INDIANA DRUG COURTS: ELIMINATING TEMPORARY-EVENT RELAPSE SANCTIONS

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INTRODUCTION

Michael Pawlowski was a working professional in New York City who struggled with substance abuse.[1] In 2010, Michael was convicted of a drunk driving offense and placed in a New York Drug Treatment Court in lieu of incarceration.[2] Michael recognized his struggle with substance abuse, sought help, and was proudly stable in recovery.[3] On July 4, 2012, at the age of 29, Michael relapsed and passed away in his apartment.[4] From the information in his apartment, Michael's mother deduced that Michael had been in a substance abuse crisis the night of his death and that he decided not to take himself to the emergency room.[5] The reason was obvious to Michael's mother: if Michael had gone to the emergency room, his relapse would have been discovered and subsequently punished by the drug court.[6] In New York, under the 911 Good Samaritan Law,[7] those on probation and in drug courts are not offered immunity in cases of overdoses, as anything in a drug court patient's medical record can be used against them in the program.[8] Because of this, Michael remained in his apartment, one block away from a hospital, and died.[9] After Michael's death, his mother described the drug court experience as a "horror" story.[10] She described how district attorneys would demean chronically ill or addicted participants, while the other participants would laugh as the judge reprimanded someone for failing to follow the program rules.[11] Michael's mother felt the judge was playing cat and mouse games to teach participants a lesson.[12] When Michael entered the program, he was constantly threatened with incarceration and was remanded to jail for relapses.[13] Because of his fear of being sanctioned

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1. Elaine Pawlowski, *Reevaluating Drug Courts: No Mother Should Have to Go Through What I Did*, HUFFPOST.COM (Dec. 6, 2017), https://www.huffpost.com/entry/drug-courts-reform_b_3671505 [https://perma.cc/2AV2-G5QY].

2. *Id.*

3. *Id.*

4. *Id.*; Elaine Pawlowski, *Release the Shame of Addiction*, HUFFPOST.COM (Nov. 25, 2013), https://www.huffpost.com/entry/release-the-shame-of-addi_b_3975492 [https://perma.cc/8XWJ-JLPS].

5. Pawlowski, *supra* note 1.

6. *Id.*

7. The New York 911 Good Samaritan Law provides immunity for anyone experiencing a drug or alcohol overdose that requires medical attention. However, drug court participants' conversations with doctors are not confidential in the program. *Id.*

8. *Id.*

9. *Id.*

10. *Id.*

11. *Id.*

12. *Id.*

13. *Id.*

with jail time for his relapse, Michael died alone in his apartment even though his life might have been saved had he gone to the hospital.[14]

Substance abuse is common throughout the United States and can often culminate into a substance use disorder (SUD). SUD is "a treatable mental disorder that affects a person's brain and behavior, leading to their inability to control their use of substances like legal or illegal drugs, alcohol, or medications."[15] There is significant overlap between individuals with SUD and the criminal system. Many imprisoned individuals struggle with a substance use disorder (SUD), though it is difficult to measure an exact number.[16] However, a "substantial prison population in the United States is strongly connected to drug-offenses . . . some research shows that an estimated 65% of the United States prison population has an active SUD."[17] A 2019 report from the American Civil Liberties Union (ACLU) found that, in 2015, approximately one in four people in Indiana prisons were incarcerated for a drug-related offense.[18] This equates to roughly 6,875 people.[19] Additionally, drug offenses are the most common offense for individuals entering Indiana prisons.[20]

To combat rising rates of SUD, overwhelmed court dockets, and overpopulation in jails, courts across Indiana and the United States developed drug courts.[21] Drug courts allow certain drug users to participate in a treatment program in lieu of spending time in jail for a drug-related criminal offense.[22] There are approximately fifty-five courts in Indiana that operate alcohol and drug courts.[23] These courts are governed by the Indiana Code and administrative rules created by the Judicial Conference of Indiana.[24] The governing law gives large discretion to drug courts for the creation and implementation of their programs.[25] At the federal level, no law exists governing drug courts; instead,

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14. *Id.*

15. *Substance Use and Co-Occurring Mental Disorders*, NAT'L INST. OF MENTAL HEALTH, https://www.nimh.nih.gov/health/topics/substance-use-and-mental-health [https://perma.cc/Q8RM-SB86] (last reviewed Mar. 2023).

16. *Criminal Justice DrugFacts*, NAT'L INST. ON DRUG ABUSE (June 2020), https://nida.nih.gov/publications/drugfacts/criminal-justice [https://perma.cc/X8SN-7JN7].

17. *Id.*

18. AM. C. L. UNION, BLUEPRINT FOR SMART JUSTICE INDIANA 8 (2019), https://50stateblueprint.aclu.org/assets/reports/SJ-Blueprint-IN.pdf [https://perma.cc/V9X8-9DM4].

19. *Id.*

20. *Id.* at 9.

21. Arthur J. Lurigio, *The First 20 Years of Drug Treatment Courts: A Brief Description of Their History and Impact*, 72 FED. PROBATION J. 13 (June 2008).

22. *Treatment Courts*, U.S. DEP'T OF JUST.: OFF. OF JUST. PROGRAMS (Apr. 11, 2024), https://ojp.gov/feature/drug-courts/overview [https://perma.cc/F39M-647H].

23. *Court Alcohol & Drug Program*, IND. JUD. BRANCH: OFF. OF CT. SERVS., https://www.in.gov/courts/iocs/cadp/#:~:text=Approximately%20fifty%2Dfive%20circuit%2C%20superior,court%20alcohol%20and%20drug%20programs [https://perma.cc/TC27-ZYQA] (last visited Feb. 14, 2024).

24. IND. CODE § 33-23-16 (2023); I.C. § 12-23-14 (2023); JUDICIAL CONFERENCE OF IND., IND. OFF. OF CT. SERVS., *Rules for Court-Administered Alcohol & Drug Programs*, IND. OFF. OF CT. SERVS. (Aug. 31, 2021), https://www.in.gov/courts/iocs/files/cadp-rules.pdf.

25. *Id.*

the Federal Drug Courts Program Office has created nonbinding guidelines for state drug courts.[26]

As it stands, the law governing Indiana drug courts is silent regarding how a court should respond to a participant's relapse. Because of this, Indiana drug court teams, including the judges, are free to treat relapse however they wish. This Note argues that the Indiana Judicial Conference should amend the Rules for Court-Administered Alcohol & Drug Programs[27] to include a provision prohibiting courts from sanctioning temporary-event relapse, and instructing courts to instead provide therapeutic adjustments because temporary-event relapse is a normal part of recovery.[28] Part I of this Note defines SUD, discusses how SUD impacts the brain, explains why relapse is a normal part of recovery from SUD, and distinguishes temporary-event relapse from return-to-use relapse. Part II describes Indiana drug courts, state law governing Indiana drug courts, and federal guidelines for drug courts before analyzing the efficacy of drug courts. Part III analyzes why courts should respond to temporary-event relapse differently than return-to-use relapse and describes therapeutic adjustments as the best response for temporary-event relapses. Finally, Part V recommends that the Indiana Judicial Conference amend the Rules for Court-Administered Alcohol & Drug Programs to include provisions prohibiting the sanctioning of temporary-event relapses and requiring therapeutic adjustments for temporary-event relapses.

I. SUBSTANCE USE DISORDER AND RELAPSE

The prevalence of SUD in drug court participants demands care and attention to drug court processes. Though the outside world often views drug use as a conscious choice made by the drug user, the reality is that drug use alters the normal brain network and processes. Because the brain is altered with drug use, relapse is a regular part of recovery. However, there are two types of relapses, and drug courts should consider which type of relapse a participant is experiencing when determining the appropriate response.

A. Diagnosing Substance Use Disorder

Roughly one in twelve Hoosiers have SUD, equating to nearly half a million people in Indiana.[29] Between 2018 and 2021, drug overdose deaths in Indiana

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26. *See* BUREAU OF JUST. ASSISTANCE, U.S. DEP'T OF JUST., *Defining Drug Courts: The Key Components* (Oct. 2004), https://www.ojp.gov/pdffiles1/bja/205621.pdf.

27. JUDICIAL CONFERENCE OF IND., IND. OFF. OF CT. SERVS., *Rules for Court-Administered Alcohol & Drug Programs* (Aug. 31, 2021), https://www.in.gov/courts/iocs/files/cadp-rules.pdf.

28. *See* discussion *infra* Part I, Sect. B.

29. *Addiction affects every aspect of Hoosier life*, IND. UNIV. (Mar. 2023), https://addictions.iu.edu/understanding-crisis/crisis-in-indiana.html [https://perma.cc/X4M5-6Z9Q].

related to opioids rose from 1,098 to 2,205, a nearly 200% increase.[30] The state drug-induced mortality rate quadrupled from 2000 to 2014, while deaths related to synthetic opioids increased by 600% between 2012 and 2016.[31] Indiana prisoners can be up to 129 times more likely to die of a drug overdose within two weeks after release from incarceration than the general population.[32] Many recently released former inmates in Indiana return to drug use because of a lack of treatment for their underlying SUD.[33]

SUD differs from substance misuse. Substance misuse is defined as the "use of alcohol, illegal drugs, and/or prescribed medications in ways that produce harms to ourselves and those around us."[34] SUD is a disorder associated with consumption of one or more of ten classes of drugs: "alcohol; caffeine; cannabis; hallucinogens . . . ; inhalants; opioids; sedatives, hypnotics, and anxiolytics; stimulants . . . ; tobacco; and other (or unknown) substances."[35] The key feature of SUD is a group of cognitive, behavioral, and physiological symptoms that show the consumer continuing substance use regardless of the negative side effects associated with it.[36] SUD can range from mild to severe, with addiction being the most severe type.[37] To qualify as a mild SUD, two or more of eleven criteria must be present.[38] With more present criteria, the SUD may be labeled moderate (four to five criteria) or severe (six or more).[39] These eleven criteria are:

(1) use of substance in large amounts or for longer periods of time than intended;
(2) failed attempts to stop use;
(3) excessive time using, obtaining, or recovering from the substance;
(4) craving the substance;
(5) failure to fulfill major obligations at work, school, or home;
(6) continuing substance use despite persistent or recurrent social/ interpersonal problems caused by the substance;
(7) sacrificing important social, occupational, or recreational activities because of the substance use;
(8) physically hazardous use of the substance;

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30. SYRA HEALTH, DRUG FACT SHEET: SUBSTANCE USE IN INDIANA 7, https://www.in.gov/fssa/dmha/files/Drug-Fact-Sheet_2023_ADA_final.pdf.

31. *Addiction affects every aspect of Hoosier life*, *supra* note 29.

32. *Id.*

33. *Id.*

34. A. Thomas McLellan, *Substance Misuse and Substance Use Disorders: Why Do They Matter in Healthcare?*, 128 TRANSACTIONS OF THE AM. CLINICAL AND CLIMATOLOGICAL ASS'N 112 (2017).

35. AM. PSYCHIATRIC ASS'N, DIAGNOSTIC AND STATISTICAL MANUAL OF MENTAL DISORDERS 481 (5th ed. 2013) [hereinafter AM. PSYCHIATRIC ASS'N, DSM-5].

36. *Id.* at 483.

37. NAT'L INST. OF MENTAL HEALTH, *Substance Use and Co-Occurring Mental Disorders*, *supra* note 15.

38. AM. PSYCHIATRIC ASS'N, DSM-5, *supra* note 35, at 484.

39. *Id.*

(9) continued use of substance despite awareness of physical or psychological problem caused by use;
(10) tolerance of the substance; and
(11) withdrawal after prolonged use.[40]

SUD can affect multiple areas of a person's life, including home life. In 2016, fifty percent of cases of children removed from their homes by the Indiana Department of Child Services were removed because of drug or alcohol use by a parent.[41] These children are four times more likely to misuse drugs or alcohol at some point in their lives.[42] Additionally, SUD affects physical and mental health.[43] Individuals struggling with SUD may "experience difficulty with sleeping, significant changes in their appetite, and even heart problems."[44] Long-term substance abuse can lead to cancer, lung disease, organ failure, and more.[45] These health problems can then take a toll on a person's mental health.[46]

B. The Science Behind Substance Use Disorder

SUD is categorized as a disorder because it involves "functional changes to brain circuits involved in reward, stress, and self-control" during and after drug use.[47] When an individual initially chooses to consume drugs, it is normally voluntary; however, with each subsequent use, self-control becomes more impaired.[48] In studies completed about individuals with addiction problems, brain imaging showed physical changes to areas of the brain that control "judgment, decision-making, learning and memory, and behavior control."[49] Risk factors,[50] biological factors,[51] protective factors,[52] environmental factors,[53]

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40. *Id.* at 483–84.
41. *Addiction affects every aspect of Hoosier life*, *supra* note 29.
42. *Id.*
43. *4 Ways Addiction Affects Quality of Life*, FAIR PARK COUNSELING, https://www.fairparkcounseling.com/4-ways-addiction-affects-quality-of-life/#:~:text=Those%20battling%20substance%20abuse%20may,and%20problems%20with%20mental%20health [https://perma.cc/8EPZ-WB9G] (last visited Jan. 21, 2024).
44. *Id*
45. *Id.*
46. *Id.*
47. *Drug Misuse and Addiction*, NAT'L INST. ON DRUG ABUSE (July 6, 2020), https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/drug-misuse-addiction [https://perma.cc/3SCM-ZF9X].
48. *Id.*
49. *Id.*
50. Risk factors can include aggressive behavior in childhood, lack of parental supervision, low peer refusal skills, drug experimentation, availability of drugs at school, and community poverty. NAT'L INST. ON DRUG ABUSE, *Drug Misuse and Addiction*, *supra* note 47.
51. Biological factors can include genes, stage of development, gender, or ethnicity. *Id.*
52. Protective factors can include self-efficacy, parental monitoring and support, positive relationships, good grades, school anti-drug policies, and neighborhood resources. *Id.*
53. Environmental factors relate to family, school, and neighborhood. *Id.*

and other factors[54] can make someone more or less vulnerable to struggling with SUD.[55]

Drug use specifically alters the way neurotransmitters are released within the brain. The brain operates using billions of cells, called neurons, in circuits and networks to control the flow of information.[56] Neurons fire back and forth to send signals to one another.[57] The circuits work together as a team to perform functions between different parts of the brain, the spinal cord, and other parts of the body.[58] To send messages, neurons release neurotransmitters into the area between themselves and another cell.[59] The neurotransmitter crosses the gap to transfer information in a key-lock style.[60] Transporters, other molecules, help limit the signal of the neurotransmitter to its designation.[61] Drugs interfere with this process by interrupting all aspects described above.[62] Some drugs can activate neurons because their chemical buildup imitates the natural neurotransmitter.[63] Though this activation mimics the normal brain process, it is actually much different when activated by a drug like marijuana or heroin.[64] Instead of normal messages flowing through the network, drugs like marijuana and heroin cause abnormal messages to be sent out.[65] Drugs like cocaine can cause massive numbers of neurotransmitters to be released, creating large disruptions in the transport process, which in turn impacts behaviors.[66]

Several areas of the brain are impacted by drug use, including the basal ganglia, extended amygdala, and prefrontal cortex.[67] The basil ganglia supports positive motivation through normal daily activities like eating and socializing.[68] Drug use causes this area to overreact, resulting in the euphoric high associated with many drugs.[69] After repeated drug use, the basil ganglia adjusts to the drug, making it more difficult to feel motivation and reward like usual.[70] The extended

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54. Other factors include early use of drugs and how the drug is taken. *Id.* The earlier the use of the drug, the more likely it may impact a developing brain. *Id.* Additionally, smoking or injecting a drug increases the addictive nature. *Id.*

55. *Id.*

56. *Id.*

57. *Id.*

58. *Id.*

59. *Drugs and the Brain*, NAT'L INST. ON DRUG ABUSE (July 6, 2020), https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/drugs-brain [https://perma.cc/KH29-WA9T].

60. *Id.*

61. *Id.*

62. *Id.*

63. *Id.*

64. *Id.*

65. *Id.*

66. *Id.*

67. *Id.*; *see also* Joanna S. Fowler et al., *Imaging the Addicted Human Brain*, 3 SCI. & PRAC. PERSPS. 4, 5 (2007).

68. NAT'L INST. ON DRUG ABUSE, *Drugs and the Brain*, *supra* note 59.

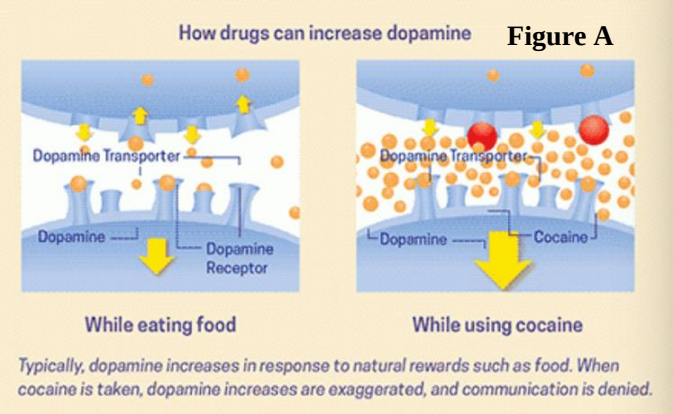
69. *Id.*

70. *Id.*

amygdala controls feelings like stress, anxiety, irritability, and unease.[71] With each subsequent drug use, the extended amygdala becomes more sensitive to discomfort and the feelings listed, resulting in the consumer wanting to use drugs for relief.[72] Finally, the prefrontal cortex enables thinking, planning, problem-solving, decision-making, and self-control.[73] Similarly to the other brain areas mentioned, the prefrontal cortex becomes susceptible to reduced impulse control after repeated drug use.[74] More severe drugs, like opioids, can impact the brain stem that controls heart rate, breathing, and more.[75]

Drugs increase pleasure by causing surges of neurotransmitters in areas like the basal ganglia (see Figure A), causing the consumer to return to use in the future.[76] Drug use produces surges of dopamine, a neurotransmitter activated by the reward circuit.[77] Dopamine is the "feel-good" hormone that allows a person to feel pleasure.[78] When dopamine is released, it signals to the brain that it should remember what caused the dopamine release.[79] Therefore, dopamine reinforces drug use by "reinforcing the connection between consumption of the drug, the resulting pleasure, and all the external cues linked to the experience."[80] Put in simpler terms, dopamine teaches the brain to want more with each subsequent drug use, creating a learned reflex.[81] This learned reflex is difficult to shake and can last decades.[82] Other brain imaging studies show that "drug use literally alters the connections between the ventral tegmental area (which is part of the reward center) and memory hubs in

Figure A



71. *Id.*
72. *Id.*
73. *Id.*
74. *Id.*; *see also* Fowler et al., *supra* note 67, at 5.
75. NAT'L INST. ON DRUG ABUSE, *Drugs and the Brain*, *supra* note 59.
76. *Id.*
77. *Id.*; *see also* Fowler et al., *supra* note 67, at 5.
78. *Dopamine*, CLEVELAND CLINIC, https://my.clevelandclinic.org/health/articles/22581-dopamine [https://perma.cc/5FM6-JG9M] (last reviewed Mar. 23, 2022).
79. NAT'L INST. ON DRUG ABUSE, *Drugs and the Brain*, *supra* note 59.
80. *Id.*
81. *Id.*
82. *Id.*

the brain (such as the hippocampus).[83] Taken together, the impact of these alterations in normal brain function results in a drug user feeling depressed and unmotivated until returning to drug use again.[84] These changes can be long-term, leading to different neurological and cognitive complications.[85] Because of this, drug users struggle to stop using drugs and often return to drug use during their recovery process.

When talking about drug addiction and SUD, relapse "refers to the reinitiation of drug seeking and drug taking after abstinence."[86] Relapse is one part of the normal process during the treatment of SUD.[87] Relapse does not mean treatment is failing;[88] rather, "it indicates that the person needs to speak with their doctor to resume treatment, modify it, or try another treatment."[89] Roughly seventy to ninety percent of individuals attempting to overcome drug addiction experience some form of relapse.[90] For SUD specifically, forty to sixty percent experience relapse.[91] Relapse generally occurs when a person experiences a craving for drugs.[92] The craving for drugs "can be induced by re-exposure to cues previously associated with drug exposure, by acute exposure to stressors and by re-exposure to the drug itself."[93] These triggers are usually what cause an individual with SUD to relapse.[94] In a study completed of 2,002 individuals "who self-reported a resolved AOD [alcohol or drug] problem . . . ,"[95] researchers found that the mean number of recovery attempts before long-term recovery was 5.35 and the median number was 2.[96] Though relapse is a normal

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83. David Sack, *Why Relapse Isn't a Sign of Failure,* PSYCH. TODAY (Oct. 19, 2012), https://www.psychologytoday.com/intl/blog/where-science-meets-the-steps/201210/why-relapse-isnt-sign-failure [https://perma.cc/XVE3-PQ27].

84. NAT'L INST. ON DRUG ABUSE, *Drugs and the Brain*, *supra* note 59.

85. Stacy Mosel, *Brain Damage from Alcohol and Drugs: Are the Effects Reversible?*, AM. ADDICTION CTRS. (Dec. 16, 2024), https://americanaddictioncenters.org/alcohol/risks-effects-dangers/brain [https://perma.cc/K8A7-6KBT].

86. Jane Stewart, *Psychological and Neural Mechanisms of Relapse*, 363 PHIL. TRANSACTIONS OF ROYAL SOC'Y B BIOLOGY SCIS. 3147 (July 18, 2008).

87. Sack, *supra* note 83; *Relapse*, ALCOHOL AND DRUG FOUND. (July 17, 2024), https://adf.org.au/reducing-risk/relapse/ [https://perma.cc/H344-WHDX]; Gilian Steckler et al., *Relapse and Lapse*, 1 PRINCIPLES OF ADDICTION 125 (Dec. 2013).

88. Sack, *supra* note 83.

89. *Treatment and Recovery*, NAT'L INST. ON DRUG ABUSE (July 6, 2020), https://nida.nih.gov/publications/drugs-brains-behavior-science-addiction/treatment-recovery [https://perma.cc/4SUX-9NBT]; *see* Norda D. Volkow et al., *Loss of Dopamine Transporters in Methamphetamine Abusers Recovers with Protracted Abstinence*, 21 J. OF NEUROSCIENCE 9414 (Dec. 1, 2001).

90. Sack, *supra* note 83.

91. NAT'L INST. ON DRUG ABUSE, *Treatment and Recover*y, *supra* note 89.

92. Stewart, *supra* note 86 at 3147; Sack, *supra* note 83.

93. Stewart, *supra* note 86 at 3147.

94. Sack, *supra* note 83; AM. PSYCHIATRIC ASS'N, DSM-5, *supra* note 35, at 483.

95. John F. Kelly et al., *How Many Recovery Attempts Does It Take to Successfully Resolve an Alcohol or Drug Problem? Estimates and Correlates from a National Study of Recovering U.S. Adults*, 43 ALCOHOLISM: CLINICAL AND EXPERIMENTAL RSCH. 1533, 1535 (2019).

96. *Id.* at 1536.

part of recovery, it can be difficult for drug courts to ascertain when a participant is taking their treatment plan seriously and genuinely struggling versus not taking treatment seriously. When a participant is not taking treatment seriously, the drug court program probably is not a good fit for them. For this reason, a distinction has been made between temporary-event relapse and return-to-use relapse, discussed in more detail below.

C. Differentiating Temporary-Event Relapse from Return-to-use Relapse

Temporary-event relapse, sometimes referred to as a lapse,[97] differs greatly from return-to-use relapse. Generally, relapse can be defined as an individual's return to drug use, either temporarily or permanently.[98] However, an occurrence of relapse does not necessarily mean that a person has returned to persistent use.[99] A temporary-event relapse "involves a few occasions of [substance] use."[100] Conversely, when an individual repeats drug use at a level similar to the pre-treatment level of use, this is deemed return-to-use relapse.[101] With psychological disorders and problem behaviors like drug use, most individuals experience multiple temporary-event relapses after beginning treatment.[102] It is difficult to define the exact moment that relapse happens; therefore, many define it as an iterative process.[103]

Distinguishing a temporary-event relapse from return-to-use relapse can affect how an individual responds to the relapse and how a treatment plan is made or adjusted. When a person relapses, "his or her perception that [it] is a temporary slip will make a significant difference in how optimistic the patient remains and how soon the patient returns to avoiding drug use."[104] Additionally, a person's treatment plan can change depending on what type of relapse they are experiencing.[105] To help ensure an individual is receiving the correct treatment, researchers created an empirical and standardized method for distinguishing temporary-event relapse from return-to-use relapse in drug court participants.[106] A statistical limit can be created by looking at the drug court program participant's history (or other similarly situated clients in the same program if a participant does not yet have history).[107] If the time in between a

97. Steckler et al., *supra* note 87.

98. Farrokh Alemi et al., *Statistical Definition of Relapse: Case of Family Drug Court*, 29 ADDICTIVE BEHAVS. 685 (2004).

99. *Addiction Relapse: Risk Factors, Coping & Treatment Options*, AM. ADDICTION CTRS. (Dec. 31, 2024), https://americanaddictioncenters.org/treat-drug-relapse [https://perma.cc/7CFL-2NX9].

100. Alemi et al., *supra* note 98, at 686.

101. Steckler et al., *supra* note 87.

102. *Id.*

103. *Id.*

104. Alemi et al., *supra* note 98, at 686.

105. *Id.*

106. *Id.*

107. *Id.* at 685.

relapse exceeds the limit, it is likely the participant has returned to persistent use.[108]

The researchers defined return to drug use as "a statistically significant deviation from a pattern of abstinence," finding that statistical charts could be used to determine what type of relapse a person is experiencing.[109] These charts, called relapse charts, can be used to display a pattern of use, especially with drug use (see Table 1 for the data that goes into the relapse chart).[110] Based on this data, an upper limit, called the Upper Control Limit (UCL), can be set to distinguish what type of relapse is occurring.[111] After compiling the case history of a participant into a table, the information on the length of relapses can be compiled into a histogram.[112] The researchers found that if a histogram shows a geometrically decaying shape, longer stretches of relapse are increasingly rare.[113] Once the histogram has been created, the UCL can be set at the point where the length of relapse "is so large that it cannot be expected by mere chance deviation from the underlying pattern of abstinence."[114] After this, 99% of the data points for a participant abstaining from drug use should fall below the limit.[115] The average length of relapse (ALR) can be calculated by dividing the number of weeks of relapse by the number of weeks of success.[116] For the participant table above, the UCL can be calculated using the following formula: $UCL = ALR + 3[ALR(ALR +1)]^{0.5}$.[117] So, the UCL for the participant would be 2.32.[118] This means that if the participant's drug use and abstinence were to be recorded for 100 weeks, the relapse rate should only be higher than 2.32 weeks one time.[119] Because the participant was only observed for 20 weeks, the

Table 1
Case history for a hypothetical patient

Week	Abstinent	Weeks abstinent	Length of relapse
1	Yes	1	0
2	Yes	2	0
3	Yes	3	0
4	Yes	4	0
5	Yes	5	0
6	No		1
7	Yes	6	0
8	Yes	7	0
9	Yes	8	0
10	No		1
11	Yes	9	0
12	Yes	10	0
13	Yes	11	0
14	Yes	12	0
15	No		1
16	No		2
17	No		3
18	Yes	13	0
19	Yes	14	0
20	Yes	15	0

108. *Id.*
109. *Id.* at 687–88.
110. *Id.* at 688.
111. *Id.*
112. *Id.*
113. *Id.* at 689.
114. *Id.*
115. *Id.*
116. *Id.*
117. *Id.*
118. *Id.*
119. *Id.*

occurrence of a relapse lasting longer than 2.32 weeks could be a sign of a return to use.[120]

After determining a participant's UCL, this line can be placed on the relapse chart (see Fig. 2).[121] If points of relapse are below the UCL, they are temporary-event relapses that do not signify a change in the repetition of abstinence; however, points above the control limit represent a change in drug use.[122] As seen in figure 2,[123] the first two episodes of drug use are below the UCL; however, the third occasion is above the control limit and is, therefore, too long of a span of drug use to be considered a temporary-event relapse.[124] Therefore, the third occasion likely suggests a return-to-use relapse because points above the UCL have less than a 1% chance of occurring randomly.[125]

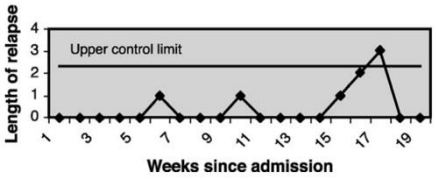

Fig. 2. Relapse chart.

After calculating the UCL and ALR, the probability of abstinence can be calculated using the following formula: probability of abstinence = 1/(1+ALR).[126] For the above participant, the probability of abstinence would be .75, or 75%. As time passes, a participant's probability of abstinence should increase; however, a 100% rate of abstinence is unlikely because, as explained before, SUD is a chronic disease.[127] By looking to this study as a guide, drug courts can distinguish between temporary-event relapse and return-to-use relapse to better aid participants in recovery. The probability of abstinence can be especially useful, as courts can determine whether a participant is heading toward or away from long-term recovery. Admittedly, this formula may be too rigid and complicated for drug courts to implement with every participant, especially when the drug court feels it has a good understanding of what the participant is experiencing. This Note argues that drug courts must consider this formula for determining when sanctions are appropriate (return-to-use relapse) and inappropriate (temporary-event relapse). If a drug court plans to sanction someone for a relapse, they must first determine, through the formula, which type of relapse is occurring.

II. DRUG COURTS

There are several state laws and nonbinding federal guidelines that drug

120. *Id.* at 689–90.
121. *Id.* at 690.
122. *Id.*
123. *Id.* at 690 fig. 2.
124. *Id.* at 690.
125. *Id.*
126. *Id.* at 691.
127. *Id.*

courts either must adhere to or can consider when implementing their respective programs. Because these guidelines are vague, implementation differs for each drug court. A lack of proper standardization can lead to different levels of efficacy in different drug courts, especially when it comes to the treatment of relapse.

A. Indiana's Drug Courts

Drug courts aim to be a therapeutic approach to jurisprudence in which the law can act as a rehabilitative agent rather than a punitive actor for individuals entering the system through a drug-defined or drug-related offense.[128] Individuals charged with a drug offense are sometimes given the opportunity to participate in a drug court program in lieu of incarceration.[129] When participants enter a drug court program, they are usually required to plead guilty to at least one of their charged offenses, which is often a felony.[130] Judgment and conviction are then withheld until the participant graduates from or fails out of the program.[131] Participants who successfully complete the program can have their criminal charge(s) dismissed, while those who fail the program must return to the normal justice system having forfeited their right to fight the charge.[132] In some instances of failure, a participant's post-program sentence can be even longer than their original sentence.[133]

There are over 4,000 drug treatment courts in the United States, including mental health courts, veterans treatment courts, tribal healing to wellness courts, and DUI/DWI courts.[134] Funding for drug treatment courts comes from local, state, tribal, and federal funding.[135] Drug courts are often managed by a multidisciplinary team comprised of different professionals like judges, prosecutors, defense attorneys, community corrections officers, social workers, and treatment service professionals.[136] Most drug courts operate using a multi-phase treatment approach that includes stabilization, treatment, and transition

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128. Lurigio, *supra* note 21, at 14.

129. *Id.* at 15.

130. *Monroe County Drug Treatment Court Program Participant Handbook and Program Information* (Feb. 2, 2024), https://www.co.monroe.in.us/egov/documents/1708717817_28317.pdf [https://perma.cc/K23T-G4V2].

131. *Id.*

132. U.S. DEP'T OF JUST.: OFF. OF JUST. PROGRAMS, *Treatment Courts*, *supra* note 22.

133. *See, e.g.*, Jessica M. Eaglin, *The Drug Court Paradigm*, 53 AM. CRIM. L. REV. 595, 604 (2016); Brook W. Kearley, *Long Term Effects of Drug Court Participation: Evidence from a 15 Year Follow up of a Randomized Controlled Trial*, J. SUBSTANCE ABUSE TREATMENT (Oct. 2017).

134. U.S. DEP'T OF JUST.: OFF. OF JUST. PROGRAMS, *Treatment Courts*, *supra* note 22.

135. *Id.*; *Tribal Healing to Wellness Courts: Program Development Guide*, TRIBAL L. AND POL'Y INST. (2002), https://www.tribal-institute.org/download/Draft_Program_Development_Guide.pdf.

136. U.S. DEP'T OF JUST.: OFF. OF JUST. PROGRAMS, DRUG TREATMENT COURTS (May 2024), https://www.ojp.gov/pdffiles1/nij/238527.pdf.

phases.[137] During participation in the program, participants are rewarded for some behaviors and sanctioned for others.[138] Rewards in drug court can include praise from the drug court judge, tokens of accomplishment awarded in open court, candy, gift cards, and curfew extensions.[139] Sanctions can include more frequent drug screens, demotion to earlier program phases, fines, incarceration periods, and termination from the program.[140] This Note argues that temporary-event relapses should not be met with either of these options; instead, they should be met with therapeutic adjustments, as discussed later.

B. State Law Governing Indiana Drug Courts

There are two governing pieces of law for Indiana drug courts: the Indiana Code and the Rules for Court-Administered Alcohol & Drug Programs.[141] First, the Indiana Code includes two chapters covering drug courts: one chapter governs all courts deemed "problem solving courts",[142] and the other governs Alcohol and Drug Services programs.[143] The Indiana Code gives problem solving courts the power to hire employees, establish policies and procedures, and adopt local court rules.[144] The code discusses court jurisdiction, individual eligibility, deferred prosecution, and other similar topics,[145] but is not specific regarding other details like quantity of personnel. The code only describes a drug court as a problem-solving court that brings "rehabilitation professionals, local social programs, and intensive judicial monitoring [together with] . . . eligible defendants or juveniles to individually tailored programs or services."[146]

Second, the Judicial Conference of Indiana adopted the Rules for Court-Administered Alcohol & Drug Programs in 1997 to better guide drug courts.[147] The Indiana General Assembly delegated the Judicial Conference of Indiana the responsibility of certification, training, and support of drug programs.[148] These rules, however, are also vague, like the Indiana Code, and only address the technicalities of drug courts, like certification, procedures, and assessments.[149]

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137. U.S. GOV'T ACCOUNTABILITY OFF, GAO-23-105272. ADULT DRUG COURT PROGRAMS: FACTORS RELATED TO ELIGIBILITY AND ACCEPTANCE OF OFFERS TO PARTICIPATE IN DOJ FUNDED ADULT DRUG COURTS 9 (Feb. 2023).

138. BUREAU OF JUST. ASSISTANCE, U.S. DEP'T OF JUST., *supra* note 26, at 13.

139. *Id.*

140. *Id.* at 14.

141. IND. CODE § 33-23-16 (2023); I.C. § 12-23-14 (2023); JUDICIAL CONFERENCE OF IND., IND. OFF. OF CT. SERVS., *supra* note 24.

142. I.C.§ 33-23-16 (2023).

143. I.C.§ 12-23-14 (2023).

144. I.C.§ 33-23-16-21 (2023).

145. I.C.§ 33-23-16-13 (2023); I.C.§ 12-23-5-2 (2023).

146. I.C.§ 33-23-16-5(a)(1)–(2) (2023).

147. *See* JUDICIAL CONFERENCE OF IND., IND. OFF. OF CT. SERVS., *supra* note 24.

148. *About*, IND. JUDICIAL BRANCH: OFF. OF CT. SERVS., https://www.in.gov/courts/iocs/cadp/about/ [https://perma.cc/39CA-YVF3] (last visited Mar. 1, 2024).

149. JUDICIAL CONFERENCE OF IND., IND. OFF. OF CT. SERVS, *supra* note 24 at §§ 7, 20, 22.

While the rules are specific on some topics, like creating forms with the rights of each program participant,[150] the rules do not address others, like how to approach a participant relapsing. None of the rules address sanctions.

C. Federal Guidelines for Drug Courts

There are a few federal guideline documents that state drug courts must abide by to receive specific federal funding.[151] The National Association of Drug Court Professionals developed ten key components of drug courts in the United States in an unsuccessful attempt to bring standardization to drug courts.[152] The key components are:

(1) integration of alcohol/drug treatment with the justice system;
(2) a nonadversarial approach that protects participants' due process rights;
(3) early identification of participants;
(4) access to treatment and rehabilitation services;
(5) abstinence monitoring;
(6) coordinated strategy for response to compliance;
(7) judicial interaction with participants;
(8) evaluation strategies to measure program goals and effectiveness;
(9) interdisciplinary education;
(10) creation of partnerships between drug courts and community-based organizations.[153]

These components are broad and do not necessarily require compliance because no federal agency or law says so.[154] A 2007 National Drug Court Survey found that, on average, respondent drug courts complied with six out of ten components.[155] Years after releasing these components, the National Association of Drug Court Professionals released the Adult Drug Court Best Practice Standards.[156] These standards offer advice regarding drug court programming, but some drug courts do not adhere to them. For example, the standards suggest that jail sanctions should only be given in extreme circumstances and should not last more than three to five days;[157] yet, in one drug court, when a participant relapsed, the participant was sanctioned to sixty

150. *Id.* at § 20.

151. *See* DEPT. OF HEALTH AND HUM. SERVS., SAMHSA TREATMENT DRUG COURTS 11–12 (2023).

152. BUREAU OF JUST. ASSISTANCE, U.S. DEP'T OF JUST., *supra* note 26.

153. *Id.*

154. *See* Brandy F. Henry, *Improving the Quality of Drug Court Clinical Screening: A Call for Performance Measurement Policy Reform*, 31 CRIM. JUST. STUD. 267, 268. (July 3, 2018).

155. *Id.*

156. NAT'L ASS'N OF DRUG CT. PROS., ADULT DRUG COURT BEST PRACTICE STANDARDS (2018), https://allrise.org/wp-content/uploads/2023/06/Adult-Drug-Court-Best-Practice-Standards-Volume-I-Text-Revision-December-2018.pdf.

157. *Id.* at 28.

days in jail.[158] While the components and standards discussed here are admirable and promising when implemented, the reality is that drug courts operationalize standards differently, if implemented at all.[159]

D. Drug Court Efficacy and Issues

The National Institute of Justice (NIJ) evaluates drug courts around the country.[160] The NIJ's 2012 Multisite Adult Drug Court Evaluation found drug courts reduce drug use and criminal offending during and after program participation.[161] Specifically, when measuring a five-year timeline, the study found that participants reported less criminal activity, were rearrested less than comparable individuals, had less drug use, and tested positive less than comparable individuals.[162] In another study, the NIJ tracked 6,500 drug court participants across ten years to determine that rearrest rates were lower five years later than similar drug offenders in the same place.[163] Though these results seem promising, drug courts could be more effective. In a study of the efficacy of five Indiana drug courts, the graduation rate of drug court participants was found to be 50% to 56%, leaving roughly 44% to 50% of participants failing the drug court program and returning to the normal justice system.[164]

A survey of recidivism rates for an Indiana drug court completed in 2014 produced factors that indicated whether a participant was more likely to recidivate.[165] Recidivism was measured up to thirty-six months.[166] The study found that "[f]irst, drug court participants who were neither employed nor a student at the time of admission were more likely to recidivate (54%) than participants who were employed or a student at time of admission (36%) . . . [s]econd, drug court participants who had a violation within the first 30 days of the program were more likely to recidivate (65%) than participants who did not

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158. Christine Mehta, *How Drug Courts Are Falling Short*, OPEN SOC'Y FOUNDS. (June 7, 2017), https://www.opensocietyfoundations.org/voices/how-drug-courts-are-falling-short [https://perma.cc/SV7Y-66ZD].

159. Shannon M. Carey et al., *What Works? The Ten Key Components of Drug Court: Research-Based Best Practices*, 8 DRUG CT. REV. 6 (2012).

160. *NIJ's Multisite Adult Drug Court Evaluation,* NAT'L INST. OF JUST. (Nov. 4, 2012), https://nij.ojp.gov/topics/articles/nijs-multisite-adult-drug-court-evaluation [https://perma.cc/Q255-JMW7].

161. *Id.*

162. Shelli B. Rossman et al., *The Multi-Site Adult Drug Court Evaluation: The Impact of Drug Courts*, 4 URB. INST. JUST. POL'Y CTR. 121 (Nov. 2011).

163. *Do Drug Courts Work? Findings From Drug Court Research*, NAT'L INST. OF JUST. (May 11, 2008), https://nij.ojp.gov/topics/articles/do-drug-courts-work-findings-drug-court-research [https://perma.cc/Q2LN-NEFC].

164. K.L. Wiest et al., NPC RSCH., INDIANA DRUG COURTS: A SUMMARY OF EVALUATION FINDINGS IN FIVE ADULT PROGRAMS 3 (Apr. 2007), https://www.in.gov/courts/iocs/files/pscourts-eval-summary.pdf.

165. John R. Gallagher et al., *The Impact of an Indiana (United States) Drug Court on Criminal Recidivism*, 15 ADVANCES IN SOC. WORK 507, 513 (2014).

166. *Id.* at 515.

have a violation with the first thirty days of the program (35%) . . . ."[167] The study also found that out of 197 participants, 108 (or 55%) participants graduated successfully while 89 (or 45%) were terminated unsuccessfully.[168] Most interestingly, the study found that "participants with no positive drug tests in drug court and those with multiple positive drug tests had equal odds of recidivating."[169]

However, these numbers are likely inflated and, therefore, an inaccurate representation of the success of drug court programs. Most drug courts "exclude people with more serious offenses or histories . . . .",[170] effectively selecting the participants who are less likely to be struggling with SUD and more likely to struggle with substance misuse. Yet, the individuals with more serious offenses are the ones who have the most need for a rehabilitative program such as a drug court. The studies also usually compare drug court participants with drug court failures, thereby leaving a net positive result no matter what.[171] Clearly, the drug court system is not perfect. This Note does not attempt to perfect the system; instead, this Note addresses relapse.

III. RELAPSE AND DRUG COURTS

This Note does not argue that sanctions should be prohibited for relapses in general. Instead, this Note argues that sanctions should not be imposed in cases of temporary-event relapses. Instead, judges should implement therapeutic adjustments for temporary-event relapses.

A. Why Courts Should Manage Temporary-Event Relapse Differently Than Return-to-Use Relapse

Indiana drug courts should manage temporary-event relapse differently than return-to-use relapse because temporary-event relapse is a normal part of recovery that often occurs when participants experience stress. It would be cruel to punish a participant for the effects of the program itself. Drug courts increase the levels of stress that often contribute to temporary-event relapse, and the consequences of treating the two comparably are severe.[172] The stress created by the way drug courts operate increases a participant's likelihood of relapsing. Though relapse is a normal part of recovery, there are external factors that can increase an individual's likelihood of relapsing. Specifically, stress "is a well-known risk factor in the development of addiction and in addiction relapse

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167. *Id.* at 513.

168. *Id.* at 513–14.

169. *Id.* at 516.

170. DRUG POL'Y ALL., DRUG COURTS ARE NOT THE ANSWER: TOWARD A HEALTH-CENTERED APPROACH TO DRUG USE.,15 (Mar. 2011), https://drugpolicy.org/wp-content/uploads/2023/09/Drug-Courts-Are-Not-the-Answer_Final2.pdf [https://perma.cc/TXM2-LK45].

171. *Id.*

172. Alemi et al., *supra* note 98, at 686.

vulnerability.[173] The structure of Indiana drug courts is stressful in several ways, including program fees and how status hearings are facilitated.[174]

Whatever the price may be for entering the drug court system, the financial burden placed on participants creates a lot of stress. The fees for drug screens can be disabling to some participants who are struggling to find or maintain a job, especially in jurisdictions like Kosciusko County, which charges a participant roughly $40 a week for a maximum of twenty-eight weeks.[175] This would equate to roughly $1,120 spent on drug screens. Additionally, drug courts need only identify testing locations and hours;[176] yet, the testing locations are not necessarily easily accessible to participants. A participant in a rural county who lives thirty miles from the testing location may have difficulty getting to the location during the specified hours, especially if they lack their own means of transportation. The stress of this can quickly take a toll.

Though the public aspect of the program is supposed to create accountability, it often leads to stress and humiliation.[177] Generally, all drug court participants with status hearings on a specific day are called into the courtroom at the same time and then appear individually before the judge.[178] Each participant appears before the judge to review their progress since the last status hearing.[179] In a study of drug courts through the eyes of participants, one participant said that they "fe[lt] like [they are] on a game show."[180] If a participant has relapsed, they can immediately be sent to jail.[181] The guilt and stress caused by relapse can lead "to self-blame and guilt that in turn mean the person is more likely to continue substance use as a coping mechanism."[182] By making drug court participants admit their normal temporary-event relapses in front of the rest of the participants,[183] Indiana drug courts increase stress levels in participants.

The consequences of punishing a temporary-event relapse can be severe. Drug court participants often stay in jail for more days than a traditional docket due to interim jail stays.[184] The penalty for relapsing can be a jail sanction where

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173. Rajita Sinha, *Chronic Stress, Drug Use, and Vulnerability to Addiction*, 1141 ADDICTION REVS. 105 (Oct. 23, 2008).

174. Susan H. Witkin & Scott P. Hays, *Drug Court Through the Eyes of Participants,* 30 CRIM. JUST. POL'Y REV. 971, 976–77 (2017).

175. *Drug Court*, KOSCIUSKO CNTY., https://www.kcgov.com/department/division.php?structureid=240#:~:text=Fees%20included%20for%20participation%3A,Fee%3A%20%2420.00%20per%20drug%20screen [https://perma.cc/3AFH-HCNT] (last visited Mar. 10, 2024).

176. JUDICIAL CONFERENCE OF IND., IND. OFF. OF CT. SERVS., *supra* note 24, at § 33(b)(5).

177. Witkin & Hays, *supra* note 174, at 978.

178. *Id.* at 976–77.

179. *Id.* at 976.

180. *Id.* at 977.

181. *Id.* at 976–77.

182. ALCOHOL AND DRUG FOUND, *supra* note 87.

183. Witkin & Hays, *supra* note 174, at 976–77.

184. REGINALD FLUELLEN & JENNIFER TRONE, VERA INST. OF JUST., DO DRUG COURTS SAVE JAIL AND PRISON BEDS*?* 6 (2000), https://www.vera.org/downloads/publications/IIB_Drug_courts.pdf.

participants have to spend a few days in jail.[185] Jail sanctions lead to isolation, which is a trigger for drug use.[186] Additionally, when a participant is sanctioned with jail time, it does not increase their likelihood of program retention or completion.[187] Sanctioning a drug court participant for temporary-event relapses can cause a participant to feel like they are failing. How a participant perceives their relapse can impact how soon the participant returns to sobriety.[188] In reality, "drug court jail stays are 'associated with a higher likelihood of re-arrest and a lower probability of program completion.'"[189] These jail stays can affect employment and child custody arrangements, further setting a participant back. A study of fifty-six Kentucky drug court participants discovered and analyzed employment needs and hardships that drug court participants face.[190] A theme derived from this study is that "participation in drug court treatment programs often conflicted with work schedules, thus making jobs difficult to obtain and maintain."[191]

Finally, relapses can be sanctioned with demotion to earlier program phases, resulting in stress and incorrect alterations to a participant's treatment plan.[192] While demotion to earlier treatment phases may be appropriate and productive for return-to-use relapse, it is not appropriate for temporary-event relapse. When a participant returns to an initial treatment phase after a temporary-event relapse, they usually "[report] experiencing further guilt, shame, and loss of self-esteem."[193] Additionally, returning to initial treatment services prevents the participant from receiving the adjustment to their current treatment plan that they need.[194]

Without this difference in treatment, misinterpretations of which type of relapse is occurring can have serious consequences.[195] For example, if a clinician mistakes a client's relapse for return-to-use instead of temporary-event, the participant's treatment plan may be drastically altered instead of adjusted accordingly, resulting in backward progress.[196] Additionally, when a judge feels a participant has returned to drug use, the judge usually takes more

185. *Id.* at 5.

186. Nora Volkow, *Addiction Should be Treated, Not Penalized,* NAT'L INST. ON DRUG ABUSE (May 7, 2021), https://nida.nih.gov/about-nida/noras-blog/2021/05/addiction-should-be-treated-not-penalized [https://perma.cc/W794-3PHJ].

187. John R. Hepburn & Angela N. Harvey, *Effect of the Threat of Legal Sanction on Program Retention and Completion: Is That Why They Stay in Drug Court?*, 53 CRIME & DELINQ. 255 (Apr. 2007).

188. Alemi et al., *supra* note 98 at 685.

189. Wayne A. Comstock, *Drug Courts: The Risk of an Increased Number of Drug-Related Arrests and Long Jail Sentences,* 13 U. MIAMI RACE & SOC. JUST. L. REV. 22 (2023).

190. Michele Staton et al., *Employment Issues Among Drug Court Participants,* 33 J. OFFENDER REHAB. 73 (2001).

191. *Id.*

192. BUREAU OF JUST. ASSISTANCE, U.S. DEP'T OF JUST, *supra* note 26, at 14.

193. Alemi et al., *supra* note 98, at 695.

194. *Id.*

195. *Id.* at 685.

196. *Id.*

severe actions that are inappropriate for temporary-event relapses.[197] Ultimately, a participant's path to sobriety is a learning process where each temporary-event relapse should be used as a teaching moment for the participant's recovery process.[198]

B. Therapeutic Adjustments

Drug courts can operate differently than standard courts because of the treatment options, rewards, and punishments that they give participants in lieu of jail time. This unique feature is admirable and has the potential to thrive. However, the response to temporary-event relapses should differ from the traditional sanction and reward system. Instead, drug courts should use therapeutic adjustments when responding to temporary-event relapses. Therapeutic adjustments can include medication, counseling, and inpatient treatment.[199]

The National Institute on Drug Abuse considers drug addiction a "relapsing disorder."[200] The National Association of Drug Court Professionals points out that relapses should not be punished; instead, relapses should be met with "a therapeutic adjustment."[201] Participants should "not receive punitive sanctions if they are otherwise compliant with their treatment and supervision requirements but are not responding to the treatment interventions."[202] These decisions and adjustments to treatment should be made based on recommendations of trained treatment professionals.[203] When a court imposes "substantial sanctions for substance use early in treatment, the team is likely to run out of sanctions and reach a ceiling effect before treatment has had a chance to take effect."[204] This is where the distinction between temporary-event and return-to-use relapse is most important. Sanctions can be appropriate for return-to-use relapse, but they are not appropriate for temporary-event relapse.[205]

IV. ACCOMMODATING TEMPORARY-EVENT RELAPSE IN DRUG COURTS

The Indiana Judicial Conference should amend the Rules for Court-Administered Alcohol & Drug Programs to include a provision that prohibits sanctions and requires therapeutic adjustments for temporary-event relapse. This section discusses why standardization is needed to protect drug court participants experiencing a temporary-event relapse, and concludes by offering

197. *Id.* at 686.
198. BUREAU OF JUST. ASSISTANCE, U.S. DEP'T OF JUST., *supra* note 26, at 13.
199. NAT'L ASS'N OF DRUG CT. PROS., *supra* note 156, at 31.
200. *Drug Misuse and Addiction*, *supra* note 47.
201. NAT'L ASS'N OF DRUG CT. PROS., *supra* note 156, at 31.
202. *Id.* at 27.
203. *Id.*
204. *Id.* at 31.
205. *Id.*

a model administrative rule that Indiana should adopt.

A. Standardization Is Needed for Responses to Temporary-Event Relapse

Standardization is needed across the board for temporary event-relapses so that all drug court participants will receive the appropriate therapeutic adjustment if they experience temporary-event relapse, rather than sanctions. As the law stands now, drug court teams, which often do not include psychiatrists or sufficient interaction with mental health professionals, are left with the difficult, unguided responsibility of determining whether a drug court participant is refusing treatment and actively returning to drug use, or if a participant is experiencing a normal temporary-event relapse. Without standardization, Indiana drug courts can choose to treat relapse however they desire, just as they can implement other aspects of the program however they choose.[206]

An administrative response clarifying when sanctions are inappropriate is the best response because it will ensure that all Indiana drug courts are treating temporary-event relapse the same. In an analysis of eighteen Indiana problem-solving courts, a researcher found that treatment teams normally consisted of a judge, a prosecutor, a defense attorney, at least one counselor, and at least one case manager.[207] Thirteen of the courts had a police officer, twelve had a probation officer, and two had a physician.[208] In this study, "[e]very problem-solving court judge stated that treatment decisions are made through the court by the treatment team" and that the team is made up of treatment professionals (like mental health counselors and social workers) and non-treatment professionals (like attorneys).[209] Generally, the non-treatment professionals deferred treatment plans to the treatment professionals, even though the number of treatment professionals was limited.[210] As described, current non-treatment professionals in Indiana drug courts defer treatment to the limited number of

206. Currently, Indiana's drug courts can use a lot of discretion when implementing aspects of their programs because of the vague laws. Therefore, standardization is needed for temporary-event relapse. Under the Rules for Court-Administered Alcohol & Drug Programs, Indiana drug court participants are liable for the costs of drug screens required by the program. JUDICIAL CONFERENCE OF IND., IND. OFF. OF CT. SERVS., *supra* note 24, at § 33. Neither the Rules nor the Code specify how much a program can charge for each drug screen fee; therefore, different programs charge different fees. The Kosciusko County Drug Court charges a fee of $20 for each drug screen. *Drug Court*, *supra* note 175. The Grant County Drug court charges a fee of $5 for each drug screen. *Drug Court*, GRANT CNTY. CTS, https://www.in.gov/counties/grant/courts/courts/problem-solving-courts/drug-court/ [https://perma.cc/VQ55-3CYZ] (last visited Mar. 1, 2024).

207. Barbara Andraka-Christou, *What is "Treatment" for Opioid Addiction in Problem-Solving Courts? A Study of 20 Indiana Drug and Veterans Courts*, 13 STAN. J.C.R. & C.L. 189, 197 (June 1, 2017).

208. *Id.*

209. *Id.* at 200.

210. *Id.*

treatment professionals on drug court staff. This leaves the treatment of relapse in the hands of an individual who might not be qualified to respond to it (for example, a social worker without a medical background) or who may be overwhelmed with their caseload to give the time needed to evaluate and distinguish a temporary-event relapse from return-to-use relapse.[211] An administrative response would reduce this problem by guiding drug court teams through a statistical definition of the types of relapse. Therefore, the Indiana Judicial Conference should amend the Rules for Court-Administered Alcohol & Drug Programs to include a relapse provision that courts must follow to distinguish the treatment of temporary-event relapses versus return-to-use relapses and only sanction the latter.

B. Proposed Model Statute for Temporary-Event Relapse

Currently, neither the Indiana code, the Rules for Court-Administered Alcohol & Drug Programs, nor the federal guidelines define sanction, incentive, or therapeutic adjustment. So, the Rules for Court Administered Alcohol & Drug Programs must also distinguish incentives and therapeutic adjustments from sanctions and give examples of each. No state has specifically distinguished temporary-event relapse from return-to-use relapse, making this an innovative approach. Still taking guidance from other state statutes that can add to the current Indiana statutes and Rules for Court Administered Alcohol & Drug Programs, an example of provisions prohibiting sanctions for temporary-event relapses may read:

"Temporary-event relapse"

Sec. 1. As used in this chapter, "temporary-event relapse" means an occurrence of relapse that does not signify a return to persistent drug use by a participant. This statistical definition is calculated for each individual participant.

"Return-to-use relapse"

Sec. 2. As used in this chapter, "return-to-use relapse" means an occurrence of relapse that is "a statistically significant deviation from a pattern of abstinence."[212] This statistical definition is calculated for each individual

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211. Though a reformation of drug court staff is needed to ensure qualified personnel are handling medical decisions, this Note does not address this topic here. The only qualification required of drug court personnel in Indiana is the Court Substance Abuse Management Specialist credential. JUDICIAL CONFERENCE OF IND., IND. OFF. OF CT. SERVS., *supra* note 24, at 23–25. To earn the credential, a program staff member must meet the following requirements: obtain a bachelor's degree; have at least nine months of employment experience relating to assessment, referral and case management of substance abuse; be employed at an Indiana Office of Court Services certified program; have 500 hours of direct supervision in the last five years of assessment, referral and case management of substance abuse clients with 100 of those being assessment; attend and complete an Indiana Office of Court Services staff orientation training, have a passing score of the CSAMS test, and complete a CSAMS application. *Id.* This does not ensure a person has the medical knowledge to make treatment decisions.

212. Alemi et al., *supra* note 98, at 687–88.

participant.

"Therapeutic adjustment"

Sec. 3. As used in this chapter, "therapeutic adjustment" "means alterations to a participant's treatment requirements that are intended to address unmet clinical or social service needs, and are not intended as an incentive or sanction."[213] Therapeutic adjustments "should be suggested by a licensed treatment provider."[214] Therapeutic adjustments may include counseling, inpatient treatment, group meetings, writing a letter to future self, changes in frequency of treatment, and medication adjustments.

"Incentive"

Sec. 4. "Incentives may include small, tangible rewards provided by the drug court team, a temporary decrease in drug court requirements, and an increase or advancement in phase."[215]

"Sanction"

Sec. 5. Sanctions are administered to discourage certain behaviors and equate to punishments. However, "[i]ncarceration [should be] imposed judiciously and sparingly. Unless a participant poses an immediate risk to public safety, jail sanctions are administered only after less consequences have been ineffective at deterring infractions."[216] When jail sanctions are used, they should not last beyond "three to five days."[217]

Relapse in general

Sec. 6. "The drug court judge shall recognize relapses and restarts in the program which are part of the rehabilitation and recovery process. The judge shall accomplish monitoring and offender accountability by . . . providing incentives"[218] and ordering therapeutic adjustments when a participant experiences a temporary-event relapse. The judge shall provide adjustments at the recommendation of a licensed treatment provider.

Distinguishing temporary-event relapse from return-to-use relapse

Sec. 7. A temporary-event relapse can be distinguished from a return-to-use relapse by plotting a participant's weeks of abstinence and length of relapse in a table. After this, a histogram can be completed to determine the length of relapse weeks against the frequency of relapse of specified length. An upper control limit (UCL), or the point at which the relapse length becomes long enough to suggest an alteration in a pattern of abstinence, can be calculated by using the following formula: UCL = average length of relapse (ALR) + 3[ALR(ALR + 1)]. The UCL is the relapse length limit where 99% of the data in the participant table should fall. Observing a relapse that is longer than the UCL is likely to represent return to use. Relapses that are shorter than the UCL

213. U.S. NAT'L SCI. FOUND., I.R.T.C. Rule 2(o) (2024).
214. KY AP PART XIII § 12 (2023).
215. *Id.*
216. *Id.* at § 12(3)(e) (2023).
217. *Id.*
218. OKLA. STAT. § 22-471.7 (2023).

can most likely be deemed temporary-event relapses.

Incentives, Sanctions, and Therapeutic Adjustments

Sec. 8. "Incentives, sanctions, and therapeutic adjustments shall be administered by the drug court judge"[219] to encourage behaviors, discourage behaviors, and help participants move forward with treatment.

Prohibition on sanctioning temporary-event relapse

Sec. 9. A drug treatment court may not sanction a participant for a temporary-event relapse.

(a) **"**Participants [will] not receive punitive sanctions if they are otherwise compliant with their treatment but are not responding to the current treatment interventions."[220] When a participant experiences a temporary-event relapse, "the treatment provider [must] reassess the individual and adjust the treatment plan accordingly."[221]
(b) Incarceration is never appropriate in response to a temporary-event relapse.
(c) If a court wishes to sanction a relapse, the court must first determine that the relapse is a return-to-use relapse as is calculated under these provisions.

Adjustment of treatment plan after temporary-event relapse

Sec. 10. When a participant experiences a temporary-event relapse, the drug court must make therapeutic adjustments to the participant's treatment plan.

Treatment of return-to-use relapse

Sec. 11. A drug treatment court may sanction a participant for return-to-use relapse and must adjust the participant's treatment plan. The adjustments to the participant's treatment plan must address the individual needs of the participant and consider any factors that lead to a return to use.

CONCLUSION

The sanctioning of temporary-event relapse is not medically sound and harms participants and their road to recovery. This Note argued that the current, vague statutory framework allows for the punishment of relapse even though the framework of Indiana drug courts is stressful to participants and can increase the likelihood of relapse. Because of this, Indiana drug courts must distinguish temporary-event relapses from return-to-use relapses. The proposed model administrative rule ensures protection for temporary-event relapses while also appropriately responding to return-to-use relapses. Because of the modern-day realization that relapse is a normal part of recovery, the Indiana Judicial Conference should adopt the proposed model rule.

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219. KY AP PART XIII § 12 (2023).
220. *Id.* at § 12(4) (2023).
221. *Id.*