Revised 3/30/2022

Hillsborough County Superior Court

Northern District

Drug Offender Program

Hillsborough Superior Court Northern District Adult Drug Court

Application, Requirements, and Instructions

DRUG COURT STRUCTURE

The Hillsborough Superior Court Northern District Drug Court will use a post-plea model. Individuals determined to be eligible for the program will plead guilty to their offense and **will be placed on probation for a minimum of 3 years.** As a condition of probation, individuals will be required to successfully complete the drug court program and any aftercare recommendations.

APPLICATION AND SCREENING PROCESS

Any defendant charged with a felony level offense can apply to enter into the Hillsborough County Superior Court Northern District Drug Court. An applicant shall complete the full admission application and sign all proper releases of information, so all agencies can communicate with one another. All applications should include discovery from all pending cases. The application submitted by a participant shall not be admissible in any court proceedings and shall be protected by the confidentiality policy of the Hillsborough County Superior Court Northern District Drug Court. The application should be submitted to the County Attorney team members, the Coordinator of the Drug Court, the Defense Attorneys, the Probation/Parole Officer, and the Clerk for the initial legal screen.

Upon application, a legal screening will be conducted by the prosecutor team member to determine if the individual can legally be supervised by the Drug Court. This screen will include review of the discovery from every pending case, input from the law enforcement team member as well as the probation team member, and a review of the offender's criminal record. The case will be transferred to the presiding Drug Court Judge once an application has been submitted.

The County Attorney drug court team members will conduct the legal screen. If approved on the legal screen, the participant will complete a clinical screen which will be scheduled by the coordinator and a risk assessment which will be completed and scheduled by the Probation/Parole Officer. If approved on both the clinical screen and legal screen, the Probation/Parole officer will complete a residence check to approve or disapprove of where the individual plans to live if accepted to drug court. The individual will be required to observe a drug court session before final acceptance. The Defense Attorney handling the case will communicate the day and time of the court observation to the individual. Drug Court takes place every Tuesday at the Superior Courthouse (300 Chestnut Street Manchester, NH) at 2:00PM. Plea & Sentencing hearing will not be scheduled until all of these steps (legal screen, clinical screen, risk assessment, residence check, and court observation) have been completed. The Clerk on the Drug Court team will schedule the Plea & Sentencing hearing once all of these steps have been completed.

If a defendant is denied at the legal screen, the state will complete the denial form and explain the reason for the denial.

If a defendant is denied at the legal screen because of the victim's position, because of the nature of the charged offense, because of the defendant's criminal record, or because the underlying prosecutor does not want the defendant in drug court, the case may move forward to a contested sentencing hearing, utilizing the procedure outlined below.

The underlying defense attorney will determine if the defendant wants to move forward with a contested sentencing hearing to request entry into drug court. The parties must either reach a capped plea agreement or the defendant must agree to enter a naked plea. If the defendant does not agree to

either a capped plea or a naked plea, no clinical or risk screen will take place and the defendant's sentence will not involve drug court.

If the defendant agrees to either a capped plea or a naked plea, the coordinator will schedule the clinical screen and risk screen. All parties will be notified of the result of the clinical screen and the risk screen.

If the defendant is approved by the clinical screen and risk screen, a contested sentencing hearing (either a capped plea or a naked plea) will occur in front of a drug court judge. The Hillsborough County North drug court judge will be the default judge for these hearings. However, another drug court judge can be utilized if scheduling or other issues arise.

The drug court judge will accept the defendant's plea and hear argument regarding sentencing. The drug court judge will then determine sentencing, including whether to allow the defendant to enter drug court.

TARGET POPULATION

The target population shall be individuals who are diagnosed as chemically dependent on one or more substances, and who have committed a crime or a combination of crimes (felony, misdemeanor, probation violation, parole violation) and who have not been diagnosed low risk or low need. The prospective participant:

1. Must be diagnosed as having a substance abuse disorder as defined by DSM V, moderate or severe.
2. Produce a validated risk assessment higher than low.
3. Must be at least 18 years of age.
4. Be a resident in the jurisdiction of the Drug Court.
5. May have a diagnosed mental health disorder, but if so must follow recommendations by a counselor.
6. Must have a felony charge to plead to

Participant Characteristics

Disqualifiers

1. Offenders with serious medical conditions outside the resources of the Drug Treatment Court.
2. Offenders with mental health issues that cannot be stabilized within the resources of the Drug Treatment Court.
3. Substance Abuser (Low Need).
4. Low Risk offenders.

5. Drug Profiteers.
6. Offenders may be disqualified for the following reasons: validated active gang member, sex offender, arson charge -> any of these flags will warrant additional review by the DC team and the offender may be denied based on these types of convictions.

Qualifiers

1. Adult offenders facing criminal charges that include a felony charge.
2. Offenders who have failed probation and or other treatment programs.
3. Offenders with unstable housing, peers, and lack of employment.
4. Offenders with a mental health condition that can be managed through medication and or counseling.

WAIT LIST MANAGEMENT POLICY

Referrals will undergo legal screens as quickly as feasible to determine legal eligibility for the program. If eligible under the legal screen, participants will undergo a risk assessment and substance use screening to determine whether they fit the high-risk, high-need criteria within 3 weeks. If an applicant is deemed ineligible by the Prosecuting Attorney, the Drug Court assigned Prosecutor shall complete a denial form and send it to the coordinator in a timely fashion.

If a referral does NOT show for a screening appointment, the Coordinator and the court will be notified. The Deputy Clerk may schedule a court hearing for the court to follow-up on repeated missed screenings. The referral will not be removed from the list automatically for failing to attend screening appointments.

New participants will plead in on average 3 times per month, based primarily on the **date of referral**. However, this is dependent upon completion of screenings. Other factors may also be considered such as whether the referred is incarcerated or in the community. Generally speaking, transfers requests of *active* participants from other Drug Courts will be prioritized.

In consultation with Treatment and Case Management, a reasonable schedule for pleading in new participants will be developed around times of anticipated vacancies.

CONTACT INFORMATION

Name/Position	Agency	Phone	Email
Dan Canniff Drug Court Coordinator	Elliot Hospital 140 Tarrytown Road Manchester, NH 03103	603-663-4431	DCanniff@Elliot-HS.org
Sarah Rothman Defense Attorney	NH Public Defenders 20 Merrimack Street	603-669-7888	srothman@nhpd.org

	Manchester, NH 03101		
Kyle Robidas Defense Attorney	NH Public Defenders 20 Merrimack Street Manchester, NH 03101	603-669-7888	krobidas@nhpd.org
Matt Cessna ACA	Hillsborough County Attorney's Office 300 Chestnut Street Manchester, NH 03101	603-627-5605	mcessna@hcnh.org
Sean Karkos ACA	Hillsborough County Attorney's Office 300 Chestnut Street Manchester, NH 03101	603-627-5605	skarkos@hcnh.org
Tim Miller PPO	Probation/Parole 60 Rogers Street Manchester, NH 03103	603-656-6683	Timothy.Miller@doc.nh.gov
Mike Scanlon Clerk	Hillsborough Superior Court – North 300 Chestnut Street Manchester, NH 03101	1-855-212-1234	MScanlon@courts.state.nh.us

CHECKLIST

- Determine if client is potentially appropriate for drug court
- Determine if Hillsborough North Drug Court is the correct program based on the address your client plans to reside at upon entering drug court
- Have client review handbook and complete application
- Send completed application to

  Sean Karkos - skarkos@hcnh.org

  Matt Cessna - mcessna@hcnh.org

  Dan Canniff - DCanniff@Elliot-HS.org

  Prosecutor handling the case

  Sarah Rothman – srothman@nhpd.org

  Kyle Robidas – krobidas@nhpd.org

  Mike Scanlon - MScanlon@courts.state.nh.us

  PPO Tim Miller – Timothy.J.Miller@doc.nh.gov

- If client has charges in other counties, they should be transferred to Hillsborough North Superior Court prior to the Plea & Sentencing hearing. This can be coordinated through the Clerk on the Drug Court team.

Hillsborough County North Drug Treatment Court (Manchester)
ADMISSION APPLICATION

Docket # _____

Name: _____ Age: _____DOB: _____ Race: _____Hispanic: ____

Address: _____Town: _____ ZIP_____

Home Phone: _____Work Phone: _____ Cell Phone: _____

Email Address: _____

Emergency Contact: _____Relation:_____Phone:_____

Social Security Number: _____/_____/_____ Are you a US citizen? _____

Currently incarcerated: Y or N If yes, facility name:_____

Family and relationships:

Please name and give the relationships of supportive people in your life right now:

_____

_____

Marital Status: _____ Spouse Name/Significant other: _____

Do you have children: Y or N (circle one) If yes, how many: _____

Please list name and ages: _____

_____

Living:

Address where you plan to live upon entering drug court:

_____

Name and phone number of landlord or person living at the residence to be contacted by probation to verify address:

_____

Time at current residence? _____

Name, age and relationship of persons living with you: _____

_____

Charge information:

Current charge you are facing: _____

Arrest date(s): _____ Arraignment Date(s): _____

Are you facing a probation or parole violation? Y or N

Next court date that you are aware of: _____ Location: _____

Attorney's name: _____ Prosecutor's name: _____

Do you have charges pending in another court/county Y or N

Please list:

_____

_____

I certify that the above information is correct to the best of my knowledge.

*I also understand that as part of my Drug Court application and admission procedure that there will be discussions between Drug Court team staff including but not limited to; Probation/Parole Officer, Judge, Prosecutor, Clerk, Treatment Providers, and Defense Attorney. I grant permission for these discussions to take place to assist in determining my eligibility for Drug Court.

However, I understand that if I am not accepted into the Hillsborough County North Drug Treatment Court Program, the information above will not be further disclosed and will not be used by the prosecutor or anyone else once my case is transferred back to the regular court docket.

_____ _____

Client signature Date

_____ _____

Attorney signature Date

Conclusion

This handbook outlines the basic principles, protocols and procedures of the Hillsborough County North Drug Court Program. Should you have any questions along the way, please be sure to ask the appropriate Team Member. We want you to be successful during this program and far beyond your time with us. We recognize that it won't be easy, but we feel *you are well worth it!*

In support of your recovery and growth,
The Hillsborough County North Drug Court Team

Acknowledgment

By signing this I acknowledge and agree to follow the rules contained in the Drug Court Handbook.

If I have any questions I will contact my case manager.

_____ _____
Signature Date

_____ _____
Attorney Date

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(Copy)
By signing this I acknowledge and agree to follow the rules contained in the Drug Court Handbook.
If I have any questions I will contact my case manager

_____ _____
Signature Date

_____ _____
Attorney Date

Consent to Release Substance Use Disorder Information

REMEMBER: Information disclosed pursuant to patient consent must be accompanied by the notice prohibiting re-disclosure

PATIENT IDENTIFICATION:

I_____, born on _____hereby authorize _____EHS Substance Use Disorder Department – Drug Court

(name of individual or entity/program)

To disclose the following information**:**

The extent of information to be disclosed is my diagnosis, information about my treatment attendance, results of all of my urinalysis tests, treatment recommendations, Emergency Room visits – including date, time, reason for visit, and results of the visit, treatment progress and barriers to progress, and medication checks.

To the following members of the Hillsborough County- North Drug Court and Hillsborough County- North Drug Court Team Members outlined below.

(name of recipient entity, which does not have a treating provider relationship with the patient)

Hillsborough County Superior Court – North, NH Public Defenders – Manchester Office, Hillsborough County Attorney's Office – Northern District, NH DOC – Probation & Parole – Manchester Office, Manchester Police Department, Hillsborough County Department of Corrections, Manchester Fire Department, NH Judicial Branch – NH Office of Drug Offender Program

(names of individuals from the entity listed above.)

PURPOSE of the disclosure is: Legal Matter

I UNDERSTAND THAT:

My substance use disorder treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

I know that this authorization is voluntary, and I may refuse to sign this form. I understand that refusing to sign this form will not affect my ability to obtain treatment from Elliot Health System, the payment for my treatment, or my enrollment or eligibility for benefits unless allowed by law. I understand that I may revoke this authorization at any time verbally or in writing, except to the extent that action has been taken in reliance on it. Upon request, I am entitled to a list of entities and/or individuals that have received information under this authorization for the past two years as of the date the request is made.

EXPIRATION DATE:

I have read this entire form or have had it read to me. I understand the authorization and herby authorize the release of my patient information stated above. Unless I verbally revoke my authorization earlier, this authorization expires automatically on: _____ or ____upon my death_____.

Fax Release Notice: I am aware and understand the risks to confidentiality involved in transmission of my substance use disorder information by e-mail and fax and I agree to assume those risks.

_____ _____

Patient/Parent/Legal Representative Signature Date

_____

Identification (if other than patient)

Date Consent Revoked: _____

Providers Initials: _____

Consent to Release Substance Use Disorder Information

REMEMBER: Information disclosed pursuant to patient consent must be accompanied by the notice prohibiting re-disclosure

PATIENT IDENTIFICATION:

I _____, born on _____ hereby authorize _____EHS Substance Use Disorder Department – Drug Court
(name of individual or entity/program)

PATIENT INFORMATION TO BE RELEASED:

to disclose the following information: ***All of my substance use disorder information*** or the following selected information:

☒ Intake, progress and discharge reports and notes ☒ Medications ☒ Referrals for treatment

☒ Evaluations and assessments by my providers ☒ Case management notes ☒ Treatment plans

☒ Urine toxicology tests and results ☐ Other (specify)

_____

AUTHORIZATION TO:

To All of my past, present and future treating providers at SolutionHealth and SolutionHealth covered entities and their affiliates

AND_____

(Name of Health Insurance and/or other entities)

PURPOSE of the disclosure is:

☒ Treatment/Continuity of Care ☒Healthcare Payment ☐Other:_____

I UNDERSTAND THAT:

My substance use disorder treatment records are protected under the federal regulations governing Confidentiality of Alcohol and Drug Abuse Patient Records (42 CFR Part 2) and the Health Insurance Portability and Accountability Act of 1996 (HIPAA), 45 C.F.R. pts. 160 & 164 and cannot be disclosed without my written consent unless otherwise provided for by the regulations.

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_____ _____

Patient/Parent/Legal Representative Signature Date

_____

Identification (if other than patient)

Date Consent Revoked: _____

Providers Initials: _____

SOLUTIONHEALTH

NOTICE OF PRIVACY PRACTICES FOR PART 2 PROGRAMS

As a patient receiving substance use disorder prevention and treatment services by our Substance Use Disorder Treatment staff at SolutionHealth or an affiliated provider, your treatment records have additional privacy protections under federal law. Private information regarding your health and substance use disorder care is protected by two federal laws including HIPAA and what we refer to as "Part 2." The full description of these laws is: the Health Insurance Portability and Accountability Act of 1996 ("HIPAA"), 42 U.S.C. § 1320d *et. seq.*, 45 C.F.R. Parts 160 & 164, and the Confidentiality Law, 42 U.S.C. § 290dd, 42 C.F.R. Part 2 ("Part 2"). Specifically, Part 2 includes confidentiality provisions relating to the access, use, and disclosure of substance use disorder patient records. These protections go above and beyond the protections described in our SolutionHealth Notice of Privacy Practices.

Under Part 2, you must give written consent before information identifying you as a patient who needs or is receiving substance use disorder prevention and treatment is disclosed, including to entities or individuals who are paying your insurance claims. We ask you to help us care for you and support your treatment goals by providing a written consent that allows your providers to receive from and disclose to other treating providers your identity and information in order to provide you the care you need, to obtain payment for care and treatment, and to allow for communication with other professionals, friends and advocates involved in your treatment or recovery.

Under federal law, we may disclose information about your care and treatment for substance use disorder services *without* your written consent for the following reasons:

1) The disclosure is allowed by court order;
2) The disclosure is made to medical personnel in a medical emergency;
3) The disclosure is made to appropriate authorities to report suspected child abuse or neglect;
4) The disclosure is made to a qualified service organization/business associate;
5) The disclosure is made to qualified personnel for research, audit or program evaluation; or
6) The disclosure is made in connection with a suspected crime committed on the premises or a crime against any person who works for us or about any threat to commit such a crime.

For example, the SolutionHealth or an affiliated provider can disclose information *without your consent* in order to provide services in a medical emergency to ensure your emergency is treated effectively.

Violation of Part 2 is a crime and suspected violations may be reported to the following:

SolutionHealth Compliance and Privacy Department

Elliot Health System ATTN: Compliance and Privacy Officer 4 Elliot Way, Suite 303 Manchester, NH 03103 Email: Compliance@Elliot-hs.org Phone: (603) 663-2932 Compliance Hotline: (844) 390-9807	**Southern New Hampshire Health** ATTN: Compliance and Privacy Officer 8 Prospect Street Nashua, NH 03060 Email: Compliance@snhhs.org Phone: (603) 281-9857 Compliance Hotline: (888) 414-2743
SolutionHealth Email: Compliance@SolutionHealth.org	

SOLUTIONHEALTH

The New Hampshire Attorney General's Office
United States Attorney's Office
53 Pleasant Street, 4th Floor
Concord, NH 03301
(603) 225-1552

Substance Abuse and Mental Health Services Administration (SAMSHA)
New Hampshire Department of Health and Human Services
(603) 271-5889

Acknowledgement of Receipt of SolutionHealth's Notice of Privacy Practices for Part 2 Programs

I acknowledge that I have received and reviewed SolutionHealth's Notice of Privacy Practices for Substance Use Patients, which includes particular information relating to the disclosure and use of information relating to substance use treatment (entitled Notice of Privacy Practice for Substance Use Patients).

_____
Patient or Authorized Representative Name

_____ _____
Patient or Authorized Representative Signature Date

If Authorized Representative, please check applicable relationship:

❑ Court appointed guardian ❑ Health Care Power of Attorney Agent
❑ Parent of a minor child