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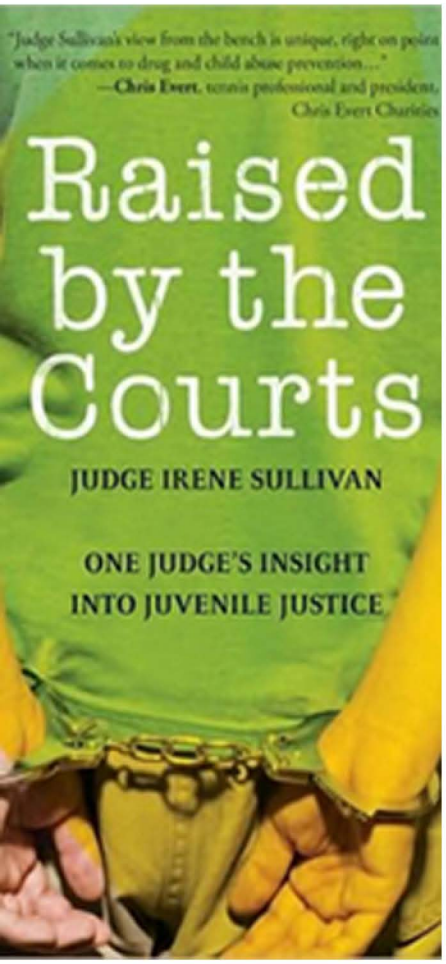

Substance Abuse and the Role of the Court System: Problems and Policy Solutions from Prenatal Exposure to Adulthood

Drug abuse creates challenges for the individual and society throughout the continuum of life. This issue addresses the effects on society of personal choices about substance abuse at each phase and proposes solutions that incorporate both realism and compassion.

In an excerpt from her new book, Raised by the Courts, Judge Irene Sullivan presents a picture of the juveniles who have appeared in her courtroom and the underlying issues of drug abuse that inform and complicate her decisions. The development of the drug court system is outlined by West Huddleston, and Dr. Angela Hawken examines a new approach to probation for drug offenders that is proving successful in Hawaii – HOPE. Dr. Hendree E. Jones and others provide an international perspective on the special challenges presented by substance use disorders during pregnancy and the need for a global consensus on treatment for these women. Dr. Bertha K. Madras provides a commentary on the public health implications of the upcoming vote in California to legalize marijuana.

The Journal of Global Drug Policy and Practice, a joint effort of the Institute on Global Drug Policy and the International Scientific and Medical Forum on Drug Abuse, is an international, open access, peer-reviewed, online journal with the goal of bridging the information gap on drug policy issues between the medical/scientific community, policymakers and the concerned lay public. Edited by Eric A. Voth, MD, FACP and David A. Gross, MD, DFAPA, our intended readership includes clinicians, clinical researchers, policymakers, prevention specialists and the interested public.

IN THIS ISSUE

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Recreational, Reactive, and Really Bad Crimes: Uncovering the Role of Sex and Drugs in Juvenile Court

Judge Irene Sullivan

I began to sort juvenile crimes into three broad categories, which I called "recreational," "reactive," and "really" bad crimes.

Recreational crimes include teenage pranks such as knocking down mailboxes, pulling fire alarms, and covering the school bathroom with graffiti—all wrong deeds and all misdemeanors.

Reactive crimes require more analysis. Did Ashley stab her mother's boyfriend because he'd been coming on to her for weeks? Did Donnel steal his friend's iPod after being taunted that his mom and dad were in prison and could never buy one for him? Did Christopher set fire to his grandmother's house because he overheard her telling child welfare workers that she was returning him tomorrow? Aggravated battery, robbery by sudden snatching, arson. Those are all felonies.

Really bad crimes frighten everyone, particularly the innocent victims. Burglaries, home invasions, gun thefts, drug dealing, carjacking, rape, and murder. They need to be resolved swiftly, sternly, and punitively.

Sex and drug crimes fit into all three categories. Sex between a seventeen-year-old and a fourteen-year old might be recreational and consensual, even Romeo and Juliet–type young love. Yet, in juvenile justice, it is considered sexual battery. A pat on the fanny can result in a charge of lewd and lascivious behavior, even though the "patter" is imitating mom's boyfriend. Forcible rape is always a horrendous crime; in many cases putting the perpetrator behind bars for life. Likewise, popping an occasional beer or puffing a joint puts you in the category of recreational drug criminal if you are a minor. Treating serious depression or bipolar disorder by self-medicating with marijuana, cocaine, or stolen prescription drugs is clearly reactive behavior. Drug trafficking is a really bad crime that can send a kid straight to prison.

I hold very strong opinions about sex, drugs, and hip-hop music and culture:

1. We should almost never require juveniles to register as sex offenders.

2. We should never legalize marijuana, as it is the most dangerous gateway drug for kids to use.

3. We should enjoy the intellectual ingenuity of certain hip-hop artists.

There, I've said it, and many will disagree.

Sex Offenses: Labeling a youth a sex offender has far-reaching, often unintended, diabolical consequences. Under the federal Adam Walsh Child Protection and Safety Act of 2006, and some state laws, the juvenile's picture, name, age, and address become public record, accessible on the Internet by pedophiles and adult sex offenders. Registration requirements can last many years or even a lifetime. Yet research shows that juvenile sex offenders are highly responsive to effective treatment and rarely reoffend, in contrast to adult sex offenders, who have a high recidivism rate. Many youths are reacting to having been sexually abused themselves, or imitating the adults who live in their home. Others may find pornography that's carelessly left for them to view. These are problematic cases for the juvenile judge. Of course, there is empathy for the victim. Regardless, many judges think the juvenile defendant doesn't deserve the punishment of lifetime sexual offender registration, in spite of the fact that he is found guilty of lewd and lascivious conduct, or even a sex battery, a touching not amounting to forcible rape.

Like Brad. An honor student with no prior record, and a member of the wrestling team, the teenager lost his temper when his former girlfriend taunted him in front of her friends in the high-school weight room and training room they both used. As she stood at an exercise machine in nylon shorts, her left leg fully extended behind her, he passed by and stuck his hand into her shorts, digitally penetrating her vagina with the tip of his finger. She screamed in alarm, and he was arrested. Because this was nonconsensual, and involved some force and penetration, the charge was a capital sexual battery. Clearly, Brad deserved punishment, anger management and sexual counseling, and perhaps probation. The victim needed vindication. But should Brad be required to register as a sex offender for at least twenty-five years?

After a trial, I found Brad guilty as charged but ordered the counseling and probation rather than the commitment the state was seeking. I declined to find the "force" necessary to invoke the sex offender registration requirements, fully aware that the state could appeal—which it didn't.

Drug-Related Offenses: Research shows that severe, chronic drug addiction is more predictable in youths who (1) have been abused, (2) start using drugs or alcohol at a very young age, or (3) inherit an addictive trait, as some people are born genetically predisposed to the effects of alcohol and other drugs. Abused kids as young as eleven or twelve often use marijuana to relieve the stress created by an alcoholic or drug-addicted abuser. It's three strikes against the kid out of the box, and if we make marijuana more available by legalizing it for adults, we'll lose the whole ball game, as marijuana is the most common illicit drug used by youths in the United States. Kids model their parents who use marijuana illegally. They model their neighbors gathered on street corners, buying, selling, and using marijuana. They model their peers.

In poor neighborhoods, marijuana is cheaper and easier to get than alcohol, cocaine, ecstasy, or the powerful prescription painkiller OxyContin. The very kids who need all the help they can get must confront another obstacle when surrounded by adults who smoke marijuana. And the kids, stressed and depressed, are really reaching out for help.

The scene repeats itself again and again in my truancy and delinquency courts. Mom and fourteen-year-old Ashley stand at the podium. Mom begins her litany of complaints about her daughter: skipping school, failing grades, surly attitude, disrespect, a different child from last year. "If we drug tested you today," I ask Ashley, "would you test positive for marijuana?" In many cases, the answer is yes, and in well over half of those, Mom isn't really surprised because the drug is available at home.

Kids don't lie about this in court. They know their lives are unhappy, and they are reaching out for help. Individual or family counseling, drug treatment, a psychiatric or psychological exam, a change in schools or caregivers—give them all these things but don't give them greater access to a drug that robs them of ambition to do well in school and encourages them to drop out of a productive life.

How does marijuana do this? Physiologically, it creates a sense of euphoria, calmness, and sedation in kids, masking stress and real problems. It's the "avoidance" drug for teens. Teens have to learn to deal with success and failure, praise and rejection, happiness and disappointment, choices and consequences. Adolescence is a time of intense change, in which a child transitions to an independent, functioning adult.

As pediatrician Edward A. Jacobs wrote in the Journal of Global Policy and Practice, "If one turns to the use of marijuana to avoid or blunt the negative experiences or to try to enhance the positive experiences of adolescence, he/she never learns these lessons and the coping mechanisms necessary to successfully manage them." Basically, these kids never grow up.

I see them as little slacker soldiers, marching into court as early drug users at age twelve or thirteen, then marching out to jail or prison at seventeen or eighteen—not for marijuana use, mind you, but for the felonies they've committed during an adolescence of poor choices, little education, and unmet needs. But I blame the marijuana and the culture it creates.

"It was with great sadness that I sat through your truancy court hearings, watching one young person after another stand before the judge," Calvina Fay wrote to me. Ms. Fay is the executive director of the Drug Free America Foundation. "Although all of these young people were very different, with varying backgrounds, almost all of them had one link in common: drug use, primarily marijuana.

"As I asked myself why each one of them might have turned to drugs, the answer varied. For some it was probably a case of 'self-medicating' to feel better about their circumstances and to cope. For others it was possibly an act of defiance or even a tactic to get attention. For still others it may have been to counter boredom. And there is no doubt in my mind that for quite a few it was peer pressure—the desire to fit in.

"One thing that I have learned about youthful drug use is that many youngsters do not really have a strong desire to try drugs the first time. They simply do so to fit in when it is offered to them by a friend. That is why I see drug use as a 'contagious' behavior. It spreads among friends just as fashion trends spread," she concluded.

I'm not advocating for more prosecution of juvenile drug charges or misdemeanor sex crimes, nor am I ignoring the use and sale of cocaine and prescription drugs and other substances. I'm advocating to get help for kids and for an understanding of the teenage brain and the danger of an entry drug. The kid who "cops a feel" or "takes a toke" while listening to hip-hop is not a sex offender or a drug dealer. He's a teen engaging in age-old risky behaviors. We shouldn't make it any easier for him to do so by making marijuana more accessible, as his behavior will likely get a whole lot worse.

Hip-Hop: Here I agree with Professor Michael Eric Dyson, of Georgetown University, in his book Know What I Mean? Reflections on Hip-Hop:

"And what do great artists do? They see and they say. They don't have to live it, but they can make you believe they've lived it. It's the same with the politics of authenticity. Within hip-hop, the elevation of the ghetto is often a metaphysical complaint against society's failure to recognize the humanity of those who come from the ghetto. And by the same token, hip-hop artists are rarely given credit for the kind of intellectual ingenuity it takes to create narratives that spark debates about whether what they say is true or not. That's a great deal of the ingenuity of the art form itself. Also, I think very few people are willing to acknowledge the genius of our black children."

How can we not admire the rhetorical genius of the rapper Nas, an eighth-grade dropout from the projects in Queens, New York, in one of his earliest verses:

> It's only right that I was born to use mics,
> And the stuff that I write, it's even tougher than dice
> I'm takin' rapping to a new plateau through rap slow
> My rhyming is a vitamin held without a capsule.

In four rhymed lines, Nas has shown kids creativity, personal expression, toughness, and an alternative to drug use, while not using profanity, promoting violence, or degrading women.

Genius!

Author Information

Judge Irene Sullivan

Judge Irene Sullivan has served since 2002 as a juvenile Judge for the Unified Family Court in Clearwater, Florida. She was a family court judge prior to that and a general partner at Harris, Barrett, Mann & Dew, L.L.P. in St. Petersburg, Florida, where she was an A-V rated trial lawyer.

Judge Sullivan obtained her Juris Doctorate degree from Stetson University College of Law, cum laude, and a Bachelor of Science in Journalism, with honors, from Northwestern University's Medill School of Journalism.

Judge Sullivan has received the following awards: The Florida Network of Youth and Family Services, Inc. Outstanding Community Partner Award; St. Petersburg Bar Associations' Annual Judicial Appreciation Award; Stetson University College of Law Ben C. Willard Distinguished Alumni Award; Guardian ad Litem Community Advocate Award; Florida Association of School Social Workers' Diamond Award; Salvation Army's Children's Justice Award; Pinellas Enrichment Through Mental Health Services (PEMHS) P.A.C.E. Award; Family Resource's Family Advocate Award; Community Action Stops Abuse (CASA) Domestic Violence Champion Sponsor Award.

Judge Sullivan has been an adjunct professor at Stetson University College of Law and is currently the Juvenile Track Leader for Education, Florida Conference of Circuit Court Judges. Judge Sullivan has presented at many conferences and seminars involving juvenile crime, truancy, domestic violence and mental health issues for juveniles.

Judge Sullivan currently sits on the following Task Forces: Juvenile Arrest Avoidance Project; Florida Disproportionate Minority Contact Task Force; Blueprint Commission to Reform Juvenile Justice; Juvenile Indigent Defense Action Network at Barry University Law School, funded by the MacArthur Foundation.

Judge Sullivan is also the author of a book, *Raised by the Courts: One Judge's Insight into Juvenile Justice*, to be published by Kaplan Publishing Company in November, 2010.

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Drug Courts: A Viable Solution to Drug Dependent Offenders

West Huddleston

Abstract

In the late 1980s, many of the courts in the United States were overwhelmed with drug-addicted offenders. In 1989, in an effort to stem the tide of drug-involved cases, the court system in Miami began taking offenders into an intensive court-based drug treatment program designed as an alternative to incarceration. The program was called Drug Court. Now 20 years since this experiment was initiated, an impressive 2,301 Drug Courts operate throughout all fifty states and U.S. Territories, serving 120,000 adult and juvenile offenders annually.

Drug Courts keep nonviolent, drug-addicted individuals in treatment for long periods of time while supervising them closely. Clients receive the treatment and other services they require to stay clean and to lead productive lives, but they are also held accountable by a judge for meeting their own obligations to society, themselves and their families.

In the late 1980s, many of the courts in the United States were overwhelmed with drug-addicted offenders. A dramatic increase in arrests for drug and drug-involved cases, along with mandatory minimum sentences for the possession and distribution of drugs, especially crack cocaine, had led to overflowing courts, jails and prison populations. In Miami, Florida, and other major metropolitan areas, the problem was particularly daunting. In 1989, in an effort to stem the tide of drug-involved cases, the court system in Miami began taking offenders into an intensive court-based drug treatment program designed as an alternative to incarceration. The program was called Drug Court.

Now 20 years since this experiment was initiated, an impressive 2,301 Drug Courts operate throughout all fifty states and U.S. Territories, serving 120,000 adult and juvenile offenders annually.

While this article discusses Drug Courts in the context of the adult criminal justice system, the Drug Court model also has been successfully applied to juvenile delinquents, parents at risk for losing custody of their children due to drug abuse, offenders charged for driving while under the influence of alcohol or other drugs, veterans, the mentally ill, and parolees. In addition, because Drug Courts are well positioned to address emerging community trends among arrestees, the Drug Court model has also been successfully applied to specific drug-user populations with methamphetamine, marijuana and heroin dependence.

The recent emergence of methamphetamine and prescription drug abuse and dependence has led to an increase in arrests for drug-related crimes; from possession of a controlled substance without a prescription and shoplifting to prescription fraud and burglary. Unless drug-abusing offenders are treated, they will remain at high risk for criminal activity, victimization and overdose.

Traditional Methods Fail

The traditional U.S justice system has been inadequate to the task of breaking the cycle of substance abuse and crime. Four out of every five offenses are committed by someone with a drug or alcohol problem in the U.S.

In just the past 20 years alone, state prison systems have added 1 million new cells to incarcerate the 2.3 million adults now behind bars in the U.S. That's far more than any other country on the globe with 1 out of every 100 adult Americans currently serving time.(1) Approximately one-half of these individuals are addicted to drugs or alcohol,(2) and most do not pose a serious threat to public safety.

Drug and alcohol abuse has driven much of this explosion in the inmate population. Approximately 80% of inmates have a serious history of substance abuse,(3) and one-half are clinically addicted to drugs or alcohol.(4) Most of these individuals do not pose a serious threat to public safety. More than three-quarters of state inmates were incarcerated for a nonviolent offense, and most of them have no history of a violence offense anywhere on their records.(5)

In the traditional approach to such offenders, many of the defendants received probation or prison sentences, often without the availability of treatment. If treatment was available and the court ordered treatment as a part of the sentence, no formal partnership existed between the court, case management, treatment and supervision. If offenders did not comply with treatment conditions or continued to use drugs, there was no system of intermediate sanctions and incentives designed to keep the offender engaged in treatment. Often the reaction to noncompliance was a discharge from treatment. Offenders on probation would reappear before the judge for a revocation hearing where they would potentially face the prison time

that had been suspended at their sentencing. Offenders expelled from treatment programs in the prison system would find themselves back in the prison main population.

As such, the traditional system created a "revolving door" of justice. Judges, prosecutors and defense attorneys were accustomed to seeing the same defendants month after month returning to court, many for property offenses, fueled by their drug dependency. Without treatment, the offenders continued in active addiction and continued to victimize others to fuel their addiction.

It is no secret that prison has accomplished little to stem the tide of crime or drug abuse. Upon their release from prison, between 60% and 80% of drug abusers commit a new crime (typically a drug-related crime),(6) and 85% to 95% relapse quickly to drug abuse.(7) More than half will be returned to prison in a now familiar revolving door pattern, and in some states such as California, more than 75% will be returned to prison.

Amazingly, these disappointing figures have done little to curb prison overspending. National expenditures on corrections well exceed $60 billion annually.(8) On average, states spend $65,000 per bed per year to build new prisons and $23,876 per bed per year to operate them.

Judge Dennis Challeen (ret.), author and faculty member of both the National Judicial College and the National Association of Drug Court Professionals, said it best.

About sending the addicted to prison:

> **We want them to have self-worth**
> So we destroy their self-worth
> **We want them to be responsible**
> So we take away all responsibility
> **We want them to be positive and constructive**
> So we degrade them and make them useless
> **We want them to be trustworthy**
> So we put them where there is no trust
> **We want them to be non-violent**
> So we put them where violence is all around them
> **We want them to be kind and loving people**
> So we subject them to hatred and cruelty
> **We want them to quit being the tough guy**
> So we put them where the tough guy is respected
> **We want them quit hanging around losers**
> So we put all the losers in the state under one roof
> **We want them to quit exploiting us**
> So we put them where they exploit each other
> **We want them to take control of their lives, own problems and quit being a parasite on society**
> So we make them totally dependant on us

Each year in the U.S., there are approximately 1.2 million prison-bound offenders who are at risk for addiction and who pose little threat to public safety.(9) For them, there is a better way.

Drug Courts: Changing the Face of the Justice System

Drug Courts are judicially supervised court dockets that strike the proper balance between the need to protect community safety and the need to improve public health; between the need for treatment and the need to hold people accountable for their actions; between hope and redemption on the one hand and good citizenship on the other.

Drug Courts keep nonviolent, drug-addicted individuals in treatment for long periods of time while supervising them closely. Clients receive the treatment and other services they require to stay clean and to lead productive lives, but they are also held accountable by a judge for meeting their own obligations to society, themselves and their families. They are regularly and randomly tested for drug use, required to appear frequently in court for the judge to review their progress, receive rewards for doing well and sanctions for not living up to their obligations.

Most Drug Court programs target non-violent offenders. These offenders are placed in programs which may take a variety of forms:

- Diversion (charges are held until program completion, and upon successful completion, they are dismissed);
- Probation (a participant pleads guilty and is placed on probation with the successful completion of Drug Court a special condition of Drug Court); and
- Probation revocation (a participant already on probation and in violation for reasons caused by drug addiction continues on probation and is placed in Drug Court).

Drug Courts deal with charges ranging from drug possession to property crimes. Since many drug addicts steal to finance their drug habit, Drug Courts also target these drug-driven property crimes. If a Drug Court

participant has committed a crime that involves a victim, such as in a theft case, the program typically requires restitution.

Drug Courts Work

Remarkably, there has been more research published on the effects of Drug Courts than on virtually all other criminal justice programs combined. The scientific community has put Drug Courts under its microscope and concluded that **Drug Courts work better than jail or prison, better than probation and better than treatment alone. Drug Courts significantly reduce drug abuse and crime and do so at less expense than any other justice strategy.**

Drug Courts Reduce Crime

Nationwide, 75% of Drug Court graduates remain arrest-free at least two years after leaving the program.(10) Compare this to the typical re-arrest rates on standard probation in which 46% of probationers commit a new offense and over 60% commit a probation violation,(11) not to mention the high re-arrest rates ensuing after release from prison, which, as noted, generally exceed 60% to 80%.

The U.S. Government Accountability Office (GAO) agrees and in 2005 concluded that Drug Courts significantly reduce crime and save money for taxpayers by offsetting the costs of law enforcement, court case processing and victimization resulting from future criminal activity.(12)

In the ensuing years since the GAO Report, researchers have continued to uncover definitive evidence for the efficacy and cost-effectiveness of Drug Courts. Five independent meta-analyses have now all concluded that Drug Courts significantly reduce crime by as much as 35% in comparison to traditional case dispositions.(13) Researchers have also concluded they reduce drug abuse and improve employment and family functioning.(14)

These effects are not short-lived. Rigorous studies examining long-term outcomes have found that reductions in crime lasted at least three years,(15) and in one case the effects on crime lasted over 14 years.(16)

Drug Courts Save Money

Drug Courts also save considerable money for taxpayers. Eighteen rigorous cost/benefit studies have found average cost savings ranging from $4,000 to $12,000 per client. The most conservative estimates show that for every $1 invested in Drug Court, $3.36 are saved by the justice system, and up to $12.00 are saved by the community (for every $1 invested) when impacts on things such as emergency room visits and other medical care, foster care and property loss are factored in.(17)

National Association of Drug Court Professionals (NADCP), representing over 25,000 Drug Court practitioners in the United States, was founded in 1994 and is located in Alexandria, Virginia. NADCP boasts the largest conference in the world focusing on substance abuse and crime. Its principal objectives are to train justice professionals on current practices and trends in the treatment of drug-using and mentally-ill offenders, to connect with policy makers on the direction of funding and relevant legislation and to provide a forum for professionals to network and interface with producers of products and services developed to meet the needs of the industry.

The research, scholarship and training arm of NADCP, the National Drug Court Institute (NDCI), was founded in 1997. NDCI is supported by the Office of National Drug Control Policy, which falls under the auspices of the Executive Office of the President, and the Bureau of Justice Assistance at the U.S. Department of Justice. NDCI provides over 70 Drug Court training and technical assistance events each year throughout the United States and around the world.

Author Information

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West Huddleston is the Chief Executive Officer of the National Association of Drug Court Professionals and the National Drug Court Institute.

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HOPE for Probation: How Hawaii Improved Behavior with High-Probability, Low-Severity Sanctions

Angela Hawken, Ph.D., Associate Professor of Economics and Policy Analysis, School of Public Policy,

Abstract

Inflation-adjusted spending on corrections in the United States has more than doubled over the past two decades. Concern over the cost of corrections has forced policy makers to consider alternatives to incarceration for drug offenders and make efforts to improve the performance of community supervision. The challenge is to find ways to keep drug offenders out of jail and prison without compromising public safety. Hawaii has achieved this goal, using an innovative low-cost approach that dramatically improves probationer compliance and reduces drug use and crime. The program is called Hawaii's Opportunity Probation with Enforcement, known as HOPE.

This paper describes HOPE and documents interviews with two individuals responsible for putting HOPE into practice: Judge Steven S. Alm, creator of HOPE, and Cheryl Inouye, supervisor of the probation unit that managed the first HOPE caseloads.

Introduction

Inflation-adjusted spending on corrections in the United States has more than doubled over the past two decades.(1) Concern over the cost of corrections has forced policy makers to consider alternatives to incarceration for drug offenders and make efforts to improve the performance of community supervision. Many states have introduced treatment-diversion programs, which give drug offenders the option of community-based treatment rather than serving jail or prison time. These programs, however, have done little to improve probation and parole outcomes.(1) The challenge is to find ways to keep drug offenders out of jail and prison without compromising public safety. Hawaii has achieved this goal, using an innovative low-cost approach that dramatically improves probationer compliance and reduces drug use and crime. The program is called Hawaii's Opportunity Probation with Enforcement, known as HOPE. HOPE started as a small pilot program in 2004 but has since been expanded because of the impressive improvements in probationer compliance under the program. Today, nearly one-in-five felony probationers on Oahu are supervised under HOPE. This paper describes HOPE and documents interviews with two individuals responsible for putting HOPE into practice: Judge Steven S. Alm, creator of HOPE, and Cheryl Inouye, supervisor of the probation unit that managed the first HOPE caseloads.

Background

Community supervision is intended to be an alternative to incarceration: Instead of serving a prison or jail term, an offender promises to comply with a set of probation or parole conditions, and an officer is assigned to enforce these conditions with authority to report violations to the court or parole board for possible sanctions. This should be a win-win. For taxpayers, it avoids the costs of incarceration, and for offenders, it permits them to live lawfully in their home community. But community supervision has a poor track record. Large percentages of offenders fail to complete their terms of supervision, and recidivism is high; about two-thirds of prisoners are rearrested on a new crime within three years of release.(2,3)

Why is community supervision so ineffective in most jurisdictions? There are many reasons. Probation and parole officers manage large caseloads, which makes it difficult to reliably monitor compliance with terms of supervision. Most police agencies give low priority to serving bench warrants for probation absconders, making it difficult to actually enforce the terms of probation and parole. The sanctions process is time consuming, puts large demands on probation officers, and often leads to no action. As a result, many probation officers attempt to cajole probationers into improving their behavior rather than taking formal action to impose sanctions. And there is not nearly enough emphasis on managing drug use.

Even though drug offenders are at high risk for continued drug and alcohol abuse, they are drug tested too infrequently, and sanctions for continued drug use are too rarely delivered to produce behavior change. As a result, noncompliance is high. When sanctions for noncompliance are made, they tend to be too severe (months, sometimes even years, in jail or prison), which defeats the rationale for probation as a less costly alternative to incarceration.

HOPE provides evidence that re-engineering the probation-enforcement process can improve compliance with all types of probation conditions, including desistance from drug use, among even heavily drug-involved probationers.(4) And it achieves these results at a relatively low cost.

How HOPE works

High-risk probationers are assigned to HOPE. HOPE probationers have long histories of drug use and

involvement with the criminal-justice system (they have an average of 17 prior arrests). Probationers are referred to HOPE if their probation officer or a judge believes they face a high risk of failing probation and being returned to prison. HOPE begins with a formal warning, delivered by a judge or hearings officer in court, that any violation of probation conditions will not be tolerated: Each violation will result in an immediate, brief jail stay. Probationers with substance-abuse issues are assigned a color code at the warning hearing. The probationer is required to call the HOPE hotline each weekday morning. Those probationers whose color is selected must appear at the probation office before 2 pm that day for a drug test. During their first two months in HOPE, probationers are randomly tested at least six times per month (good behavior through compliance and negative drug tests is rewarded with an assignment of a new color associated with less-regular testing). If a probationer fails to appear for testing, a bench warrant is issued immediately and is served by the Honolulu Police Department. The sanctioning process happens quickly. Probationers who test positive for drug use or fail to appear for probation appointments are arrested and held in custody. As soon as the violation is detected, the probation officer completes a "Motion to Modify Probation" form and sends it to the judge (the Motion to Modify form was designed to be much simpler than a Motion to Revoke Probation and can be completed very quickly). The hearing on the Motion to Modify is held promptly (most are held within 72 hours), with the probationer confined in the interim. Unlike a probation revocation, a modification order does not sever the probation relationship. A probationer found to have violated the terms of probation is immediately sentenced to a short jail stay (typically several days servable on the weekend if employed, but increasing with continued non-compliance), with credit given for time served. The probationer resumes participation in HOPE and reports to his or her probation officer on the day of release. If a positive drug-test result is disputed, the probationer is released pending confirmation testing and given a court date for one week later. These probationers are warned that their jail sanction will be enhanced if drug use is confirmed.

A probationer may request a treatment referral at any time, but probationers with multiple violations are mandated to intensive substance abuse treatment services (typically residential care). The court continues to supervise the probationer throughout the treatment experience and consistently sanctions noncompliance (positive drug tests and no-shows for treatment or probation appointments).

Theoretical underpinnings of HOPE

The combination of testing and sanctions as implemented under HOPE has a strong theoretical foundation that is research based:

1. A clearly defined behavioral contract

Clearly defined behavioral contracts enhance the perceived certainty of punishment, which improves compliance.(7,8,9,10) Probationers in HOPE are informed about the conditions for compliance with the terms of their probation and the consequences for any violation are carefully laid out.

2. Sanctions are delivered consistently

The consistent application of rules of a behavioral contract improves compliance and enhances perceptions of fairness.(7) Probationers in HOPE are monitored closely, and every detected violation is sanctioned.

3. Sanctions are swift

A swift response to infractions improves the perception that the sanction is fair.(7,11). And the immediacy of a sanction helps shape behavior.(12) HOPE probationers are arrested immediately when a violation is detected and are taken before a judge.

4. Sanctions are parsimonious

Parsimonious use of punishment (ideally, the least punishment necessary to bring about the desired behavior change) improves the perceived legitimacy of the sanction and reduces the potential negative impacts of longer jail sentences.(13)

5. Awareness of dignity (also called "procedural justice")

The supervision process itself affects compliance.(7) Probationers who are managed fairly and respectfully show improved compliance. (14,15,16) Probation officers in Hawaii are well trained in motivational interviewing and cognitive-behavioral therapy. Both the supervising judges and the probation officers make it clear that they want the probationer to succeed.

Testing and Sanctions in Practice

Prior to HOPE, the strongest evidence for testing and sanctions came from the Washington, D.C. Drug Court Experiment conducted in 1993. The purpose of this experiment was to evaluate the role of treatment and sanctions in deterring drug use among drug offenders.(5) Subjects in the randomized controlled trial were assigned to one of three dockets: Docket 1 (the standard docket) received the normal process of drug testing and judicial monitoring with no sanctions for failed drug tests; Docket 2 (the treatment docket) was assigned to intensive treatment; and Docket 3 (the sanctions docket) received immediate sanctions (the graduated sanctions package began with three days in a jury box, then to three days in jail, then 5–7days in detoxification, then 7 days in jail) for failed drug tests or missed appointments, with treatment

provided if needed or desired. The study showed that the sanctions docket was the most effective for reducing drug use and recidivism (and was much less costly than the treatment docket).

Despite the strong theoretical underpinnings of testing-and-sanctions programs and the experimental evidence provided by the Washington, D.C. Drug Court Experiment, there have been relatively few instances of widespread testing-and-sanctions programs implemented in practice. The success of the programs that have been implemented seems to be correlated with how reliably the conditions of probation are enforced.(6) The credibility of these programs is key. Idle threats are not sufficient to motivate behavior change, and programs that have failed to deliver on their threats have performed poorly. But delivering on threats is no small task. HOPE is a rare example of a jurisdiction that managed to reconfigure its probation system to swiftly and credibly make good on its promises.

How has HOPE performed?

The Hawaii Office of the Attorney General has collected statistics to track the performance of HOPE since the program started in 2004. Early research reported by the Attorney General's office showed impressive improvement in outcomes for probationers who were supervised under HOPE. These early findings attracted the attention of criminal justice researchers and the U.S. Department of Justice. There have now been two formal evaluations of HOPE in two probation offices: a quasi-experimental study to compare HOPE probationers to a similar group of comparison probationers and a true intent-to-treat randomized controlled trial to compare HOPE to probation as usual.(4)

The Integrated Community Sanctions Unit (Honolulu's intensive-supervision high-risk probation unit) was the first unit to pilot a HOPE program. The rate of positive drug tests fell by 93 percent for HOPE probationers during the first six months (from 53 percent to 4 percent), compared with 14 percent for comparison probationers (from 22 percent to 19 percent). These improvements in probationer behavior translated into other benefits. Recidivism fell sharply, as did arrests (arrests were more than halved), revocations, and incarceration (an average of 130 prison days were saved per probationer). Findings then were later replicated with a randomized controlled trial of high-risk, primarily methamphetamine-using probationers in a general probation unit.

Interviews with the key players responsible for implementing HOPE show that the program is held in high regard.(4) We found positive general perceptions of HOPE, with the highest levels of satisfaction reported by judges and probation officers. A sizable majority (95 percent) of probation officers reported that they were able to manage their caseloads more effectively under HOPE, and they were unanimous in their assessment that their HOPE cases improved once placed on HOPE.

HOPE probationers remain under court supervision while in treatment. Once a HOPE client is referred to treatment, it is not sufficient that he/she merely appear for treatment; the client has to abstain from drug use to avoid a jail sanction. This positions the treatment provider as an ally in the client's efforts to avoid sanctioning. HOPE treatment providers in Hawaii remark that they prefer clients who are supervised under HOPE as they are easier to work with. Indeed, Hawaii's treatment providers are among the strongest supporters of HOPE.

And what about the probationers? Among the more surprising results from the HOPE evaluation was how strongly the HOPE probationers support the program. Figure 1 describes the perceptions of HOPE probationers under active supervision in the community, in treatment, and in jail.(19) Even the probationers who were surveyed while serving a jail sanction under HOPE reported overwhelmingly positive perceptions of the program. In open-ended questions probationers remarked that they appreciated that the program is fair.(19)

Figure 1

HOPE as "Behavioral Triage"

HOPE identified a small minority of probationers who were unwilling or unable to desist from drug use under sanctions pressure alone. Only 40 percent of HOPE probationers had any post-warning violation (i.e., positive drug test) within the first year; of those who had one violation, only half had a second violation; of those with two violations, only half (10 percent of the total) had a third or subsequent violation. I refer to this as the "behavioral triage" function of HOPE - the program identifies those most in need of treatment by observing their actual conduct.(17) This approach has intuitive appeal, but it is not how treatment services are delivered in practice.

The standard approach used by drug courts and treatment-diversion programs is to mandate every offender to receive drug treatment (even those without diagnosable substance-abuse disorders) and then base treatment decisions on self-reported behavior. Under HOPE, an offender is subjected to regular random drug testing with the threat of an immediate, though relatively mild, sanction if they test positive for drug use. This allows treatment decisions to be gauged to an offender's observed behavior rather than through self-reporting.

An "assess-and-treat" model that relies on self-reported behavior is a poor approach to managing criminal justice-involved clients. Criminal offenders are well aware that their self-reported drug use can influence their sentences and the types of treatment to which they will be referred. They have a clear incentive to manipulate their self-report in pursuit of a desired outcome. The not-so-surprising observation is that, quite often, offenders lie.

In our survey of 211 drug-involved offenders under community supervision in Hawaii, 48 percent reported willfully exaggerating their drug use on a prior assessment to secure a referral to treatment to avoid jail time, and 53 percent reported willfully underreporting their drug use on a prior assessment to avoid a treatment referral.(17) Similar mismatches between self-report and actual drug use have been found in other offender research that compared self-reported drug use to drug use measured from hair assays. Of those whose hair tested positive for cocaine use in the past 90 days, 43% had denied any drug use during the previous year. (18) Over-reliance on self-reports means that offenders will be misclassified and treatment resources will likely be misallocated.

By contrast, under a Behavioral Triage Model (such as HOPE) an offender's observed behavior signals their need for treatment services. Those who can desist from using drugs on their own should not be forced into formal treatment. This allows treatment resources to be used more strategically by providing high-quality, longer-term care to those probationers whose behavior has indicated they are most in need of intensive services.

Implications of HOPE

HOPE has demonstrated that community supervision can be a meaningful alternative to incarceration. HOPE is receiving a great deal of attention from national media and policy makers because of the improvements in probationer behavior observed, but many questions remain. Implementing a HOPE-style program that delivers swift-and-certain sanctions requires a great deal of cooperation across multiple agencies and a willingness to change work practices. Whether HOPE can be implemented with fidelity in other jurisdictions remains an open question. A number of replication studies of HOPE are underway, including HOPE-style models in Alaska, Nevada, Arizona, Oregon, and California. These replications will determine whether Hawaii's HOPE experience is generalizable to the mainland and whether HOPE merits designation as an evidence-based practice.

HOPE and Behavioral Triage represent an important new approach to probation operations and have important implications for probation management, for treatment resource allocation, and for correctional decision-making more generally. The existing findings on HOPE are cause for optimism. The HOPE evaluations have shown that even offenders with long histories of heavy methamphetamine use can and will modify their behavior when faced with high-probability sanctions.(20) It now remains to be seen if other jurisdictions can reorganize their criminal-justice systems to deliver on credible threats.

Interview with Judge Steven S. Alm

Felony Trial Judge, First Circuit Court, Honolulu Hawaii

Q. Judge Alm, how did the idea for HOPE Probation come about?

A . In June of 2004, I was assigned to a felony trial docket. From that first week, I would receive Motions to Revoke Probation often with 10, 20, or 30 or more probation violations. The probation officer was returning the offender back to court with a nearly universal recommendation that I sentence the probationer to the underlying 5, 10, or 20 years in prison. I thought that this system was broken and was the wrong way to try to change anybody's behavior.

Q. So what was the alternative?

A. Well, I thought to myself, what changes a person's behavior? Swift and certain consequences for misbehavior. I thought about how I had raised my son. If he misbehaved, I would talk to him about what he had done wrong and warned him that he shouldn't do it again. Then, if he did it again, I would give him a swift and sure, but proportionate, punishment for breaking the rules. That way, he would learn from his mistake. I thought that it made sense to apply that thinking to the probation system.

Q. Adult Probation is a large and cumbersome system in any state, including many agencies in different branches of government. How did you go about trying to change the system?

A. First, I looked at the relevant statutes and thought about the roles of the different agencies involved. I then spoke to a committed and gifted probation supervisor, Cheryl Inouye. She headed up the Integrated Community Sanctions Section, responsible for monitoring high-risk probationers, including sex offenders and others convicted of a variety of felonies (e.g., burglaries, assaults, drugs) who had failed at drug treatment or refused to participate and who were still using drugs. Ms. Inouye was great. She was willing to try something new and help the offenders by bringing more accountability to the system.

Q. Was anybody else involved in the planning?

A. I then invited a prosecutor supervisor and the State public defender to the table. I explained that we wanted to bring swift and certain, but proportionate, consequences for all probation violations. They both agreed that what we were doing wasn't working for many offenders and were willing to try something new. The prosecutor supervisor agreed to design a new, fill-in-the-blanks Motion to Modify Probation (i.e., with a short time in jail, then out to see the probation officer). The public defender, noting that the rules were going to be the same but we were actually going to enforce them for the first time, asked if we could warn his clients of the new procedures. That made sense to me.

I spoke to the jail to advise them of the small project we were starting, talked with the Sheriff about the probation program, and asked for their help in taking these violators into custody if they tested positive for drugs at the probation office or turned themselves in when a warrant was outstanding.

I also realized that warrant service was not always a high law enforcement priority. Drawing on my years as the United States Attorney (chief federal prosecutor) here in Hawaii, I asked the head of Hawaii's High Intensity Drug Trafficking Area program (HIDTA) if they would assist. He agreed and spoke to the United States Marshal. As a result, the Marshal agreed to have his Federal Fugitive Task Force serve the warrants for my court for this project, and HIDTA would pay any task force overtime.

Q. How many offenders are in HOPE Probation?

A. We started with 34 offenders at the Warning hearing on 10/1/04. We currently have more than 1,700 offenders in HOPE. More than 1,500 are felons (out of 8,200 offenders on felony probation or deferral on this island), plus another 200 or so domestic violence misdemeanants.

Q. This sounds like it's a real team effort? Is it?

A. It certainly is. I am so proud of all these public employees who were willing to work a little smarter, harder, and faster to create and operate a new system. This includes probation officers, court staff, judges, prosecutors, the defense, sheriffs, corrections, and treatment providers. All involved here have made good suggestions to make HOPE Probation work better.

Q. Speaking of treatment providers, how do they seem to like HOPE Probation?

A. They fully support HOPE. Alan Johnson, CEO of Hina Mauka, Honolulu's largest substance abuse program, and Chair of the Hawaii Substance Abuse Coalition (HSAC) has said that HOPE probationers are more responsive to treatment than non-HOPE probationers. HOPE probationers are more engaged in treatment which provides improved outcomes. The providers acknowledge that treatment and HOPE provide better outcomes than treatment alone.

Q. How did the name HOPE come about?

A. I had a contest among the court staff and probation officers to name the program. An early tongue-in-cheek entry was Yank and Spank. When Hawaii's Opportunity Probation with Enforcement was suggested, I knew we had a winner.

Q. You have referred to HOPE as being "swift, certain and proportionate." Why is "proportionate" important?

A. Probationers have told the researchers that they feel they are being treated fairly in HOPE. They are told what the rules are and what the consequences will be if they violate; e.g., for missing a probation appointment but turning themselves in, they are sanctioned for a few days or a week. They feel like they are being punished, but it's for a bad choice they made and that the punishment fits the crime. If the offenders believe the system is fair, they are much more likely to buy into it and be successful.

Q. HOPE sounds like it's going well in Hawaii. Are other jurisdictions looking at HOPE?

A. Yes. There has been a lot of interest from all across the country. Alaska, Nevada, Oregon, and Arizona have recently started their HOPE-type efforts, and California and Virginia are getting organized. At the end of 2009, federal legislation was introduced to set up 20 HOPE pilots around the country, and there have been a number of hearings on HOPE before Congress in 2010.

Q. What is the future of HOPE?

A. Great! I believe HOPE is that rarest of strategies in the criminal justice system - a true win-win proposition. HOPE reduces crime and victimization; it helps offenders and their families by keeping them employed and out of prison; and it saves taxpayers millions of dollars.

Interview with Ms. Cheryl Inouye

Probation Supervisor, Integrated Community Sanctions Section, Honolulu, Hawaii

Q. Ms. Inouye, how and when did you first get involved with HOPE Probation?

A. In 2004, Judge Alm called and presented this idea of taking swift and certain sanctions for probation violations involving drug and alcohol use. He asked if I might be interested in working with him on this, and I said absolutely.

Q. What did you think of the HOPE concept at first?

A. I didn't have to think twice about it, although I did feel Judge Alm would have to work miracles to make it happen. This was just not the way the courts, including probation, did business, so I admit I wasn't entirely convinced at first that this would work.

It was exciting to be approached by a judge who understood the issues and challenges probation officers (POs) face in carrying out our mandate of rehabilitating offenders. As skilled as POs are in identifying risk factors and intervention techniques and strategies, such as motivational interviewing and cognitive behavioral therapy, we saw little evidence of change. Probation officers genuinely care about improving the lives of others, and I was confident I could count on this fact to get them to give HOPE a chance.

Q. How did it change the way your probation officers did their jobs?

A. To really appreciate the changes, you need to picture how it used to be. POs would manage their probationers as they lived in the community for as long as possible, using whatever intermediate sanctions were available at their disposal, until the PO felt the risk to the public or the severity of violations warranted the revocation of probation. The PO would then start the laborious process of completing an affidavit, violation report, and recommendation letter, then attend and testify in court, only to have the case frequently returned for a new term of probation. The time between violations and the court hearing could extend well over several years. When imprisonment was ordered, offenders faced five-, ten- and 20-year terms.

Under HOPE, POs immediately respond to a violation by completing a check-listed motion for modification, arrest the offender on-site, and arrange to have the hearing that day or soon thereafter. The violation report and recommendation are sent to the judge by an email template. The time between violation and court hearing is generally no more than two days, and confinement is brief and immediate.

The difference has been tremendous with HOPE. The PO is able to spend less time on the sanctioning process and spend more time with the client on his/her rehabilitation.

Q. Don't the HOPE Probation procedures cause your probation officers to lose discretion? If so, how do you and your officers feel about that?

A. Yes, POs do lose discretion in some ways, but there are advantages to this. The clients are warned about the consequences of violating probation in a group so they know each client will be treated in the same way depending on the violation. Prior to HOPE, clients were more likely to regard a PO's recommended sanctions personally since violations were handled differently among the POs. The line at which revocation would be initiated was left to the PO's discretion. Often, clients would request a change in POs, believing their PO was stricter than others.

The POs do maintain discretion in their recommendations to the judge for how severe the sanctioning should be once the client has been arrested. For some clients, the mere fact of being immediately arrested could have the same impact as serving time in jail. POs take into consideration the individual and his/her situation and recommend sanctions accordingly.

Q. What share of your officers' caseloads is now in HOPE?

A. Nearly all of the clients in this section are in HOPE (over 1,000).

Q. Six years into HOPE, how do you and your officers feel about HOPE, and how does it compare to probation-as-usual?

A. The POs prefer HOPE to non-HOPE cases as it increases their efficacy as change agents. To effect changes in behavior, offenders need to see there are distinct disadvantages to maintaining the status quo. The experience and consequences of losing their liberty and seeing the impact on others who are meaningful to them help to provide the reason or need to change. Sobriety provides them the opportunity to experience the benefits of change, and we're hoping these benefits will reinforce the internal motivation to sustain the change after probation expires.

HOPE has not only improved offender accountability but has enhanced the credibility and accountability of probation in serving in the interests of community safety.

Q. How do the offenders you supervise feel about HOPE?

A. Based on what the POs tell me, at the onset, offenders are not likely to appreciate HOPE because the HOPE requirements -- such as the daily call-ins, frequent and random drug testing, and quick arrest and immediate, though often short term, jail time -- does interrupt, and sometimes disrupts, their lives. It's usually only after overcoming their addiction or after successfully doing probation do they see the benefits. It's akin to the realization that you learned the most from the strictest teacher, but only in hindsight and not at the time.

Q. What advice would you give to other jurisdictions that are considering trying HOPE Probation?

A. The results are amazing. I've been involved in nearly all of the probation department's major initiatives during my 28-year career, and this, by far, has been the most exciting and innovative. I see the positive impact it's had on clients and POs, and it fits in nicely with evidence-based practices.

Author Information

Angela Hawken, PhD is associate professor of economics and policy analysis at the School of Public Policy at Pepperdine University. She is from South Africa, where she taught undergraduate and graduate econometrics and microeconomics before moving to Los Angeles in 1998 to complete a PhD in policy analysis at the RAND Graduate School. She teaches graduate classes in research methods, statistics, applied methods for policy analysis, crime, and social policy. Her research interests are primarily in drugs, crime, and corruption. At RAND, she conducted research on early education, sentencing, and tort reform. Hawken conducted the statewide cost-benefit analysis of California's Proposition 36, and led the randomized controlled trial of Hawaii's Opportunity Probation with Enforcement (HOPE), a swift-and-certain-sanctions model to manage high-risk probationers. Drug Czar, Gil Kerlikowske, identified HOPE as the most promising initiative that "not only prevents recidivism, but also actively assists individuals to transition to productive lives."

Hawken consults regularly for the UN and the State Department. She advised a State Department-supported think tank in Georgia. She is developing measurement instruments to study corruption and gender issues in the Asia-Pacific region, for the UN regional office, and her work is featured regularly in the UN Human Development Reports. She has visited Afghanistan twice, and is co-author of the Afghanistan corruption-monitoring system used by the UN and State Department to track public-sector corruption. She is also working on counternarcotics policy for Afghanistan, for the State Department. Hawken actively includes students in fieldwork for her research and in writing projects. She involved a dozen School of Public Policy students in the HOPE evaluation, and has placed over two dozen students in international internships.

Conflict of Interest Statement

I declare that I have no proprietary, financial, professional or other personal interest of any nature or kind in any product, service and/or company that could be construed as influencing the position presented in, or the review of, the manuscript entitled: HOPE for Probation: How Hawaii improved behavior with high-probability, low-severity sanctions.

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20. The extent to which these effects persist after the testing and sanctions are no longer in effect has yet to be established and in currently being assessed as part of a separate recently-funded study conducted by the author.

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A Multi-national Pre-consensus Survey: The Principles of Treatment of Substance Use Disorders during Pregnancy

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Abstract

While substance use disorders during pregnancy are a problem that every nation and community faces, there is a lack of written consensus or guidance on the principles that should serve as the foundation for best treatment practices for these women during this finite life experience. An on-line survey was completed by 62 individuals representing 22 countries. Findings from this pre-consensus survey indicate over 90% agreement on many of the principles of treating pregnant women for substance use disorders found in the literature. These data suggest that substance-using pregnant women are in need of treatment for abuse of multiple and diverse substances and that treatment must be readily available, dynamic, monitored, individualized, and address multiple social, medical, psychological functioning, and psychiatric issues in an integrated way. Areas where agreement fell below 90% included: (a) the efficacy of medications to treat nicotine-dependent pregnant patients; (b) incarceration as an ineffective intervention for stopping substance use during pregnancy; and (c) the need for treatment to be voluntary. These data also indicate strong support for a global consensus statement on the principles of substance use treatment during pregnancy. These findings, representing respondents from 22 countries from 6 continents, provide the critical momentum needed to pursue a formal global consensus statement on the principles of substance use treatment during pregnancy in an effort to improve the treatment of this vulnerable population of women.

Keywords: Pregnancy; Substance Abuse; Treatment; Women; International

Introduction

Substance use, including tobacco, alcohol, opioids (e.g., opium, heroin, prescription opioids), cocaine, other stimulants, marijuana, sedatives/hypnotics, hallucinogens, and volatile solvents, is a public health problem in every region of the world (1). Like non-pregnant individuals with substance use disorders, pregnant women with substance use disorders use substances in combination rather than in isolation. For example, opioid-abusing pregnant women report tobacco use at a rate more than four times higher than in the general pregnant population (2), and the combination of heavy-smoking in opioid-dependent pregnant women is associated with more adverse neonatal medical and developmental consequences than is lighter-smoking (3-4). These data underscore the need to treat women for the abuse of multiple substances during pregnancy and the challenge of isolating the contributions of individual drugs on neonatal outcomes.

Substance use disorders are both multifaceted medical illnesses and complex social problems (5-7). Among those individuals with substance use disorders, pregnant women are both the most vulnerable and most stigmatized. For almost all pregnant women, their substance use disorder precedes their pregnancy, and they face, like non-pregnant women, significant health disparities in the context of scarce financial resources, little formal education, inadequate/non-existent job skills, unemployment, a limited social support network – and, notably, a lack of access to substance abuse treatment, especially women- and pregnancy-specific treatment (8). Consequently, these health issues may also adversely impact their children, both in the short-and long-term.

While every community and nation must confront the issue of how best to address substance use disorders during pregnancy, there is a lack of written consensus or guidance on the principles that should serve as the foundation for best treatment practices for these women during this finite life experience.

Therefore, in 2009 the US National Institute on Drug Abuse (NIDA) sponsored the first in a series of international symposiums on this topic. Over 100 international researchers, clinicians, and government regulators and policy-makers, representing countries from 6 of the 7 continents (excepting Antarctica) who had a shared interest in improving the treatment of substance use disorders in pregnant women participated.

This first symposium's purpose was to begin a multi-national dialogue with regard to the development of principles of best practices for the treatment of pregnant women with substance use disorders. The first meeting's objectives included: (1) synthesizing the agreement level expressed by the international audience with regard to the current state of treatment of substance use disorders in pregnant women in their community and country; (2) determining the extent of agreement with potential principles for best practices in substance use disorder treatment of pregnant women based upon NIDA's principles of effective treatment (9); and (3) presenting data from and the experience of experts who treat the focus population. This paper summarizes the results of the survey that served as the foundation for this multi-national dialogue.

Methods

Survey

Before the symposium, an English survey containing 46 closed-ended and Likert-type questions (response options included "not at all", "a little", "somewhat" and "tremendously") was developed (by NIDA staff and authors HJ & GF). The survey asked participants about the current state of treatment in the respondent's local community (e.g., a specific locality with a shared government where the respondent works); the current state of treatment in the participant's country; the extent to which the respondent personally agreed with statements related to NIDA's principles of effective treatment (NIDA, 2009) tailored for pregnant women; and the extent to which a multi-national consensus statement would help improve the treatment of pregnant women for substance use disorders. [A pdf copy of the survey instrument is available from the corresponding author upon request.]

Participants and Sampling

An online survey invitation was sent to 223 individuals in one or more groups: NIDA International Forum registrants, International Women's and Children's Health and Gender Group members, and past pregnancy and addiction symposium/workshop attendees.

Procedures

Survey Monkey responses were collected from 1 April to 1 June, 2009. Respondents identified themselves by city and country.

Psychometrics of the Instrument

Internal consistency a was calculated for three separate sets of items on the survey (the 5 Community items, the 5 Country items, and the 15 items that assessed the extent to which participants personally agreed with statements related to NIDA's principles of effective treatment tailored for pregnant women) to assess consistency of responding to the survey on the part of participants. The Community and Country items were scored 1 = "Yes", 0 = "Don't Know", and -1 = "No", while scoring for the 15 endorsement items was based on the 4-point Likert scale used to collect the data: 1 = "not at all", 2 = "a little", 3 = "somewhat", and 4 = "tremendously". The resulting a values were .62, .78, and .81, respectively. These values clearly indicate consistency of responding on the part of the participants, particularly given the fact that there were only 5 Community and 5 Country binary items on which each a was calculated. [If the "Don't Know" responses are considered missing for the Community and Country items, the resulting as are .69 and .81, respectively.]

Analyses

Percentages were calculated to evaluate the response patterns associated with the survey questions that pertained to categories (a)-(d) (see Survey). Response options "not at all" and "a little" were collapsed into a disagree category; responses of "somewhat" and "tremendously" were collapsed into an agree category.

Results

Sample

Sixty-two individuals completed the survey [27.8% response rate, a rate similar to other anonymous surveys of professionals regarding substance use in pregnant women (e.g., (10)], representing 22 countries [M=2.7 (SD=1.2) respondents/country]: Africa (Nigeria, South Africa), Asia (Georgia, Indonesia, Israel, Pakistan, Thailand), Australia, North America (Canada, Puerto Rico, United States), South America (Brazil, Columbia, Uruguay) and Europe (Austria, France, Kosovo, Netherlands, Norway, Romania, Sweden, and United Kingdom). Forty-six percent of respondents reported working in a multidisciplinary unit or in an organized treatment network for substance-abusing pregnant patients.

State of the Treatment of Pregnant Women for Substance Use Disorders in Respondent's Community and Country

Substances Used in Respondent's Communities

Respondents most commonly indicated that tobacco (76%) and alcohol (76%) were substances used by

pregnant women, followed by marijuana (61%), cocaine (56%), heroin (46%), benzodiazepines (44%), prescribed opioids (32%), methamphetamine (11%), amphetamines (9%), and inhalants (4%).

Community and Country Treatment Responses

As shown in Table 1, specialized care was more frequently reported as available in respondent's community than available on a country-level for treating substance use disorders during pregnancy. This finding may reflect where the respondents work (i.e., in specialized areas with high prevalence). Opioid maintenance treatment was available for pregnant women in over 70% of both respondent's communities and countries. Methadone and buprenorphine were most widely available. Naltrexone, a medication with pre-clinical data raising concerns about its use in pregnant patients and lacking adequate maternal and neonatal safety (11) was infrequently reported. The majority of respondents said that incarceration was not used in their country or community in an attempt to stop pregnant women from using substances during their pregnancy. Most programs for treatment of pregnant women for substance use disorders in local communities and in their respective countries provide screening and assessment for co-occurring psychiatric disorders, problems in psychological functioning, and current smoking of nicotine/other tobacco forms. Unfortunately, only a minority of respondents indicated that assessment and treatment for drug use was offered to co-dependent partners of pregnant patients in their local communities or countries.

Greatest Consensus

As shown in Table 2, there was 100% agreement with the statement that a pregnant woman's treatment and services plan must be assessed continually and modified as necessary to ensure that the treatment plans meet her changing needs. Over 90% also agreed that drug treatment for pregnant women's substance use disorders needs to be readily available, attends to multiple needs of the pregnant patient, includes the use of medications such as methadone to treat opioid dependence, and has co-existing mental disorders treated in an integrated way. Respondents (98%) also consistently agreed that treatment programs for pregnant women should provide assessment for HIV/AIDS and other infectious diseases and counseling to help patients alter behaviors that place themselves or others at risk of infection. Finally, and most important to future endeavors, 93% agreed that a global consensus statement would help improve the treatment of pregnant women for substance use disorders in their country and in the world.

Greatest Discussion

There were three areas where respondent agreement fell below 90%. First, 81% agreed (19% disagreed) that medications are an effective element of treatment for nicotine-dependent pregnant patients. Second, 77% agreed (23% disagreed) that incarceration was not effective for preventing illicit substance use during pregnancy. Third, 63% agreed (37% disagreed) that treatment does not need to be voluntary to be effective for pregnant women.

Discussion

Main Conclusions

The findings from this pre-consensus survey indicate a high level of agreement on many of the literature-supported principles of treating pregnant women for substance use disorders. These results also suggest that pregnant women are in need of treatment for use of multiple and diverse substances of abuse. There is overwhelming agreement that treatment for this patient population must be readily available, dynamic, monitored, individualized, and address multiple social (e.g., education, parenting) , medical (e.g., obstetrical, infectious diseases), psychological functioning (e.g., autonomous self-regulation, feelings of self-worth), and psychiatric (e.g., depression, anxiety, and psychotic disorders) issues in an integrated way. Further, the use of agonist medications to treat opioid dependence during pregnancy (12) was a common and important treatment component. These findings also indicate that momentum for a multi-national consensus statement on the principles of drug treatment during pregnancy would make a highly welcomed positive public health impact on the treatment of pregnant women for substance use and other secondary disorders in many locations throughout the world.

Discussion of Lower Consensus Areas

As would be anticipated, there are several areas for greater discussion. Relatively lower levels of agreement were observed in the areas where clinical research is actively evolving and ethical debates continue. The somewhat lower level of agreement regarding medications as an effective element of treatment for nicotine-dependent pregnant patients may be due to the controversy surrounding safety concerns and lack of efficacy of nicotine medication products in pregnant humans (13-18) and the lesser known safety and efficacy of other smoking cessation medications such as Bupropion SR (a non-nicotine medication) and Varenicline [nicotinic receptor partial agonist (19)]. In fact, current research data cannot provide definitive conclusions about the risks and benefits of any medication for smoking cessation during pregnancy (19). Thus, focusing on non-pharmacological/behavioral approaches for treating tobacco use during pregnancy is important. Second, the lowest agreement was in regard to the related areas of involuntary treatment and incarceration. U.S. research has shown that non-pregnant participants subjected to judicial treatment-entry pressure results in similar or improved outcomes relative to participants without such legal pressure (9, 20-21). Other U.S. data support the use of "family treatment drug courts" (22) or adaptive interventions to enhance the efficiency and effectiveness of "drug court" programs (23). However, on an international level, the strength of the data supporting the effectiveness of drug treatment programs for drug-using offenders in the courts or the community is limited, given wide methodological variation in drug court implementation and outcome measurement (24). Moreover, the present survey findings suggest an appropriately heightened concern regarding the efforts of some

members of some societies to criminalize drug use during pregnancy (e.g., removal of child custody, involuntary institutional commitment, or incarceration) or use potentially coercive or punitive policy approaches to treat substance use disorders and the need to educate health care providers and policy makers on the illness of addiction (25). Survey responses may also reflect many medical societies' conclusions that a stigmatizing criminalization approach to substance use in pregnancy is contraindicated from multiple perspectives including public health policy, health care perspectives, and ethical standards in many societies. In countries where a global change evolved (as in France during the 90s) from a stigmatizing perspective to a medical, social, and psycho-ethic one, a dramatic improvement in both mother and newborn child health status was effected (26, 27). A criminalization approach also ignores the contextual issues of gender inequality, poverty, victimization, violence, and unequal access to education, employment, and child care opportunities experienced by substance-using pregnant women (28).

Strengths and Limitations

Several limitations of this study are noted. First, this sample was composed of respondents who comprehended written English from many non-English-speaking, albeit diverse countries, with a range of backgrounds in terms of formal educational and professional expertise. Thus, their responses may not reflect responses of other providers/researchers/policy-makers working in other treatment modalities or employed in other geographical areas. Second, while the response rate is typical of surveys on this topic, use of techniques to maximize postal-style survey response rates may have improved the final response rate (29) .Third, the questions and to whom the responses were to be submitted may have influenced the respondents' responses; however, the anonymous nature of the survey should have helped minimize demand characteristics. Fourth, other interesting questions were outside the scope of this survey (e.g., co-occurring physical disorders). Finally, the degree to which these findings will generalize to the broader treatment environment worldwide is unknown. Regardless of these potential limitations, findings from this survey nonetheless begin the process of creating an evidence-based consensus regarding the treatment of pregnant women for substance use disorders.

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Conflicts of Interest
The authors declare that they have no proprietary, financial, professional or other personal interest of any nature or kind in any product, service and/or company that could be construed as influencing the position presented in, or the review of, this manuscript.

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Prop 19: Indifference to Public Health

Bertha K. Madras, PhD

Proposition 19 on the November 2, 2010 California statewide ballot asks the people of California to permit the state to legalize marijuana, collect taxes on its sale, and apply tokens of face-saving regulations. With windfall profits in store, the proponents have shaped the legalization argument stating that it would (1) help to offset California's budget deficit, (2) cut into profits of violent drug cartels, and (3) free law enforcement resources to focus on more dangerous crime. Rigorous scrutiny can dismantle each of these arguments. Tactic (3) is recognizable from earlier use in the marijuana decriminalization (Prop. 2) debate in Massachusetts. It was featured in hourly TV ads narrated by an allegedly well-reimbursed former policeman. Massachusetts district attorneys informed me that after careful analysis of the scant number of arrest records for marijuana possession, no credible evidence could be found that law enforcement was being diverted away from serious crimes, because they were occupied with arresting people in possession of small personal quantities of marijuana - none. Two years ago, the Democratic Massachusetts Attorney General Martha Coakley and I shared a podium to speak in opposition of Prop 2. A few weeks ago, Attorney General Eric Holder weighed in on Prop 19 by stating that, regardless of how California votes, Federal anti-marijuana laws will be enforced. His appropriate response, however, is compromised by his refusal to enforce Federal laws regulating "medical marijuana".

Propaganda can be effective. In 1996 it convinced Californians to approve Prop. 215 and its heir SB420 which allowed for a smoked (!!) leaf of unknown chemical composition, unregulated doses of psychoactive ingredients, and hundreds of other potentially hazardous chemicals to treat serious medical conditions including "AIDS, anorexia, arthritis, cachexia, cancer, chronic pain, glaucoma, migraine, persistent muscle spasms, seizures, epilepsy, severe nausea, any other chronic or persistent medical symptom that substantially limits the ability of the person to conduct major life activities". The most obvious objection to passage was the use of smoking as a delivery system, after a 40 year campaign to stop smoking. The second objection was the poor quality of evidence (or no evidence) for marijuana's safety and efficacy. A few years after Prop 215 passage, Governor Davis funneled millions of dollars into medical marijuana research to seek validity for these "ballot-approved" medical claims. After a decade of funding, this California Center for Medicinal Cannabis Research has issued 24 publications. Only four were clinical studies that examined the medical indications stated in the ballot initiative, and these recruited only experienced marijuana users. One conscientious study recorded the side effect profile of marijuana: patients reported pain reduction, but also reported feeling high, being impaired, feeling sedated, and showed cognitive impairment in learning, speed recall, and attention. Five major clinical studies were discontinued because the investigators could not recruit enough patients to study marijuana effectiveness for cancer pain relief, muscle spasticity, multiple sclerosis, severe nausea and vomiting, and neuropathic pain. The third objection is that Californians, in electing to vote in favor of this "medicine" (Prop 215), circumvented stringent FDA standards, a measure that threatens our elaborate and sophisticated drug approval system. FDA standards have protected Americans from fraudulent, dangerous or ineffective drugs for decades with an approval system, although imperfect, that is among the most rigorous in the world. Consider the wise FDA response to ballot initiatives for the sham cancer treatment laetrile and denial of approval for thalidomide and a host of other unacceptable drugs. Circumventing FDA approval by a ballot initiative is a dangerous, slippery slope that can create chaos in the approval process for evidence -based medicines. The FDA requires that a new drug is a pure compound, its chemistry, manufacturing, and composition of matter are tightly controlled so that each batch is identical, that its production methods are validated, that its pharmacology and toxicology in animals is known, and that its rate of entry, bioavailability, toxicology, microbiology, dose response, efficacy, safety, side effect profiles are documented. After approval, case reports and safety updates are required to be submitted to the FDA for ongoing evaluation.

The practice of medicine increasingly is evidence-based, but marijuana has no academic presence in medical training; there is no requirement to extract medical history or give a detailed medical exam, discuss long term treatment, effects, or follow-up, provide informed consent, consult with other physicians, keep proper records that support recommending marijuana instead of safe approved alternatives, have a good faith relationship with patient rather than a "marijuana mill", or be able to identify substance abusers or the addicted.Dispensaries had no product liability, no product regulation, no chain of custody, no accountability. At the time the ballot passed, was marijuana's scientific record sufficient to fulfill FDA's rigorous standards of safety, efficacy, and side effect profile? Was smoked marijuana a safe and effective treatment for over 12 diseases, including the myriad forms of chronic pain that respond uniquely to different class of drugs (e.g. non-steroidal anti-inflammatory, steroids, GABA-based, opioid drugs)? The smoked marijuana leaf does not even begin to meet acceptable standards.

Fourteen years later Californians face another ballot initiative, with the same strategies used in passing Prop 215. It is not accidental that the legalization bill landed in California. A well-funded itinerant machine

has traveled from vulnerable state to state, using propaganda to overturn evidence-based Federal laws and regulations that are shaped by well informed professional judgment. Normalization of marijuana use via a "medical" moniker was a tactic to drive the incremental process in California, a receptive state that takes great pride in leading social change in America. Prop 215 ignored the paucity of science. Prop 19 ignores the abundant science. Prop 19 focuses on law enforcement, crime, and tax windfalls, but the mammoth in the room - public health, the potential for creating unacceptable human suffering and disproportionate taxpayer costs – is ignored. Even Prop 19 opponents, with their focus on public safety, workplace, and federal funding, do not fully address a critical spectrum of marijuana-related health issues. Personal and public well-being have been the primary motives driving marijuana laws. Maintaining these laws are more compelling than ever, as marijuana potency and availability soar, in parallel with escalating scientific evidence of marijuana's adverse consequences. Unlike opioids, marijuana is not likely to cause death by overdose, but it resides in Schedule I because of its high abuse liability, intoxicating properties, and no medical indications – essentially because it adversely affects brain function and biology. As an intoxicant, a Saturday night marijuana binge can have residual cognitive deficits on learning and memory for several days (marijuana research protocols generally wait at least 5-30 days for marijuana to clear before measuring its long term residual cognitive effects). These deficits are readily quantified, exaggerated in schizophrenics, and should refute the advocates who expound the benefits of marijuana for Alzheimer's diseased patients. The 2009 National Highway Traffic Safety Administration (NHTSA) showed that more people are driving weekend nights under the influence of marijuana (8.3%) than alcohol (2.2%). It is unacceptable for airline pilots, marines, physicians, nuclear power plant operators, or policemen to be impaired on the job but acceptable for drivers, teachers, day care providers, construction workers, students, nurses, or miners? Emergency department mentions of marijuana in the US have increased from 281,619 to 374,435 during 2004-2008, in parallel with linear increases in marijuana potency and marijuana addiction. With the California population at 12% of the nation's population, marijuana conceivably can add at least $60 million (in 2004 dollars) to ED health care costs.

Are there enduring effects of marijuana? Marijuana is addictive for about 9-10% of users, and progression to addiction is more rapid than progression to nicotine addiction. Abstinence in the heavily addicted unmasks physical and psychological neuroadaptation, manifest by an unnerving withdrawal syndrome. Nationwide, more people have a medical (DSM-IV) diagnosis of marijuana abuse/addiction than for any other illicit drug, and more youth are DSM-IV positive for marijuana than for alcohol. Extrapolating from national statistics, a parsimonious estimate is that half a million people in California harbor a DSM-IV diagnosis for marijuana addiction/abuse. With an average cost of $4,000 for addiction treatment in an ambulatory setting and at least four times that amount for residential care, this can add an estimated $2 billion in marijuana treatment needs for California annually. The addiction rates of marijuana are 6-fold higher in youth who initiate marijuana use at age 14 or younger. In a perfunctory token to concerned citizens, Prop 19 attempts to wall off youth from marijuana access. Yet there is no reasonable evidence that California will effectively block marijuana use by young adolescents. Our abysmal failure at preventing youth from smoking cigarettes should be our intuitive guide. Early onset of marijuana use is also associated with addiction to other drugs in adulthood, including alcohol and heroin. This phenomenon can be explained away by a host of factors, genetics, social environment, poverty, child abuse, or psychiatric conditions. But how to explain that rats exposed to the most active constituent of marijuana, delta-9-tetrahydrocannabinol or THC, *only during adolescence*, seek heroin at higher rates after they mature into adults and display a fundamental change in brain opioid systems long after their last dose? Social, environmental, poverty, child abuse, or psychiatric conditions do not apply to inbred rats – in this case the drug alone alters the trajectory of brain and behavioral development.

A link between marijuana use and neuropsychiatric disorders is developing. In population studies of more than 75,000 people from seven different countries, early marijuana use was found to be associated with an average two-fold higher risk for later-onset psychosis and schizophrenia in vulnerable populations. The influential medical journal *Lancet*, which declared in 1995 that "The smoking of cannabis, even long term, is not harmful to health" changed this conclusion in 2007 by stating that "Research published since 1995, including [the] systematic review in this issue, leads us now to conclude that cannabis use could increase the risk of psychotic illness… governments would do well to invest in sustained and effective education campaigns on the risks to health of taking cannabis." A current debate is being waged on whether to revise comparative risk assessment in the Global Burden of Disease (GBD) to include the attribution of psychosis to marijuana use. Degenhardt et al argue that the risk assessment should be included because the evidence is as good as that for many other risk factors in the GBD. Some scientists have estimated that marijuana contributes about 8% to new cases of schizophrenia. If this estimate is accurate, unfettered marijuana access in California conceivably would add 25,000+ cases of schizophrenia, with a lifetime estimated cost of caring for this cohort in excess of $6 billion (based on a low estimate of $8,000/per patient/year, for 30 years).

Heavy daily marijuana use across protracted periods can exert harmful effects on brain tissue and mental health. Brain imaging of long-term heavy marijuana users has shown exposure-related structural abnormalities in brain regions critical for learning, memory and emotional responses, with changes associated with impaired verbal memory and other symptoms. Abnormal brain size and circuitry in brains of adolescent marijuana users have also been documented recently. Compromised academic performance, school drop-out, and a host of other adverse consequences are elevated in high school and college students who use marijuana. Accurate price tags for these lost educational and employment opportunities don't exist, but at the very least, they should weigh heavily on the voter's conscience. Peripheral health is also affected, as marijuana use is associated with increased risks for bronchitis, compromised pulmonary function, precancerous lung changes, cardiovascular events, problematic pregnancies, and teratogenic and hormonal effects.

Despite this evidence, 2009 was a banner year for marijuana use in our nation. Compared with 2008, in 2009 1.5 million more marijuana users were added to the ranks. The steady decline in marijuana use among youth over the past 6 years was reversed in 2009. Marijuana use among 12-17 year olds increased by over 7%, with a 14% increase among boys and a 13% increase among college students. Expanding acceptance of medical marijuana, reduced perception of harm, and proliferating availability conceivably are driving a pivotal upward swing in use. Imagine the impact of Prop 19 approval on California use/addiction/health/psychosis/school performance statistics in the coming years!

The commercials on TV and editorial support of Prop 19 are misguided and misleading. Who are the real beneficiaries from normalization of marijuana use? Intelligent California voters will perform due diligence, examine the biomedical literature on marijuana (e.g. NIDA: http://drugabuse.gov/infofacts/marijuana.html), and make evidence-based decisions. Californians have a unique opportunity to display to the nation and to bewildered citizens of other countries that they do not base important decisions on seductive propaganda.

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