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THE RATIONALIZATION OF DRUG TREATMENT PROGRAMS: THE EMERGENCE OF COURT-ENFORCED DRUG TREATMENT BUREAUCRACIES

A Thesis

Presented to

The Faculty of Department of Sociology

The College of William and Mary in Virginia

In Partial Fulfillment

of the Requirements for the Degree of Master of Arts

By

John Gregory Richardson

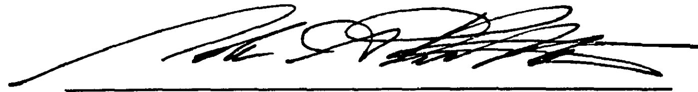
December 1994

APPROVAL SHEET

This thesis is submitted in partial fulfillment of

the requirements for the degree of

Master of Arts



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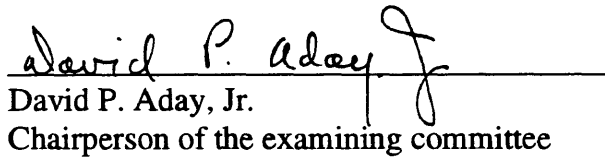

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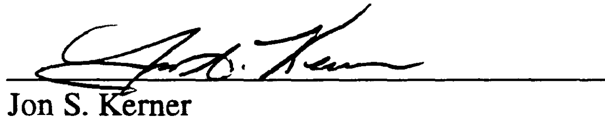

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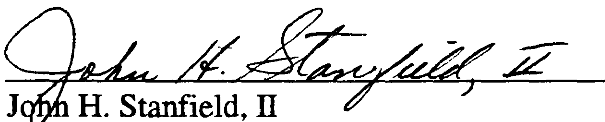

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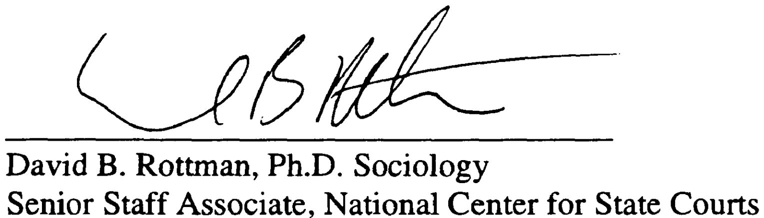

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To my wife, soul-mate, and best friend, Terra with all my love. Thank you for your love, patience, and support throughout this entire ordeal.

To my loving mother, who always encouraged me with her kind words.

To my erudite father, who challenged me to strive to learn more.

TABLE OF CONTENTS

Page

ACKNOWLEDGMENTS....................v

LIST OF TABLES....................vi

ABSTRACT....................viii

CHAPTER I: INTRODUCTION AND STATEMENT OF THE QUESTION....................2
Introduction....................2
Statement of the Question....................3

CHAPTER II: THEORETICAL BACKGROUND....................5
Review of Relevant Literature....................5
The Extension of Court Bureaucracy and Authority: An Organizational Approach....................21
Methodology....................26

CHAPTER III: FINDINGS AND IMPLICATIONS....................31
Bivariate Analysis: Cross Tabulations to Examine Key Relations and Questions....................31
Univariate Analysis: Frequency Distributions and Possible Implications....................62
Broader Implication of Frequency and Formality on Other Drug Treatment Program Characteristics....................75

CHAPTER IV: CONCLUSION....................82

APPENDIX A: Questionnaire....................84

APPENDIX B: List of Drug Treatment Programs....................95

BIBLIOGRAPHY....................114

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LIST OF TABLES

Tables 1-5. Frequency of Contact by Formality of Ties....................33-37

Tables 5-10. Frequency of Contact by
Frequency of Involvement in Treatment Decisions....................39-43

Tables 11-15. Frequency of Contact by Level of Control....................45-49

Tables 16-20. Frequency of Involvement
in Treatment Decisions by Formality of Ties....................51-55

Tables 21-25. Formality of Ties by Level of Control....................57-61

Tables 26-32. Criminal Justice Goals
Incorporated into Drug Treatment Program Goals....................64-66

Tables 33-36. Criminal Justice Objectives
Incorporated into Drug Treatment Program Objectives....................68-69

Tables 37-44. Criminal Justice Procedures
Incorporated into Drug Treatment Program Procedures....................72-74

Table 45. Clustering of Drug Treatment
Programs According to Formality/Value of (FF)....................77

Table 46. Drug Treatment Program Formality of
Contact with Judges by Incorporation of
Criminal Justice Goals (CJG) into Drug Treatment Goals....................80

Table 47. Drug Treatment Program Formality of
Contact with Judges by Incorporation of
Criminal Justice Objectives (CJO) into Drug Treatment Objectives....................80

Table 48. Drug Treatment Program Formality of
Contact with Judges by Incorporation of
Criminal Justice Procedures (CJP) into Drug Treatment Procedures....................81

"Rationalism in morals may persuade men in one moment that their selfishness is a peril to society and in the next moment it may condone their egoism as a necessary and inevitable element in the total social harmony."

Reinhold Niebuhr, *Moral Man and Immoral Society* (1960:41)

Our current national policies for combating the use of *illicit* drugs can be understood as reasonable in the sense that policy makers are trying to protect against the self-destructive behavior of drug users. Are they rational? Clearly, those persons who choose to use certain mind- and body-altering drugs assume risks such as addiction, loss of good judgment, and perhaps irreparable physiological damage. The costs, however, extend beyond individual drug users. The violence that is associated with the buying, selling, and use of certain drugs claims not only those who are drug-involved, but innocent bystanders as well. The truth is that many families, neighborhoods, communities, and large metropolitan areas are now suffering from the so called ravages of crack-cocaine.

Many social control mechanisms, including the *War on Drugs*, can be viewed as rational, or even profitable social phenomena. There is no question that some people who deal in controlled-substances make vast sums of money. And, combating drug dealers and drug cartels has created an industry. Many politicians, bureaucrats, criminologists, and drug rehabilitators have enlisted in the war and are engaged in fighting the battle to control illicit drug use. The drug war has produced numerous organizations, bureaucracies, and institutions and injected life into many that had heretofore lost their social relevance.

Perhaps, the truth is that the drug war and its soldiers, villains, and victims are a part of a persistent social arrangement. Whether the arrangement is rational or reasonable, in one sense, it is matter of values. The current research examines the rationality of certain aspects of the drug war in a more specific and technical sense.

ABSTRACT

This thesis focuses on understanding emerging relationships between criminal courts and drug treatment agencies, primarily in terms of consequences for drug treatment agencies. It is expected that court-related drug treatment programs will tend to become standardized, formalized, and rationalized as their relationships with courts develop. The conceptual framework for the study combines the constructs of social control, Weberian bureaucratization, and key concepts from contemporary organizational theories. Generally, I expect that the degree of bureaucratization of drug treatment programs will increase as the level of interaction with courts increases. More specifically, I expect that frequency of court-drug treatment program interaction will be related to formality in the relationships. Generally, the data support this expectation.

THE RATIONALIZATION OF DRUG TREATMENT PROGRAMS: THE EMERGENCE OF COURT-ENFORCED DRUG TREATMENT BUREAUCRACIES

Chapter I

INTRODUCTION AND STATEMENT OF THE QUESTION

Introduction

Increasingly, criminal courts are utilizing drug treatment programs in efforts to supplement judicial sanctions and to deal with drug-related crimes (Milkman and Beaudin 1993; Zimring and Hawkins 1992). A recent study concludes that many courts utilize some form of drug treatment approach as a standard component in the disposition of cases against defendants who have substance abuse problems (Milkman and Beaudin 1993).

The reasons for the increased use of court-mandated drug treatment are many and diverse. Some argue that increased drug use and stricter criminal statutes have led to the overburdening of state courts, forcing them to search for solutions to caseload backlogs and delays in dispositions (Goerdt and Martin 1989; Inciardi 1993; Milkman and Beaudin 1993). Others stress the limits of monetary, material, and personnel resources (Inciardi 1993; Milkman and Beaudin 1993; Zimring and Hawkins 1992). For instance, budget cutbacks may limit the available resources for dealing with drug law violators. Still others point to the need for a change in philosophy toward all drug-related behaviors -- a shift

from the crime control approach to a public health-treatment approach (Tauber 1993).

Perhaps because there is limited evidence that drug treatment works, some researchers have developed arguments that favor coercion to improve the outcomes of treatment for drug involved criminal defendants (Inciardi 1992; 1993; Tauber 1993; Nation Council on Drug Policy 1993; The White House 1992). Proponents of mandatory drug treatment argue that judicial leaders and policy makers are trying to resolve issues brought before them through collaborative partnerships with public and private institutions (Hillsman 1993; Inciardi 1992; 1993; Tauber 1993; Nation Council on Drug Policy 1993; The White House 1992). It may be that the association between courts and drug treatment programs are part of such collaborative efforts[1] (Casey, 1994; Hillsman, 1993; President's Commission on Model State Drug Laws, 1993). The focus of this research, *court-enforced drug treatment,*[2] is one example of such collaborative efforts.

Statement of the Question

Courts and drug treatment programs have begun to work together in drug intervention efforts. Courts can sanction and coerce and drug treatment programs provide

---

[1] Other collaborative efforts focus on court cases involving children, their families, and domestic violence.

[2] The term, *court enforced drug treatment*, refers to a broad range of existing efforts to incorporate or mandate drug treatment strategies into court processes and procedures. Throughout this paper I use the term court-enforced treatment; however, I also refer to court-enforced treatment programs as court-drug treatment relationships, the collaborative efforts of courts and drug treatment programs. All of these terms are meant to be synonymous.

alternative (i.e., behavioral, chemical, and clinical) approaches to case dispositions. What are the consequences of the court-drug treatment collaboration? I decided to narrow the focus of my research to one aspect of this relationship. Specifically, are courts extending characteristics of formal authority and bureaucratic organization to drug treatment programs through inter-organizational ties?[3]

This thesis seeks to answer this question from the perspective of drug treatment staff. My initial objective was to determine a useful method for characterizing existing court-drug treatment program relationships. I suspected that the degree of formalization, rationalization, and bureaucratization among *court-enforced drug treatment* programs would vary according to the frequency of court-related personnel interaction with drug treatment program staff. I also believed that the more court-related personnel[4] are involved in managing drug treatment programs and mandating treatment for drug offenders, the more bureaucratized drug treatment programs would become. Evidence of the rationalization of drug treatment programs would manifest itself in the incorporation of standard court-related goals, objectives, and procedures into drug treatment procedures, goals, objectives, and program components.

---

[3] The concept of formal authority is from Weber (1978) and will be defined more fully in subsequent discussions. Likewise, the concept of bureaucratization is from Weber (1978). It incorporates a host of social processes and will be defined in detail.

[4] This term refers to the activities of judges, court administrators, probation officers, prosecutors, and public defenders. Here, the focus is on three primary issues. ***Who*** is involved? ***How*** are they involved? ***What*** is the extent of their involvement?

Chapter II

THEORETICAL BACKGROUND

Review of Relevant Literature

Aday and Thomson define social control as "...punishment for a *violation*, which is an individual or collective act that departs from formal or informal norms" (1992). All human societies both impose constraints and limitations on the behavior of their individual members and punish people for violations of norms (Aday 1990; Durkheim [1893] 1984; Ritzer 1984; Weber 1968). Some have argued that individuals comply to a greater or lesser degree with norms and laws, partly as result of their attachments to norm- and law-abiding significant others (Hirschi 1969). Others maintain that individuals adhere to normative standards because of their concern with a loss of positive standing or status within the dominant culture (Aday 1990; Robertson 1987). And, still others contend that compliance with norms also results in part from the effects of threatened or imposed sanctions (Maume and Aday 1994: *under review*).[1]

The control of drug use (i.e., norm-, value-, and attitude-based formal and informal sanctions) is one of the most fascinating aspects of American society. Since the 1906 Pure

---

[1] These are simplified, but useful applications of theories of social control.

Food and Drug Act, efforts to *control*[6] drug use in the U.S. have revolved around two opposing paradigms: the crime control model and the treatment model (Aday and Thomson 1992; King 1972; Musto 1973; Zimring and Hawkins 1992). The crime control model views drug users as potentially dangerous deviants and suggests threats and punishments as the proper mechanisms of control (Aday and Thomson 1992; King 1972; Musto 1973). Pursuit of this model has resulted in criminal laws, the enforcement of these laws, and the development of formal mechanisms to control drug possession and use (Aday and Thomson 1992; King 1972; Musto 1973; Zimring and Hawkins 1992). The treatment model considers the habitual drug user as a person in need of medical and psychological treatment for a chemical dependency, which is characterized by chronic and relapsing disorder (Brill and Lieberman 1972; Inciardi 1990; McCoy and Block 1992; Zimring and Hawkins 1992). Social controls within the treatment model tend to be informal and oriented to persuasion. These approaches emphasize managing, reducing, or eliminating the psychological, sociological, and physiological aspects of drug dependency.

---

[6] Why does our society wish to control drugs? The complexities and motivations behind the control of drug usage are not a primary focus of this study. However, it is interesting to note some of the arguments behind the criminalization of drugs. Some authors and researchers (King 1972; Musto 1973) point to the wider society's perceptions of certain ethnic groups and the association of those populations with certain drugs (i.e., African Americans and cocaine, Mexican immigrants and marijuana, and Chinese immigrants and opium). Others cite evidence that drugs lower inhibitions, erode personal behavioral controls, and cause individuals to loose their *willpower*, leading them to engage in what many consider concomitant crimes (e.g., prostitution, robbery, and murder; Inciardi 1992; 1993). Perhaps, drug control is the result of laws aimed at stemming the loss of *personal control* or *willpower*. Viewed from this perspective, drug laws and policies appear to be a governmental substitute for public and personal responsibility regarding drugs (much in the same way that speed limit laws discourage dangerous driving). Nonetheless, this issue and this analogy grow even more complex when one asks, "Why do manufacturers offer to the general public, vehicles capable of 140 miles-per-hour?" Why do other substances such as alcohol and caffeine bear few regulations or restrictions in comparison to certain other drugs? Certainly, there is no shortage of research that demonstrates that alcohol is a primary causal factor in many forms of violence in our society (i.e., domestic, public, and motor vehicle).

There is little or no emphasis on coercion or formal punishment for drug-taking behavior (Aday and Thomson 1992; Inciardi 1990; McCoy and Block 1992; Zimring and Hawkins 1992).

Other efforts in the early part of this century and in the 1960's were based on involuntary civil commitment, which involved removing drug abusers from public and placing them in a hospital environment. These hospital "clinics" also were considered a form of mandatory drug treatment, albeit a *kinder and gentler* form (Musto 1973; Hafemeister and Amirshahi 1992). Involuntary civil commitment remains a complex issue because there are legal limitations to what the government can do to drug users who pose no threat to themselves or society other than their drug usage.[7]

Many regard mandatory drug treatment as the most promising solution for the complex problems associated with substance abuse (Cooper and Trotter 1994; Inciardi 1992, 1993; Leukefeld and Tims 1982; Office of National Drug Control Policy 1993, 1994; Tauber 1993; The White House 1992).[8] However, some researchers believe the efficacy of drug treatment has not yet been fully demonstrated (Biernacki 1986; Goldkamp and Weiland 1993). Furthermore, drug treatment programs are organized in diverse ways, pursue various treatment modalities, and have differing program objectives.

---

[7] Hafemeister and Amirshahi's (1992) manuscript, *Civil Commitment for Drug Dependency: The Judicial Response,* is a very comprehensive study on involuntary civil commitment of drug users.

[8] Cooper and Trotter's (1994), *Drug Case Management and Treatment Intervention Strategies in the State and Local Courts*, and the National Center for State Courts' *The Justice System Journal* (1994, Vol. 17, No. 1) are the latest and most comprehensive publications available on the subject of mandatory drug treatment.

A central question in the examination of the social control of drugs concerns the source and character of *authority* to impose either punishment or treatment. Weber (1968) distinguished three types of authority: *rational, traditional,* and *charismatic.* The current study focuses on *rational authority*, in which the exercise of social control is legitimized by rules. In the U.S., crime control generally, and the control of certain drugs in particular, have operated through *rational authority* and the logic of a deterrence doctrine (Aday and Thomson 1992). The logic of deterrence is grounded in the assumption that punishment will discourage and reduce the use of drugs and drug-related behaviors. Hence, this study defines deterrence as the use of negative sanctions aimed at discouraging certain activities, the use, possession, and sale of certain drugs.[9]

Furthermore, this thesis concentrates on the social control of drugs efforts through formal and bureaucratic processes. One of the major consequences of the our society's *rational authority*-based approach to drugs has been "the creation of laws" and law enforcement bureaucracies whose function is to create and direct drug deterrence strategies (Chambliss and Seidmann, 1982:291). There is considerable research that focuses on the rationalization and bureaucratization of the American criminal justice system (Blumberg 1979; Chambliss and Seidmann 1982; Heyderbrand and Seron 1990). Much of that research emphasizes a continuing trend toward bureaucratic responses to drug problems (Aday and Thomson 1992; King 1972; Musto 1973).

---

[9] Deterrence can be reflected in other than criminal laws or policies (e.g., high taxes on cigarettes and alcohol to discourage their use).

According to Weber, a rational-legal authority will manifest itself through a formal, bureaucratic structure[10] (Weber 1978: 217-226). Bureaucracies tend to be organized around fulfilling predetermined goals; a rational means of achieving such goals is an inherent characteristic of bureaucratic structure (Scott 1987:31):

> "From the rational system perspective, organizations are instruments to attain specified goals. How blunt or fine an instrument they are depends on many factors that are summarized by the concept of rationality of structure. The term rationality in this context is used in the narrow sense or *technical* or *functional* rationality...and refers to the extent to which a series of actions is organized in such a way as to lead to predetermined goals with maximum efficiency. Thus, rationality refers not only to the selection of goals but to their [organization and] implementation."

Blumberg's thesis (1979) on courts as rational bureaucracies provides this study with the groundwork for examining some of the consequences of the relationship between courts and drug treatment programs. Blumberg asserts that courts are bureaucratic entities with structures and processes that are aimed at carrying out the goals and objectives of courts (1979). This is particularly true for contemporary large metropolitan courts that handle vast numbers of criminal cases with some degree of efficiency (Blumberg 1979; Chambliss and Seidmann 1982; Heyderbrand and Seron 1990). However, the pursuit of criminal court efficiency is not without consequences (Blumberg 1979; Chambliss and Seidmann 1982; Slate 1990; Tauber 1993). Some believe it has produced bureaucratic structures

---

[10] Weber's conception of bureaucracies includes a list of characteristics inherent in their administrative structure(Weber 1978: 220-221): 1) a fixed division of labor and specialization administrative staff members; 2) a hierarchical structure among departments, offices, and personnel; 3) the accomplishment of organizational goals through directives, standards, guidelines, rules, and procedures; 4) the distinction between personal and organizational resources, specifically, the presence of formalized financial and budgetary categories and procedures; 5) personnel are selected on the basis of formal knowledge, credentials, training or other background skills and experiences, and they typically view their work as a career.

and procedures, such as plea bargaining and other negotiation-based case management techniques, that tend to undermine traditional due processes and "...exalt the goals and requirements of the court organization itself" (Blumberg 1979:146):

> "...rational-instrumental goals of the court organization, in its urgent demand for guilty pleas, have produce a bargain-counter, assembly-line system of criminal justice which is incompatible with traditional due process...Traditional constitutional elements of criminal law, when placed in the institutional setting of a modern criminal court, are reshaped by a bureaucratic organization to serve its requirements and goals."

Heyderbrand and Seron (1990) discuss four aspects of courts that reflect this bureaucratization. Discussion of these points is relevant to the current study because it provides an additional, useful way of thinking about the way courts have begun to extend their own form of organization and authority into their relationships with drug treatment programs. First, court business is routinized; that is the mission of courts is achieved, in significant degree, through highly routinized work (Heyderbrand and Seron, 1990). The operations and procedures associated with processing court caseloads, particularly in large courts, tend to be stable, routine, and repetitive.

> ...there are some definite changes occurring in the organizational structure of courts, commonly referred to as bureaucratization...It is as if Max Weber's pessimistic vision of the "iron cage" -- the increasing and inevitable bureaucratization of modern life is accepted as axiomatic...the bureaucratization of the judiciary, like the bureaucratization of the world , cannot be avoided (Heyderbrand and Seron, 1990:137).

As a result, many courts have developed routine ways of handling the recent flood of drug cases (Casey 1994; Inciardi 1993; Milkman and Beaudin 1993). A further extension of this process is that a significant number of these courts also have begun to

develop routine ways of collaborating with drug treatment programs through court-enforced treatment (Casey 1994; Inciardi 1993; Milkman and Beaudin 1993).

Second, court cases are managed according to formalized strategies and procedures. Thus, to handle new and evolving issues in workloads, many courts have developed formal strategies for managing, resolving, and reducing the number of cases that go to trial. As a part of this overall process of formalizing management techniques, courts have recently developed new sentencing approaches that rely upon frequent and increasingly formal relationships with drug treatment programs. These include a variety of increasingly routine management procedures such as pretrial hearings and diversions, negotiation-based procedures such as plea bargains, new types of hearings to expedite dispute resolution, and other methods such as mandatory settlement hearings. However, to make these management strategies work efficiently courts often must change their *structure* as well as their operations and procedures.

> Courts, like other organizations, also respond to fluctuations in demand with changes in internal processing routines. When a special kind of case [e.g., drug cases] become troublesome, courts may establish new routines to accommodate them. For instance,. a large influx of criminal appeals in California apparently led to the first district appellate court to establish a central legal staff to process "routine" criminal appeals in the name of the court. Likewise, trial courts often establish special divisions for particular cases, even though their formal jurisdiction is general (Jacob in Boyum and Mather, 1983:199).

> A contemporary urban court or metropolitan court typically must deal with a large number of drug-related cases and would be expected to have numerous pretrial and post-trial programs to assist with its burden of defendant risk assessment, processing, and sentencing (Milkman and Beaudin, 1993:11).

> It [the American criminal court] seems to have articulated structures of a highly rational character, calculated to achieve maximum production and near maximum rates of conviction. If these are the ends to be pursued, then the criminal court is highly "efficient." (Blumberg, 1979:173).

Third, in response to increasing caseloads and the changing composition of cases, many judicial leaders have added court executives and administrative positions to ensure the business and operations of the court are professionally managed. These personnel have often instituted management techniques to increase productivity and decrease case processing time. The flood of drug cases has enhanced this process in many urban courts.

> The inundation of these [drug] cases has caused judges to take more control over the proceedings, over the entire process, to set the tone for the process and to try to develop programs that would be of assistance (Slate, 1990:317)

Finally, fourth, courts have a significant impact on how other organizations and institutions operate. Courts sometimes exercise their institutional power to affect significantly how societal institutions attempt to deal with society's problems by influencing the structures, processes, and procedures that constitute a proposed solution. Courts also extend their power and authority into executive and legislative bureaucracies through orders that systematically affect law-making and social policy-making decisions.

> We can assume that legitimation of...social control of individual criminal activity and of the role of law falls not only upon the organs of law enforcement and the executive branch, but also on the courts....Under the doctrine of "judicial review," it is judicial authority that must ultimately legitimate social control and state intervention in the name of formal legality and the rule of law (Heyderbrand and Seron 1990:134).

If courts become involved significantly with drug treatment programs in drug-control methods that are outside of both their traditional and contemporary, bureaucratic roles, what form is this involvement likely to take? I believe such court involvement, particularly *court-enforced drug treatment*, is likely to follow structures and procedures

that are formal, bureaucratic, and rational. Furthermore, I believe relationships between courts and drug treatment programs will be based, in a large degree, on the bureaucratic procedures of criminal courts.

The implications of efforts aimed at the social control of drugs can be developed further through another Weberian concept: *formal rationality.* According to Ritzer (1993:19), "*formal rationality* means that the search by people for the optimum means to a given end is shaped by rules, regulations, and larger [or alternative] social structures." The *rational authority* of courts and the American criminal justice system is constituted and legitimized in the rules, processes, and procedures of law (Chambliss and Seidmann 1982). Court efforts concerning the social control of drugs involve both *rational* and *formal* procedures. There are two fundamental issues that clarify the distinction between rational authority and formal rationality. First, court authority is rational authority. That is, court authority is rule-based. Second, pursuit of court authority is achieved through formal rationality (Blumberg 1979). Simply put, court organization is explicit and specialized for some purpose or objective. In terms of this thesis, when drug treatment is mandated and organized through court bureaucracy, it becomes a part of the *formal* (explicit), *rational* (rule-based) social control efforts of the court. I believe that judicial leaders are likely to extend their use of court-enforced treatment strategies through newer and more complex alliances with drug treatment programs. At the same time, treatment

programs may struggle with how to use the power of the court to coerce their *custodial clients*[11] to pursue treatment goals.

Courts have the responsibilities of adjudicating and disposing of criminal cases. However, courts often find themselves constrained by their environment. For example, the increased demands from the public, politicians, and law enforcement agencies have produced harsher laws and penalties (e.g., mandatory minimum prison sentences for certain drug offenses; King 1972; Musto 1973). Furthermore, the expectations of the public, police, and politicians are very different with regard to the outcome of drug cases. These expectations can potentially alter the procedure and outcome of such cases. The public, which wants to be protected from the theft of property and the violence that often is associated with buying, selling, and the use of certain drugs, would like to see their streets and neighborhoods free of all crime -- drug-related or otherwise. Police officers, who face potentially dangerous situations in the streets, would like to see their work rewarded with longer prison sentences (preferably without the possibility of parole). Of course, politicians, who sometimes govern according to prevailing public and media opinion (at times tough on crime and drugs, having little tolerance for illicit drugs or at other times compassionate, showing patience and understanding towards those caught in the cycle of drug dependency), want to win elections and advance their agendas. In short, social controls, financial and environmental constraints, and conflicting organizational demands placed on the court system by executive and policing agencies, as well as public

[11] This term refers to those clients who have been referred to treatment as a result of court stipulation or disposition.

perceptions and political agendas have created pressure on criminal courts to seek out alternatives to incarcerating offenders. At the same time, other organizations within the court environment introduce constraints, including, for example, prisons that are at or beyond their legal capacity.

Increasing public and political demands and environmental constraints extend far beyond local court and drug treatment program relationships. They extend to matters of national policy. In their critical analysis of the 1989 National Drug Strategy, Aday and Thomson (1992), employ a general theory of social control to analyze the logic of the National Drug policy. According to Aday and Thomson, the logic of the 1989 White House drug policy is grounded in the following argument (pg. 420):

> Premise 1: Drug use is dangerous to the user and to others (including unborn children and other family members, property owners, and other innocent bystanders).
>
> Premise 2: Some people choose to use drugs in spite of prevailing negative attitudes and known risks.
>
> Conclusion: Laws must be passed to discourage drug use, to protect those who might be tempted to use drugs, to protect the interest of the community, and to protect those who may be victimized by drug users and dealers.

Aday and Thomson contend that the 1989 National Drug Strategy policy argument is flawed and that policies based on that logic are flawed as well. They point to theoretical and empirical analyses that support alternative strategies. The emerging 1993 national strategy on drugs seems to be more reflective of the current views of judicial leaders who are proponents of *court-enforced drug treatment.* According to the President and the National Council on Drug Abuse Policy (1993:2), the interim strategy for dealing with the

drug problem will take a new direction, which could offer support to alternative efforts such as court-enforced drug treatment:

> "...mak[ing] drug control policy a cornerstone of domestic policy in particular, by **acknowledging drug abuse as a public health problem** and by linking drug policy to our efforts to...reform health care."
>
> "...target[ing] hard-core drug users, both inside and outside of the criminal system, for treatment to reduce their drug use and its consequences."
>
> "...support[ing] research to assist treatment providers to more effectively treat drug addicts."

Indeed, the treatment-centered tenets of the 1993 interim strategy appear to be a slight departure from the more crime control-based approaches of previous administrations. However, a closer inspection of the 1993 policy reveals it to be consistent with previous *rational authority*-based formal social control efforts. Treatment will be a part of the interim strategy; however, the current administration will continue to emphasize traditional criminal justice based social control efforts against drug use by:

> "...expanding community policing, putting more police on the streets..."
>
> "...promot[ing] **certainty of punishment by ensuring that all drug offenders- particularly young offenders- receive some type of sanction** [my emphasis] *when they first encounter the criminal justice system.*"
>
> "...increas[ing] international commitment to narcotics control and will work with other nations *that demonstrate political will to end illegal drug-trafficking."*

Some of the chānges in the national drug strategy lend legitimacy to court-enforced treatment. That is, mandatory treatment, based on the logic of linking formal coercive control and drug treatment, may be a viable alternative to traditional drug-control (Inciardi 1992; 1993). Furthermore, when viewed from an inter-organizational

perspective, the compulsory treatment linkage may be mutually beneficial to both courts and drug treatment programs. Courts can sanction and coerce, but traditional adjudicative efforts regarding drug offenses have not produced persuasive results (Tauber 1993). Drug treatment could provide courts with an additional tool for disposing of drug cases, maybe with more positive outcomes for offenders. Furthermore, drug treatment programs need clients to stay in business (i.e., collect revenue from private, public, and government funding and insurance agencies for services rendered). Yet, drug programs lack the authority constraints to force clients into treatment or to compel them to stay in treatment. Courts can provide drug treatment programs with this force.

Pursuing drug-control goals has produced consequences for both courts and for drug treatment organizations. One of the most important issues that court-drug treatment program relationships must contend with is the institutionalization of their efforts. One of the most significant aspects of this institutionalization process is "...developing working relationships between courts and treatment providers, which, while recognizing treatment standards and objectives, support the constraints of the criminal process" (Cooper and Trotter, 1994:96). As do all organizations, courts and drug treatment organizations operate within environments and are part of the environments of other organizations. This leads to a central question concerning the nature and consequences of inter-organizational relationships. It may be that these linked and increasingly coordinated efforts provide an optimal approach to rational social control of the drug problem. Furthermore, the degree of bureaucratization of *court-enforced drug treatment* may be a reflection of the links and

coordinated efforts between the courts and treatment programs. *Court-enforced drug treatment* combines the coercive power of a court system's rational authority with the helping, problem-solving orientation of drug treatment. The result may be that courts have a more *efficient, predictable, calculable,* and *controllable*[12] form of formal social control for dealing with drug offenders. Or maybe not.

Courts exercise considerable influence over other organizations and institutions with which they intersect, including the drug treatment industry. One way to measure inter-organizational relationships is through the observed frequency of routine interactions between courts and other agencies, in this case, drug treatment programs (Hall, 1987). Another way is to measure the degree of formality associated with these relationships. Here, formality concerns the extent to which activities and agreements between courts and drug treatment programs are made explicit in documents such as manuals of procedures. Furthermore, examining the frequency and the degree of formality in these organizational interactions between courts and drug treatment programs provides a beginning point for analyzing other aspects of their emerging inter-organizational relationships (Hage and Aiken, 1969; Hall 1987). Hall (1987:247) notes that:

> Apparently, the presence of a formal agreement is based on frequent and important interactions among organizations, with the agreement serving to simplify interactions, since each interaction does not need to be weighed in terms of its contributions to the organizations involved.

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[12] These concepts are borrowed from Ritzer (1993). In his book, the *Mc Donaldization of Society,* he asserts these four concepts are the primary goals of Weberian rationalized bureaucracy.

It is expected that drug treatment programs that become aligned with court-enforced programs and become part of court processes will reveal evidence of direct and indirect court management in the business and operations of the drug treatment programming. For example, courts will begin to determine who will be referred to treatment programs and set the conditions of their referral, including dictating the conditions of treatment assignment and of release from such programs. Observations of court-related personnel, involvement in treatment decisions, and the degree of that control over the release of drug defendants from treatment programs provide a way to measure the level of such court involvement in the business and operation of drug treatment programs.

Organizations may collaborate in problem solving arrangements of power and authority, and the ability to punish is a central indicator of organizational power (Hall, 1987). Courts are potentially powerful in such inter-organizational arrangements because they have rule-based authority. In this case, courts have the authority to impose punishments on drug-involved offenders. Courts may try to extend such power to drug treatment programs through collaborative partnerships, in which the actions of both courts and drug treatment staff are "coordinated" (Hall, 1987:255; Jacob in Boyum and Mather, 1983:199). Coordinating mechanisms provide a "formal structure" for ordering the actions of organizations that are engaged in the pursuit of common goals (Jacob in Boyum and Mather, 1983:199). Under such arrangements, courts also may extend their authority

to or over those drug treatment programs with which they collaborate (Heyderbrand and Seron 1990).

> "...the dominant principle of inter-organizational interaction is to secure cooperation and perhaps subservience...Such formally created arrangements are most likely to develop among interdependent organizations that have standardized, continuing, and repetitious relationships over long periods of time..." (Jacob in Boyum and Mather, 1983:199).

This extension of judicial power and authority into drug treatment programs can sometimes be seen in the goals and actions of those organizations (Hall, 1987; Scott 1987). The acceptance and, indeed, incorporation of court-related goals and objectives into drug treatment program goals and objectives can be measured and taken as evidence of the extension of court authority into such programs. For example, the Substance Abuse Bureau of the Baltimore City Health Department in Maryland collaborated with Baltimore City court officials to develop the Addictions Assessment Unit (AAU). The AAU has a single mission that it performs for the court: assessing the severity of addiction for drug defendants and, if necessary, referring those defendants to treatment programs. According to Diana Anim, the director of the AAU, the general goals and objectives of the AAU are organized around the needs of the court, including:

> [1.]...distinguishing between those defendants who are experiencing substance abuse problems requiring intervention and those defendants whose substance abuse does not appear to necessitate referrals at the time of assessment; [2.]...initiating individualized treatment referrals for defendants; and, [3.]...assisting the court in making informed decisions regarding a defendant's need for treatment (Anim 1994:1).

Inter-organizational alliances such as court-enforced treatment can be understood better when the organizational links between them are examined for their degree of

routinization, formalization, and bureaucratization (Hall, 1987). Organizational change resulting from the extension of judicial power and authority often is more apparent when viewed from the perspective of the institution over which authority is being extended (i.e., drug treatment). While both organizations will change as their relationship becomes more institutionalized, the latter is likely to be affected significantly more because as the relationship grows, some of the power and authority from drug treatment programs is transferred to courts. Thus, this thesis focuses on court-enforced drug treatment from the perspective of drug treatment providers.

The Extension of Court Bureaucracy and Authority

Court-enforced drug treatment programs are highly variable in organization and purpose. It seems likely that they vary also in degree of routinization, specialization, and differentiation of activities. And, it seems likely that they vary also according to their contact with courts and court-related personnel. In terms of this research, variations in court-drug treatment program contacts are observed in terms of the frequency; the degree of formality; level of court-related personnel involvement in decisions; degree of authority of court personnel; and, the incorporation of court-related goals, objects, and standard procedures into drug treatment programs. My general expectation is that courts are formalized, rationalized, and bureaucratized agencies and their characteristics will be extended to drug treatment programs with whom they operate. I expect to find a positive

correlation between the frequency and formality of court-drug treatment program organizational interactions and the degree of formalization, rationalization, and bureaucratization among court-enforced treatment programs. My general contention about court-drug treatment program relationships concentrated on the following question:

> Are courts extending characteristics of formal, rational authority and bureaucratic organization to drug treatment programs through inter-organizational ties?

This thesis seeks to answer this question from the perspective of drug treatment staff. I designed a survey instrument for the study with these key connections and personnel relationships in mind. The questionnaire and follow-up telephone interviews were developed to understand how drug treatment providers perceived several issues relating to the influence that courts and court-related personnel have over them. Several questions focused on the effects of judicial authority, formal court structure, and court operations on drug treatment programs.

Drug treatment program ***frequency of contact*** with court-related personnel was the fundamental variable identified for investigation in the survey. This is because frequency of contact between organizations is fundamental to inter-organizational relationships (Hage and Aiken , 1969; Hall, 1987).

The degree of ***formality of contacts*** between organizations is also fundamental to inter-organizational relationships (Hage and Aiken, 1969, Hall, 1987). Important organizational relationships are rarely left to chance. They are managed by agreements,

rules, or contracts (Hage and Aiken, 1969; Hall, 1987). This principle reflects the logic of *formal rationality*. It is a general organization principle that the more important the inter-organizational relationships between two organizations, the more likely those relationships are to be governed according to some formal rationality. Given that, I expect that the frequency of contact between court personnel interactions with drug treatment staff will reflect the importance of the relationship. Further, I expect the greater the importance of the relationship, the greater the likelihood that the relationship will be formalized. Finally, the greater the frequency and degree of formality of the relationship, the greater the bureaucratic effects on the relationship.

Court-related personnel frequency of ***decision making involvement*** in the treatment regimen of drug treatment clients should be related to both frequency of contact with court-related personnel and the formality of those contacts. In this dimension, courts utilize their inter-agency decision making power as part of a problem-solving strategy. For example, a drug treatment program that has infrequent contact with court-related personnel should have no need to involve court-related persons in the decisions regarding individual clients. Perhaps in some programs, courts exercise some minimal decision making involvement over clients referred to treatment, and yet have no input in decision making within treatment programs. Courts may order offenders into treatment, but require only those to individuals *enroll in treatment.* They may require some follow-up report or some notice of exit from the programs. Here, courts mandate treatment, but are not involved subsequently in decisions relating to the length of treatment or type of

treatment. In this model, courts operate in the traditional role of courts and confine their activities to legal processing and decisions. Offenders may return, either as a result of some violation of imposed conditions or for new criminal charges. In the extreme cases, clients may be responsible for finding and enrolling in treatment programs without any help or guidance from courts.

Frequency of contact and degree of formality also may be related to the ***level of control*** that court personnel have over treatment programs. Control is expressed as the use of formal, coercive authority by court personnel. In this dimension, courts utilize their coercive authority as part of a problem-solving strategy. Courts could maintain control over clients in drug treatment through the threat of imposing criminal sanctions. This control may be extended to drug treatment programs as well. In this thesis, there are two measures for the ***level of control.*** First, control refers to the ability of court personnel to ***recommend*** release or to influence the release of a client from treatment.[13] Second, control refers also to the power of court personnel to ***authorize*** the release of clients from treatment.[14]

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[13] For example, a public defender in a pretrial court-enforced drug treatment program is satisfied with the progress that a defendant has made in treatment. The public defender may formally recommend to the court that the client be released from drug treatment and the threat of prosecution under the current charges. However, if the prosecutor disagrees with the public defender, she may recommend that the defendant remain in drug treatment for another six months. All of this clearly extends the roles of both defense and prosecution lawyers.

[14] In this same scenario, the drug treatment counselor may agree that client has made good progress in treatment, but recommends that the client continue with weekly counseling sessions and weekly drug testing for at least three more months. Here, only the judge has the power to authorize the release of the client from drug treatment. The structure of the pretrial program also gives the judge the power to authorize the clearing criminal charges against the client once he has successfully completed the court-enforced program. As a compromise, the judge may order the client to continue in treatment, including weekly counseling and weekly drug testing for another four months.

Courts also can extend their authority into treatment programs through decisions that may affect certain aspects of treatment programming. This extension of court authority into drug treatment can be indicated by the incorporation of court-related ***goals, objectives, and standard procedures*** into drug treatment programs. In rational organizations, goals, and the actions by which they are achieved (i.e., objectives and procedures), provide the criteria for selecting courses of action (Scott, 1987). Furthermore, rational organizations can "coordinate" inter-organizational exchange through (Hall, 1987:255):

> "...concerted decision-making or action in which in two or more organizations participate with some sort of deliberate adjustment to one another. A key factor here is the idea that the transactions are deliberate and involve a goal that is collective."

Deliberate and coordinated action between courts and drug treatment programs that is aimed at the common goal of providing mandatory drug treatment for criminal defendants is consistent with the principles above. A central aspect of this deliberate and coordinated action, is the exchange of ***goals, objectives, and standard procedures*** on the part of the involved organizations (Cooper and Trotter, 1994:96). This is the framework for the relationship between courts and drug treatment programs. It also the basis for my examinations of court-enforced drug treatment program relationships. My general hypothesis concerning court-drug treatment relationships in as follows:

> Courts are extending characteristics of formal, rational authority and bureaucratic organization to drug treatment programs through inter-organizational ties.

More specifically, I hypothesize as follows:

1. The more ***frequent*** the contact between courts and drug treatment programs the more ***formal*** the relationship between the two organizations.
2. The more frequent and formal the organizational contact between courts and drug treatment programs, the higher the ***frequency of involvement of courts in drug treatment-related decisions***; the greater the court ***control over the release of clients from drug treatment.***

Generally, drug treatment programs that have more frequent and formal contact with court-related personnel are more likely to have court-related ***goals and objectives incorporated into drug treatment programming***; and, court-related ***standard processes and procedures incorporated into standard drug treatment programming***.

Methodology

The alliance between courts and drug treatment programs may have changed the manner in which both organizations pursue goals relative to the social control of drugs. This thesis attempts to describe the emergent court-treatment program relationship in the context of bureaucratized and rationalized social controls. Organizational theory and Weber's model of bureaucracy clarify the theoretical foundation of the research.

I have attempted to triangulate data, drawing from relevant literature, examining court and drug treatment archival data, conducting on-site observations at several courts and drug treatment facilities, collected questionnaire data, and conducting interviews with relevant court and drug treatment staff.

The primary data come from a mail survey questionnaire (Appendix A) and follow-up telephone interviews. Data collection proceeded with the following two objectives in mind:

1. To describe the operation of drug treatment programs in relation to courts.
2. To examine the inter-organizational linkages between courts and drug treatment programs to determine the effects of these linkages on the structure and operation of and drug treatment programs.

The questionnaire focuses on drug treatment programs that provide services to clients that have been defendants in criminal court proceedings. The respondents are drug treatment professionals who manage these programs. The strategy for selecting and surveying prospective programs proceeded along two lines. First, I examined a list of agencies that provide treatment as a form of alternative sanction for drug defendants. These programs included those that:

1. Are court initiated or developed;

2. Operate within the administrative structure of a court (i.e., included in the court budget or under court supervision);

3. Treat clients who have been referred to drug treatment;

4. Provide courts with information about drug defendants (i.e., assessing, monitoring, reporting on the progress of treatment); and or

4. Operate in a court (or jail) environment.

This list was compiled through personal and professional contacts and accumulated through *snow-ball* procedures. Essentially, I began to brainstorm and ask colleagues for help in identifying those courts or jurisdictions that were using drug treatment programs or strategies to handle drug defendants. Those persons (n=83) who directed such programs were added to the list of prospective survey respondents.

The second group of prospects was selected from among the substance abuse treatment and non-treatment (e.g., assessment and referral, and education and prevention) programs listed in the U.S. Department of Health and Human Services (DHHS) National Directory of Drug Abuse Treatment Programs (1992). This directory is published annually by the DHHS and is compiled to:

> "...serve as a resource for program managers, treatment personnel, researchers, the Center for Substance Abuse Treatment Hotline, and others interested in the location and selected characteristics of alcoholism and drug abuse facilities."

One hundred and thirty-four programs (n=134) were selected at random from the DHHS directory for the survey. Taken together, the two listings (Appendix B) provided a sample of two hundred and seventeen programs (217) with identified managers.

The questionnaire and a letter of explanation were mailed to those on the list at the end January, 1994. After three weeks, a follow-up letter was sent to those persons who had not responded. Two weeks later, a second follow-up letter was sent out.

In the middle of March, I began telephoning those treatment managers who had not responded. The telephone follow-ups were done for three purposes:

1. To ask if any staff member received the questionnaire in the mail. (If not, I offered to mail or to fax another copy of the survey.
2. To explain the purpose and context of the survey and to answer any questions concerning the survey, and finally;
3. To remove the anonymity from the survey by personalizing it through friendly and professional telephone conversation.

The telephone follow-ups significantly increased the survey response rate and by the April 30, 1994 survey return deadline, one hundred and twenty three (123) of the original two hundred and seventeen (217) questionnaires were completed and returned. Forty-seven (47) of those who were mailed questionnaires either declined to participate in the study or did not return their completed questionnaires by the deadline date.

The final status of the remaining forty-seven (47) questionnaires is as follows:

1. Fourteen (14) were returned as undeliverable by postal service. The names or addresses were incorrect or unknown (in some of the cases, the drug treatment program had closed). An attempt was made to find a correct name and address for each of these dead-end cases; however, no forwarding or correct addresses could be found.
2. Twenty-six (26) were sent to persons who were not drug treatment professionals. Several of these individuals worked in programs that were closely linked to the drug treatment profession; however, neither they nor their agencies actually provided drug rehabilitation or treatment. A number of these persons worked for state commissions on drug abuse. Others worked in drug education and prevention programs that did not contain drug treatment components.
3. Seven (7) were later found to be duplicate addresses or programs that were inadvertently surveyed twice.

The total number of questionnaires from the three categories above (47) was subtracted from the sample N=217 to give an adjusted sample of 170. The final response rate was 72.4 percent. Data generated by questionnaire were analyzed using SPSS.

Chapter III

FINDINGS AND IMPLICATIONS

Bivariate Analysis: Cross Tabulations to Examine Key Relations and Questions

To begin to describe courts' involvement in drug treatment programs, treatment providers were asked the following question:

> How **frequently** does your program have on-going working relationships or administrative links with court, legislative, executive, or other criminal justice staff or agencies?[1]

Frequency of contact with courts was measured by the following responses: *daily, weekly, monthly, some,*[2] *or never.* Frequency of contacts between court-related personnel and drug treatment staff were scored from four (4) to zero (0).

Respondents also were asked to characterize their contacts with court-related personnel. *Formality* and *informality* were scored two (2) and one (1) respectively.

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[1] See question 15 in Appendix A.

[2] A number of the respondents indicated contact with court-related personnel that was more frequent than *Never* and less frequent than *Monthly*. These respondents wrote in answers such as occasionally, rarely, quarterly, or less than monthly, but several times a year. Due to the significant number of these responses, an addition ordinal value of *Some* was created.

Treatment programs that reported no contact with court-related personnel were scored as zero (0) on this variable.

> Are relationships (ties) ***formal*** (defined by statute, contract, or written agreement) or ***informal*** (defined by casual cooperation or verbal agreement)?[17]

Gamma was chosen as the statistical technique for evaluating the relationship among variables. This was due to gamma's stability, strength, and versatility in measuring the direction and degree of association between ordinal-level variables, **including handling small and zero cell values** (see Champion 1976:223).

The following tables present descriptions of the frequency of contacts among the treatment program staff and court-related personnel and the formality of those contacts. Table 1 suggests a very strong positive relationship between frequency of contact between judges and drug treatment staff, and the degree of formality of those contacts.[18]

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[17] See question 15 in Appendix A.

[18] A gamma value measures the strength of association between two variables. A gamma of .70 or higher indicates a very strong relationship; .69 to .40 indicates a strong to moderate relationship; .40 to .0 indicates a moderate to weak or no relationship. Some of the gamma values are influenced by the number of "No Ties" programs; however, the strength of the relationship without these programs is relatively unchanged.

Table 1

FREQUENCY OF CONTACT WITH JUDGES BY FORMALITY OF TIES WITH JUDGES

N=123, (32 or 26 % of the programs have no contact with Judges).

Gamma = 0.93543

CONTACT BY FORMALITY	FORMAL TIES 2	INFORMAL TIES 1	NO TIES 0	ROW TOTAL
DAILY CONTACT 4	22 **88.0**	3 **12.0**		25 20.3
WEEKLY CONTACT 3	14 **73.7**	5 **26.3**		19 15.4
MONTHLY CONTACT 2	13 **35.1**	24 **64.9**		37 30.1
SOME CONTACT 1	0.0 **0.0**	10 **100.0**		10 8.1
NO CONTACT 0			32 100.0	32 26.0
COLUMN TOTAL	49 39.8	42 34.1	32 26.0	123 100.0

Table 2

FREQUENCY OF CONTACT WITH PROBATION OFFICERS BY FORMALITY OF TIES WITH PROBATION OFFICERS

N=123, (**3** or 2.4 % of the programs have no contact with Probation Officers).

Gamma = 0.80620

CONTACT BY FORMALITY	FORMAL TIES 2	INFORMAL TIES 1	NO TIES 0	ROW TOTAL
DAILY CONTACT 4	46 **88.5**	6 **11.5**		52 42.3
WEEKLY CONTACT 3	14 **53.8**	12 **46.2**		26 21.1
MONTHLY CONTACT 2	12 **34.3**	23 **65.7**		35 28.5
SOME CONTACT 1	0.0 **0.0**	7 **100.0**		7 5.7
NO CONTACT 0			3 100.0	3 2.4
COLUMN TOTAL	72 58.5	48 39.0	3 2.4	123 100.0

Table 3

FREQUENCY OF CONTACT WITH ADMINISTRATIVE STAFF BY FORMALITY OF TIES WITH ADMINISTRATIVE STAFF

N=123, (**34** or 27.6% of the programs have no contact with Administrative Staff).

Gamma = 0.91956

CONTACT BY FORMALITY	FORMAL TIES 2	INFORMAL TIES 1	NO TIES 0	ROW TOTAL
DAILY CONTACT 4	28 **93.3**	2 **6.7**		30 24.4
WEEKLY CONTACT 3	14 **53.8**	12 **46.2**		26 21.1
MONTHLY CONTACT 2	9 **36.0**	16 **64.0**		25 20.3
SOME CONTACT 1	1 **12.5**	7 **87.5**		8 6.5
NO CONTACT 0			34 100.0	34 27.6
COLUMN TOTAL	52 42.3	37 30.1	34 27.6	123 100.0

Table 4

FREQUENCY OF CONTACT WITH PUBLIC DEFENDERS BY FORMALITY OF TIES WITH PUBLIC DEFENDERS

N=123, (**39** or 31.7% of the programs have no contact with Public Defenders).

Gamma = 0.88901

CONTACT BY FORMALITY	FORMAL TIES 2	INFORMAL TIES 1	NO TIES 0	ROW TOTAL
DAILY CONTACT 4	18 66.7	9 33.3		27 22.0
WEEKLY CONTACT 3	9 69.2	4 30.8		13 10.6
MONTHLY CONTACT 2	10 26.3	28 73.7		38 30.9
SOME CONTACT 1	1 16.7	5 83.3		6 4.9
NO CONTACT 0			39 100.0	39 31.7
COLUMN TOTAL	38 30.9	46 37.4	39 31.7	123 100.0

Table 5

FREQUENCY OF CONTACT WITH PROSECUTORS BY FORMALITY OF TIES WITH PROSECUTORS

N=123, (**49** or 39.8% of the programs have no contact with Prosecutors).

Gamma = 0.94661

CONTACT BY FORMALITY	FORMAL TIES 2	INFORMAL TIES 1	NO TIES 0	ROW TOTAL
DAILY CONTACT 4	17 **85.0**	3 **15.0**		20 16.3
WEEKLY CONTACT 3	13 **76.5**	4 **23.5**		17 13.8
MONTHLY CONTACT 2	9 **34.6**	17 **65.4**		26 21.1
SOME CONTACT 1	1 **9.1**	10 **90.9**		11 8.9
NO CONTACT 0			49 100.0	49 39.8
COLUMN TOTAL	40 32.5	34 27.6	49 39.8	123 100.0

Tables 2 to 5 report findings concerning the relationship between frequency of contact and formality that are highly consistent across court personnel roles. Frequency of interaction also may be related to the formal authority that courts exercise over drug treatment program decisions.

Court personnel involvement in drug treatment decisions also was measured by frequency: ***daily***, ***weekly***, ***monthly***, ***some***, and ***never***. Court personnel involvement in drug treatment decisions also was scored from four (4) to zero (0).[19] Tables 6 to 10 present the results. The data suggest a strong positive relationship between frequency of contact between court personnel and drug treatment staff and the frequency with which court personnel are involved in drug treatment program decision making.[20]

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[19] See question 24 in Appendix A.

[20] Some of the gamma values are influenced by the number of "No Invlmnt" programs; however, the strength of the relationship without these programs is relatively unchanged

Table 6

FREQUENCY OF CONTACT WITH JUDGES BY
FREQUENCY OF INVOLVEMENT (INVLMNT) OF JUDGES IN TREATMENT DECISIONS
N=123, (32 or 26 % of the programs have no contact with Judges).
Gamma = 0.66464

CONTACT BY INVLMNT	DAILY INVLMNT 4	WEEKLY INVLMNT 3	MONTHLY INVLMNT 2	SOME INVLMNT 1	NO INVLMNT 0	ROW TOTAL
DAILY CONTACT 4	8 32.0	3 12.0	4 16.0	2 8.0	8 32.0	25 20.3
WEEKLY CONTACT 3	1 5.3	5 26.3	1 5.3	1 5.3	11 57.9	19 15.4
MONTHLY CONTACT 2	1 2.7	3 8.1	12 32.4	3 8.1	18 48.6	37 30.1
SOME CONTACT 1				1 10.0	9 90.0	10 8.1
NO CONTACT 0					32 100.0	32 26.0
COLUMN TOTAL	10 8.1	11 8.9	17 13.8	7 5.7	78 63.4	123 100.0

Table 7

FREQUENCY OF CONTACT WITH PROBATION OFFICERS BY FREQUENCY OF INVOLVEMENT (INVLMNT) OF PROBATION OFFICERS IN TREATMENT DECISIONS

N=123, (3 or 2.4 % of the programs have no contact with Probation Officers).

Gamma = 0.48521

CONTACT BY INVLMNT	DAILY INVLMNT 4	WEEKLY INVLMNT 3	MONTHLY INVLMNT 2	SOME INVLMNT 1	NO INVLMNT 0	ROW TOTAL
DAILY CONTACT 4	18 34.6	9 17.3	8 15.4	3 5.8	14 26.9	52 42.3
WEEKLY CONTACT 3	1 3.8	6 23.1	7 26.9	1 3.8	11 42.3	26 21.1
MONTHLY CONTACT 2		2 5.7	16 45.7		17 48.6	35 28.5
SOME CONTACT 1		1 14.3	1 14.3		5 71.4	7 5.7
NO CONTACT 0					3 100.0	3 2.4
COLUMN TOTAL	19 15.4	18 14.6	32 26.0	4 3.3	50 40.7	123 100.0

Table 8

FREQUENCY OF CONTACT WITH COURT ADMINISTRATIVE STAFF BY FREQUENCY OF INVOLVEMENT (INVLMNT) OF COURT ADMINISTRATIVE STAFF IN TREATMENT DECISIONS

N=123, (**34** or 27.6% of the programs have no contact with Administrative staff).

Gamma = 0.51945

CONTACT BY INVLMNT	DAILY INVLMNT 4	WEEKLY INVLMNT 3	MONTHLY INVLMNT 2	SOME INVLMNT 1	NO INVLMNT 0	ROW TOTAL
DAILY CONTACT 4	2 6.7	2 6.7	1 3.3	1 3.3	24 80.0	30 24.4
WEEKLY CONTACT 3	2 7.7	2 7.7	3 11.5	1 3.8	18 69.2	26 21.1
MONTHLY CONTACT 2			4 16.0		21 84.0	25 20.3
SOME CONTACT 1					8 100.0	8 6.5
NO CONTACT 0					34 100.0	34 27.6
COLUMN TOTAL	4 3.3	4 3.3	8 6.5	2 1.6	105 85.4	123 100.0

Table 9

FREQUENCY OF CONTACT WITH PUBLIC DEFENDERS BY FREQUENCY OF INVOLVEMENT (INVLMNT) OF PUBLIC DEFENDERS IN TREATMENT DECISIONS

N=123, (39 or 31.7% of the programs have no contact with Public Defenders).

Gamma = 0.60284

CONTACT BY INVLMNT	DAILY INVLMNT 4	WEEKLY INVLMNT 3	MONTHLY INVLMNT 2	SOME INVLMNT 1	NO INVLMNT 0	ROW TOTAL
DAILY CONTACT 4	4 14.8	2 7.4	4 14.8		17 63.0	27 22.0
WEEKLY CONTACT 3		3 23.1	2 15.4	1 7.7	7 53.8	13 10.6
MONTHLY CONTACT 2	1 2.6		11 28.9		26 68.4	38 30.9
SOME CONTACT 1				1 16.7	5 83.3	6 4.9
NO CONTACT 0					39 100.0	39 31.7
COLUMN TOTAL	5 4.1	5 4.1	17 13.8	2 1.6	94 76.4	123 100.0

Table 10

FREQUENCY OF CONTACT WITH PROSECUTORS BY FREQUENCY OF INVOLVEMENT (INVLMNT) OF PROSECUTORS IN TREATMENT DECISIONS

N=123, (49 or 39.8% of the programs have no contact with Prosecutors).

Gamma = 0.63821

CONTACT BY INVLMNT	DAILY INVLMNT 4	WEEKLY INVLMNT 3	MONTHLY INVLMNT 2	SOME INVLMNT 1	NO INVLMNT 0	ROW TOTAL
DAILY CONTACT 4	2 10.0	1 5.0	2 10.0	1 5.0	14 70.0	20 16.3
WEEKLY CONTACT 3		3 17.6	2 11.8	2 11.8	10 58.8	17 13.8
MONTHLY CONTACT 2			5 19.2	1 3.8	20 76.9	26 21.1
SOME CONTACT 1				2 18.2	9 81.8	11 8.9
NO CONTACT 0					49 100.0	49 39.8
COLUMN TOTAL	2 1.6	4 3.3	9 7.3	6 4.9	102 82.9	123 100.0

Frequency of contact also may be related to the ***level of control*** that court personnel have over their relationship with drug treatment programs. Control is expressed as the use of coercive authority by court personnel. Does this control extend into drug treatment programs? In *court-enforced drug treatment*, control is expressed ultimately through the power to keep individuals in or release them from drug treatment programs. Two levels of control can be described. First, control refers to the ability of court personnel to ***recommend*** or to influence the release of clients from treatment. Second, control refers also to the power of court personnel to ***authorize*** the release of clients from treatment.

Drug treatment staff were asked about the level of control that court personnel had over the release of clients from their treatment programs. Responses were scored two (2) when court personnel had the power to ***authorize*** the release of clients from treatment, one (1) where court personnel could merely ***recommend*** the release of a client from treatment, and zero (0) where neither was possible.[21] Tables 11 to 15 present the results of these analyses. Again, the results indicate a moderate to strong relationship between frequency of contact between drug treatment staff and court personnel, and the level of control that court personnel have over the release of clients from drug treatment programs.

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[21] See question 23 in Appendix A.

Table 11

FREQUENCY OF CONTACT WITH JUDGES BY LEVEL OF CONTROL OF JUDGES

N=123, (32 or 26 % of the programs have no contact with Judges).

Gamma = 0.63956

CONTACT BY RELEASE CONTROL	AUTHORIZE 2	RECOMMEND 1	NO CONTROL 0	ROW TOTAL
DAILY CONTACT 4	16 64.0		9 36.0	25 20.3
WEEKLY CONTACT 3	12 63.2	1 5.3	6 31.6	19 15.4
MONTHLY CONTACT 2	14 37.8	5 13.5	18 48.6	37 30.1
SOME CONTACT 1	4 40.0	1 10.0	5 50.0	10 8.1
NO CONTACT 0			32 100.0	32 26.0
COLUMN TOTAL	46 37.4	7 5.7	70 56.9	123 100.0

Table 12

FREQUENCY OF CONTACT WITH PROBATION OFFICERS BY LEVEL OF CONTROL OF PROBATION OFFICERS

N=123, (3 or 2.4 % of the programs have no contact with Probation Officers).

Gamma = 0.44629

CONTACT BY RELEASE CONTROL	AUTHORIZE 2	RECOMMEND 1	NO CONTROL 0	ROW TOTAL
DAILY CONTACT 4	17 32.7	17 32.7	18 34.6	52 42.3
WEEKLY CONTACT 3	5 19.2	8 30.8	13 50.0	26 21.1
MONTHLY CONTACT 2	4 11.4	7 20.0	24 68.6	35 28.5
SOME CONTACT 1	1 14.3	1 14.3	5 71.4	7 5.7
NO CONTACT 0			3 100.0	3 2.4
COLUMN TOTAL	27 22.0	33 26.8	63 51.2	123 100.0

Table 13
FREQUENCY OF CONTACT WITH ADMINISTRATIVE STAFF BY LEVEL OF CONTROL OF ADMINISTRATIVE STAFF
N=123, (34 or 27.6% of the programs have no contact with Administrative staff).
Gamma = 0.41509

CONTACT BY RELEASE CONTROL	AUTHORIZE 2	RECOMMEND 1	NO CONTROL 0	ROW TOTAL
DAILY CONTACT 4	4 13.3	3 10.0	23 76.7	30 24.4
WEEKLY CONTACT 3		6 23.1	20 76.9	26 21.1
MONTHLY CONTACT 2	3 12.0	4 16.0	18 72.0	25 20.3
SOME CONTACT 1		1 12.5	7 87.5	8 6.5
NO CONTACT 0			34 100.0	34 27.6
COLUMN TOTAL	7 5.7	14 11.4	102 82.9	123 100.0

Table 14

FREQUENCY OF CONTACT WITH PUBLIC DEFENDERS BY LEVEL OF CONTROL OF PUBLIC DEFENDERS

N=123, (**39** or 31.7% of the programs have no contact with Public Defenders).

Gamma = 0.60775

CONTACT BY RELEASE CONTROL	AUTHORIZE 2	RECOMMEND 1	NO CONTROL 0	ROW TOTAL
DAILY CONTACT 4	2 7.4	8 29.6	17 63.0	27 22.0
WEEKLY CONTACT 3		5 38.5	8 61.5	13 10.6
MONTHLY CONTACT 2		14 36.8	24 63.2	38 30.9
SOME CONTACT 1			6 100.0	6 4.9
NO CONTACT 0			39 100.0	39 31.7
COLUMN TOTAL	2 1.6	27 22.0	94 76.4	123 100.0

Table 15

FREQUENCY OF CONTACT WITH PROSECUTORS BY LEVEL OF CONTROL OF PROSECUTORS

N=123, (49 or 39.8% of the programs have no contact with Prosecutors).

Gamma = 0.65045

CONTACT BY RELEASE CONTROL	AUTHORIZE 2	RECOMMEND 1	NO CONTROL 0	ROW TOTAL
DAILY CONTACT 4	5 25.0	4 20.0	11 55.0	20 16.3
WEEKLY CONTACT 3	1 5.9	4 23.5	12 70.6	17 13.8
MONTHLY CONTACT 2		7 26.9	19 73.1	26 21.1
SOME CONTACT 1		4 36.4	7 63.6	11 8.9
NO CONTACT 0			49 100.0	49 39.8
COLUMN TOTAL	6 4.9	19 15.4	98 79.7	123 100.0

Do court personnel with more frequent involvement in drug treatment decisions also have more formalized ties with drug treatment programs? Tables 16 to 20 examine this relationship. The results indicate a strong correlation between frequency of court personnel involvement in drug treatment decisions and formality of ties.

Table 16

JUDGES' FREQUENCY OF INVOLVEMENT IN TREATMENT DECISIONS BY FORMALITY OF TIES WITH JUDGES
N=123, (32 or 26 % of the programs have no contact with Judges).
Gamma = 0.76214

INVOLVEMENT BY FORMALITY	FORMAL TIES 2	INFORMAL TIES 1	NO TIES 0	ROW TOTAL
DAILY INVOLVEMENT 4	8 80.0	2 20.0		10 8.1
WEEKLY INVOLVEMENT 3	10 90.9	1 9.1		11 8.9
MONTHLY INVOLVEMENT 2	9 52.9	8 47.1		17 13.8
SOME INVOLVEMENT 1	4 57.1	3 42.9		7 5.7
NO INVOLVEMENT 0	18 23.1	28 35.9	32 41.0	78 63.4
COLUMN TOTAL	49 39.8	42 34.1	32 26.0	123 100.0

Table 17

PROBATION OFFICERS FREQUENCY OF INVOLVEMENT IN TREATMENT DECISIONS BY FORMALITY OF TIES WITH PROBATION OFFICERS

N=123, (3 or 2.4 % of the programs have no contact with Probation Officers).

Gamma = 0.56444

INVOLVEMENT BY FORMALITY	FORMAL TIES 2	INFORMAL TIES 1	NO TIES 0	ROW TOTAL
DAILY INVOLVEMENT 4	18 94.7	1 5.3		19 15.4
WEEKLY INVOLVEMENT 3	12 66.7	6 33.3		18 14.6
MONTHLY INVOLVEMENT 2	20 62.5	12 37.5		32 26.0
SOME INVOLVEMENT 1	2 50.0	2 50.0		4 3.3
NO INVOLVEMENT 0	20 40.0	27 54.0	3 6.0	50 40.7
COLUMN TOTAL	72 58.5	48 39.0	3 2.4	123 100.0

Table 18

ADMINISTRATIVE STAFF FREQUENCY OF INVOLVEMENT IN TREATMENT DECISIONS BY FORMALITY OF TIES WITH ADMINISTRATIVE STAFF

N=123, (**34** or 27.6% of the programs have no contact with Administrative staff).

Gamma = 0.60972

INVOLVEMENT BY FORMALITY	FORMAL TIES 2	INFORMAL TIES 1	NO TIES 0	ROW TOTAL
DAILY INVOLVEMENT 4	4 100.0			4 3.3
WEEKLY INVOLVEMENT 3	3 75.0	1 25.0		4 3.3
MONTHLY INVOLVEMENT 2	4 50.0	4 50.0		8 6.5
SOME INVOLVEMENT 1	1 50.0	1 50.0		2 1.6
NO INVOLVEMENT 0	40 38.1	31 29.5	34 32.4	105 85.4
COLUMN TOTAL	52 42.3	37 30.1	34 27.6	123 100.0

Table 19

PUBLIC DEFENDERS FREQUENCY OF INVOLVEMENT IN TREATMENT DECISIONS BY FORMALITY OF TIES WITH PUBLIC DEFENDERS

N=123, (39 or 31.7% of the programs have no contact with Public Defenders).

Gamma = 0.71854

INVOLVEMENT BY FORMALITY	FORMAL TIES 2	INFORMAL TIES 1	NO TIES 0	ROW TOTAL
DAILY INVOLVEMENT 4	4 80.0	1 20.0		5 4.1
WEEKLY INVOLVEMENT 3	3 60.0	2 40.0		5 4.1
MONTHLY INVOLVEMENT 2	9 52.9	8 47.1		17 13.8
SOME INVOLVEMENT 1	1 50.0	1 50.0		2 1.6
NO INVOLVEMENT 0	21 22.3	34 36.2	39 41.5	94 76.4
COLUMN TOTAL	38 30.9	46 37.4	39 31.7	123 100.0

Table 20

PROSECUTORS FREQUENCY OF INVOLVEMENT IN TREATMENT DECISIONS BY FORMALITY OF TIES WITH PROSECUTORS

N=123, (49 or 39.8% of the programs have no contact with Prosecutors).

Gamma = 0.67509

INVOLVEMENT BY FORMALITY	FORMAL TIES 2	INFORMAL TIES 1	NO TIES 0	ROW TOTAL
DAILY INVOLVEMENT 4	2 100.0			2 1.6
WEEKLY INVOLVEMENT 3	4 100.0			4 3.3
MONTHLY INVOLVEMENT 2	3 33.3	6 66.7		9 7.3
SOME INVOLVEMENT 1	3 50.0	3 50.0		6 4.9
NO INVOLVEMENT 0	28 27.5	25 24.5	49 48.0	102 82.9
COLUMN TOTAL	40 32.5	34 27.6	49 39.8	123 100.0

Is there a relationship between formality of ties and the control that court personnel have to release clients from treatment? The cross-tabulated results are represented in Tables 21 to 25. The results indicate a moderate to strong positive relationship between formality of ties and level of control.

Table 21

FORMALITY OF TIES WITH JUDGES BY LEVEL OF CONTROL OF JUDGES

N=123, (32 or 26% of the programs have no relationship with Judges).

Gamma = 0.70253

FORMALITY BY RELEASE CONTROL	AUTHORIZE 2	RECOMMEND 1	NO CONTROL 0	ROW TOTAL
FORMAL TIES 2	29 59.2	2 4.1	18 36.7	49 39.8
INFORMAL TIES 1	17 40.5	5 11.9	20 47.6	42 34.1
NO TIES 0			32 100.0	32 26.0
COLUMN TOTAL	46 37.4	7 5.7	70 56.9	123 100.0

Table 22

FORMALITY OF TIES WITH PROBATION OFFICERS BY LEVEL OF CONTROL OF PROBATION OFFICERS

N=123, (32 or 26 % of the programs have no relationship with Probation Officers).

Gamma = 0.56757

FORMALITY BY RELEASE CONTROL	AUTHORIZE 2	RECOMMEND 1	NO CONTROL 0	ROW TOTAL
FORMAL TIES 2	22 30.6	23 31.9	27 37.5	72 58.5
INFORMAL TIES 1	5 10.4	10 20.8	33 68.8	48 39.0
NO TIES 0			3 100.0	3 2.4
COLUMN TOTAL	27 22.0	33 26.8	63 51.2	123 100.0

Table 23

FORMALITY OF TIES WITH ADMINISTRATIVE STAFF BY LEVEL OF CONTROL OF ADMINISTRATIVE STAFF

N=123, (**32** or 26 % of the programs have no relationship with Administrative staff).

Gamma = 0.50000

FORMALITY BY RELEASE CONTROL	AUTHORIZE 2	RECOMMEND 1	NO CONTROL 0	ROW TOTAL
FORMAL TIES 2	6 11.5	6 11.5	40 76.9	52 42.3
INFORMAL TIES 1	1 2.7	8 21.6	28 75.7	37 30.1
NO TIES 0			34 100.0	34 27.6
COLUMN TOTAL	7 5.7	14 11.4	102 82.9	123 100.0

Table 24
FORMALITY OF TIES WITH PUBLIC DEFENDERS BY LEVEL OF CONTROL OF PUBLIC DEFENDERS
N=123, (32 or 26 % of the programs have no relationship with Public Defenders).
Gamma = 0.74610

FORMALITY BY RELEASE CONTROL	AUTHORIZE 2	RECOMMEND 1	NO CONTROL 0	ROW TOTAL
FORMAL TIES 2	2 5.3	15 39.5	21 55.3	38 30.9
INFORMAL TIES 1		12 26.1	34 73.9	46 37.4
NO TIES 0			39 100.0	39 31.7
COLUMN TOTAL	2 1.6	27 22.0	94 76.4	123 100.0

Table 25

FORMALITY OF TIES WITH PROSECUTORS BY LEVEL OF CONTROL OF PROSECUTORS

N=123, (32 or 26 % of the programs have no relationship with Prosecutors).

Gamma = 0.77203

FORMALITY BY RELEASE CONTROL	AUTHORIZE 2	RECOMMEND 1	NO CONTROL 0	ROW TOTAL
FORMAL TIES 2	6 15.0	10 25.0	24 60.0	40 32.5
INFORMAL TIES 1		9 26.5	25 73.5	34 27.6
NO TIES 0			49 100.0	49 39.8
COLUMN TOTAL	6 4.9	19 15.4	98 79.7	123 100.0

Univariate Analysis:
Frequency Distributions and Possible Implications

The survey results indicate that frequency of contact and formality of ties are central to the nature of the relationship between courts and drug treatment programs . Furthermore, frequency and formality are closely related to other aspects of court-drug treatment program relationships (i.e., court involvement in treatment decisions, and court control over the release of clients from treatment). The results also suggest a significant extension of court authority into drug treatment organizations.

Further evidence of the extension of court authority into drug treatment is indicated by the substantial number of drug treatment staff stating that they have incorporated criminal justice goals, objectives, and standard procedures into their own goals, objectives, and procedures. These results are presented in frequency distribution tables below. Table 26 presents the number of drug treatment programs where staff have incorporated goals that are aimed at general criminal justice issues into their treatment strategies. Tables 27 to 32 present treatment staff responses for goals aimed at more specific criminal justice issues, (*post-arrest, pretrial, pre-sentencing, post-sentencing, probation, and parole*).[22] For example, drug treatment programs that handle only pre-trail drug defendants tend to incorporate goals that are aimed at treating clients who, generally, have less severe drug-addiction problems. According to Chaiken and Johnson, these

[22] See question 25 in Appendix A.

individuals tend to be occasional users, whose drug involvement and associated behavioral problems are characterized by (1988:4):[23]

> 1. Typical drug use [that is] light to moderate or single-substance, such as alcohol, marijuana, cocaine, or combination use.
>
> 2. Driving under the influence [and] lowered work productivity.
>
> 3. Little to no contact with the criminal justice system.

These clients tend to be first-offenders, and generally, do not have severe drug addiction problems. Conversely, a parole oriented program is more likely to incorporate goals that are aimed at treating clients who tend to have more severe drug addiction and behavioral problems. Chaiken and Johnson also note that these drug offenders generally (1988:6):[24]

> 1. Engage in moderate to heavy drug use; often [with] addiction to heroin and cocaine use.
>
> 2. Commit many crimes in periods of heaviest drug use including robberies; major source of income from criminal activity; low status roles in drug hierarchy.
>
> 3. [Have] high contact with criminal justice system; [and,] high incarceration.

---

[23] This profile is taken from Chaiken and Johnson's (1988) manuscript, *Characteristics of Different Types of Drug Involved Offenders.*

[24] This profile is based from Chaiken and Johnson's (1988) manuscript, *Characteristics of Different Types of Drug Involved Offenders.*

DRUG TREATMENT PROGRAMS THAT HAVE INCORPORATED CRIMINAL JUSTICE GOALS INTO DRUG GOALS

Table 26
N=123

GOALS AIMED AT GENERAL JUDICIAL ISSUES	RESPONSES	PERCENT	CUMULATIVE PERCENT
YES 1	76	61.8	**61.8**
NO 0	47	38.2	100.0
TOTALS	123	100.0	100.00

Table 27
N=123

GOALS AIMED AT POST-ARREST ISSUES	RESPONSES	PERCENT	CUMULATIVE PERCENT
YES 1	30	24.4	**24.4**
NO 0	93	75.6	100.0
TOTALS	123	100.0	100.00

Table 28
N=123

GOALS AIMED AT PRE-TRIAL ISSUES	RESPONSES	PERCENT	CUMULATIVE PERCENT
YES 1	43	35.0	**35.0**
NO 0	80	65.0	100.0
TOTALS	123	100.0	100.00

Table 29
N=123

GOALS AIMED AT PRE-SENTENCING ISSUES	RESPONSES	PERCENT	CUMULATIVE PERCENT
YES 1	33	26.8	**26.8**
NO 0	90	73.2	100.0
TOTALS	123	100.0	100.00

Table 30
N=123

GOALS AIMED AT POST-SENTENCING ISSUES	RESPONSES	PERCENT	CUMULATIVE PERCENT
YES 1	38	30.9	**30.9**
NO 0	85	69.1	100.0
TOTALS	123	100.0	100.00

Table 31
N=123

GOALS AIMED AT PROBATION ISSUES	RESPONSES	PERCENT	CUMULATIVE PERCENT
YES 1	63	51.2	**51.2**
NO 0	60	48.8	100.0
TOTALS	123	100.0	100.00

Table 32

N=123

GOALS AIMED AT PAROLE ISSUES	RESPONSES	PERCENT	CUMULATIVE PERCENT
YES 1	38	30.9	**30.9**
NO 0	85	69.1	100.0
TOTALS	123	100.0	100.00

Drug treatment staff were asked about other criminal justice objectives, (*accelerated case disposition, case backlog reduction, sentencing alternatives, and reducing corrections overcrowding*).[25] Responses were coded two (2) when identified as a primary objective, one (1) when identified as secondary, and zero (0) where neither was indicated. Tables 33 to 36 present these results.

[25] See question 19 in Appendix A.

CRIMINAL JUSTICE OBJECTIVES INCORPORATED INTO DRUG TREATMENT PROGRAM OBJECTIVES

Table 33
N=123

ACCELERATED CASE DISPOSITION	RESPONSES	PERCENT	CUMULATIVE PERCENT
PRIMARY 2	12	9.8	9.8
SECONDARY 1	27	22.0	31.7
NOT APPLICABLE 0	84	68.3	100.0
TOTALS	123	100.0	100.0

Table 34
N=123

CASE BACKLOG REDUCTION	RESPONSES	PERCENT	CUMULATIVE PERCENT
PRIMARY 2	10	8.1	8.1
SECONDARY 1	24	19.5	27.6
NOT APPLICABLE 0	89	72.4	100.0
TOTALS	123	100.0	100.0

Table 35
N=123

SENTENCING ALTERNATIVES	RESPONSES	PERCENT	CUMULATIVE PERCENT
PRIMARY 2	37	30.1	30.1
SECONDARY 1	36	29.3	**59.3**
NOT APPLICABLE 0	50	40.7	100.0
TOTALS	123	100.0	100.0

Table 36
N=123

REDUCE JAIL OVERCROWDING	RESPONSES	PERCENT	CUMULATIVE PERCENT
PRIMARY 2	23	18.7	**18.7**
SECONDARY 1	39	31.7	**50.4**
NOT APPLICABLE 0	61	49.6	100.0
TOTALS	123	100.0	100.0

Drug treatment staff also were questioned about standard criminal justice procedures that have been incorporated into their drug treatment programs. For example, creating or updating the criminal history of defendants is a standard part of maintaining court and arrest records. Drug treatment programs that are part of court-enforced treatment programs may tend to maintain records on the criminal history and substance abuse history of clients. There are drug treatment programs that are structured to handle court-enforced treatment clients whose physical whereabouts must be monitored (e.g., judges may order clients to stay away from known drug trafficking areas). Also, if court-enforced treatment clients do not comply with court orders, they may be incarcerated; therefore, some drug treatment programs may be structured to deal with clients who are in jail. It may be common also for court-enforced programs to have standard eligibility criteria that defendants must meet in order to receive drug treatment. Some courts allow only defendants who are facing non-violent, misdemeanor drug possession charges to participate in court-enforced treatment programs. Other courts, such as those that have pretrial diversionary programs, may require defendants to waive certain constitutional rights (e.g., the right to a trial) in exchange for participation in drug treatment. Typically, this type of court-enforced program drops criminal charges against defendants after they successfully complete drug treatment. Courts also may require their drug treatment partners to provide standardized reports on defendants such as drug testing results. These reports help courts monitor the compliance of defendants with treatment-related guidelines. Finally, courts may require defendants to satisfy other standard guidelines or

stipulations as conditions of release from court-enforced treatment. Tables 37 to 44 present the results on the incorporation of the above standard criminal justice/court related components, (i.e., *standard review of criminal record/history, standard monitoring of clients, standard incarceration of clients, standard court-related eligibility criteria for participation in program, standard waiving of their constitution rights/granting consent, standard progress reports, standard drug testing, and standard criteria for release of clients from treatment*) into standard drug treatment program procedures.[26]

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[26] See question 20 in Appendix A.

CRIMINAL JUSTICE PROCEDURES INCORPORATED INTO DRUG TREATMENT PROGRAM PROCEDURES

Table 37
N=123

CRIMINAL/DRUG HISTORY REVIEW	RESPONSES	PERCENT	CUMULATIVE PERCENT
YES 1	76	61.8	**61.8**
NO 0	47	38.2	100.0
TOTALS	123	100.0	100.00

Table 38
N=123

MONITORING	RESPONSES	PERCENT	CUMULATIVE PERCENT
YES 1	39	61.8	**61.8**
NO 0	47	38.2	100.0
TOTALS	123	100.0	100.00

Table 39
N=123

INCARCERATION	RESPONSES	PERCENT	CUMULATIVE PERCENT
YES 1	10	8.1	**8.1**
NO 0	113	91.9	100.0
TOTALS	123	100.0	100.00

Table 40
N=123

ELIGIBILITY CRITERIA	RESPONSES	PERCENT	CUMULATIVE PERCENT
YES 1	30	24.4	**24.4**
NO 0	93	75.6	100.0
TOTALS	123	100.0	100.00

Table 41
N=123

CLIENT WAIVES RIGHTS	RESPONSES	PERCENT	CUMULATIVE PERCENT
YES 1	43	35.0	**35.0**
NO 0	80	65.0	100.0
TOTALS	123	100.0	100.00

Table 42
N=123

DRUG TESTING	RESPONSES	PERCENT	CUMULATIVE PERCENT
YES 1	33	26.8	**26.8**
NO 0	90	73.2	100.0
TOTALS	123	100.0	100.00

Table 43
N=123

PROGRESS REPORTS TO COURTS	RESPONSES	PERCENT	CUMULATIVE PERCENT
YES 1	38	30.9	**30.9**
NO 0	85	69.1	100.0
TOTALS	123	100.0	100.00

Table 44
N=123

RELEASE FROM PROGRAM CRITERIA	RESPONSES	PERCENT	CUMULATIVE PERCENT
YES 1	63	51.2	**51.2**
NO 0	60	48.8	100.0
TOTALS	123	100.0	100.00

The results of these analyses suggest that criminal justice goals, objectives, and other standard criminal justice or court-related procedures have become incorporated into some of drug treatment programs. We have seen the association between frequency and formality (Hage and Aiken, 1969; Hall, 1987). Are there any measurable associations between drug treatment program frequency and formality of contact with courts and drug treatment program goals, objective, and procedures? Do drug treatment staff who have frequent and formal contact with courts also tend to incorporate criminal justice goals, objectives, and procedures into the structure of their treatment programs? The next section will examine these issues.

<u>Broader Implication of Frequency and Formality on Other Drug Treatment Program Characteristics</u>

Analyses to this point suggest that measures of association concerning *frequency of contact* and *formality of contact* with drug treatment programs are consistent across court-related personnel roles. Analyses from this point will focus on judges rather than other court-related personnel. That is, I will focus on judges because they have the primary criminal justice role. Tauber (1994:17) provides a useful summary:

> Judges are in a unique position to provide effective leadership in promoting coordinated drug control and treatment efforts, both within the criminal justice system and in their local communities. Judges have the political influence, the ties to government agencies, the moral authority, the perceived fairness and impartiality, and the expertise and focus necessary to bring leadership to coordinated anti-drug efforts.

Survey responses regarding frequency and formality of contact with judges were compressed into a new frequency and formality interaction term: **FF**. Table 45 shows the clustering of the drug treatment programs sampled according to the formality of contact with judges. Each of the formality clusters was then assigned an ordinal value for **FF.** Drug treatment programs with formal ties to judges (n=49) were assigned a value of 2. Programs with informal ties to judges (n=42) were assigned a value of 1. Those drug treatment programs with no ties to judges (n=32) were given a value of 0.

Using formality as a basis for clustering the sample population is based on its relationship to frequency as set forth in previous analyses (Tables 1-5). These analyses show a very strong positive relationship between drug treatment program frequency of contact with courts and the degree of formality of contact with courts. Proceeding with further analyses by clustering the sample population according to formality of contact with courts is conceptually consistent with previous analyses: according to drug treatment program frequency of contact with courts.

Table 45

CLUSTERING OF DRUG TREATMENT PROGRAMS ACCORDING TO FORMALITY/VALUE OF FF

N=123

VALUE OF FF	NUMBER OF DRUG TREATMENT PROGRAMS
FORMAL TIES FF = 2	49
INFORMAL TIES FF = 1	42
NO TIES FF = 0	32

This section examines the relationships between FF and the incorporation of court-related *goals, objectives, and procedures* into drug treatment program structures and processes. The questions remain the same:

1. To what degree do court structures and processes influence the structures and processes of drug treatment programs?
2. Do court-related personnel with more frequent and more formal relationships with drug treatment programs also have more influence over the goals, objectives, and procedures those drug treatment programs?

The survey results suggest that drug treatment programs are related to courts in different ways and in varying degrees. Generally, the pattern persists: the more closely court staff are related to courts the more likely they are to be involved in drug treatment program structures and processes.

Table 46 presents the results on the relationship between FF and criminal justice-related goals.[27] Table 47 presents the results between FF and court-related objectives.[28] Criminal justice-related objectives that were identified as primary or secondary drug treatment program objectives were recoded as one (1). If neither was indicated, it was coded zero (0). Table 48 presents the results between FF and criminal justice-related

[27] Coding of responses for court-related goals (i.e., *post-arrest, pretrial, pre-sentencing, post-sentencing, probation, and parole*) was unchanged.
[28] Court-related objectives included, *accelerated case disposition, case backlog reduction, sentencing alternatives, and reducing corrections overcrowding.*

standard procedures.[29] Tables 46 to 48 suggest that there is a positive, moderate relationship between FF and the aforementioned drug treatment program characteristics.

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[29] Coding of responses for court-related standard procedures (i.e., *standard review of criminal record/history, standard monitoring of clients, standard incarceration of clients, standard court-related eligibility criteria for participation in program, standard waiving of their constitution rights/granting consent, standard progress reports, standard drug testing, and standard criteria for release of clients from treatment*) was unchanged.

DRUG TREATMENT PROGRAM
FORMALITY (FF) OF CONTACT WITH JUDGES
BY INCORPORATION OF
CRIMINAL JUSTICE-RELATED GOALS (CJG)
INTO DRUG TREATMENT GOALS

Table 46

(Gamma=0.50115)

FF BY CJG	CJG YES (1)	CJG NO (0)	ROW TOTAL
FF 2	43 87.8	6 12.2	49 39.8
FF 1	27 64.3	15 35.7	42 34.1
FF 0	18 56.3	14 43.8	32 26.0
TOTALS	88 71.5	35 28.5	123 100.0

DRUG TREATMENT PROGRAM
FORMALITY (FF) OF CONTACT
WITH JUDGES BY INCORPORATION OF
CRIMINAL JUSTICE-RELATED OBJECTIVES (CJO)
INTO DRUG TREATMENT OBJECTIVES

Table 47

(Gamma=0.55917)

FF BY CJO	CJO YES (1)	CJO NO (0)	ROW TOTALS
FF 2	39 79.6	10 20.4	49 39.8
FF 1	30 71.4	12 28.6	42 34.1
FF 0	11 34.4	21 65.5	32 26.0
TOTALS	80 65.0	43 35.0	123 100.0

DRUG TREATMENT PROGRAM FORMALITY (FF) OF CONTACT WITH JUDGES BY INCORPORATION OF CRIMINAL JUSTICE-RELATED PROCEDURES (CJP) INTO DRUG TREATMENT PROCEDURES

Table 48

(Gamma=0.57082)

FF BY CJP	CJP YES (1)	CJP NO (0)	ROW TOTAL
FF 2	47 95.5	2 4.1	49 39.8
FF 1	39 92.9	3 7.1	42 34.1
FF 0	25 78.1	7 21.9	32 26.0
TOTALS	111 90.2	12 9.8	123 100.0

Chapter IV

CONCLUSION

This represents a first attempt to examine the relationship between courts and drug treatment programs in terms of consequences for drug treatment agencies. However, there is a proliferation of court-oriented research emerging from a variety of court, government, academic, and even media institutions. The results of this thesis support a relationship between increasing frequent and formal contact between courts and drug treatment programs and the increasing influence that courts have over the management and operations of drug treatment programs. This is highly consistent with research on organizations generally.

The process of bureaucratization is more complex than can be captured through the variables I examined here. Bureaucratization is not a unidimensional concept. It includes a number of different factors such as routinization, formalization, specialization, and standardization. These concepts are reflected more or less fully by the variables contained in the study. Defining and measuring bureaucratization seemed simple enough in the initial stages of the study. However, combining the variables to measure bureaucratization as a unitary concept proved too complex and the data were not

adequate. I found that I was unable to take the several measures of the several dimensions and combine them into a single measure of bureaucratization. Individual measures of bureaucratization are not necessarily additive, nor are they necessarily linear. For example, a highly specialized court-drug treatment program relationship doesn't necessarily mean that the involved drug treatment program is highly oriented toward court-related standard procedures. Specialization, does not necessarily mean more standardization.

What this study accomplished was an examination of several dimensions of court bureaucratization of drug treatment programs presented. More research is needed to define and measure the various dimensions of bureaucratization as it relates to inter-organizational relationships. Such research is necessary for understanding inter-organizational relationships generally and the consequences of court-drug treatment program relationships more specifically.

APPENDIX A. Questionnaire[30]

IDENTIFICATION (for contact purposes only)

Name of person responding to survey/ Title		
Program Name		
Street Address		
City	State	Zip Code
County	Telephone No. Ext. (if any)	

1. Does your program distinguish between drug-dependent offenders and other drug-dependent voluntary clients in implementing treatment strategies?

Yes ☐ No ☐

2. If yes, estimate the percentage of clients who are presently participating in your treatment program under some form of judicial order or court supervision, (including probation or court monitoring program).

____

(Estimate the percentage, 0%-100%)

3. What is the average number of judicially-ordered or court-supervised clients participating in your program during a one month period (estimate, if necessary)?

____

[30] One of the primary lesson that I gained from this thesis exercise was how to build a better survey instrument. In retrospect, I tried to gather too much information. I also learned to carefully plan my survey instrument in terms of data analysis as well. In addition, I used only a fraction of the data that I gathered for my thesis. The format of this questionnaire has been altered for publication in this thesis.

4. Is your program structured to address the needs of a specific population (e.g., dually diagnosed females, young black males, suburban youth)?

Yes ☐ No ☐

(If yes, briefly describe or list the target population(s):

____

5. What type(s) of substance abuse problem(s) does your program address? (Check appropriate boxes.)

Cocaine	☐	Amphetamines	☐
Crack	☐	Barbiturates	☐
Heroin	☐	Hallucinogens	☐
Marijuana	☐	Prescription Drugs	☐
Alcohol	☐	Other	☐
		(Specify)________________	

6. What treatment approaches or modalities are utilized in your program? (Check appropriate boxes.)

Detoxification	☐	Counseling and Therapy	☐
Pharmacological maintenance (e.g., Methadone, Naltrexone)	☐	Acupuncture	☐
		Intervention (e.g., family)	☐
Physical Control (e.g., confinement)	☐	Other(s)	☐
Monitoring (e.g., probation, random drug testing, electronic device)	☐	(Specify)________________	

7. Please describe the type and length of each phase or stage of your treatment program (e.g., detoxification is Phase 1 and it lasts three weeks):

Phase 1____

Phase 2____

Phase 3____

Phase 4____

Phase 5____

8. Briefly describe the overall management structure of your program by departments: (e.g., detoxification, counseling, and supervision departments and the program director oversees all of these departments). Alternatively, if available, may we have a copy of your organizational chart?

____

9. Where is your program located? (Check appropriate boxes.):

Outpatient Facility	☐	Community Mental Health Center	☐
Residential Facility	☐	Halfway House/Recovery Home	☐
Hospital (Including VA Hospitals)	☐	Other	☐
		(Specify)____________________	

10. What geographic area is served by your program? (Check appropriate box.)

Serves one county/jurisdiction	☐	Serves the entire state	☐
Serves two counties/jurisdictions	☐	Other	☐
Serves three or more counties/jurisdictions	☐	Specify_______________	

11. In the following table, please indicate the number of staff or personnel working in your program according to their educational disciplines and training or credentials. Please distinguish between full-time and part-time staff, and full-time and part-time volunteer personnel:

Staff/Personnel Positions	Number of Full-Time Paid Staff	Number of Part-Time Paid Staff	Number of Full-Time Volunteers	Number of Part-Time Volunteers
Executive (e.g., Program Director)				
Psychologists (Master's Level and Above)				
Social Workers (Master's and Above)				
Other Professional Counselors (Credentialed and/or Counseling Degree)				
Social Workers (Bachelor's and Below)				
Counselors (Bachelor's and Below)				
Registered Nurses				
Physicians				
Acupuncturists				
Attorneys				
Advocates/Paralegal				
Administrative Staff (e.g., secretaries, receptionists)				
Other (Please Specify)				

12. Does your program charge clients personally for treatment services (i.e., fees that are not reimbursable by insurance or government fees)?

Yes ☐ No ☐

13. Does your program charge and receive any reimbursed fees? (If yes, check appropriate boxes.)

Yes ☐ No ☐

Federal Government Reimbursed Fees	☐	Local Government Reimbursed Fees	☐
State Government Reimbursed Fees	☐	Private Insurance Reimbursed Fees	☐
Court Reimbursed Fees	☐	Other	☐
		(Specify)________________________	

14. Does your program receive any public or private program grants or support? (If yes, check appropriate boxes.)

Yes ☐ No ☐

Federal Government Grants	☐	Private Grants/Donations	☐
State Government Grants	☐	Court Grants	☐
Local Government Grants	☐	Court-Controlled Grants/Funds	☐
		Other	☐
		(Specify)________________________	

15. How frequently does your program have on-going working relationships or administrative links with court, legislative, executive, or other criminal justice staff or agencies? Are relationships (ties) *formal* (defined by statute, contract, or written agreement) or *informal* (defined by casual cooperation or verbal agreement)? (Check appropriate boxes.)

	Frequency of Contact				Type of Relationship	
	Never	Daily	Weekly	Monthly	Formal	Informal
Judges	☐	☐	☐	☐	☐	☐
Court Staff	☐	☐	☐	☐	☐	☐
Probation Officers	☐	☐	☐	☐	☐	☐
Prosecutors	☐	☐	☐	☐	☐	☐

Public Defenders

☐ ☐ ☐ ☐ ☐

Briefly describe the nature of the relationships noted above (e.g., judge reviews clients' treatment progress before their release from program):

Judges____

Court Admin/Staff____

Probation Officers____

Prosecutors____

Public Defenders____

17. Has working with drug-dependent offenders or other court-monitored clients in any way changed the structure or operation of your treatment program?

Yes ☐ No ☐

If yes, briefly describe how your program has changed:

18. Has working with courts or court-related personnel in any way changed the structure or operation of your treatment program?

Yes ☐ No ☐

If yes, briefly describe how your program has changed:

19. Please indicate the objectives of your program by checking the appropriate boxes below. Are these *primary objectives* (i.e., part of overall goals of your program) or are they *secondary benefits* (i.e., additional advantages resulting from the pursuit of specific objectives)?

Intensive Intervention
Primary ☐ Secondary ☐ Not Applicable ☐

Drug Demand Reduction
Primary ☐ Secondary ☐ Not Applicable ☐

Drug treatment and prevention
Primary ☐ Secondary ☐ Not Applicable ☐

Rehabilitation
Primary ☐ Secondary ☐ Not Applicable ☐

Accelerated Drug Case Dispositions
Primary ☐ Secondary ☐ Not Applicable ☐

Case Backlog Reduction
Primary ☐ Secondary ☐ Not Applicable ☐

Sentencing Alternatives
Primary ☐ Secondary ☐ Not Applicable ☐

Reduce Corrections Overcrowding
Primary ☐ Secondary ☐ Not Applicable ☐

Other (Specify)__________________
Primary ☐ Secondary ☐ Not Applicable ☐

20. Does your program use standard program procedures or components for all clients to accomplish treatment objectives (e.g., all clients are drug tested by urinalysis, all clients undergo detoxification)?

Yes ☐ No: Each Client Given Personalized/Individualized Program. ☐

(If yes, check all components that are standard program procedures for all clients in your program.)

Detoxification	☐	Drug Testing/Urinalysis	☐
Formal Client Eligibility Criteria	☐	Acupuncture	☐

Client Criminal History Review	☐	Treatment Progress Review	☐
Client Waives Rights/Gives Consent	☐	Formal Release from Program	☐
Counseling/Therapy	☐	Other	☐
		(Specify)________________	

21. Does your program utilize administrative manuals, policies, or guidelines for accomplishing treatment objectives (i.e., general rules that govern responsibilities or performance)?

Yes ☐ No ☐

What is the source or authority of these manuals, policies, and guidelines? ____________

____

22. Does your program utilize standardized forms or documents in recording treatment activities?

Yes ☐ No ☐

What is the source or authority of these forms or documents? ____________________

____

23. Who has the jurisdiction to authorize or recommend the release of a client from your treatment program? (Please check all appropriate boxes.)

Judge

Authorize ☐ Recommend ☐ Not Applicable ☐

Court Admin/Staff

Authorize ☐ Recommend ☐ Not Applicable ☐

Probation Officer

Authorize ☐ Recommend ☐ Not Applicable ☐

Prosecutor

Authorize ☐ Recommend ☐ Not Applicable ☐

Public Defender

Authorize ☐ Recommend ☐ Not Applicable ☐

Clients (Voluntary)

	Authorize	Recommend	Not Applicable
Clients (Voluntary)	☐	☐	☐
Treatment Counselor	☐	☐	☐
Other	☐	☐	☐

(Specify)________________

24. How involved are the following court personnel in actual treatment decisions regarding individual clients?
(Please check all appropriate boxes.)

	Never	Daily	Weekly	Monthly
Judges	☐	☐	☐	☐
Prosecutors	☐	☐	☐	☐
Court Administrators	☐	☐	☐	☐
Probation Officers	☐	☐	☐	☐
Public Defenders	☐	☐	☐	☐
Treatment Counselors	☐	☐	☐	☐
Clients	☐	☐	☐	☐

Briefly describe the nature of the involvement noted above:

____

25. Are the goals of your program aimed at any particular part of the judicial process?

Yes ☐ No ☐

(If yes, check all boxes that apply to your program.)

Post-arrest/Diversion	☐	Post-sentencing	☐
Pre-trial/Diversion	☐	Probation	☐
Pre-sentencing	☐	Parole	☐
Other	☐	(Specify)________________	

26. If your program is certified by an official body or agency, what is the name of the body or agency?

____

27. How often must your certification be renewed or reevaluated?

____

28. If a board or commission oversees the activities of your program, what is the name of the board or commission? ________________________________

29. Does your program have any procedure, department, or personnel aimed at evaluating the overall performance of your program? Yes ☐ No ☐

If yes, briefly describe the evaluation process:

____

30. Under what authority was your program created? (Check appropriate box.)

By Statute ☐ By Judicial Administrative Directive ☐
By Executive Order ☐ By Other Administrative Directive ☐
By Private Agency/Citizen Action ☐ (Specify)____________________

31. Are there any laws or government policies that specifically regulate or monitor the programmatic operation or content of your program (e.g., your state prohibits violent drug offenders from participation in your program)?

Yes ☐ No ☐

32. Please list one of these laws or policies below:

____

Thank you for participating in this survey. Your cooperation is greatly appreciated. We hope that our findings will lead to more informed court decisions regarding substance abuse programs and drug treatment strategies. Please return the completed survey in the prepaid/addressed envelope. In making any inquiries about this questionnaire, please make reference to the Drug Treatment Component Survey. The person for this project is listed below:

National Center for State Courts
300 Newport Avenue
Williamsburg, VA 23185-8798
(804) 253-2000

Primary Contact Person
John G. Richardson
Research Analyst
Extension 205

Appendix B. List of Drug Treatment Programs[31]

PROGRAM	CASE # STATUS
Treatment Director P.O. Box 134* Wendell, MA 01379	UNK
Bay Cove Human Services Outpatient Substance Abuse Services 66 Canal Street Boston, MA 02114	104
Mass General Hospital Addiction Services/Outpatient 15 Parkman Street Ambulatory Care Center, Suite 812 Boston, MA 02114	111
Join Together: A Nat'l Resource * for Communities Fighting Substance Abuse 441 Stuart Street, 6th Floor Boston, MA 02116	UNK
After Care Services Outpatient Substance Abuse Services 1A Monmouth Square Boston, MA 02128	64
The Kennedy Center Outpatient Substance Abuse Services 27 Winthrop Street Charlestown MA 02129	21
Harvard Community Health Plan Substance Abuse Day Treatment 23 Miner Street Boston, MA 02215	58

[31] Legend for List of Drug Treatment Programs is as Follows:
UNK, dead-end or incorrect address/contact person;
NT, not treatment program/provider;
DR, officially declined to participate in survey or missed return deadline; and,
*, program chosen by *snow-balling* method.

Out-Client Services* Connecticut Halfway House 136 Collin Street Hartford, CT 06105	DUPLICATE OF # 15
Outpatient Services* Greater Hartford Multi-Service Center 136 Collin Street Hartford, CT 06105	15
Office of Alternative Sanctions* 2275 Silas Deane Highway Rocky Hill, CT 06109	28
Mount Carmel Guild Substance Abuse Therapy Program 17 Mulberry Street Newark, NJ 07102	4
Essex Substance Abuse Treatment Center, Inc 164 Blanchard Street Newark, NJ 07105	11
Choices, Inc United Community Corp. 169 Roseville Avenue Newark, NJ 07107	DR
Domestic Violence Chemical Dependency Unit 21 Main Street, Rm 111W Hackensack, NJ 07601	72
Bergen County Action Program Addictions Program 214 State Street Hackensack, NJ 07601	30
Addiction Recovery Program 905 Herrontown Road Princeton, NJ 08540	60
Mercer Council on Alcoholism and Drug Addiction 408 Bellevue Avenue Trenton, NJ 08618	NT
Comm Guidance Center of Mercer Cnty Substance Abuse Recovery Program 2300 Hamilton Avenue Trenton, NJ 08619	62
NY Center for Addiction Treatment Services Medically Supervised Outpatient 568 Broadway, 8th Floor New York, NY 10012	DR

Washton Institute, Inc. Drug Abuse Treatment 4 Park Avenue Ground Floor New York, NY 10016	DR
John Jay College of Criminal Justice CUNY Substance Abuse Prevention Program 899 10th Avenue Room 410 New York, NY 10019	NT
TRI Center, Inc. 1776 Broadway Suite 300 New York NY 10019	17
Phase Piggy Back Outpatient 507 West 145th Street New York, NY 10031	DR.
Project Return 1600 Macombs Road Bronx, NY 10452	DR
Director of Substance Abuse* LIncoln Hospital 349 East 140 Street Bronx, NY 10454	47
Narco Extended Entry Program 2780 3rd Avenue Bronx, NY 10455	DR
Argus Community Center Unit 1 760 East 160th Street Bronx, NY 10456	59
TRI Center, Inc Drug Abuse Treatment/Bronx 400 East Forham Road Bronx, NY 10458	DUPLICATE of #17
Riverdale Mental Health Assoc. Riverdale MH Clinic/Outpatient DF 5676 Riverdale Avenue Bronx, NY 10471	DR
Health Science Center Brooklyn Polydrug Unit 600 Albany Avenue Building K, Box 9 Code 26 Brooklyn, NY 11203	26

Canarsie Aware Unit Outpatient 1310 Rockaway Parkway Brooklyn, NY 11236	NT
Saint Francis Center for Chemical Dependency Treatment 45th Street & Pennsylvania Avenue Pittsburgh, PA 15201	43
Western Psychiatric Inst. & Clinic 3811 Ohara Street Pittsburgh, PA 15213	NT
Drug and Alcohol Specialist* Court of Common Pleas, 16th District, Courthouse Somerset, Pennsylvania 15501	NT
Drug & Alcohol Unit* GECAC TASC 809 Peach Street Erie, Pennsylvania 16501	89
Drug & Alcohol Treatment & Prevention Servs.* 108 North Stratton Street Gettysburg, Pennsylvania 17325	123
Treatment Access Center 820 N. French Street, 5th Floor Wilmington, DE 18801	UNK DUPLICATE
Frankford Hospital First Days Outpatient 4936 Griscom Street Philadelphia, PA 19124	32
Addiction Treatment Services Outpatient 111 North 49th Street Philadelphia, PA 19139	DR
Jefferson Intensive Cocaine Treatment Program 1021 21st Street 2nd Floor Philadelphia, PA 19146-2632	66
Treatment Access Center* 820 N. French Street, 5th Fl Wilimington, DE 19801	UNK DUPLICATE
Treatment Access Center* 1100 N. French Street, 5th Floor Wilmington, DE 19801	UNK DUPLICATE
Net Counseling Center* Line Stone Professional Bld. 2055 Line Stone Rd., Ste 201 Wilmington, Delaware 19808	DR

DC Superior Court Social Services Div. Probation/Parole Resource Ctr 409 E. Street, NW Building B, Room 205 Washington, DC 20001	122
Administrative Services* Pretrial Service, District of Columbia 400 F Street, N.W. Washington, DC 20001	DUPLICATE OF 122
The Model Treatment Center 1300 First Street, NE Washington, DC 20002	120
Alcohol & Drug Abuse Services Admin Substance Abuse Detox Center 1900 Massachusetts Avenue SE Building 12 Washington, DC 20003	119
Latin American Youth Center Drug Treatment Program 3045 15th Street, NW Washington, DC 20009	22
Bureau of Rehabilitation Inc Community Care Center 3301 16th Street, NW Washington, DC 20010	25
Change Inc Consulting & Mental Health Services 5000 Nannie Helen Burroughs Ave, NE Washington, DC 20019	101
Kenilworth Parkside Resident Management Treatment Prgm 4500 Quarles Street, NE Washington, DC 20019	DR
Foundation for Contempory MH Next Step 2112 F Street, NW Suite 404 Washington, DC 20037	DR
Alcohol & Drug Administration* Maryland Department of Health 201 West Preston Street Baltimore, MD 21201	NT
University Medical Systems Alcohol and Drug Abuse Program 630 W. Fayette Baltimore, MD 21201	88

University of MD Drug Treatment Center Drug Free and Aftercare Clinic 630 West Fayette Street Baltimore, MD 21201	84
East Baltimore Drug Abuse Center Treatment Unit 707 Constitution Street Baltimore, MD 21202	DR
Substance Abuse Bureau* Baltimore City Health Depart 303 E. Fayette Street, 6th Fl Baltimore, MD 21202	NT
Baltimore County Office of Substance Abuse 401 Washington Avenue Suite 300 Towson MD 21204	16
Community Counseling & Resource Center Intensive Outpatient Cocaine Treatment 208 Washington Avenue Towson, MD 21204	55
Comprehensive Women's Center Johns Hopkins Hospital 911 North Broadway Baltimore, MD 21205	56
Drug Treatment Court/Corr. Options* Division of Parole & Probation 6776 Reisterstown Road, Suite 305 Baltimore, MD 21215	NT
Total Health Care Inc. Substance Abuse Services 1501 Division Street Baltimore, MD 21217	7
Daybreak Rehabilitation Program 2490 Giles Road Baltimore, MD 21225	51
Executive Assistant* 300 E. Joppa Rd, Ste 1105 Towson, MD 21286	NT
Office of the Court Drug Task Force P.O. Box 2448 Raleigh, NC 27602	UNK
NC Depart. of Human Resources* 325 N. Salisbury Street Raleigh, NC 27603	NT

Court Services* Mecklenburg County 720 East Fourth Street Charlotte, North Carolina 28202	UNK
TASC* 145 Remount Road Charlotte, NC 28203	96
Substance Abuse Services 429 Billingsley Road Charlotte, NC 28211	80
Blue Ridge Area Mental Health/Mental Retard.* and Substance Abuse Services 283 Biltmore Avenue Asheville, North Carolina 28801	DR
Charleston County Substance Abuse Commission 25 Courtenay Drive Charleston, SC 29401	NT
Treatment Services Charleston County Department of Alcohol and Other Drug Abuse Services 615 Wesley Drive P.O. Box 31398 Charleston SC 29417	36
Community-Based Services* Florence County Commission on Alcohol and Drug Abuse 601 Gregg Avenue Florence, South Carolina 29502	DR
Prevention Centers for Disease Control* 1600 Clifton Road, N.E. Atlanta, GA 30202	NT
Bradford-Union-Putnam* Guidance Clinic Inc. P.O. Drawer 1355 Palatka, Florida 32077	78
Stewart-Marchman Center* 120 Michigan Avenue Daytona Beach, Florida 32114	9
DISC Village, Inc.* 3333West Pensacola Street Suite 300 Tallahassee, FL 32304	77
Leon County Felony Drug Ct* 501-B Appleyard Drive Tallahassee, FL 32304	2

Clinical Resources Coordination* HRS-PDADMAD 1317 Winewood Boulevard Tallahassee, FL 32308	UNK
Pathway Add. Treatment Ctr* 9851 University Parkway Pensacola, FL 32514	DR
Center for Drug Free Living* 100 W. Columbia Street Orlando, Florida 32801	61
Drug and Alcohol Treatment* US Pretrial Services 330 Biscayne Blvd, Ste 500 Miami, FL 33132	108
Drug and Alcohol Treatment* U.S. Pretrial Services 330 Biscayne Blvd, Ste 500 Miami, FL 33132	DUPLICATE OF #108
Drug Court of Tampa* DACCO 3630 N. 50th Street Tampa, FL 33607	33
Operation PAR, Inc.* 10901-C Roosevelt Blvd., Suite 1000 St. Petersburg, FL 33716	65
Operation PAR, Inc.* 10901-C Roosevelt Boulevard St. Petersburg, FL 33716	DUPLICATE OF # 65
Coastal Recovery Ctrs, Inc.* 410 Cortez Rd, W., Ste 410 Bradenton, Florida 34207	DR
TASC* Operation PAR, Inc. 4400 140th Avenue North Clearwater FL 34622	8
Cullman Area Mental Health Center Substance Abuse Services 1909 Commerce Avenue, NW Cullman, AL 35055	NR
Fellowship House, Inc. 1625 12th Avenue South Birmingham, AL 35205	27
Alcohol & Drug Abuse Council 1923 14th Avenue South Birmingham, AL 35205	NT

Jefferson County Economic Opport. Alcoholism Outreach/Aftercare Pgm. 3040 Ensley Avenue Birmingham, AL 35208	
University of Alabama in Birmingham UAB Substance Abuse Programs 3015 7th Avenue, South Birmingham, AL 35233	91
TASC* Birmingham , AL TASC Program 3015 7th Avenue, S. Birmingham, AL 35233	DUPLICATE of #91
Court Referral Program 300 Dexter Avenue Montgomery AL 36104	6
Baptist Medical Center Addictive Disease Program 2105 East South Boulevard Montgomery, AL 36116	118
Court Referral Programs* Administrative Office of Courts 817 S. Court Street Montgomery, Alabama 36130	NT
Agency for Substance Abuse Prev of Calhoun and Cleburne Counties 1302 Noble Street Lyric Square, Suite 3-B Anniston, AL 36201	NT
First Step Substance Abuse Treatment Smiley Street Red Level, AL 36474	DR
Dauphin Way Lodge Treatment Services Quarterway/Halfway/Int Outpatient 1009 Dauphin Street Mobile, AL 36604	54
Franklin Memorial Diversion and Treatment Program* P.O. Box 2048 Mobile, AL 36652	DR
Veterans Affairs Medical Center Psychiatry Serv Alc/Drug Dep Trt Pgm 1030 Jefferson Avenue Memphis, TN 38104	DR
Methodist Outreach Inc 2009 LaMar Avenue Memphis, TN 38114	DR

Frayser/Millinton Mental Health Ctr. Alcohol & Drug Abuse Services 2150 Whitney Avenue Memphis, TN 38127	DR
Surveillance & Treatment on Probation Prog.* 201 Mechanic Street Lexington, Kentucky 40507	NT
North Central Mental Health Services Drug and Alcohol Treatment Program 1301 North High Street Columbus, OH 43201	37
Neighborhood House, Inc Alcohol/Drug Counseling Program 1000 Atcheson Sttet Columbus, OH 43203	10
Criminal Justice Administrator* Two Nationwide Plaza, 12th Fl 280 North High Street Columbus, OH 43215	NT
Two Nationwide Plaza, 12 Fl* 280 North High Street Columbus, OH 43215	NT
Community Guidance Inc Genesis House 3134 Euclid Avenue Cleveland, OH 44106	DR
Matt Talbot Inn Residential 2270 Professsor Avenue Cleveland, OH 44113	93
Catholic Social Services of Cuyahoga County Chemical Dependency Services 3135 Euclid Avenue Room 202 Cleveland, OH 44115	20
Cleveland Treatment Center 1127 Carnegie Avenue Cleveland, OH 44115	114
Quest Recovery Services-Alernatives Prog.* 1341 North Market Street Canton, Ohio 44714	DR
Hamilton County Alcohol and Drug Addiction Services Board* 830 Main Street, Suite 1205 Cincinnati, OH 45202	NT

Department of Probation* Montgomery County Court of Common Pleas 41 North Perry Street Room 107. Dayton, Ohio 45422-2001	53
Elkhart County Alcohol & Drug Abuse Program* 315 South 2nd Street Elkhart, Indiana 46516	23
Cass County Alcohol Drug Court Program* 928 1/2 East Market Street Logansport, Indiana 46947	18
Miami County Alcohol & Drug Court Program* Peru Court House, 3rd Floor Peru, Indiana 46970	19
Fulton County Court* Wabash Addiction Care Center, Rochester 100 West Ninth Street, Suite 301 Rochester, Indiana 46975	UNK
Wabash Addiction CareCenter 710 N. East Street Wabash IN 46992	34
Fountain County Court* Wabash Valley Hospitalty Outpatient Services/101 Suzie Lane Attica, Indiana 47918	35
Newton Co. Superior Court,* c/o Ryan & Ryan Consulting Medical Arts Building 125 South McKinley Street Rensselaer, Indiana 47978	NT
Comprehensive Services, Inc. 4630 Oakman Boulevard Detroit, MI 48204	95
BAPCO Substance Abuse TRT and Prev Prgm 17357 Klinger Street First Community Baptist Church Detroit, MI 48212	DR
Community Corrections Center Monica House 15380 Monica Street Detroit, MI 48238	86
Drug Case Management* State Court Admin Office 611 W. Ottawa Post Office Box 30048 Lansing, MI 48909	81

Office of Cummunity Corr.* 1500 Lamont Kalamazoo, MI 49001	82
Gateway Villa* Residential Substance Abuse Treatment Center 1910 Shaffer Road Kalamazoo, MI 49001	1
Gateway Villa* 1910 Shaffer Road Kalamazoo, MI 49001	DUPLICATE OF # 1.
61st District Court* 333 MoDRoe Avenue N.W. Grand Rapids, Michigan 49504	5
Kent County Court Services Dept.* Hall of Justice Room 302 333 MoDRoe Avenue, NW Grand Rapids, Michigan 49504	49
Rock Valley Correctional Programs* Treatment Alternatives Program 431 Olympian Blvd. Beloit WI 53511	14
Lifeworks Chemical Dependency Center Ottawa Substance Abuse Services 214 North Ottawa Street Joliet, IL 60431	DR
Illinois Depart of Alcoholism* & Substance Abuse Adv Council 1560 Sanburg Terrace, #1104 Chicago, IL 60610	NT
Northwestern Memorial Hospital Chemical Dependency Program 448 East Ontario Street 8th Floor Chicago, IL 60611	DR
Interventions Northside Clinic 2723 North Clark Street 1st & 2nd Floors Chicago, IL 60614	DR
Brass Foundation Inc 8000 South Racine Avenue Chicago, IL 60620	DR
BASTA Drug Abuse Treatment Program 3054 West Cermark Road Chicago, IL 60623	UNK

Alternatives Inc 1126 West Granville Avenue 2nd Floor Chicago, IL 60660	92
Substance Abuse Services* Human Resources Dev. Inst. 222 South Jefferson Street Chicago, IL 60661	99
Chemical Dependency Services* Central K.C. Mental Health Service 600 East 22nd Street Kansas City, MO 64108	40
Addiction Treatment Center* St, Joseph Medical Center 3600 E. Harry Wichita,KS 67218	DR
Jefferson Alc/ Drug Abuse Clinic* 401 Veterans Boulevar, Ste 102 Methrie, LA 70005	DR
Jefferson Regional Medical Center First Step Chemical Dependency Unit 1515 West 42nd Avenue Pine Bluff, AR 71603	94
VGS Inc 2525 San Jacinto St. Houston, TX 77002	97
Assoc for the Adv of Mexican Americans Comp Inhalent Drug Abuse Program 204 Clifton Street Houston, TX 77011	76
MCC Behavioral Care Inc. 1900 West Loop South Suite 675 Houston, TX 77027	85
Methodist Hospital & Baylor College of Medicine Chem Depend. Program 6565 Fannin Street Houston, TX 77030	UNK
Adult Rehabilitation Services 6624 Hornwood Street Houston, TX 77074	3
Gulf Coast Community Services Assoc. Substance Abuse Services Program 6300 Bowling Green Street Houston, TX 77201	DR

Jefferson Cnty Intervention Prgm* Jefferson County Courthouse 1149 Pearl Street Beaumont, TX 77701	31
Mexican American Unity Council Casa Del Sol/Casa Adelante 2303 West Commerce Street San Antonio, TX 78207	50
Drug Court* Pretrial Services Travis Cty Drug Diversion Ct 316 West 12th St, #101 Austin, Texas 78701	DR
Pretrial Services* Drug Diversion Court Travis County Pretrial Srvs P.O. Box 1748 Austin, Texas 78767	DR DUPLICATE
Drug and Alcohol Treatment Institute Clarence Lawson Foundation 2230 North 24th Street Phoenix, AZ 85008	63
44th Street Drug Abuse Program Larkspur Medical Center 12426 North 28th Drive Phoenix, AZ 85029	13
Counseling Supervisor Phoenix LARC 3101 East Watkins Road Phoenix, AZ 85034	46
Prehab of Arizona, Inc. Homestead Girls Residence Program P.O. Box 5860 Mesa, AZ 85211	52
Maricopa Punishment Program* Substance Abuse Component Administrative Office of the Courts 400 N. Seventh St. Maricopa, AZ 85239	DR
Criminal Justice Program* COPE Behavioral Services 101 S. Stone, Suite 200 Tucson, AZ 85701	41
PASAR* 101 S. Stone, Suite 200 Tucson, AZ 85701	42

ADAPT, Inc. La Frontera Central Office 502 West 29th Street Tucson, AZ 85713	110
Charles E. Drew First Offender King Drew Substance Abuse Program 9307 South Central Avenue Los Angeles, CA 90002	98
Bay Area Addiction Research/TRT Inc. BAART/CAL Detox/Southeast Clinic Los Angeles, CA 90011	115
Depart of Health Services* Alcohol & Drug Program Admin. 714 West Olympic Boulevard Los Angeles, CA 90015	44
East Los Angeles Health Task Force Comprehensive Substance Abuse Pgm 630 South Saint Louis Street Los Angeles, CA 90023	DR
SunRise Community Counseling Center In/Outpatient 1925 West Temple Street Suite 205 Los Angeles, CA 90026	90
MCC Managed Behavioral Care of CA 400 South Spulveda Street Manhattan Beach, CA 90026	DR
Gay and Lesbian Community Ser. Ctr. Addiction Recovery Srvces/Los Angeles 1625 North Hudson Avenue Los Angeles, CA 90028	107
Behavioral Systems 1800 N. Highland Avenue Suite 318 Los Angeles, CA 90028	79
LAC/USC Med Ctr Prof Staff Assoc. Infants of Subst Abuse Mothers Clinic 1129 North State Street Room 1D35 Los Angeles, CA 90033	DR
Alternative Action Programs 2511 South Barrington Avenue Los Angeles, CA 90064	UNK
Kaiser Permanente/Culver Marina Chemical Dependency Recovery Pgm 1201 West Washington Boulevard Los Angeles, CA 90066	DR

Compton Special Services Center 404 North Alameda Street Compton, CA 90221	112
Inglewood Mental Health Service Drug Abuse Treatment Program 4450 West Century Boulevard Inglewood, CA 90304	48
Fresh Start Training Center 1167 East 215th Place Carson, CA 90745	UNK
Long Beach Alcohol & Drug Rehab Pgm North Clinic 6335 Myrtle Avenue Long Beach, CA 90805	109
Impact Drug and Alcohol * Treatment Center P.O. Box 93607 Pasadena, CA 91109	75
City of Chino Human Services Division 13271 Central Avenue Chino, CA 91710	121
Alvarado Parkway Institute Chemical Dependency Program 7050 Parkway Boulevard La Mesa, CA 91942	DR
Episcopal Community Services (ECS) East County Accord 900 North Cuyamaca Street Suite 100 El Cajon, CA 92020	73
Episcopal Community Services (ECS) East County Neighborhood Recovery Ctr 1089 El Cajon Boulevard El Cajon, CA 92020	NT
Professional Community Services 900 North Cuyamaca Street Suite 201 El Cajon, CA 92020	NT
Desert Dawn Centers Drug & Alcohol Prevention 569 East King Street Banning, CA 92220	DR
Imperical County MH ALC and Drug Programs Outpatient Clinic 1073 West Ross Avenue, Suite F El Centro, CA 92243	105

Volunteers of America Imperical Alcohol and Drug Program 1331 Clark Road El Centro, CA 92243	71
Treatment and Recovery Ventura Cnty 4651 Telephone Road #210 Ventura, CA 93003	70
Special Projects 955 east Telephone Road Ventura, CA 93003	69
County of Ventura, Alcohol Drug Programs* 4651 Telephone Rd, #210 Ventura, CA 93003	67
Mom and Kids Recovery Center 4651 Telephone Rd. Ventura, CA 93003	68
Special Treatment Education and Prevention Services, Inc. (STEPS) 3533 Mount Vernon Avenue Bakersfield, CA 93306	45
Central Coast Headway/Lompoc Drug & Alcohol Awareness Program 1100 West Laurel Avenue Lompoc, CA 93436	100
Haight Ashbury Free Clinics Alcohol Treatment Services 1698 Haight Street San Francisco, CA 94117	117
Oakland Community Counseling Center 2647 East 14th Street Suite 420 Oakland, CA 94601	113
14th Street Clinic & Medical Group 1124 East 14th Street Oakland, CA 94606	102
Diversion/Design Committee* Oakland Municipal Court 661 Washington Street Oakland, California 94607	103
Merritt Peralta Institute Treatment Services 435 Hawthorne Avenue Oakland, CA 94609	DR
Department of Corrections* Probation and Parole 1700 K Street, Fifth Floor Sacramento, CA 95814	UNK

Alcohol and Drug Program* 3701 Branch Center Road Sacramento, CA 95827	DR
ASAP Treatment Services, Inc. 919 SW Taylor Street 7th Floor Portland, OR 97205	DR
De Paul Adult Treatment Center 1320 SW Washington Street Portland, OR 97205	DR
Harmony House Inc* 4940 SE Woodstock Portland, OR 97206	74
Kaiser Permanente Recovery Resource 2330 N.E. Siskiyou Portland, OR 97212	38
Providence Addictions/Diversion Program* 5228 NE Hoyt Street Portland, OR 97213	12
InAct, Inc.* 1135 S.E. Salmon St. Portland, OR 97214	39
Northwest Treatment Services 948 NE 102nd Street Suite 101 Portland, OR 97220	29
Coda Drug Treatment Services 306 NE 20th Street Portland, OR 97232	116
Oregon Office of Alcohol and Drug Abuse Programs* 500 Summer Street, N.E. Salem, OR 97310	NT
Drug Free Systems/TASC* 811 First Avenue, Ste 610 Seattle, WA 98104	83
Cornerstone Treatment Centers, Inc. 610 44th Street, NW Seattle, WA 98107	DR
Central Seattle Recovery Center Jefferson Street Unit 1401 East Jefferson Street, Suite 300 Seattle, WA 98122	DR
Therapeutic Treatment Center 17962 Midvale Avenue North Suite 150 Seattle, WA 98133	DR

Detox Center/Outpatient Treatment 622 Tacoma Avenue South Suite 6 Tacoma, WA 98402	106
Pierce County Alliance* 710 South Fawcett Tacoma, WA 98402	24
Project/Drug Issues* Washington Department of Social and Health Services P.O. Box 45330 Olympia, WA 98504-5330	NT
Center for Drug Treatment East 115 Indiana Street Spokane, WA 99207	NT

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