Journal of Criminal Law and Criminology

Volume 94
Issue 1 *Fall*

Article 4

Fall 2003

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0091-4169/03/9401-0133
THE JOURNAL OF CRIMINAL LAW & CRIMINOLOGY
Vol. 94, No. 1

Printed in U.S.A.

COMMENTS

DRUG COURTS AND THE DE FACTO LEGALIZATION OF DRUG USE FOR PARTICIPANTS IN RESIDENTIAL TREATMENT FACILITIES

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The recreational possession and use of some drugs is regarded as a criminal offense in every state in the nation.[1] What this means for an offender is that the state views discrete incidents of detected possession not as manifestations of an over-arching addiction, but as isolated crimes deserving punishment. This approach comports with a traditional perception of drug addiction as being explicable as an offender's repeated and willful refusal to abstain from using drugs.[2] If repeated drug use is

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[1] *See* Robert MacCoun & Peter Reuter, *Preface: The Varieties of Drug Control at the Dawn of the Twenty-First Century*, 582 ANNALS AM. ACAD. POL. & SOC. SCI. 7, 10-11 (2002). The authors describe a universal cross-national de jure prohibition of recreational drug possession and use, with the exception of the Netherlands' formal nonprosecution policy for possession and sale of small amounts of cannabis. They note that "a dozen U.S. states have decriminalized marijuana possession to some extent," though. *Id.*

[2] Michael C. Dorf & Charles F. Sabel, *Drug Treatment Courts and Emergent Experimentalist Government*, 53 VAND. L. REV. 831, 842 (2000) (Prior to the introduction of drug courts, "the criminal justice system . . . saw infractions of the rules of sobriety as a failure of will that belied the dedication to and capability for recovery (and perhaps demonstrated criminal intent) . . . ."); *see also* DAVID F. MUSTO, THE AMERICAN DISEASE 82-87, 249 (2d ed. 1987) (describing the long-standing debate among medical practitioners over whether addiction should be viewed as merely a habit or as a treatable disease).

interpreted as a result of willful choices, then there is no theoretical difficulty in punishing isolated uses as separate crimes.[3]

However, in every state, there is a class of drug users for whom discrete incidents of use are treated, de facto, not as isolated crimes, but as part of a treatment process. Some offenders who are charged with a drug-related crime may be allowed to accept a transfer from criminal trial court to a drug court,[4] some of which are now operational in every state.[5] A drug court is "a court that closely monitors treatment for drug-addicted defendants brought before it."[6] While under supervision of the drug court, the offender is placed into a drug treatment program, with the assurance that charges will be dropped upon successful completion of the program.[7] If a drug court participant tests positive for drug use while in treatment, the judicial response is muted. Because relapse to drug use is recognized as an "expected and accepted" part of the treatment process, the typical drug court response is not immediate removal to criminal trial court, but a "smart punishment," which has been described as "not really punishment at all, but a therapeutic response to the realistic behavior of drug offenders in the grip

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[3] *Cf.* Powell v. Texas, 392 U.S. 514 (1968). In holding that a fine for public drunkenness imposed on a man claiming to be a "chronic alcoholic" did not violate the Cruel and Unusual Punishment Clause of the Eighth Amendment, the Court wrote:

> Traditional common-law concepts of personal accountability . . . lead us to disagree with appellant. We are unable to conclude, on the state of this record or on the current state of medical knowledge, that chronic alcoholics in general, and Leroy Powell in particular, suffer from such an irresistible compulsion to drink and to get drunk in public that they are utterly unable to control their performance of either or both of these acts and thus cannot be deterred at all from public intoxication.

Id. at 535.

[4] Dorf & Sabel, *supra* note 2, at 832. Note that not every offender who commits a drug-related crime is eligible for transfer to drug court. See *infra* notes 64-85 and accompanying text for a discussion of which drug-using offenders qualify for drug courts. Generally, requirements include that the offender be considered non-violent and amenable to treatment, though insufficient funding may preclude all such offenders from enrolling in drug courts.

[5] James L. Nolan, Jr., *Preface* to DRUG COURTS IN THEORY AND IN PRACTICE, at vii-ix (James L. Nolan, Jr., ed., 2002) [hereinafter DRUG COURTS]. Nolan avers that "by the summer of 2001, more than 1200 drug courts had been initiated or were in the planning and implementation stages throughout the United States, with drug courts operating in all fifty states, the District of Columbia, Guam, and Puerto Rico." *Id.* at ix. *See also* OJP DRUG COURT CLEARINGHOUSE AND TECHNICAL ASSISTANCE PROJECT, AMERICAN UNIVERSITY, SUMMARY OF DRUG COURT ACTIVITY BY STATE AND COUNTY (2003), *available at* http://www.american.edu/justice/publications/drgchart2k.pdf (showing that there are over one thousand operational, and over four hundred planned, drug courts throughout the country).

[6] Michael C. Dorf, *Legal Indeterminacy and Institutional Design*, 78 N.Y.U. L. REV. 875, 938 (2003).

[7] *See* Dorf & Sabel, *supra* note 2, at 832.

of addiction."[8] Sanctions may include more frequent contact with the drug court, increased urine testing, or short periods of incarceration.[9]

The rationale underlying the imposition of these relatively moderate sanctions is an understanding of drug addiction, not as a sequence of willful acts, but as a treatable "chronic relapsing condition" which cannot be managed successfully without missteps along the way.[10] Drug use is not viewed as "the failure of treatment, but as an inevitable stumbling block on the road to abstinence."[11]

In its application, the drug court model of addiction as disease works to create a de facto immunity against further drug-offense prosecution for drug court participants undergoing residential treatment. Because treatment facilities do not report on-site drug offenses to the police, but to drug courts,[12] and because prosecutors will generally not bring new criminal charges against a drug court participant when treatment facility personnel report her relapse to the drug court,[13] drug court participants undergoing residential treatment enjoy a practical immunity from prosecution. The result of this scheme is that some drug offenders enjoy the benefits of having their drug use viewed as a treatable disorder,[14] and may emerge from

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[8] Hon. Peggy Hora et al., *Therapeutic Jurisprudence and the Drug Court Treatment Movement: Revolutionizing the Criminal Justice System's Response to Drug Abuse and Crime in America*, 74 NOTRE DAME L. REV. 439, 469-70 (1998).

[9] Richard C. Boldt, *Rehabilitative Punishment and the Drug Treatment Court Movement*, 76 WASH. U. L.Q. 1206, 1211 (1998).

[10] Dorf & Sabel, *supra* note 2, at 841. Dorf and Sabel elaborate on the adoption of the "chronic relapsing condition" paradigm:

> There was unlikely to be a straight path from addiction to recovery; rather, addicts undertaking recovery could be expected to relapse into addiction, often many times . . . . Sanctions were necessary to demonstrate palpably that relapse was costly, but forbearance was necessary to help the addict learn through experience to anticipate the conditions that triggered relapse and the mechanisms for effectively avoiding it.

Id. at 841-42.

[11] Hora et al., *supra* note 8, at 454.

[12] *Id.* at 475; *Rehab Staffers Can Reject Queries on Noelle Bush*, ST. PETERSBURG TIMES, Oct. 1, 2002, at 5B ("[O]nly under rare circumstances is law enforcement called in if a patient is found with drugs [at residential drug treatment facilities]."); Dana Canedy, *Judge Upholds Privacy for Jeb Bush's Daughter*, N.Y. TIMES, Oct. 1, 2002, at A22 (relating the statement of a drug treatment facility's lawyer that, although centers sometimes call police to retrieve illegal drugs, they do not identify the patient who possessed them, and police typically do not seek to press new charges against the patient).

[13] Hora et al., *supra* note 8, at 528.

[14] *Id.* at 464 (stating that drug courts view addiction as a biopyschosocial disorder, in that "biological, psychological, and social factors are deeply woven in the development of addiction") (quoting John Wallace, *Theory of 12-Step-Oriented Treatment*, *in* TREATING SUBSTANCE ABUSE, 13, 15-19 (Frederick Rogers et al., eds., 1996)).

a relapse-plagued treatment with a clean record, while other offenders may be prosecuted for every discrete drug offense under the rationale that drug use is a willful act that should be curbed through deterrence and punishment.[15]

The immunity of drug court participants undergoing residential treatment from criminal prosecution for drug use is only de facto, not de jure. Drug court statutes typically provide that a drug court judge will monitor a participant's progression through treatment, returning recalcitrant offenders to criminal court if necessary.[16] They do not, however, explicitly provide that participants who relapse during treatment will be immune from prosecution for these new offenses.[17] Indeed, drug court patients undergoing outpatient treatment are prosecuted for relapse-related drug possession.[18] Instead, participants in residential treatment have three shields from prosecution. The first two, already mentioned, are prosecutorial discretion and treatment facility policy.[19] The third shield, and the only one that lies in statutory law, is arguably a federal confidentiality statute, 42 U.S.C. § 290dd-2, which provides that employees of drug treatment facilities may disclose records concerning treatment participants only in very limited circumstances.[20]

The legal status of relapsing drug court participants undergoing residential treatment is an under-examined facet of drug court jurisprudence. Since the establishment of the first drug court in Miami, Florida, in 1989, jurisdictions throughout the nation have enthusiastically embraced the concept.[21] The rapid expansion of a concept that "in many ways represent[s] a qualitatively new phenomenon in the area of criminal justice"[22] has evoked disparate reactions among commentators, ranging from gushing praise[23] to unqualified contempt.[24] But the empirical fact

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[15] Dorf & Sabel, *supra* note 2, at 842 (describing the establishment of drug courts as marking an abandonment of the view that "deterrence and punishment were the only effective 'therapies'" for drug addiction).

[16] *See infra* notes 106-09 and accompanying text.

[17] *See infra* notes 64-65 and accompanying text.

[18] *See infra* note 110 and accompanying text.

[19] *See supra* notes 12-13 and accompanying text.

[20] 42 U.S.C. § 290dd-2 (2002).

[21] *See infra* notes 55-62 and accompanying text.

[22] Sara Steen, *West Coast Drug Courts: Getting Offenders Morally Involved in the Criminal Justice Process*, *in* DRUG COURTS, *supra* note 5, at 51.

[23] Hora et al., *supra* note 8, at 462 (hailing drug courts as "a new approach to breaking the cycle of drugs and crime").

[24] *See, e.g.*, Morris B. Hoffman, *The Drug Court Scandal*, 78 N.C. L. REV. 1437, 1439 (2000) (describing the rapid spread of drug courts as a "contagion").

remains that drug courts have evolved from a single experimental program into what might be reasonably termed a "movement"[25] in the matter of a little more than a decade. Because the impetus for this rapid expansion appears to be more of a response to the structural pressures on local judicial systems from burgeoning drug-related caseloads[26] and to the strong political support for the concept[27] than a programmatic implementation of settled principles,[28] drug courts have achieved the status of a judicial institution without a thorough examination of their underlying jurisprudence. If drug courts are to continue to hold a dominant position in American drug policy, the potential they offer for treating similarly situated drug-using offenders differently should be examined.

This Comment argues that, because there is currently no legal basis providing for the immunity of relapsing drug court participants in residential treatment facilities, states should amend their statutes enabling drug courts to reflect the practical reality that such participants are immune from prosecution for drug use during court-supervised treatment. Not only is immunity for relapse-related use important to the continued vitality and success of drug courts, but a political recognition that drug courts treat drug use very differently from the rest of the criminal justice system would prompt public debate on a policy that is currently being applied *sub silentio*.

Part I of the Comment examines the rapid, decentralized rise of drug courts and details their common features, including limited eligibility and removal of the participant from the criminal justice system. Part II examines the legal issues presented by the uncertain legal status of drug-using participants undergoing residential treatment through the lens of Noelle Bush's recently completed involvement with Florida's drug court

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[25] Philip Bean, *Drug Courts, the Judge, and the Rehabilitative Ideal*, *in* DRUG COURTS, *supra* note 5, at 235.

[26] Hora et al., *supra* note 8, at 449 (stating that the focus of early drug court practitioners was on "preventing the collapse of local court systems under the weight of drug cases").

[27] *See* JAMES L. NOLAN, JR., REINVENTING JUSTICE: THE AMERICAN DRUG COURT MOVEMENT 53-4 (2001). Noting the "versatile and wide-ranging appeal" of drug courts, Nolan writes: "Supporters of drug courts span the political spectrum. Conservatives like it because of its tough, intrusive nature; and liberals like it because of its ostensibly more humanitarian and rehabilitative qualities." *Id.*

[28] *See* Hora et al., *supra* note 8, at 449 ("[F]ew early DTC [drug treatment court] practitioners worried about the jurisprudential theory behind the DTC movement. DTCs seemed to work, and the absence of analysis or debate coming from the 'ivory towers' of academia about the efficacy of drug treatment in a criminal justice setting did not much matter.").

system.[29] Part III considers the effect of 42 U.S.C. § 290dd-2 in assuring confidentiality for individuals undergoing drug treatment in residential facilities, and concludes that, because the statute cannot be reasonably interpreted to shield drug court participants from investigation of relapse-related drug offenses, the continued vitality of drug courts should rest on stronger, and more transparent, statutory grounds.

I. THE RISE OF DRUG COURTS

Drug courts have spread across the United States through a decentralized, grassroots process, in which local judges and law enforcement officials have worked to implement this unique form of jurisprudence.[30] Each participating jurisdiction has modified, and experimented with, the drug court model to fit its own needs, yielding a multiplicity of variations on the basic model.[31] Nevertheless, drug courts in different jurisdictions share common features, including "relatively restrictive definition[s] of eligibility"[32] and a removal of qualifying participants from the criminal courts and placement into drug court-supervised treatment.[33] Taken together, these two features ensure that the

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[29] Noelle Bush is the daughter of Florida Governor Jeb Bush, and the niece of President George W. Bush. *See* Peter Wallsten, *Noelle Bush Case Sparks Legal Test*, MIAMI HERALD, Sept. 23, 2002, at 1B.

[30] NOLAN, *supra* note 27, at 42-43. Nolan cites Louisville drug court judge Henry Weber, who has stated that the drug court movement is "a grassroots kind of movement. It's not something where the bureaucrats in Washington tell you what to do. Each community has developed its own program for its own particular needs and they all deal with it on a local level. . . . It's totally a grassroots kind of thing." *Id.* at 42 (quoting Bean, *supra* note 25, at 718-21).

[31] *See* John S. Goldkamp, *The Drug Court Response: Issues and Implications for Justice Change*, 63 ALB. L. REV. 923, 929 (2000). Goldkamp writes:

> [T]he original Miami [drug court] model evolved in its successive adaptations in other settings, and in substance and procedure, was itself transformed as the basic model spread across the United States and abroad. The drug court methodology has been adapted to grapple with other problems associated with court populations, including community issues, domestic violence, and mental health, and has directly and indirectly spawned a variety of related innovations . . . .

Id.

[32] Boldt, *supra* note 9, at 1209.

[33] *Id.* at 1209-12. These are not the only commonalities across jurisdictions. *See* NATIONAL ASSOCIATION OF DRUG COURT PROFESSIONALS, DRUG COURT STANDARDS COMM., DEFINING DRUG COURTS: THE KEY COMPONENTS 10 (1997). The National Association of Drug Court Professionals has identified ten "key components" of drug courts, which are: integration of treatment and case processing; a non-adversarial approach respecting due process and public safety; early identification and placement of participants; provision of a continuum of treatment services; drug testing; court responses to performance in treatment; monitoring and evaluation; continuing interdisciplinary education; and partnerships between the court and other criminal justice, health, social services agencies, and the community. *Id.*

limited number of drug offenders that qualify for drug courts can receive very different outcomes in their cases than similar non-qualifying offenders.[34] This part of the Comment traces the rise of drug courts and describes their common features in more detail.

A. THE SPREAD OF THE DRUG COURT CONCEPT

Drug courts first made their appearance in the late 1980s, against the backdrop of the "extreme pressures placed on both the judicial process and local correctional populations" by the increasingly punitive drug policies of the 1980s.[35] As has been often noted, the United States declared a "war on drugs" in the 1980s, driven at least in part by broad public fears of a perceived crack cocaine epidemic.[36] Throughout the decade, the federal government and many states "increased public spending on antidrug law enforcement and dramatically augmented criminal penalties for the sale and possession of illegal drugs,"[37] with the federal government instituting mandatory minimum sentences for some drug crimes.[38] Between 1980 and 1993, American prison and jail populations tripled, much of the increase due to increased number of drug convictions and longer sentences for drug offenses.[39] By 1994, "drug traffickers (19%) and drug possessors (12.5%) together made up 31.4% of felons convicted in [s]tate courts,"[40] and over half of all federal prisoners were drug offenders.[41] Even as law enforcement efforts intensified and sanctions for drug offenders were made more severe, publicly-funded treatment became a lower priority.[42]

The "war on drugs" created special problems for courts. As drug indictments rose precipitously during the 1980s, responsibility for the cases

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[34] *See* Boldt, *supra* note 9, at 1211 (contrasting drug courts' "array of gradually increasing penalties" for relapse-related drug use with "the usual all-or-nothing approach found in most criminal sentencing and parole revocation decisions").

[35] Goldkamp, *supra* note 31, at 945.

[36] Boldt, *supra* note 9, at 1206-07 (stating that the "war on drugs" was "provoked in part by the emergence of widespread crack cocaine use in a number of large cities and media accounts of open drug trafficking, gang violence, and rampant property crime").

[37] *Id.* at 1206.

[38] Hora et al., *supra* note 8, at 457.

[39] Michael Tonry, *Race and the War on Drugs*, 1994 U. CHI. LEGAL F. 25, 25.

[40] PATRICK A. LANAGAN & JODI M. BROWN, U.S. DEP'T OF JUSTICE, FELONY SENTENCES IN STATE COURTS, 1994 (Jan. 1997), *quoted in* Hora et al., *supra* note 8, at 460.

[41] Hora, et al., *supra* note 8, at 460.

[42] Tonry, *supra* note 39, at 25. Tonry points to the facts that seventy percent of the federal funding for drug control was consistently earmarked for law enforcement efforts by the White House Office of National Drug Control Policy, and that the Office refused to approve a "treatment on demand" policy despite knowledge that tens of thousands of drug users wanted to, but could not, gain entry into treatment centers. *Id.*

fell upon courts "already overburdened by high case volumes."[43] Nationally, drug arrests increased 134% between 1980 and 1989,[44] prompting an "almost paralyzing influx of drug cases" that threatened to "[bring] the court system to its knees by the late 1980s."[45] Moreover, some judicial officials were becoming frustrated by the fact that harsher punishments seemed to cause jail overcrowding while having no effect on drug offenders' propensity for recidivism.[46] As one drug court judge explained the problem: "Basically, we have had a revolving door phenomenon where we take an offender, lock him up for whatever appropriate period of time, and have him back out in the community without addressing the underlying source of his criminal behavior."[47]

Drug courts represented a grassroots response to these concerns. The first drug court was established in Miami, Florida, in 1989, by an administrative order of the then-Chief Judge of Florida's Eleventh Judicial Circuit.[48] By diverting certain non-violent drug cases[49] into a special court that would oversee offenders' treatment for drug use, the Circuit hoped both to relieve crushing caseloads through streamlined procedures and to reduce recidivism by ameliorating the offenders' drug addictions.[50] What began as a local innovation spread across the country in the same manner, as individual jurisdictions adopted site-specific adaptations of the Miami model, supported by locally-generated funding.[51]

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[43] Boldt, *supra* note 9, at 1207.

[44] Hora et al., *supra* note 8, at 459.

[45] *Id.* at 462. *See also* Goldkamp, *supra* note 31, at 947 (stating that the large number of drug cases created an "emergency" in the late 1980s and early 1990s).

[46] *See* NOLAN, *supra* note 27, at 45-46 ("[T]he institutional realities (e.g., limited prison space, high rearrest rate among drug offenders, overcrowded court calendars) put pressure on the judges to come up with other plans for handling this group of offenders."). See Hora et al., *supra* note 8, at 461, for a discussion of drug offenders' propensity toward recidivism. The authors cite a study showing that fifty-one percent of parolees who abuse drugs will end up in back in prison, compared to a recidivism rate of forty percent for all parolees. *Id.*

[47] NOLAN, *supra* note 27, at 45. The speaker was Judge Diane Strickland, a Roanoke, Virginia drug court judge. *Id.*

[48] Hora et al., *supra* note 8, at 454-55.

[49] Hoffman, *supra* note 24, at 1461.

[50] Goldkamp, *supra* note 31, at 947 ("The theory was not only would potentially large numbers of drug-abusing defendants be diverted from formal processing and jail, but also by treating these defendants' substance abuse problems, future returns to the justice system could be greatly reduced.").

[51] *Id.* at 948 ("The first courts were the product of local innovation and 'elbow grease,' and, as a rule, produced new initiatives with broad-based support from local justice officials and with very little, usually locally generated funding.").

The grassroots spread of drug courts entailed substantial variations in the implementation of the basic concept throughout different jurisdictions.[52] Drug courts differ in several respects, including the criteria that courts use to determine participant eligibility, the point in the criminal justice process when participants are admitted to drug court, and the types of agencies employed to provide treatment to participants.[53] Another implication of the experimental, grassroots spread of drug courts was that they were implemented without a thorough examination of their jurisprudence and relation to the traditional criminal justice system.[54]

Despite its modest beginnings, the drug court concept has become a thriving institution in just over a decade.[55] By the summer of 2001, there were over 1100 operational or planned drug courts in the United States, and an estimated 226,000 offenders had been enrolled in a drug court program.[56] The rapid proliferation of drug courts was spurred by strong political support at both federal and local levels.[57] At the federal level, Congress has appropriated steadily increasing funding for drug courts since 1994.[58] The

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[52] *See* NOLAN, *supra* note 27, at 40. Nolan writes:

> Though all the courts follow the essential style and format established in the Dade County model, each drug court has its own unique features that depend on funding, the level of community support, personnel and other contingencies. As Phillip Bean puts it, "What one finds is that there are as many variations in the locus of Drug Courts within the legal system as there are Drug Courts themselves."

Id. (quoting Bean, *supra* note 25, at 720).

[53] *See id.* at 40-41. For a more detailed discussion of these elements of drug court jurisprudence, see *infra* notes 63-110 and accompanying text.

[54] Hoffman, *supra* note 24, at 1440. Hoffman contends that:

> [t]he scandal of America's drug courts is that we have rushed headlong into them . . . . We have embraced the drug court panacea without asking, let alone resolving, even the most basic of questions: What is the purpose of drug courts? Do drug courts work? Are the costs of drug courts, including their costs in de-individualizing justice, worth their benefits?

Id. For a more sympathetic appraisal of the pragmatic motives spurring the rapid proliferation of drug courts, see *supra* note 28.

[55] *See* NOLAN, *supra* note 27, at 39 (relating how "observers" have labeled the "rapid expansion of the drug court model" as a "movement" or even a "revolution").

[56] OJP DRUG COURT CLEARINGHOUSE AND TECHNICAL ASSISTANCE PROJECT, AMERICAN UNIVERSITY, DRUG COURT ACTIVITY UPDATE: SUMMARY INFORMATION ON ALL PROGRAMS AND DETAILED INFORMATION ON ADULT DRUG COURTS 1-2 (2001), *available at* www.american.edu/academic.depts/spa/justice/publications/allcourtactivity.pdf.

[57] NOLAN, *supra* note 27, at 41-42.

[58] Hoffman, *supra* note 24, at 1463 ("In 1994, as part of the amendments to the Omnibus Crime Control and Safe Street Act of 1968, Congress authorized the attorney general to make grants and loans to state, local, and Indian tribal governments to establish drug courts."). Funding dispersed through the Department of Justice's Drug Courts Program Office increased from twelve million dollars in 1995 to forty million dollars in 1999. NOLAN, *supra* note 30, at 42. Although funding has held steady since then, President Bush

availability of this funding has worked to homogenize drug courts, as newly proposed drug courts must meet design and implementation criteria set by the Department of Justice, among them a requirement that drug courts admit only non-violent offenders,[59] in order to receive funds.[60]

State and local governments have also enthusiastically supported drug courts.[61] A Department of Justice-sponsored study found that twenty-nine state legislatures had enacted statutes funding drug courts as of May 2001, with bills pending in eight additional states.[62] Many of these statutes authorize the circuit judges of the state to set up drug courts and proscribe basic eligibility requirements and procedural formats for the courts to follow.[63] While these statutes provide a framework for the expansion and regularization of drug courts within the states, they do not explicitly address the issue of the legal status of relapsing participants. For example, Illinois's Drug Court Treatment Act[64]—which authorizes drug courts to assign participants to "outpatient, inpatient, residential, or jail-based" treatment programs—provides that drug courts "shall include a regimen of graduated requirements and awards and sanctions including . . . fines, fees, costs, restitution [and] incarceration of up to 180 days" to deal with relapse-related drug use, but it does not specify that these sanctions preempt the

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has requested that sixty-eight million dollars be earmarked for drug courts in 2004. *See* NATIONAL ASSOCIATION OF DRUG COURT PROFESSIONALS, ACTION ALERT: ACROSS THE BOARD BUDGET CUTS REDUCE FUNDINGS FOR DRUG COURTS NATIONWIDE (Feb. 27, 2003), *at* www.jointogether.org/sa/news/alerts/reader/0,1854,5619300,00.html.

[59] James J. Chriss, *The Drug Court Movement: An Analysis of Tacit Assumptions*, *in* DRUG COURTS, *supra* note 5, at 189, 194.

[60] Morris B. Hoffman, *The Denver Drug Court and Its Unintended Consequences*, *in* DRUG COURTS, *supra* note 5, at 67, 81. The criteria can be found in DEFINING DRUG COURTS: THE KEY COMPONENTS, *supra* note 33.

[61] NOLAN, *supra* note 27, at 42 ("Forty percent of the courts have been at least partially funded by state support, either through state substance abuse agencies or other state funding sources. Other jurisdictions have raised money through special tax assessments, asset forfeiture funds, or fees collected from drunk driving or traffic schools.").

[62] OJP DRUG COURT CLEARINGHOUSE AND TECHNICAL ASSISTANCE PROJECT, STATUTES ENACTED IN STATE LEGISLATURES AND TRIBAL COUNCILS RELATING TO DRUG COURTS AS OF MAY 2001, at 1 (2001), *available at* www.american.edu/spa/justice/publications/2001.stat.rev.pdf.

[63] *See, e.g.*, FLA. STAT. ch. 397.334 (2003) (directing each judicial circuit to establish, at the least, a model drug court); FLA. STAT. ch. 948.08 (2003) (outlining basic eligibility requirements and procedural format); 730 ILL. COMP. STAT. 166/15 (Supp. 2003) (authorizing the Chief Judge of each judicial circuit to establish a drug court program); 730 ILL. COMP. STAT. 166/20 (Supp. 2003) (outlining eligibility requirements); 730 ILL. COMP. STAT. 166/25 (Supp. 2003) (describing basic procedural format). *See infra* note 133 for citations to additional statutes authorizing the creation of drug courts.

[64] 730 ILL. COMP. STAT. 166/1 (Supp. 2003).

standard criminal prohibitions of drug use.[65] The next sub-part of this Comment, which examines in greater depth the unique rehabilitative orientation of drug courts, demonstrates how this sanctioning scheme has allowed drug court participants undergoing treatment in residential facilities to be treated, *sub silentio*, under a quite different paradigm of punishment than offenders punished in the criminal justice system.

B. THE ELEMENTS OF DRUG COURT JURISPRUDENCE

Despite their variations, drug courts across the nation share a common model. Two important shared elements are limited eligibility and removal of participants from the criminal justice system and placement into court supervised treatment.[66]

1. Limited Eligibility

First, eligibility for drug courts is invariably limited to certain groups of drug-using offenders.[67] The purpose of these limitations is "to insure that only nonviolent defendants thought to be amenable to substance abuse treatment participate."[68] To this end, many drug courts screen potential offenders to ensure that they have a significant substance-abuse problem and will be suitable candidates for treatment.[69] In the Baltimore City Drug Court, for example, offenders are assessed using the Addiction Severity Index, which measures medical, employment, drug, alcohol, legal, family, and psychiatric needs, to determine medical eligibility for treatment.[70]

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[65] *Id.* 166/25. *See also* MICH. COMP. LAWS. § 600.185 (2003) (authorizing fund for the creation of drug courts, but not addressing how relapsing participants should be treated); N.Y. CRIM. PROC. LAW § 170.15 (McKinney Supp. 2003) (allowing for the removal of cases from local criminal court to drug court, but not addressing how relapsing participants should be treated); N.C. GEN. STAT. § 7A-790 to -801 (2001) (establishing state-wide program to facilitate the creation of drug courts, but not addressing how relapsing participants should be treated).

[66] *See supra* notes 35-36 and accompanying text.

[67] While drug courts predominantly focus on treating offenders charged with drug possession, drug courts in some jurisdictions also admit drug-using offenders charged with drug sales, theft, DUI, and prostitution. OJP DRUG COURT CLEARINGHOUSE AND TECHNICAL ASSISTANCE PROJECT, AMERICAN UNIVERSITY, 2000 DRUG COURT SURVEY REPORT, PART I: JUDICIAL PERSPECTIVES [DRAFT] 5 (2001), *available at* http://www.american.edu/spa/justice/publications/volI.pdf [hereinafter 2000 DRUG COURT SURVEY REPORT, PART I].

[68] Boldt, *supra* note 9, at 1209.

[69] Chriss, *supra* note 59, at 194.

[70] William D. McColl, *Theory and Practice in the Baltimore City Drug Treatment Court*, *in* DRUG COURTS, *supra* note 5, at 3, 7.

Admission criteria also have a public safety aspect, as all drug courts require that participants have not been charged with a violent offense.[71] Almost all require that participants have no history of violent crimes whatsoever.[72] Some courts also have rigid requirements excluding anyone with a certain number of prior convictions.[73] For example, the Florida statute enabling drug courts stipulates that participants must not have been previously convicted of any felony, nor previously admitted to drug court or a similar felony pretrial intervention program.[74] Other common disqualifying factors include gang membership, additional pending cases, and out-of-county residence.[75] As one meta-analysis of drug court studies concluded, studies suggested that "many drug courts target offenders with midrange risk levels: higher risk than the low-level offenders typically given standard diversion [e.g., probation], and lower risk than sentenced drug offenders."[76]

In practice, the application of these criteria can result in the exclusion of a number of offenders who could plausibly benefit from treatment. Though studies on drug court screening processes are sparse,[77] data suggests that drug courts do not come close to reaching all eligible offenders. While there were approximately 1,250,000 arrests for drug possession nationwide in 1999 alone, for example, only about 220,000 individuals had ever been enrolled in an adult drug court through December 2000.[78] In a 2000 survey of drug courts, fifty-six percent of the responding programs indicated that "more people are eligible for the drug court than are accepted into it."[79] In jurisdictions served by these surveyed drug courts, there were annual totals of 59,654 felony drug cases and 51,374

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[71] Boldt, *supra* note 9, at 1209.

[72] 2000 DRUG COURT SURVEY REPORT, PART I, *supra* note 67, at 6.

[73] *Id.*

[74] FLA. STAT. ch. 948.08 (2003). *See also, e.g.*, 730 ILL. COMP. STAT. 166/20 (Supp. 2003) (outlining Illinois's eligibility requirements, including one that the defendant not have committed a violent crime in the past ten years).

[75] 2000 DRUG COURT SURVEY REPORT, PART I, *supra* note 67, at 7.

[76] STEVEN BELENKO, NATIONAL CENTER ON ADDICTION AND SUBSTANCE ABUSE, COLUMBIA UNIVERSITY, RESEARCH ON DRUG COURTS: A CRITICAL REVIEW, 2001 UPDATE 19 (2001), *available at* http://www.casacolumbia.org/usr_doc/researchondrug.pdf.

[77] *Id.* at 2 ("A fuller understanding of the impacts of drug courts in the context of the larger criminal justice system requires more research in the targeting, referral, screening, and admission process.").

[78] *Id.* at 5-6.

[79] 2000 DRUG COURT SURVEY REPORT, PART I, *supra* note 67, at 10. Nearly half of the rejected eligible offenders were rejected because there were either not enough treatment services or not enough judicial resources available. *Id.* at 11.

misdemeanor drug cases, yet drug courts served only 4104 offenders, or about 3.7% of combined felony and misdemeanor drug cases.[80]

California's experience with drug courts provides a specific example of drug court under-inclusiveness. One study alleges that "California's drug courts admit only three to five percent of those offenders who are eligible for admission into drug court."[81] This selectivity may entail racially discriminatory distinctions being made between eligible offenders, as another study of four county drug courts demonstrated that the courts admitted proportionately greater white offenders, "even though persons of color comprise a disproportionately large percentage of the low-level drug offender population eligible for drug courts services."[82]

Insufficient funding and staffing is one factor that compels drug courts to draw questionably relevant distinctions between candidates. Judge Morris B. Hoffman, a Colorado state district judge involved in the development of the Denver Drug Court, relates one example of this phenomenon.[83] In 1997, the then-presiding head drug court judge determined that a twenty-five percent reduction in caseloads was necessary for the drug court to keep up with filings.[84] Therefore, he decided to exclude all two-time felons from drug court.[85] As Hoffman writes, "[e]very two-time felon is not an unacceptable drug court risk," and, indeed, they had not been viewed as such for the first three years of the drug court's existence.[86] Moreover, Hoffman writes, "drug court proponents have long argued that the hardcore addict"—who is likely to have multiple prior drug-related convictions—"is precisely the kind of person drug courts were intended to reach"—the kind of person who is most motivated to make a lifestyle change.[87] This class of two-time felons, then, was excluded solely on the basis of inadequate funding.[88] At this point, drug courts have not

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[80] *Id.* at 3.

[81] DRUG POLICY ALLIANCE, SUBSTANCE ABUSE AND CRIME PREVENTION ACT OF 2000, PROGRESS REPORT 16 (2002).

[82] *Id.* at 16 n.30 (citing NATIONAL ASSOCIATION OF DRUG COURT PROFESSIONALS, LAW ENFORCEMENT/DRUG COURT PARTNERSHIPS: POSSIBILITIES AND LIMITATIONS, A CASE STUDY OF PARTNERSHIPS IN FOUR CALIFORNIA COUNTIES (2000)).

[83] Morris B. Hoffman, *The Denver Drug Court and its Unintended Consequences*, *in* DRUG COURTS, *supra* note 5, at 67.

[84] *Id.* at 73.

[85] *Id.*

[86] *Id.*

[87] *Id.* (citing Steven Belenko, *Research on Drug Courts: A Critical Review*, *in* FIRST NATIONAL DRUG COURT REVIEW 1 (1998)).

[88] *Id.* As Hoffman writes, also referring to the Denver Drug Court's contemporaneous blanket refusal of illegal aliens, "[T]heir ipso facto exclusion from drug court should make us all wonder about the fairness of a system that makes these kinds of arbitrary and

adequately addressed all of the populations that are eligible for, and might benefit from, treatment.

2. Removal From the Criminal Justice System

A second feature shared by drug courts across jurisdictions is the removal of participants from the criminal justice system, and placement into court-supervised treatment.[89] Most drug courts operate as "deferred prosecution" or "postdisposition" programs.[90] In deferred prosecution programs, courts evaluate offenders for drug court eligibility soon after their arrest, and stay all charges against accepted participants.[91] If a participant successfully completes the treatment program, the charges are dropped.[92] Postdisposition programs require that participants enter a guilty plea prior to transfer to the drug court, but, as in deferred prosecution programs, criminal punishment is withheld if the participant successfully completes treatment.[93]

Offenders enter court-supervised treatment upon enrollment in a drug court program.[94] The goal is to facilitate drug abstinence through treatment,[95] using the threat of expulsion from the program and concomitant adjudication of the original charge in criminal court to compel cooperation.[96] Participants are generally expected to undertake treatment for at least one year, but treatment "often lasts much longer," depending on the participant's progress.[97] Local treatment providers directly supervise participants,[98] and the types and content of treatment services offered by the

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suspicious distinctions simply because drug court proponents have bitten off more than they can chew." *Id.*

[89] *See* Boldt, *supra* note 9, at 1255.

[90] *Id.* Boldt cites a study concluding that forty-four percent of drug courts work on the deferred prosecution model, and thirty-eight percent work on a postdisposition model. *Id.* at 1255 n.283.

[91] *Id.* at 1255.

[92] *Id.*

[93] *Id.* at 1255 n.283.

[94] Hora et al., *supra* note 8, at 463 ("Now identified as 'Drug Treatment Courts,' this system of court-prompted and supervised treatment for drug offenders aims at correcting the addictive behavior of the drug offenders who enter the courts.").

[95] John Terence A. Rosenthal, *Therapeutic Jurisprudence and Drug Treatment Courts*, *in* DRUG COURTS, *supra* note 5, at 144, 161.

[96] Hora et al., *supra* note 8, at 527 ("What DTCs [drug treatment courts] provide to the drug abuser is a legal incentive to stay in drug treatment.").

[97] NOLAN, *supra* note 27, at 40.

[98] *See* Hora et al., *supra* note 8, at 480.

program differ across jurisdictions.[99] While there do not appear to be any studies indicating the percentage of participants who undergo residential treatment, a 2000 survey of drug courts indicated that at least some participants were offered short-term treatment (up to thirty days) in over fifty percent of surveyed programs, and long-term treatment (ranging from thirty to more than ninety days) in roughly forty percent of surveyed programs.[100]

After a participant's case is transferred to a drug court, the drug court judge assumes broad supervision over the case and is viewed as an integral part of the treatment process.[101] Drug court judges monitor the progress of participants by keeping tabs on the results of frequent drug tests;[102] participants are also required to make weekly, bi-weekly, or monthly group appearances before the drug court judge.[103] During these appearances, drug court judges act "more like proactive therapists than dispassionate judicial officers";[104] judges alternately praise, cajole, and reprimand participants in order to encourage compliance with the treatment process.[105]

Drug court judges hold participants responsible for continued drug use, stalled progression in treatment, or failure to make mandatory appearances through the use of "smart punishments," or intermediate sanctions.[106] In

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[99] Goldkamp, *supra* note 31, at 938. The array of treatment services includes outpatient group therapy, outpatient individual therapy, acupuncture, relapse prevention, and short-term and long-term residential treatment. *See* OJP DRUG COURT CLEARINGHOUSE AND TECHNICAL ASSISTANCE PROJECT, AMERICAN UNIVERSITY, 2000 DRUG COURT SURVEY REPORT, PART VII: TREATMENT PROVIDER PERSPECTIVES [DRAFT] 11 (2001), *available at* http://www.american.edu/spa/justice/publications/volIV.pdf.

[100] 2000 DRUG COURT SURVEY REPORT, PART VII: TREATMENT PROVIDER PERSPECTIVES [DRAFT], *supra* note 99, at 11.

[101] *See* Hoffman, *supra* note 24, at 1517 ("[T]he whole drug court mechanism depends . . . heavily on the philosophy of the particular judge who is presiding there at any time . . . ."). Hoffman contrasts the very different philosophies of two judges in the Denver Drug Court regarding the imposition of intermediate sanctions upon relapsing participants. *Id.* at 1517-18.

[102] Hora et al., *supra* note 8, at 475.

[103] NOLAN, *supra* note 27, at 40.

[104] *Id.*

[105] *Id.* at 71. As Judge Langston Kinney, a drug court judge in Syracuse, New York described the process:

> In reality, for the benefit of the people in the gallery, drug court is like a theatre, it's judicial theatre . . . . We pat some people on the back, we slap some people on the rump. We hug some people, literally, and some people we chastise. But it's all for the purpose of making sure that everybody who is here has some understanding that the purpose is all the same.

Id.

[106] Hora et al., *supra* note 8, at 475, 509-10. For examples of smart punishment, see *supra* note 9 and accompanying text.

line with the drug court's rehabilitative orientation, these sanctions are not intended to punish participants for moral failure, but to "underscore the therapeutic perspective and goal of the [drug court] concept."[107] Offenders are removed only rarely from drug court programs, after continued drug use does not respond to escalating sanctions.[108] The smart punishment regime demands that prosecutors not file additional charges based on drug use revealed through the drug court monitoring process.[109]

Drug court participants are not completely immune from prosecution on new drug charges. If a participant is re-arrested during treatment, he may be prosecuted for the new crime.[110] In the case of participants undergoing residential treatment, though, arrest for relapse-related drug use is not a likely outcome, given that treatment facilities report relapse-related drug use and possession to drug courts, and not to the police.[111] The experience of the Miami Drug Court provides striking, if anecdotal, evidence of what can happen without sufficient judicial or law enforcement oversight of treatment providers.[112] In 1994, state prosecutors concluded a two-year investigation of drug court-approved halfway houses, having determined that prostitution and narcotics trafficking were taking place in the facilities; prosecutors lacked sufficient evidence to bring any charges, though.[113] Because of the combined effect of drug courts' rehabilitative orientation and treatment facility control over police notification, drug court participants undergoing residential treatment are, for all practical purposes, insulated from prosecution for relapse-related drug use.

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[107] Hora et al., *supra* note 8, at 470. ("Smart punishment by [drug courts] means 'the imposition of the minimum amount of punishment necessary to achieve the twin sentencing goals of reduced criminality and drug use.'") (quoting JUDGE JEFFREY S. TAUBER, CALIFORNIA CENTER FOR JUDICIAL EDUCATION AND RESEARCH, DRUG COURTS: A JUDICIAL MANUAL 9 (1994)).

[108] *Id.* at 484.

[109] *See id.* at 478-79. The authors suggest that prosecutors should be amenable to this arrangement because, "[b]y understanding the nature of addiction and treatment, a prosecutor comes to realize that the therapeutic jurisprudence approach taken by a [drug court] reflects nothing more than the realization that the court process itself can and does impact the behavior of a defendant." *Id.* at 479.

[110] 2000 DRUG COURT SURVEY REPORT, PART I, *supra* note 67, at 35.

[111] *See supra* notes 12-13 and accompanying text.

[112] *See* Hora et al., *supra* note 8, at 524.

[113] *Id.* (citing Jeff Leen & Don Van Natta Jr., *Drug Court Favored By Felons*, MIAMI HERALD, Aug. 29, 1994, at 6A).

II. THE NOELLE BUSH CASE: THE PROBLEMS CREATED BY THE UNCERTAIN STATUS OF RELAPSING DRUG COURT PARTICIPANTS UNDERGOING RESIDENTIAL TREATMENT

The de facto immunity of drug court participants undergoing residential treatment, and its doubtful legal status, was brought into sharp focus in 2002 by the case of Noelle Bush, who was arrested in Florida on a charge of prescription fraud.[114] Bush was admitted to an Orange County drug court, and entered a residential treatment center.[115] She apparently relapsed on multiple occasions while undergoing treatment and, on one occasion, a fellow patient notified police that Bush had been caught with crack cocaine.[116] When police attempted to investigate, the treatment center employee who witnessed Bush's drug possession refused to cooperate.[117]

The state's attorney moved to compel the employee's testimony, but Florida's Ninth Judicial Circuit denied the motion.[118] The court relied solely on 42 U.S.C. § 290dd-2, a statute designed to ensure the privacy of drug treatment participants,[119] in holding that treatment facility employees were permitted, but could not be compelled, to notify police of crimes occurring on facility property.[120] This part of the Comment examines the facts of Bush's case and the circuit court's reasoning in holding that drug court participants undergoing residential treatment are legally insulated from criminal prosecution of their relapse-related drug use.[121]

A. BUSH'S LEGAL TRAVAILS

During the early morning of January 29, 2002, Noelle Bush was arrested in Tallahassee, Florida, after attempting to fill a fraudulent prescription for the sedative Xanax at a drive-through pharmacy window.[122] Bush allegedly had called the pharmacy herself, posing as a "Dr. Noelle Scidmore," to order the prescription.[123] Pharmacists grew suspicious after

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[114] *See infra* notes 122-27 and accompanying text.

[115] *See infra* notes 128-34 and accompanying text.

[116] *See infra* notes 135-36, 140-41 and accompanying text.

[117] *See infra* notes 142-45 and accompanying text.

[118] *See infra* notes 177-90 and accompanying text.

[119] *See infra* notes 177-90 and accompanying text.

[120] *See infra* notes 177-90 and accompanying text.

[121] The State of Florida attempted to appeal the Ninth Judicial Circuit's decision to Florida's Fifth District Court of Appeals. That court denied the State's petition for certiorari on Mar. 7, 2003 and issued a brief opinion. The reasoning underlying the opinion is discussed below. *See infra* note 190.

[122] Deborah Sharp, *Jeb Bush's Daughter Arrested on Prescription Fraud Charge*, USA TODAY, Jan. 30, 2002, at 5A.

[123] *Id.*

they determined that no such doctor presently practiced in Tallahassee, and notified police.[124] The crime with which Bush was charged, prescription fraud, is a felony of the third-degree under Florida law,[125] punishable by a maximum imprisonment of five years and a $5,000 fine.[126] Bush had no known prior criminal record.[127]

As a first–time, non–violent offender, Bush was eligible for participation in one of Florida's pretrial substance abuse education and treatment intervention programs, more commonly known as a drug court.[128] If the defendant successfully completes treatment, the court will dismiss the original charges; if treatment is not successful, the drug court judge will return the defendant's case to criminal trial court for prosecution of the original charge.[129] As is typical of other state legislatures, the Florida legislature has authorized, but not required, circuit courts to establish drug courts in their jurisdictions.[130] In addition, Florida circuit courts maintain discretion in determining which qualifying offenders will be admitted to drug court.[131] Though the offender, the State, or the court itself may file a

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[124] *Id.*

[125] FLA. STAT. ch. 893.13(7)(a)(9), (7)(c) (2002). Section 893.13(7)(a)(9) makes it illegal "[t]o acquire or obtain, or attempt to acquire or obtain, possession of a controlled substance by misrepresentation, fraud, forgery, deception, or subterfuge," and (7)(c) specifies that this crime is a felony of the third degree.

[126] *Id.* ch. 775.082–775.083.

[127] Sharp, *supra* note 122, at 5A.

[128] See FLA. STAT. ch. 948.08(6)(a) for the statutory requirements for admission into a Florida drug court program for felony drug offenders. In addition to limiting eligibility to non-violent offenders without a prior felony conviction, the statute also precludes participation by offenders who have been involved in the dealing or selling of controlled substances.

[129] *Id.* ch. 948.08(3)-(5).

[130] *See id.* ch. 948.08(6)(a). The statute authorizes qualifying felony offenders to enter into a "pretrial substance abuse education and treatment intervention program approved by the chief judge of the circuit," but does not require the chief judge of the circuit to approve any such program. The Florida legislature has passed a statute expressing the intent "to implement treatment-based drug court programs in each judicial circuit," though. *Id.* ch. 397.334 (2002). *See also* 730 ILL. COMP. STAT. 166/15 (Supp. 2003) (authorizing the Chief Judge of each judicial circuit to establish a drug court program); N.Y. CRIM. PROC. LAW § 170.15 (McKinney Supp. 2003) (allowing for removal of case from a local criminal court to a "court in the same county which has been designated a drug court by the chief administrator of the courts"); N.C. GEN. STAT. § 7A-790-801 (2001) (setting up state program to facilitate the creation of drug courts, but not requiring the same); WASH. REV. CODE ANN. § 2.28.170 (West Supp. 2003) ("Counties *may* establish and operate drug courts.") (emphasis added).

[131] FLA. STAT. ch. 948.08(6)(a).

motion to place the offender in drug court, the court must approve the motion.[132]

Bush opted for participation in drug court. Her case was transferred from Leon to Orange County, where she entered into treatment at the Center for Drug-Free Living, a residential drug treatment facility, soon after her arrest.[133] She then entered into drug court supervision in June.[134] Bush was progressing satisfactorily through treatment and tested negative for drug use for five months, until July, when an employee of the Center for Drug-Free Living found her in unauthorized possession of prescription pills.[135] The drug court judge supervising Bush's case was notified of Bush's indiscretion and sentenced her to two days in jail for violation of her treatment terms.[136]

As discussed above, the revelation of Bush's relapse only in drug court is a typical outcome for relapsing drug court participants undergoing residential treatment.[137] Under the typical drug court regime, drug treatment officials release information regarding participant relapse only in the drug court setting, when they provide the drug court judge, prosecutor, and defense counsel with reports on the participant's progress.[138] The Center for Drug-Free Living's policy, for example, is for staff members to call police when illegal drugs are found on the premises, but only to ask for advice in disposing of the drugs; staff members are not to reveal the identity of the patient possessing the drugs.[139]

After her release from jail, Bush returned to the Center for Drug-Free Living, and apparently avoided relapse again until September, when an employee allegedly found a small rock of crack cocaine in Bush's shoe.[140] Unlike the consequences that attended her previous relapse, the typical drug court protocol was short-circuited on this occasion when Orlando police became involved. After Bush was caught, a fellow patient at the Center for

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[132] *Id.*

[133] *See* Order Denying Motion to Close Drug Court Proceedings at 2, Florida v. Bush, No. 48-02-CF-6371-0 (Fla. Cir. Ct. Oct. 22, 2002), *available at* http://www.ninja9.org; *Drug Facility Staff May Remain Silent on Noelle Bush*, WASH. POST, Oct. 1, 2002, at A02 [hereinafter *Drug Facility Staff May Remain Silent*].

[134] Order Denying Motion to Close Drug Court Proceedings at 2, *Bush* (No. 48-02-CF-6371-0).

[135] Wallsten, *supra* note 29, at 1B.

[136] *Id.*

[137] *See supra* note 12-13 and accompanying text.

[138] *See* Hora et al., *supra* note 8, at 528; *see also supra* notes 15-16 and accompanying text.

[139] Wallsten, *supra* note 29, at 2B.

[140] *Id.*

Drug-Free Living called the police, related the alleged incident, and stated that Bush had been caught with drugs on previous occasions and gone unpunished.[141] Orlando police arrived at the Center to investigate the report and talked to a staff member who confirmed that Bush had been caught with cocaine.[142] The employee who had found the cocaine initially offered a sworn written statement, but she tore it up at the behest of her supervisor.[143]

The Orange-Osceola County State's Attorney's Office quickly issued investigative subpoenas to four Center employees and deposed one of them.[144] During the deposition, the employee refused to answer any questions about Bush's alleged possession.[145] The state then filed a motion to compel the clinic employee's testimony.[146] The state's attorney argued that the state, acting through law enforcement officials, had the responsibility to investigate all reports of criminal activity, and that a denial of its motion would be tantamount to granting participants in residential substance abuse treatment facilities blanket immunity from being charged with drug offenses.[147] In its defense, the Center relied solely upon a federal statute, 42 U.S.C. § 290dd-2,[148] designed to protect the privacy of individuals undergoing treatment for substance abuse at federally funded treatment facilities.[149] According to the Center's interpretation of the statute, the records of a patient at such a facility may not be released to initiate or substantiate a criminal charge against the patient unless the release is authorized by a court order, which is to be issued on the showing of good cause.[150]

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[141] *Id.* The caller stated:

> She does this all the time and she gets out of it because she's the governor's daughter . . . . But we're sick of it here 'cause we have to do what's right, but she gets treated like some kind of princess. We're just trying to get our lives together, and this girl's bringing drugs on property.

Id.

[142] *Id.*

[143] *Drug Facility Staff May Remain Silent*, *supra* note 133, at A02.

[144] Order Denying Motion to Compel at 1, *In re* Investigation, Orlando Police Department, Case No. 2002-330145 (Fla. 9th Cir. Ct. Sept. 30, 2002) [hereinafter Order Denying Motion to Compel], *available at* www.ninja9.org.

[145] *Id.*

[146] *Id.* at 1-2.

[147] *Id.* at 9.

[148] 42 U.S.C. § 290dd-2 (2000).

[149] Order Denying Motion to Compel, *supra* note 144, at 3.

[150] *Id.* at 5-6.

B. SECTION 290DD-2'S PROVISIONS

The details of § 290dd-2 are relatively complex and merit a close analysis. The confidentiality provisions now embodied in 42 U.S.C. § 290dd-2 were originally passed in 1972, in the wake of the Comprehensive Drug Abuse Prevention and Control Act of 1970, which, though it established a comprehensive policy for enforcement of federal drug laws, also provided for increased expenditures on rehabilitation and treatment efforts.[151]

The legislative history for the bill by which the confidentiality provisions were passed, the Drug Abuse Office and Treatment Act of 1972,[152] indicates that Congress had maintained its orientation toward rehabilitative programs, as this summary of testimony demonstrates: "Taking into account that the law enforcement aspects of the drug problem are serious, most witnesses generally agreed that greater emphasis on the so-called 'demand side' of the problem is required, that is, on treatment, rehabilitation, research, education and training."[153]

Statutory provisions establishing the confidentiality of records on participants in federally funded drug treatment centers were regarded as part of the scheme to facilitate demand reduction, because, as the legislative history indicates, they were passed in response to concerns that drug users would not seek treatment if they could not be assured of privacy.[154] The House Report is adamant that the confidentiality requirements are to be followed, expressing the conviction that "the strictest adherence to the

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[151] *See* H.R. REP. NO. 91-1444, pt. 1, at 1-3 (1970). The legislative history also revealed a broad intent to treat offenders on a rehabilitative model:

> If the [drug] abuser is to be penalized, he should not be punished in the spirit of retribution. The modern concept of criminology should apply—that penalties fit offenders as well as offenses. Penalties should be designed to permit the offender's rehabilitation wherever possible . . . .
>
> The deterrent effects of long sentences is debated. Some evidence indicates that the threat of long sentences may deter nonusing traffickers, but it does not necessarily deter the drug abuser. Deterrence is essentially an appeal to a normal sense of reason which the drug abuser has lost.

Id. at 9.

[152] Pub. L. No. 92-275, 86 Stat. 65 (1972).

[153] H.R. REP. NO. 92-775, at 4 (1972).

[154] *Id.* at 6.

> Every patient and former patient must be assured that his right to privacy will be protected. Without that assurance, fear of public disclosure of drug abuse or of records that will attach for life will discourage thousands from seeking the treatment they must have if this tragic national problem is to be overcome.

Id.

provisions of this section is absolutely essential to the success of all drug abuse prevention programs."[155]

The statute allows for the release of patient records only under narrow circumstances. Section 290dd-2(a) stipulates that patient records may be disclosed only in the circumstances identified in § 290dd-2(b).[156] Section 290dd-2(b) provides only four valid methods of disclosure. First, a patient may consent to the release of her records.[157] Second, the holder of a record may disclose its contents to medical personnel in the event of an emergency.[158] Third, records may be disclosed for the purpose of conducting research, but any report of such research must not disclose the identity of any patient.[159] Finally, a court of competent jurisdiction may order the release of a record, on a showing of good cause, "including the need to avert a substantial risk of death or serious bodily harm."[160] The statute commands that, in assessing good cause, a court "shall weigh the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services."[161] Section 290dd-2(c) indicates that only records released by the fourth method, issuance of a court order, may be used to conduct a criminal investigation against a patient.[162]

The Department of Health and Human Services regulations implementing the confidentiality provisions are found at 42 C.F.R. § 2.1–2.67.[163] An important point to note initially is that the regulations never require disclosure of patient records. As § 2.3(b) explains, "These regulations prohibit the disclosure and use of patient records unless certain circumstances exist. If any circumstances exists under which disclosure is permitted, that circumstance acts to remove the prohibition on disclosure

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[155] *Id.*

[156] 42 U.S.C. § 290dd-2(a) (2000). The statute extends to

> [r]ecords of the identity, diagnosis, prognosis, or treatment of any patient which are maintained in connection with the performance of any program or activity relating to substance abuse education, prevention, training, treatment, rehabilitation, or research, which is conducted, regulated, or directly or indirectly assisted by any department or agency of the United States . . . .

Id.

[157] *Id.* § 290dd-2(b)(1).

[158] *Id.* § 290dd-2(b)(2)(A).

[159] *Id.* § 290dd-2(b)(2)(B).

[160] *Id.* § 290dd-2(b)(2)(C).

[161] *Id.*

[162] *Id.* § 290dd-2(c) ("Except as authorized by a court order granted under subsection (b)(2)(C) of this section, no record referred to in subsection (a) of this section may be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient.").

[163] 42 C.F.R. § 2.1–2.67 (2002).

but it does not compel disclosure. Thus, the regulations do not require disclosure under any circumstances."[164]

The regulations also clarify aspects of the definition of "records of the identity, diagnosis, prognosis, or treatment of any patient," as used in 42 U.S.C. § 290dd-2, and of the good cause requirement. "Records" is defined in the regulations' definitions section, § 2.11, as "any information, whether recorded or not, relating to a patient received or acquired by a federally assisted alcohol or drug program."[165] "Treatment" is defined as meaning "the management and care of a patient suffering from alcohol or drug abuse, a condition which is identified as having been caused by that abuse, or both, in order to reduce or eliminate the adverse effects upon the patient."[166] "Records" of the diagnosis and treatment of a patient would seem, then, to encompass any information, whether recorded or not, that was received or acquired by a federally assisted alcohol or drug program, and that related to the management and care of that patient.

Section 2.65 contains more detail on the good cause determination required to order disclosure of records that are to be used to criminally investigate or prosecute a patient.[167] The regulation specifies five criteria that must be met for a court to authorize the release of a record, two of which are relevant in Bush's case. First, the regulation specifies that the crime to be investigated must be "extremely serious, such as one which causes or directly threatens loss of life or serious bodily injury including homicide, rape, kidnapping, armed robbery, assault with a deadly weapon, and child abuse and neglect."[168] Second, the regulation restates the balancing test articulated in 42 U.S.C. § 290dd-2(b)(2)(C), requiring that "the potential injury to the patient, to the physician–patient relationship and to the ability of the program to provide services to other patients is outweighed by the public interest and the need for the disclosure."[169]

Section 2.65's requirement that the crime involved be "extremely serious, such as" one mentioned in the subsequent list, deserves special notice in the context of drug possession cases because of a 1987 amendment of that requirement.[170] The original regulation required only

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[164] *Id.* § 2.3(b).

[165] *Id.* § 2.11.

[166] *Id.*

[167] *Id.* § 2.65. See 42 U.S.C. § 290-dd-2(b)(2)(C) for the good cause requirement.

[168] 42 C.F.R. § 2.65(d)(1).

[169] *Id.* § 2.65(d)(4). The other three criteria concern the importance and necessity of the information to the investigation and the adequacy of counsel for the holder of the records.

[170] *See* Confidentiality of Alcohol and Drug Abuse Patient Records, 52 Fed. Reg. 21,796, 21,802 (June 9, 1987).

that a crime be "extremely serious."[171] In order to provide a better guide for courts, the agency added the "one which causes or directly threatens loss of life or serious bodily injury" clause and the examples of crimes that fit that definition.[172] "[S]ale of illicit drugs," was proposed for the list of examples, but that crime was removed when many commentators charged that including the crime "would make almost all patients in drug rehabilitation or treatment programs vulnerable to investigation or prosecution by means of court-ordered use of their own treatment records."[173] In the Federal Register, though, the agency asserted that the absence of "sale of illicit drugs" from the list did not preclude courts from determining that, in a given circumstance, sale of illicit drugs qualified as an "extremely serious" crime.[174]

Finally, the enabling regulations also include an exception to confidentiality requirements that is highly relevant to Noelle Bush's case. Section 2.12(c)(5) states:

> The restrictions on disclosure and use in these regulations do not apply to communications from program personnel to law enforcement officers which . . . [a]re directly related to a patient's commission of a crime *on the premises of the program or against program personnel or to a threat to commit such a crime* . . . ."[175]

Such communications must be "limited to the circumstances of the incident, including the patient status of the individual committing or threatening to commit the crime, that individual's name and address, and that individual's last known whereabouts."[176]

As the discussion in the next two sub-sections will demonstrate, this regulatory exception sits uncomfortably with § 290dd-2(c)'s requirement that information about a crime on program premises cannot be disclosed without a court order issued pursuant to a showing of good cause.

C. THE NINTH JUDICIAL CIRCUIT COURT'S APPLICATION OF § 290-DD2

Florida's Ninth Judicial Circuit Court applied § 290dd-2 in denying the state's motion to compel the testimony of the employee of the Center for Drug-Free Living who observed Bush's alleged possession of cocaine, in an opinion issued on September 30, 2002.[177] The court began its opinion by observing that the case was one of first impression, and involved "a

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[171] *Id.*

[172] *Id.*

[173] *Id.*

[174] *Id.*

[175] 42 C.F.R. § 2.12 (c)(5), (c)(5)(i) (2002) (emphasis added).

[176] *Id.* § 2.12 (c)(5)(ii).

[177] Order Denying Motion to Compel, *supra* note 144, at 1, 5-9.

clash between important public policy interests: the state law enforcement and prosecutorial agencies' duty to investigate crime, versus the state Legislature's intention to address the serious social problem of drug abuse and addiction through programs outside of the criminal justice system."[178] The court then turned its attention to § 290dd-2, noting that the purpose of the statute was "to encourage people to get help for addictions" by assuring them that their privacy would be as protected as it would have been had they not sought treatment.[179]

The court first dealt with § 2.12's exception to confidentiality requirements for "communications from program personnel to law enforcement officers which . . . [a]re directly related to a patient's commission of a crime on the premises of the program or against program personnel or to a threat to commit such a crime . . . ."[180] The State argued that "the issuance of an investigative subpoena is enough to enable Center employees to divulge *to law enforcement personnel* what they observed of alleged crimes committed on the premises, without fear of penalties."[181] While the court agreed that the purpose of § 2.12(c) was to enable treatment facility employees to relate information regarding patient crimes to law enforcement officials without suffering legal penalty, it concluded that neither the regulation nor the State's issuance of an investigative subpoena created a duty for employees to reveal such information.[182]

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[178] *Id.*

[179] *Id. See also* 42 C.F.R. § 2.3(b)(2) (2002).

> [These regulations] are intended to insure that an alcohol or drug abuse patient in a federally assisted alcohol or drug abuse program is not made more vulnerable by reason of the availability of his or her patient record than an individual who has an alcohol or drug problem and who does not seek treatment.

Id.

[180] 42 C.F.R. § 2.12(c)(5), (c)(5)(i) (2002).

[181] Order Denying Motion to Compel, *supra* note 144, at 6 (emphasis in original). Having defined "records" as including "patient identities, diagnoses, treatment plans, and progress reports," the court did not address the issue of whether the non-cooperative employee's unmemorialized personal observations of a patient's criminal actions were records under § 290dd-2, though it implicitly held that they were, given that the court found the statute applicable. *Id.* at n.2.

[182] *Id.* at 8.

> Since the federal statute provides for penalties to be imposed against treatment centers if they make impermissible disclosures, it is evident that Regulation 2.12 is designed to *allow* a facility to report to the police that a non-drug-related crime has been committed on its premises without fear of being penalized for violating patient confidentiality. It is certainly not intended to compel center employees to talk to police officers.

Id.

Instead, the court held that, even in a case where a patient had committed a crime at the facility, and a treatment facility employee could legally *volunteer* to report information about the crime to law enforcement officials, the State must abide by the requirements of § 290dd-2(b)(2)(C) and 2(c) when trying to obtain information from a non-cooperative treatment facility employee.[183] Because §290dd-2(c) requires that only information released through court order may be used in conducting a criminal investigation of a patient, the court concluded, the State would have to demonstrate good cause for the court to compel the testimony of the non-cooperative employee.[184]

The court held that the State had not shown good cause for the issuance of a court order to compel the testimony.[185] The court, as commanded by § 290dd-2(b)(2)(C), weighed "the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services."[186] In weighing these competing interests, the court drew a distinction between crimes involving illegal drugs and other crimes, and explained that to allow the release of drug treatment facility records regarding patient relapse would undermine Florida's drug court program by "thwart[ing] the Legislature's purpose to make the drug court the entity that monitors a person's treatment progress and determines whether he or she has successfully completed the program."[187] The court described the drug court system as an alternative to the criminal justice system, wherein relapse is expected, and taken into consideration when assessing a participant's progress.[188] The court dismissed the State's argument that denying a motion to compel testimony would amount to a blanket license to commit drug crimes by describing it as "based on the misguided notion that each incident of drug possession constitutes a new crime, unrelated to the patient's presence in the

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[183] *Id.*

The State's argument that an investigative subpoena is all that is needed is belied by 42 U.S.C. § 290dd-2.(c), which clearly states that only a court order may compel such testimony. *It takes a court order issued pursuant to § 290dd-2.(b)(2)(C) before drug clinic employees may be ordered to disclose patient information to police pursuant to Regulation 2.12.*

Id.

[184] *Id.* ("[A] court order will not issue unless State shows good cause and the Court finds that the balancing test of § 290dd-2(b)(2)(C) favors police investigation under the circumstances of the particular case.").

[185] *Id.* at 8-10.

[186] 42 U.S.C. § 290dd-2(b)(2)(C) (2000).

[187] Order Denying Motion to Compel, *supra* note 144, at 8.

[188] *Id.*

program."[189] The State Attorney's Office attempted to appeal the decision to Florida's Fifth Circuit Court of Appeals, but its petition for review was denied on March 7, 2003.[190]

III. CONFIDENTIALITY, IMMUNITY, AND THE CONTINUED VITALITY OF DRUG COURTS

The Ninth Judicial Circuit's denial of the State's motion to compel the testimony of the non-cooperative Center employee raises two issues. The first is whether the court correctly interpreted § 290dd-2 and its enabling regulations, which are the only conceivable nationwide[191] legal bases for the de facto immunity of drug court participants undergoing residential treatment. The court's holding that, although § 2.12(c) permits record holders to voluntarily release records related to a patient's commission of a crime on treatment program premises, a state's attorney attempting to obtain such records must obtain a court order pursuant to § 290dd-2(b)(2)(C), is suspect. The court's reading of § 2.12(c)'s requirement that the information be in the form of a communication "from program personnel to law enforcement officers" as denoting an intent that the regulation concerns only communications initiated by program personnel is unduly restrictive.[192] The regulation is more reasonably construed as applying to all communications regarding patient crimes, regardless of the party that motivates the disclosure. The court should have found that § 290dd-2 did not shield the Center for Drug-Free Living from the state's motion to compel.

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[189] *Id.* at 9.

[190] *See* Petition for Certiorari Review of Order, Florida v. Center For Drug–Free Living, No. 5D02–3356 (Fla. 5th Dist. Ct. App. Mar. 7, 2003), *available at* http://www.5dca.org/Opinions/Opin2003/030303/5D02-3356.op.pdf. The district court of appeals agreed with the circuit court's reading of the regulatory exemption for information regarding crimes committed on facility property to pertain only to communications initiated by facility employees. *Id.* at 7. The court also agreed that a court order allowing disclosure of the witnessing employee's observations should not issue because disclosure would discourage addicts from seeking out treatment and would hobble the drug court system. *See id.* at 4, 7-8.

[191] The qualifying term "nationwide" is necessary, because some states have enacted drug treatment confidentiality statutes that differ from § 290dd-2, and may provide independent bases for challenging the release of information to law enforcement officials. *See* NAT'L DRUG COURT INST., FEDERAL CONFIDENTIALITY LAWS AND HOW THEY AFFECT DRUG COURT PRACTITIONERS 4 (1999) (noting that, while some states have enacted confidentiality statutes that incorporate federal provisions, "[o]ther states have confidentiality provisions that do not rely on federal law").

[192] *See* Order Denying Motion to Compel, *supra* note 144, at 8; *see also supra* notes 180-82 and accompanying text.

The second issue is whether the court was correct in determining that the Florida legislature's enactment of a statute authorizing drug courts reflected a policy determination to draw a distinction between drug-related and other offenses, whereby drug-related offenses committed during court-supervised treatment are viewed not as new crimes, but as part of the original crime that put the treatment participant in the drug court program.[193] While the court made this point in relation to its decision to deny that the state had shown good cause under § 42 U.S.C. 290dd-2(b)(2)(C), the court could have conceivably used this supposed intent as a basis to rule that Florida's drug court statute pre-empted general statutes criminalizing drug use. The court's reading of the legislative intent is undercut by the universal state practice of prosecuting drug court participants for new rearrests, though.[194] While the court correctly perceived that state ability to investigate and prosecute relapse-related drug use through discovery of residential treatment records could threaten the future of drug courts,[195] it was incorrect to believe that either the Florida legislature or Congress had addressed this problem. This part of the Comment argues that, because there is no legal basis for the de facto, and necessary, immunity of drug court participants undergoing residential treatment, states should amend statutes enabling drug courts to explicitly provide for such immunity.

A. DOES 42 U.S.C. § 290DD-2 SHIELD DRUG COURT PARTICIPANTS?

The issue of whether 42 U.S.C. § 290dd-2 requires law enforcement officials to obtain a court order for release of patient records concerning patient drug use on the premises of a treatment program is significantly more problematic than the Ninth Judicial Circuit's opinion would imply. As the legislative history indicates, the statute and its implementing regulations were undoubtedly intended to create broad privacy rights for individuals in drug treatment;[196] they cannot, however, reasonably be read

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[193] *See* Order Denying Motion to Compel, *supra* note 144, at 9; *supra* note 189 and accompanying text.

[194] *See* 2000 DRUG COURT SURVEY REPORT, PART I, *supra* note 67 and accompanying text.

[195] *See* Order Denying Motion to Compel, *supra* note 144, at 10.

> If the Court were to grant State's motion in this case, then all patients who suffer relapses could be hauled out of treatment programs and into criminal courts on the whim of a state prosecutor or police officer responding to calls from fellow patients whose motives for reporting the "crimes" might be questionable. That would destroy the drug court program.

Id.

[196] *See supra* notes 151-52 and accompanying text.

to contain the broad insulation from the criminal justice system that the court found in them.

The court was correct to conclude initially that employee observation of Bush's drug use was a record protected by § 290dd-2.[197] As 42 C.F.R. § 2.11 makes clear, "records" refer to any information, whether recorded or not, that was received or acquired by a federally assisted alcohol or drug program, and that related to the treatment of that patient's drug abuse, or to the management and care of that patient.[198] Information regarding relapse-related drug possession is clearly related both to the treatment of drug abuse, and the management of the offending patient.

The court erred in its conception of the relationship between § 290dd-2(b)(2)(C)'s good cause requirement and § 2.12(c)'s exception of communications regarding on-premise patient crimes from disclosure and use restrictions, though. Section 290dd-2(c) mandates that a patient record may not be used to conduct a criminal investigation of a patient unless released pursuant to a court order issuing on a showing of good cause.[199] The sole statutory criterion for making this determination is that courts balance "the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services."[200]

Part 2.12(c)'s exemption of disclosure and use prohibitions for communications from treatment providers to law enforcement officials must be read against the backdrop of the good cause exception in § 290dd-2(b)(2)(C). If § 2.12(c) is not read as providing that "a patient's commission of a crime on the premises of the program or against program personnel or to a threat to commit such a crime"[201] represents a circumstance in which the balancing test of § 290dd-2(b)(2)(C) is satisfied irrebuttably, then it is a practical nullity.

Take, for example, the case of a program employee who witnesses a patient vandalizing the employee's car. Under § 290dd-2(b)(2)(C) and § 2.65(d)(1) alone, a court could not find good cause to disclose information regarding the incident. According to § 2.65(d)(1), a court shall not find good cause to revoke confidentiality for patient records unless the crime is

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[197] *See supra* note 181.

[198] *See* 42 C.F.R. § 2.11 (2002).

[199] 42 U.S.C. § 290dd-2(c) (2002) ("Except as authorized by a court order granted under subsection (b)(2)(C), no record referred to in subsection (a) may be used to initiate or substantiate any criminal charges against a patient or to conduct any investigation of a patient.").

[200] *Id.* § 290dd-2(b)(2)(C).

[201] 42 C.F.R. § 2.12(c) (2002).

one that is "extremely serious, such as one which causes or directly threatens loss of life or serious bodily injury including homicide, rape, kidnapping, armed robbery, assault with a deadly weapon, and child abuse and neglect."[202] If § 2.12(c)'s exception for communications regarding crimes committed on facility grounds is not read as circumventing the good cause requirement, then treatment facility could report the incident to police, but the police would be unable to open an investigation or file charges.

Section 2.12(c) must be read as authorizing circumvention of the good cause requirement, then, if it is not to be a practical nullity. At first blush, this circumvention is flatly inconsistent with § 290-dd2(c)'s requirement that only records disclosed by court order pursuant to a showing of good cause may be used to instigate criminal investigations or prosecutions; for § 2.12(c) to be meaningful, it must be construed to permit disclosure in absence of court order.

This inconsistency is explicable, though, when § 2.12(c) is viewed in the context of § 290dd-2(b)(2)(C)'s purpose. By requiring a court to find good cause, the statute is requiring an adjudicator to weigh "the public interest and the need for disclosure against the injury to the patient, to the physician-patient relationship, and to the treatment services."[203] Section 2.12(c) fleshes out the good-cause balancing test and establishes that disclosure of information regarding crimes committed on facility property disclosed in a communication "from program personnel to law enforcement officers" will *always* be deemed to satisfy the test. The regulation renders unnecessary adjudication of whether there is good cause to release information concerning crimes committed on facility premises by providing that there will always be good cause to release this information. Given the reality that program personnel may need to quickly release information about such crimes to police in emergency situations, the regulation's interpretation of the good-cause balancing test is not unreasonable. Moreover, even in an emergency situation, a court may still issue an order confirming good cause at an early stage of the criminal process—at the time of arraignment, for example, when charges are initiated against the patient.

The Ninth Judicial Circuit made much of § 2.12(c)'s requirement that information be disclosed in a communication "from program personnel to law enforcement officials," concluding that:

> [I]t is evident that Regulation 2.12 is designed to *allow* a facility to report to the police that a non-drug-related crime has been committed on its premises without fear of

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[202] *Id.* § 2.65(d)(1).

[203] 42 U.S.C. § 290-dd2(b)(2)(C) (2002).

> being penalized for violating patient confidentiality. It is certainly not intended to compel center employees to talk to police officers.[204]

While § 2.3(b)'s mandate that the regulations never compel disclosure undoubtedly supports the court's conclusion that § 2.12(c) was not intended to force treatment personnel to talk to police, the court's reading of § 2.12(c) as applying only to communications initiated by employees is unconvincing.

Assuming *arguendo* that the court's reading of "communications from treatment personnel to law enforcement officials" as referring only to communications initiated by employees is one reasonable construction, the court did not explain why the regulation could not also be construed to refer to all communications of information held by employees to law enforcement personnel. After all, any communication, however compelled, must be directed *from* the holder *to* the recipient.

This second reading is more plausible because compelled disclosures of patient information actually pose less of a threat to the values protected by § 290dd-2(b)(2)(C)'s balancing test than voluntary ones. Even the court's narrow reading concedes that § 2.12(c) permits treatment personnel to voluntarily disclose information regarding a crime committed on facility property. Section 2.12(c), then, must implicitly provide that voluntary disclosure of information related to crimes on facility property irrebuttably meets the good cause requirement. Thus, under the balancing test, disclosure should be permissible in any situation where the public interest is as strong and the harm is as minimal as in situations governed by § 2.12(c).

Section 2.12(c) should be construed to refer to compelled disclosures as well as voluntary disclosures, because compelled disclosures are less harmful to the interests protected by § 290dd-2(a)'s balancing test than are voluntary disclosures. In both cases, the weight of the public interest—the detection and punishment of crime—will be identical. In both cases, the harm to the patient will be the same, and his criminal activities will be revealed to the state. In the case of voluntary disclosures, the harm to the physician-patient relationship and to the treatment services might actually be *more* severe than in the case of compelled disclosure. Voluntary disclosure could cause patients to doubt whether treatment personnel could be trusted with confidential information. Given that the allowance of compelled disclosures is consistent with both § 2.12(c)'s plain language and purpose of circumventing good cause hearings for disclosures that are clearly in the public interest, § 2.12(c) is most reasonably read to allow

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[204] Order Denying Motion to Compel, *supra* note 144, at 8; *see* discussion *supra* note 148.

communications from treatment personnel to law enforcement officials regardless of motivation.

One counter-argument to this position might be that, in the case of non-violent drug offenses, the public interest in detecting and punishing crime might be outweighed by the damages to a treatment process in which relapse is expected.[205] The Department of Health and Human Services, anticipating that drug treatment facilities would not likely report drug-related offenses to police, propounded § 2.12(c) in order, as the court believed, "to *allow* a facility to report to the police that a non-drug-related crime has been committed on its premises without fear of being penalized for violating patient confidentiality."[206]

This argument is not convincing because it proves too much. While such a reading might justifiably insulate treatment participants from arrests on drug charges, it would also prevent compelled disclosures of information regarding every other species of non-serious crime on facility property. As discussed above, compelled disclosures of these crimes fare just as well, if not better, under § 290dd-2(b)(2)(C)'s balancing test, than voluntary disclosures do. This reading would foreclose them completely, because the only other regulation permitting compelled disclosures, § 2.65, limits these disclosures to information involving "extremely serious crimes, such as one which causes or directly threatens loss of life or serious bodily injury."[207] The results would be absurd: treatment personnel would be given, essentially, the discretion to choose whether or not to prosecute all offenses that do not fall under 42 C.F.R. § 2.61's "extremely serious crime" requirement—a list that could include crimes such as theft, assault, battery, prostitution, or, depending on the court making the good cause determination, drug trafficking.[208]

This argument is also undercut by the fact that § 2.12(c) refers to information "directly related to a patient's commission of" *any* "crime on the premises of the program."[209] Crucial to the premise of the counter-argument is the idea that prosecution of drug offenses inflicts a special harm on the treatment process. If the Department of Health and Human

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[205] *See, e.g.*, Dorf & Sabel, *supra* note 2, at 841 ("There [is] unlikely to be a straight path from addiction to recovery; rather, addicts undertaking recovery could be expected to relapse into addiction, often many times . . . .").

[206] Order Denying Motion to Compel, *supra* note 144, at 8; *see* discussion *supra* note 148.

[207] 42 C.F.R. § 2.65 (2002).

[208] According to the notes accompanying the 1987 amendments to enabling regulations, drug trafficking may or may not necessarily be considered an "extremely serious crime," depending on the circumstances. *See supra* notes 170-74.

[209] 42 C.F.R. § 2.12(c) (2002).

Services viewed drug-related offenses as especially threatening to the goals of treatment, it is unclear why it promulgated a rule that placed no restrictions on the types of crimes that treatment facilities could report to authorities. While the agency might have anticipated that treatment facilities would not disclose information regarding patient drug use, the regulation in no way prevents them from doing so.

The Ninth Judicial Circuit wrongly held that § 2.12(c) applied only to disclosures of patient crimes initiated by treatment personnel; information regarding Bush's alleged possession of crack should have been disclosed to police when treatment center employees were issued an investigative subpoena.

B. THE CONSEQUENCES OF THE UNCERTAIN LEGAL STATUS OF DRUG COURT PARTICIPANTS UNDERGOING RESIDENTIAL TREATMENT

As the above discussion demonstrates, § 290dd-2 does not provide an adequate legal basis for the immunity of drug court participants undergoing residential treatment from prosecution on new drug charges. Because state statutes authorizing drug courts do not provide for such immunity, either,[210] the de facto immunity from prosecution that participants undergoing residential treatment currently enjoy[211] has no legal basis. Because this uncertain status of drug court participants poses a threat to the continued vitality of the drug court sanctioning regime, and yields vastly different results in the treatment of similarly-situated drug offenders, states should amend their statutes enabling drug courts to explicitly state that participants in residential treatment are immune from prosecution for relapse-related drug offenses.

The uncertain legal status of participants undergoing residential treatment threatens the continued vitality of drug courts because of the unique nature of residential treatment. In drug court systems, residential treatment is often reserved for participants with the most intransigent addictive behaviors.[212] Residential treatment is regarded as a much more invasive therapy than outpatient regimes because it involves "constant supervision" of the offender.[213]

This constant supervision results in a greater assemblage of evidence that could be used to prosecute a participant than does outpatient treatment.

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[210] *See supra* notes 63-65 and accompanying text.

[211] *See supra* notes 12-13 and accompanying text.

[212] *See* Hora et al., *supra* note 8, at 511.

[213] *Id. See also* ROBERT L. HUBBARD ET AL., DRUG ABUSE TREATMENT: A NATIONAL STUDY OF EFFECTIVNESS 56 (1989) ("[Residential] programs are highly structured, with nearly every moment accounted for.").

While participants in outpatient treatment must submit urine tests to the drug court,[214] positive results from these urine tests alone would not by themselves provide an adequate evidentiary record for prosecution on a new drug charge. Under the constant supervision of residential treatment, however, such a record could be compiled. The constant scrutiny of treatment personnel can yield direct, and memorialized, observations of drug possession and uses among patients, as it did in Bush's case.[215]

In residential treatment, moreover, patient drug use is committed, and dealt with by treatment personnel, in front of other patients. While treatment personnel might be expected to confine voluntary disclosure of patient crimes to the drug court,[216] treatment patients might not be so motivated to protect the privacy of other patients. As the Ninth Judicial Circuit stated:

> If the Court were to grant State's motion in this case, then all patients who suffer relapses could be hauled out of treatment programs and into criminal courts on the whim of a state prosecutor or police officer responding to calls from fellow patients whose motives for reporting the "crimes" might be questionable. That would destroy the drug court program.[217]

While the Ninth Judicial Circuit's conclusion might be exaggerated, the uncertain status of participants undergoing residential treatment does pose an under-examined threat to the continuing vitality of drug courts.

This uncertain status also raises an issue about the unacknowledged disparate treatment of similarly-situated drug offenders. As discussed above, drug courts have not begun to reach all offenders who meet eligibility requirements, much less all offenders who might benefit from drug treatment.[218] Insufficient funding and staffing can lead to arbitrary distinctions being drawn between similarly-situated offenders.[219] One Department of Justice-sponsored report describes the imposition of escalating sanctions that awaits offenders that do not qualify for drug courts:

> It is particularly common for defendants on probation for drug offenses to fail to comply with probation conditions . . . . Frequently, . . . failure to comply is evidenced by a new arrest for a drug or drug-related offense . . . which generally results in imposition of the original sentence suspended when the defendant was placed on

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[214] Hora et al., *supra* note 8, at 475.

[215] *See supra* note 140-43 and accompanying text.

[216] *See supra* note 12 and accompanying text.

[217] Order Denying Motion to Compel, *supra* note 144, at 10; *see supra* note 148 and accompanying discussion.

[218] *See supra* Part II.B.

[219] *See supra* notes 77-88 and accompanying text.

> probation, and (2) conviction for the new offense, often resulting in an additional sentence of incarceration. It is common for the cycle to continue indefinitely once the defendant is released, with an enhanced incarceration sentence imposed each time to reflect the defendant's lengthening criminal history.[220]

Meanwhile, drug court participants undergoing residential treatment enjoy a de facto immunity from prosecution for further drug offenses.

This Comment does not suggest that the creation of these two groups of drug offenders raises the possibility of equal protection violations.[221] Nevertheless, the fact that one group of drug offenders is being treated on a very different model of punishment from another group is suspect given that the de facto immunity for participants undergoing residential treatment has been created *sub silentio*. As discussed above, statutes enabling drug courts do not provide that drug court sanction schemes were intended to preempt criminal punishment of further drug use. If state legislatures had intended the statutes to do so, they should have made their intent explicit, given that criminal anti-drug laws are active in every state.[222] As some media accounts of Bush's case indicated, the public does not seem to be aware of the de facto immunity given to some offenders under the drug court scheme.[223] Political recognition that the drug court system allows some offenders to be treated as patients, while the vast majority of other offenders are treated as enemies in the war on drugs, would prompt necessary public debate on the fairness of this scheme.

IV. CONCLUSION

In the fifteen year period since the creation of the first drug court, drug courts have proliferated rapidly and enjoyed a great deal of political support. In the rush to implement drug courts, however, states and local jurisdictions have overlooked important aspects of their effect on the rest of the criminal justice system. Among these is the system's enshrinement of a rehabilitative model of punishment for drug court participants undergoing

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[220] U.S. DEP'T OF JUSTICE, LOOKING AT A DECADE OF DRUG COURTS, DRUG COURT CLEARINGHOUSE AND TECHNICAL ASSISTANCE PROJECT 4 (1998).

[221] In all drug courts, either the prosecutor or drug court judge holds plenary authority to exclude particular offenders. *See, e.g.*, FLA. STAT. ch. 948.08 (2002). Thus, in the absence of evidence of discrimination against a suspect class, the state could argue that its exclusion of a particular offender is rationally related to the state objective of selecting only those offenders whom it determines would be able to benefit from treatment.

[222] *See supra* note 1 and accompanying text.

[223] As one commentator wrote, "[T]he rich and powerful are judged by a very different set of rules [than most drug offenders]. That's why the staff at Noelle's rehab center tore up a sworn statement incriminating Noelle . . . ." Arianna Huffington, *A Crack House Divided*, TEXAS OBSERVER, (Sept. 27, 2002), *at* http://www.texasobserver.org/showArticle.?asp?ArticleID=1099 (last visited Nov. 5, 2003).

residential treatment. This class of drug offenders is given the opportunity to avoid prosecution for relapse-related episodes, in contrast to the many other offenders who have each relapse-related episode treated as a new crime. This immunity is necessitated by the drug court sanctioning scheme, yet state legislatures have not faced the political consequences of mandating rehabilitative treatment for some drug offenders, and punitive treatment for others.

This dilemma is one caused by half-measures. As one commentator has written, American drug policy has historically "vacillated in a pendulum-like manner between viewing drug abuse as a public safety concern requiring a punitive correctional response or as a public health concern requiring a treatment-oriented response."[224] The rehabilitative orientation of drug courts is not likely to be the last word in America's shifting relationship with drug use. Yet if state governments are to cast their weight behind rehabilitative efforts, as they have with drug courts, they should be expected to do so openly, and with due consideration of the effect on all illegal drug users within their jurisdictions.

[224] Douglas B. Marlowe, *Effective Strategies for Intervening with Drug Abusing Offenders*, 47 VILL. L. REV. 989, 990 (2002).