Key:

J = Jason Cantone

K = Chief Magistrate Judge M. Page Kelley

L = Joseph LaFratta

J: Thank you, Judge Kelley and Mr. LaFratta for joining us from the District of Massachusetts. Today we're going to talk about alternatives to court and drug courts, and in particular, the CARE program in your district. But before we get to that program, we'd like to start more broadly. So, what is it that alternative court programs and drug courts offer the federal courts?

K: So, these programs really offer courts the chance to take people who are at the very highest risk of recidivism, and especially drug courts, where people are suffering from substance use disorder, and are at a very high risk to relapse and go back to prison. So, what we're trying to do is give people structure, encouragement, and access to all the programming that we can think of that might assist them in sort of getting back on their feet, getting the treatment that they need, and not going back to prison.

J: Would you say that there are key components or program elements that make a drug court successful?

L: Absolutely. I mean, I think one of the biggest components, the key component of the drug court program is, or an alternative court program, would be the judge, actually. It's actually the most proven point, is that the judge can make or break the success of that particular court. But yeah, the judge in a particular court really needs to be the right personality, in terms of being able to be nurturing to the person, but yet firm. And I think that that's probably the most key component. Otherwise, the other key components for a drug court, or an alternative court -- and we based ours on the National Association of Drug Court Professionals' key components, are just consistency, consistency both in your practice, consistency in your population that you choose. For us, we chose to make sure we are going to get the most bang for our buck. So, we chose to pick the highest risk individuals that are highest risk to relapse.

K: You also really need to just put together a good team. So, in our district, for example, we have really good, experienced, highly trained probation officers. We have a great drug treatment specialist, who kind of weighs in on all our decisions about treatment for the people who are participating. And then we have a great defense lawyer, who's very invested in looking after people and reacting quickly when they need her. And then we have a really good representative, too, from the U.S. Attorney's office. I think another key element is to have people who understand, you're going to step out of your traditional role in order to be in this court. So, for example, the defense lawyer is not going to be a traditional defense lawyer, because she's not just going to be a mouthpiece for her clients; she's going to be talking to the clients in a realistic way about their getting better. So, when someone denies using, you're going to push back on that if you're the defense lawyer, if you think they really are using. So, the team is really key.

J: And so, let's focus a little more about the CARE program in your district. So, how did it start? And how did you assemble that excellent team?

L: The CARE program itself started back in 2006, and it was really started by a district judge who was, at the time, a magistrate judge, Leo Sorokin, in the District of Massachusetts. And he was very interested in drug courts. And Massachusetts had had state drug courts forever. And we started some research, trying to figure out how it could work in the federal system. We decided it was probably best for our population to do post-conviction.

And with that, we started to develop the team. And the team was made up of, obviously, probation officers. At the time, we pulled in some federal defender, which Judge Kelley was at the time. And we got the U.S. Attorney's office involved, and actually the marshals involved, because they're a player in this whole team as well. And the focus was really -- it was on three things, and it remains those three things today: sobriety, employment, and a law-abiding lifestyle.

K: The CARE program itself is voluntary, so nobody's there who doesn't want to be there. And what they get for participating in the program, if they complete it successfully, is a year off their term of supervised release. So we're actually pretty carefully screening people as they come out of prison, and then oftentimes you'll find people who are just perfect for the program, but they don't want to participate in the program, they don't want the extra scrutiny, and they'll say, "I'm good, I can do this on my own." And then after, they relapse, and their supervised release gets revoked, and maybe they have to

go to prison for a short time, and they come back out. Then we find they're ready to say, “I need that extra structure, and I want to join the program."

J: Let's take a minute to just work through the CARE program, which stands for Court Assisted Recovery Effort. What does it involve for individuals? How do they start? How do they just become part of the program, and then what happens once they're part?

L: So, we -- the probation office meets with these individuals before they're even released. We identify them, actually, even before that. We identify them at the pre-sentence stage. We know what their substance abuse history's like, we know what their criminal history's like. So, we can identify them very early on. As they're getting ready to get released from the Bureau of Prisons while they're at the Residential Re-Entry Center, we have an officer go out there and meet with them and explain to them what the program's all about, and try to get some buy-in. We allow them to come and observe the program. When they come and observe, they get a chance to see the program in operation. If they choose to join it -- because as the judge said, it is voluntary, it's a voluntary program -- what they then do is, they meet with the defense attorney that would represent them in the program. And they sign a contract. And as part of that contract, they agree to attend all of the sessions, to agree to additional drug testing that they wouldn’t normally do if they were on regular supervision without the CARE program. They agree to an intensified level of supervision. And then they attend the court sessions, and the court sessions themselves are broken into four phases. And the first phase, everybody comes twice a month to the court session. And then it decreases down to once a month.

What we do on the front end of the program is incredibly important. And what we do is, we have every individual that goes through the program at the beginning participate in an assessment, and that assessment looks at both what risk they are, both to recidivate criminally what risk they're at, to relapse with drugs, and then it looks at needs as well, so to look at whether employment , education is in need. It looks at a number of different things; cognitions may be a need to address with these individuals. And through that assessment, we start to develop a plan for that person. And they have say into what that plan itself is.

K: No one really has the same path. So, one of the things you have to understand is, there's no one size fits all with these courts, or even just in general with treatment.

J: And so, thinking about the program, how do we know if it was successful? Is that something that's tracked on, for example, recidivism rates, and if it's changing them?

L: So, what we've seen is that folks that go through our program are, when compared to similarly situated individuals, are successful, are more successful because they go through our program. What we've -- the program has had two different studies done in Massachusetts; there are countless studies nationally, but in Massachusetts we've had at least two studies done, that have proven the fact that they're more likely to be successful. Now we see it on a daily basis. Now we -- I think -- and the judge and I have spoken about this a number of different times -- I think there are different bars, right? You set a bar, and your bar may be no relapse and no recidivism. And for these folks, sometimes maybe less relapse is a better bar, and no recidivism, right? So, because when you think about a drug addiction, and somebody that's suffering with a substance use disorder, this isn't something that they can just hit a switch and turn it off. And they can't just hit that switch and turn it off because the judge told them, "Stop using drugs," or the probation office said, "We're going to lock you up," or, you know, it doesn't happen because of those things. They need to make these lifestyle changes. And when we see those lifestyle changes, that's when we know that it's working.

K: In our district, we've noticed that our program has been a kind of innovation lab for probation. So, for example, there's a lot of examples of that, but one is that several years ago when people started talking about medically assisted treatment, it wasn't really widely available to people on supervised release in our district. And in fact, there was some pushback, that maybe it wasn't appropriate for, say, a person who's addicted to heroin to be on methadone. You know, there was a view in the treatment community that that was just a continuation of your drug addiction.

So, we invited doctors from the Boston Medical Center to talk to our participants, and they were really opposed to medically assisted treatment, the participants at the time. But gradually, over time, we've developed a really good relationship with the Boston Medical Center. And now, for example, if we have a participant who's decided to try medically assisted treatment, we can get them in there for an appointment almost immediately. And also, when probation first meets with people who have just gotten out of prison, and they sign up for health insurance, they'll try to persuade them to go to the Boston Medical Center and get a primary care physician who's board certified in addiction medicine, so that they'll know what to do with that person.

J: And you've mentioned that success can be very different for different people. But how do you know when there's someone that's resisting treatment, is resisting medically assisted treatment, is resisting the CARE program, that the program is just not going to be a good fit for them?

K: We have such sort of close supervision of the people in the program, that we generally know if someone is with us or not. So, for example, the defense lawyer will be sometimes in daily contact with people. If someone has a tragedy in their lives, we'll go to the funeral. We'll be -- I've texted with people whose loved ones have died and sent them flowers or some gift after the funeral. And you're trying to let the person know, number one, we're here, but also, we're watching you. And after someone has experienced some event that makes them more likely to recidivate, we're all over it. And the probation officer will be seeing them more frequently, you know? I think one of the key elements of a program like this is just, it is very intensive supervision. And not in a nasty way, but in a way that if someone is going off the rails, we're going to react immediately.

L: And I think just to speak to that, I think -- so you need to know that on the front end of the program, for at least the first four months or so, these folks have a built-in meeting with their probation officer, judge, defense attorney, and representative from the U.S. Attorney's office, because we're meeting twice a month with them, in court. The probation officer is also meeting with them outside of that court session, at least once or twice a month. They're coming in for drug tests eight or nine times a month. So, we're -- we have, on that front end of the program, we have a tremendous amount of contact with these individuals, so we can tell where they're at; we have a good sense of where their state of mind is.

J: What tips or tricks for dealing with those with substance abuse, with opioid use disorder, do you have that you'd like to share with others?

K: So I think for myself, as a judge, one of the things I had to learn was, that someone might stand in front of you just begging you to release them, and promising you that they're not going to use again, and perhaps even denying that they have used, when everyone knows they have. And then you relent and let them go, and they just resume using. So I think it's easy to get very frustrated with such a person, and think they're being dishonest and manipulative, and all of that -- part of what you have to do, I think, to understand their behavior, is just to understand the neurological problems that a

person with substance use disorder has. They may very well be earnestly pledging not to use again, but when they get back out in the world, they honestly can't help themselves. And so, I think it's really important just to understand that science. That doesn't mean that then you just let everyone go, perhaps you get less frustrated with them. But I think if people are not ready to get treatment, and they're not ready to take a good, honest look at themselves, you can't make them do that. And there does come a time when you have to say to someone, look, we've spent a lot of resources on you, we've offered you all the help that we know to offer you. You're not taking advantage of it. One of the things we've learned in the drug court is, when people do relapse, you, instead of immediately reacting in the punitive way, you offer them more treatment or different treatment, and make sure you're being very informed about it, and not just coming to some kind of snap decision about what they need. And then a lot of times people will take advantage of that.

L: I mean, I think the one thing that I would emphasize is that there is no magic bullet. There's no one magic bullet that's going to fix every single person with a substance use disorder. And I think that the judge describes it perfectly. You've got a situation where you've got somebody in front of you, and they're begging you, telling you they're never going to use again if you let them out, or this is the last time. It won't happen again, please -- we hear that regularly when we've got somebody that relapsed. And I think that it's very easy to buy into that, especially with this population, because they're very convincing. A good number of them are very convincing. And they've done it all their lives, to get by, to get over that next hump. And I think what we've tried to do -- and again the judge is exactly right -- what we try to do is, whether we put somebody into custody or not, there's always a treatment response, because we're trying to do things differently. I think these folks are used to being just kind of cast off, you know? They use their cast off by their family, they use their cast off by the court, they use the cast off by their employer. And we're trying to say to them, listen, you did something wrong. You knew you shouldn't have used, you used. We're going to put you in custody for the day or two days. But when you come back, this is what we're going to do for you. We're going to put you in treatment, and it's going to be a different modality of treatment. It's going to be more intense than what you were doing before, because clearly, what you were doing before wasn't working. So, we're going to intensify this a bit more.

J: So, with almost 15 years of experience with the CARE program, what would you say the lessons learned? And what would you tell other courts if they wanted to create a similar program?

K: So, what I would say is, it's a ton of work. And you have to have some people who are really enthusiastic and kind of persistent. You also have to have the buy-in of the court. If the court is not with you as a whole, it's very difficult. I would also say that one of the things that is really critical is that you just make sure you get as much information as you can about each person. I think our biggest failures have been when we just didn't know something about someone. And this is where the drug court model, I think, can be so much more effective than the regular path to supervised release revocation in front of a judge who's just seeing something for the first time, or maybe they sentenced someone years ago, and now they're back 10 years later to have a supervised release revocation hearing. So, we just have so much information about these people, that I think we're in a much better position to try to keep them from re-offending.

L: I would say one of the lessons that we learned very early on is that people need to be okay with stepping out of their traditional role. I think it goes for every player in the court. So, from the probation officer being willing to share information about the person that they're supervising, to sort of showing their hand about what their decisions are going to be with the course of supervision for an individual. So the U.S. attorney's office, around their decisions and their thought process around a particular individual that's in the program, to the defense attorney where we've had defense attorneys who have been completely in opposition to us putting somebody in custody, and we've had defense attorneys in the program that have went and said -- come in to the meeting saying, "This person needs to be in custody today," which is a very different role for a defense attorney.

J: And so, the last question I have is beyond the CARE program. What tips do you have for judges, for officers in dealing with people with opioid use disorder, and what benefits alternative programs might offer?

K: So, some important things that I have learned are, first of all, to educate myself about substance use disorder. And there's a great video in this series where a doctor is talking about the neurology and the brain science behind addiction that I thought was fantastic. And if you know more about substance use disorder, you're going to be able to react in a more appropriate way to the defendants before you who are suffering from that

problem. Secondly, I would just try to learn as much as I can about the background of the person who's standing in front of me. If there's a pre-sentence report to look at, if you can talk to their supervising probation officer, if you can ask questions about whether they are suffering from some kind of trauma that they've had in the past, or what medications they're taking, it can really give you some insight into the person.

Also, I really rely on our probation department. I just think they're fantastic, they're very well-trained, and they know a lot more than I do about the person who's standing in front of me. And then finally, I've learned really not to give people ultimatums. So, for example, I might say to someone, "If you test positive again, I'm going to take you into custody," but I don't think it's really productive, or I don't think it really incentivizes the person not to use if you announce in advance that you're going to give them some terrible result if they use again, because I really do think you should wait and see what are the circumstances of their use, what are the treatment options afterward, how did it happen? How did the person react? Did they lie about it, or did they come asking for help? And so, the ultimatum, I think, a lot of times, backfires.

J: **Well, thank you very much for taking the time to talk to us about such an important program.**

K: Thank you.

L: Thank you.