaining criminogenic needs that Roger has referred to including such things as benefits because of lack of income, additional services needed such as life skills, anger management, employment and when they will be addressed. Finally, I need to know the level of supervision needed and we base that on the assessment and the risk and that will also include specific orders or encouragements I need to give the defendant as to where he or she cannot go, staying away from certain persons and the like. I utilize all of this information to discuss the beginning, starting, of a treatment plan with the defendant so that he or she is clear as to what is expected of them right now when they leave the courtroom. Also Caroline and Roger, I think it is important to note that reassessments down the line, I find, are just as important as the first assessments. And that assessment is really on ongoing process based on what the client does or does not do while out in the community participating in treatment. I receive far more reassessments each day than I do assessments. The information I need and use in a reassessment requires far more personal discussion with the defender or defendant or offender and a lot more motivational effort by the judge. What went wrong, can the defendant identify what needs to be changed, what's going to be different this time, and what are the recommendations that are going to help the defendant get there. These are the challenges in a reassessment and I think it's an important area to always keep in mind.

Q: In your experience, what effect has coercion for drug court participants resulted in the population you've dealt with?

Well Caroline, it most certainly has been effective and I use coercion every day. I think we've learned a lot about coercion in the courts and it's not simply that the offender is mandated. The coercion I that use, that I find, is not only effective but is absolutely necessary, is not the negative kind of coercion – the jail sanctions, the threats, the punishment or holding out what will happen horribly next if one does not do what I tell them they should be doing. I view coercion by a judge as an ongoing effort to engage a defendant in treatment, motivated the offender to stay in treatment and again and again reengage the defendant in treatment when they leave it or stop participating. I find the drug users and mentally ill clients, they really have little self-esteem. They quit easily; they don't believe they can make it. They are always looking for the easy way out by going back to drugs, and not taking their medication. And that if judges beat people down for failure, that simply doesn't work. That doesn't coerce anything. Because most high needs/high risk offenders, if not all of them, are really very used to being beaten down and the more the judge does it, the more you reinforce failure. I view that my role is to find the positives, and the incentives that will work on an individual basis to keep the offender coming back. My question to myself always is, "What can we come with as a team that will keep this offender engaged?" This all takes far more effort on the part of the judge and the team than imposing inflexible sanctions schedules. Negative sanctions are a last resort for me, not a first intervention, and I make them very short with quick turnarounds to see the outcomes. What I spend most of my time doing is convincing people again and again to stay in treatment and to keep trying. I think that's the kind of coercion that judges can be most effective with because offenders are not used to hearing it.

Q: How important have you found immediacy to be in terms of the effectiveness of drug court outcomes for individual participants?

Well I think Roger has really hit it on the head. This is a critical area that we must improve in. Over the years I have moved to placing immediacy at the top of all of my lists and goals and we have basically changed the way we operate our drug court calendars. I have learned that the best chance you have of high risk/high needs offenders, to turn someone around and back into treatment or get them into treatment, is to let them know right away that you recognize that they are in crisis and that you're going to do something about it. Defendants are not prepared for this approach and I find that they respond to it. They are used to always waiting for things and putting this off. So how do we accomplish immediacy in my programs? My treatment teams perform many reassessments and assessments. The initial assessments are right in the courtroom while the defendant is in custody or comes into the courtroom having be compensated or actively using drugs. We do this while court is in session. I then present a plan or a new plan to the defendant and work on obtaining their buy-in and putting the burden on the client to carry out the new plan and demonstrate to themselves that they can do it. Next, we work very hard to have resources available - somewhere to go, someone to see, someone to push you out of the door of the courtroom, out the front door to your next appointment. Rather than leave someone in custody or put them in custody, I tell them what they need to do, give them the instructions, the immediate appointments, and the steps they need to take. Get their medications started again, get into detox, move into sober living or other residential treatment, whatever the plan calls for or the need that is most critical at the moment for them. In other words, I ask them to pick themselves up, get out there and solve their problem themselves by taking action themselves. Then they come back to see me right

away which is another critical factor in immediacy. If the offender doesn't know that I want to know the results in a day or two or a week, nothing will happen. But if we can keep the offender's focus in the immediate moment to doing something, we'll keep them engaged, in my view. And I think we're demonstrating that. If we get them into treatment and keep getting them back into treatment, we'll have a lot more success and most importantly, it will be their success, not ours - their achievement and their triumph.

Q: Just turning to the issue of co-occurring disorders, we know that they are so prevalent among drug court participants, how have you found the presence of a co-occurring mental disorder affects a participant's ability to participate in a drug court?

Well, it affects their ability dramatically if you don't consider it in assessment and also in the treatment arena. We know that co-occurring disorders need to be treated at the same time. If you don't treat all of the disorders, you're not going to get anywhere, but reaching that goal is very challenging. If an offender has decompensated with street drugs and stopped taking their medications, for example, we have to realize that they cannot really benefit from substance abuse treatment, cognitive treatment, until they are back on their medications. They also need a treatment plan and treatment providers who understand how to work with individuals who may be delusional much of the time or very low functioning. This is a special modality of treatment, in my view, and needs specialized providers. In my county, until we developed this modality, our substance abuse providers repeatedly rejected co-occurring disorder defendants as not individuals who would understand nor benefit from substance abuse treatment. So we changed our system and I think that's what you need to do. You have to reach out and find providers who understand and are sensitive to these multiple issues and will work with them including the very low functioning client and those with traumatic head injuries and those who have suffered severe trauma, our veterans coming home. I also think that judges must change. We so often have these very high expectations of individuals who appear before us. And with the co-occurring disorder defendant, you have to change your expectations and not make them so high. You have to more realistic and understanding of the offender and of where he or she is at.

Q: Could you just give an example of how you've changed your expectations?

Well, for example, a very clear example to me is sanctions. Jail sanctions may have no meaning at all to a very low functioning offender who's mentally ill. The offender is not in my reality. My jail is a place he sleeps one day or not. It doesn't make any sense to him when I say you go to jail for four days because you didn't go to treatment. He doesn't get it. So I have to find a way to engage him in treatment without using my traditional sanctions-type schedules. I find that jail sanctions are very ineffective with most individuals with co-occurring disorders, particularly the seriously mentally ill.

Q: How important do you find assessing for criminogenic needs has been and how do you use this information?

Well, I find it very important because I work with high risk parole violators and I've done so for a number of years. And I've found that understanding and addressing the criminogenic factors is critical or a judge will have no success at all with this group. Where the individual lives, who is around them, all of these

issues are critical. I cannot focus just on substance abuse, drug use. I have to recognize that these high need individuals must be given the tools and the support to address their issues. For this high needs group we stress the basics of stable housing, life skills training, controlling anger, dealing with a lousy life, finding in any and all activities that are in some way different from the way they have lived their lives in the past. I stress such things as going to a class, or a program, sports, going to school to get your GED - basic steps that socialize the individual outside of that criminal justice brand and associate environment. I never confront these offenders because I have found that one of the biggest steps they can take towards socialization and changing their behavior is to learn how to get along with a judge. Most of them hate judges and hate parole agents and they don't want to spend ten seconds with me. So I work to get them to engage with me. I do that by praising the smallest change, by telling them can do better and they're doing just fine when they don't think they are. I realize that I must have a tremendous amount of patience because antisocial attitudes and behaviors – having no purpose in life, no skills, and being best at doing crime and nothing else – these are as difficult and challenging to change as getting someone to stop using drugs. And we must address all of these other needs or we will get nowhere with substance abuse treatment.

Q & A Session

Q: What advice do you have for other judges taking on the drug court assignment in terms of what they need to know about substance abuse treatment?

Well, certainly judges need a basic understanding of addiction, substance abuse, the effects of drugs and alcohol, commonly used drugs, brain chemistry; these are all important and basic. However, in my view, the biggest hurdle for a judge to overcome is to understand that substance abuse and co-occurring disorders are relapsing medical conditions. You have to understand that an offender with a disease and a condition that requires chronic care will not get better when we utilize our usual role of giving orders, setting conditions with expectations that the offender will either do what they've been told to do or they will pay the price for not doing so. And that's what we need to understand. I think we need to understand that what works is treatment. The role of the judge is to engage people in treatment, motivate them in treatment, and be willing to reengage them when they slip and fall and fail without doing blame. This is a tough job, but I think it's one of the most fulfilling assignments that any judge can ever find.

Q: How can the judge and other program staff work with treatment providers to support the use of evidence based treatment practices?

Well certainly those practices can be found in documents such as the checklist that is included with the materials for this webinar. However, I believe that the judge leads by encouraging best practices and acknowledging that we as judges should not be establishing or mandating those practices, but ask that the treatment providers identify them, bring them forward and utilize them. My treatment system is led by the county and that is a fortunate fact because evidence based practices are identified in the MOUs that the providers sign with the county so they can be found in the very treatment agreements that the providers enter into to obtain their funding. As to individual providers, I believe that the entire team

should visit the provider out in the community, learn what is taking place, what practices they are using now that they have not used before, engage them in a discussion and understand how we can, in the courtroom, reinforce those best practices or evidence based practices that they are utilizing in treatment. Most importantly, because many evidence based practices require resources, training, and funding and these are very, very difficult times and many providers simply do not have the capability of implementing these practices overnight, I believe it is essential that the judges support treatment and being creative and help them obtain those resources to implement the best practices.

Q: A participant has failed their last three drug tests. He has been sanctioned in each instance with jail and yet he continues to test positive. Do you have any suggestions before we terminate this participant? How do you know when it is time to terminate someone from drug court?

Well as to the three positive drug tests, Caroline, I mean, to me that demonstrated that our sanctions are not very effective. In other words, we're not getting anywhere by throwing people in jail every time they test dirty. So the thing that needs to change is the way we're approaching the offender. We need to change the treatment. We need to come up with some better alternative. We maybe need to offer this person an incentive rather than a sanction for not using drugs. I do that all the time. And I find that's far more effective. So I'll let Roger address that fact, that issue, as well and then we can move on.

Q: Judge Manley, when do you make the determination that it's time to terminate someone?

Well, as I think you gathered from what I've said thus far, I believe that this is a relapsing condition, it's a chronic disease. I am very… I'm very cautious about terminating offenders. I would rather give them additional opportunities and I do so. And my entire team and my programs operate that way. We give people a large, a substantial number of opportunities because we recognize how hard it is for people to change. Things that will lead to determination are usually outside factors. Such as the commission of a new serious offense, some behavior out in the community that is unacceptable. But the simple continuing to use drugs, being antisocial, hanging around with the wrong people, we're going to keep working on that because we always, I think, need to remember that people don't become the way we see them in the criminal justice system overnight. So much of this is developed over many years. And we're not going to change it in three months or kick them out. I view it that we need to be prepared to reengage offenders repeatedly.

Q: Some programs require a participant to become employed as soon as they enter the program. Do you feel that is a distraction from their being able to work on their recovery or is that a good idea and how do you make that determination?

Sure, well again, as Dr. Peters has said, it's individualized. I just don't believe in having a standard for everyone that they have to get a job within 30 days. I mean, our treatment programs stress obtaining employment. However the economy is so bad, it amazes me how many of my parolees are able find employment without my ever saying anything to them other than giving them an opportunity to participate in a job skill training program. But I don' think that that should be a requirement, particularly at the beginning. Because you can only ask people to do so much and if you put a barrier – and getting a job in my county is a very high bar – if you put that up there and expect, they're going to concentrate on

meeting that bar. They're not going to do the things that are far more important. They'll just get the job and be loaded instead of working on their treatment. So I would never make that a requirement.

Q: How can you address the non-use of evidence-based practices by a treatment provider when there is no other treatment provider option for drug court participants?

Well there, I think, is the reason the judge is so important on your team. I mean, the judge should be playing the role of the convener. You should turn to the judge to engage the treatment provider in a positive way to discuss, just have a general discussion of new practices that have been observed. For example, if you go to the NADCP annual conference or you take or see a webinar, such as this and ones to come, it would seem to me to have a discussion with the sole treatment provider regarding the best practices and what their views are and why they aren't using them and do they plan to use them and approach it in a positive way of trying to coerce them to change is going to be far more effective than to refuse to use the provider or to confront them.

Q: When, if ever, would residential treatment be preferable to outpatient?

Sure, very quickly going back to your example or your question regarding the offender who tests positive repeatedly, is given jail sanctions and nothing happens - that, to me, cries out for a referral to residential treatment. Because I work with very high risk/high needs offenders, we do utilize residential treatment for a very simple reason: we do not want to see the offender rearrested repeatedly. And that's what happens in my jurisdiction. So, we don't need the offender to have seven felony drug cases because we didn't try to address the level of treatment they needed. And I think residential, I agree with Dr. Peters, it is not the preferred modality, but when you have non-stop use, you really need to consider it and it doesn't have to be long-term. I think the evidence is showing that residential treatment can be relatively short and effective.