Written Statement for U.S. Sentencing Commission
For Hearing on March 15, 2017
Shannon Carey, Ph.D.

Drug Court Program Design and Eligibility Criteria

Drug courts are designed to guide defendants identified as drug- or alcohol-addicted into treatment that will reduce substance dependence and improve the quality of life for the defendants and their families. Benefits to society take the form of reductions in crime, decreased use of emergency health care services, decreased child welfare involvement, and increased employment, resulting in reduced costs to taxpayers and increased public safety.

In the typical drug court program, participants are closely supervised by a judge who is supported by a team of agency representatives operating both within and outside of their traditional roles. The team typically includes a drug court coordinator, case managers, substance abuse treatment providers, prosecuting attorneys, defense attorneys, law enforcement officers, and probation officers who work together to provide needed services to drug court participants. Prosecuting and defense attorneys modify their traditional adversarial roles to collaborate in support of the treatment and supervision needs of program participants. Drug courts blend the resources, expertise and interests of a variety of jurisdictions and agencies.

Drug courts are complex programs designed to deal with some of the most challenging problems that communities face. These courts bring together multiple and traditionally adversarial roles plus stakeholders from different agencies and systems with different training, professional language, and approaches. They take on groups of clients that have serious substance abuse treatment needs. Adults with substance abuse issues involved in the criminal justice system must be seen within an ecological context; that is, within the environment that has contributed to their attitudes and behaviors. This environment includes their neighborhoods, families, friends, and formal or informal economies through which they support themselves. The drug court must understand the various social, economic, mental health and cultural factors that affect their participants.

Drug courts have been shown to be effective in reducing criminal recidivism (GAO, 2005), improving the psycho-social functioning of participants (Kralstein, 2010), and reducing taxpayer costs due to positive outcomes for drug court participants (including fewer re-arrests, less time in jail and less time in prison) (Kissick, Waller & Carey 2013; Carey & Waller, 2011; Carey, Finigan, Waller, Lucas, & Crumpton, 2005). Some drug courts have been shown to cost less to operate than processing defendants through business-as-usual in the court system (Carey & Finigan, 2004; Carey et al., 2005). Multiple meta-analyses have also shown that drug courts

consistently show positive outcomes for their participants, particularly when they engage in known, research-based best practices.

The **eligibility criteria** for drug court participation in any particular jurisdiction should be based on an assessment of the criminal justice population in that jurisdiction to help focus the program on the specific needs the program intends to address. For example, if there are large numbers of defendants with property crimes that are fueled by their drug use, then it would be appropriate for a program to specifically target property crimes as eligible charges.

In addition, drug court programs have the biggest impact on individuals who are high risk (i.e., they are likely to fail on traditional probation and likely to continue to commit new crimes) and high need (specifically, they are diagnosed with moderate to severe substance use disorder). However, drug courts can also have substantial impacts on individuals that are high-risk/low-need and low risk/high need. (Low-risk/low-need individuals should not go to a drug court programs and should be redirected out of the criminal justice system as quickly as possible.) It is recommended that drug court programs either focus on high-risk/high-need participants, or that they create separate tracks in their program to treat the unique risk and need levels of each of their participants.

Absolutely key in the eligibility process is the use of **standardized risk and need assessment** instruments that are validated for the specific population of participants. Risk assessments and clinical needs assessments are also crucial in determining the appropriate level of supervision as well as the appropriate type and level of substance abuse and other treatment provided by the drug court program for each participant. Individuals who receive less treatment than they need get worse. Individuals who get more treatment than they need also get worse.

Please see NADCP's Adult Best Practice Standards Volume I, Standard I (2013) for more information on drug court participants and eligibility criteria.

Drug Court Evaluation

Evaluation of drug courts can include process, outcome and cost evaluation. A **process evaluation** considers a program's policies and procedures and examines whether the program is meeting its goals and objectives. Process evaluations generally determine whether programs have been implemented as intended and are delivering planned services to target populations. To do this the evaluator must have criteria or standards to apply to the program being studied. In the case of drug treatment courts, some nationally recognized guidelines have been established and used to assess drug court program processes. Standards have been established by the National Association of Drug Court Professionals through a thorough review of the extant research on drug courts. Two volumes of the Adult Best Practice Standards were published in 2013 and 2015. In addition, there is a seminal article on the fundamental model defining drug courts called the "10 Key Components of Drug Courts" (NADCP, 1997). Good process evaluation should provide useful information about program functioning related to

known best practices in ways that can contribute to program improvement. The main benefit of a process evaluation is improving program practices with the intention of increasing program effectiveness for its participants. Program improvement leads to better outcomes and impacts and in turn, increased cost-effectiveness and cost-savings.

The purpose of an **outcome evaluation** is to determine whether the program has improved participant outcomes. In other words, did the program achieve its intended goals for its participants? An outcome evaluation can examine short-term outcomes that occur while a participant is still in the program. For drug courts, this includes whether the program is delivering the intended amount of services, whether participants are receiving the right services, whether participants are successfully completing the program in the intended amount of time, whether drug use is reduced and what factors lead to participants successfully completing the program. An outcome evaluation can also measure longer term outcomes (sometimes called an "impact evaluation") including participant outcomes after program completion. In the case of drug court programs, one of the main impacts of interest is recidivism. Are program participants avoiding the criminal justice system "revolving door?" How often are participants being re-arrested, and spending time on probation and in jail? Does participation in the program result in reduced criminal justice recidivism? Other outcomes of interest include reduced emergency room visits, reduced involvement in child welfare, increased likelihood of employment and paying taxes and increased education.

In order to determine whether a drug court program is effective in reducing recidivism and having other positive outcomes it is necessary to have a **comparison group**. The question is, "Is recidivism reduced compared to what?" To answer this question, it is necessary to compare the program to a condition with no program. This is accomplished through developing a comparison group of individuals who did not participate in the program but are otherwise as similar as possible to those who did participate. There are many strategies for gaining this type of comparison group and there are benefits and drawbacks to each.

The "gold standard" for a comparison group in research is a randomized design where individuals who are eligible for the program are randomly assigned to either participate or receive the traditional court process. However, this is generally not practical in drug court research for several reasons. Two main reasons are that: (1) It requires the agreement of the drug court Judge and the team to randomly assign eligible individuals who they believe would benefit from the program to NOT receive drug court services; and (2) It requires a very long study period since after individuals are assigned to the drug court or traditional court, we must wait for the participants to go through the course of the program and then allow further time for outcomes AFTER program participation.

Other, non-random, study designs are called "quasi-experimental." These strategies can include a quite rigorous research design while still being practical for the program under study. One strategy is to use a group of individuals who were found eligible for drug court but who chose not to participate. This has the benefit of ensuring that the comparison group is equivalent to

the drug court participants, at least in terms of criminal history and other possible eligibility requirements, but is commonly criticized for the possibility that those individuals who choose against drug court are not as motivated to change their lives and stop using drugs.

A second strategy involves identifying eligible individuals who were never offered the program for various reasons, such as issues with the ability of the referring agencies to find and refer all eligible individuals, capacity issues, or because the program was not yet implemented. In our previous research in multiple drug courts we have found that eligible individuals have "slipped through the cracks." The most ideal comparison group is similar clients who cannot be served by the drug court because the court has reached its capacity for enrollment. Another possible comparison group are those individuals who would have been eligible for program but whose "eligible," or recent, charge happened prior to program implementation and therefore could not be offered the program. For the most part, both these options have the benefit of avoiding the issue of motivational differences, although the latter is subject to potential "historical" differences in the community context (e.g., policy changes, variability in treatment resources, etc., that might change over time regardless of the program). Selecting these comparison groups generally involves obtaining a list of people with the same charges as program-eligible participants and then examining certain key characteristics of each possible comparison group member to determine whether he or she fits the program's eligibility criteria. However, the one unavoidable drawback to this approach is if the program eligibility criteria include a measurement of addiction severity and/or mental health issues, it is nearly impossible to be certain that the group is truly equivalent, since this measurement is not generally done for people as a part of the traditional court process. However, we have found in our prior research that the vast majority of the time drug court staff very rarely exclude participants who have been referred and are legally eligible for their programs. Therefore, identifying eligible individuals who were never offered the program is generally the most valid as well as practical approach to gaining a comparison group.

Once the comparison group is identified then propensity score matching or weighting can be performed to "match" the drug court participant group and the comparison group. The use of propensity scores is a statistical method that mimics random assignment and can be used to match the groups on as many background characteristics as possible (e.g., age, gender, race/ethnicity, risk level, substance use issues, marital status, criminal history). It is crucial that the drug court participant group and the comparison group match as closely as possible to increase the certainty that any differences in outcomes for the two groups can be attributed to participation in the drug court rather than some other existing difference. For example, research has shown that older individuals are less likely to engage in new crime than younger individuals so if the drug court participant group was older than the comparison group, any reduction in recidivism could be due to the age of the participants rather than due to the drug court.

Finally, to conduct an outcome evaluation it is important to have **sufficient numbers** of participants to perform valid statistical analysis. With larger programs (e.g., those that take at least 50 participants per year) this is not a concern. However, some drug court programs are quite small. In these instances it might be necessary to wait for several years until enough

participants have been through the program to increase the sample size. Alternatively, small programs can at the very least participate in a process evaluation to ensure that they are engaging in known best practices that will result in positive outcomes for their participants.

As mentioned earlier, there are three main types of evaluation, process, outcome and cost. In **cost evaluation** there is an important distinction between the meaning of the term "cost-effective" and the term "cost-benefit." A *cost-effectiveness* analysis calculates the cost of a program and then examines whether the program led to its intended positive outcomes. For example, a cost-effectiveness analysis of drug courts would determine the investment cost of the drug court program and then look at whether the number of re-arrests were reduced by the amount the program intended (e.g., a 50% reduction in re-arrests compared to those who did not participate in the program).

A *cost-benefit* evaluation calculates the cost of the program and also the cost of the outcomes, resulting in a cost-benefit ratio. For example, the cost of the program is compared to the cost-savings due to the reduction in re-arrests. In some drug court programs, for every dollar spent on the program, over $10 is saved due to positive outcomes.[1] A *cost-benefit* analysis provides a greater detail of cost information

A cost-benefit evaluation is designed to address the following study questions:

1. How much does the program cost?
2. What is the cost impact on the criminal justice system of sending offenders through drug court compared to traditional court processing?
3. What is the cost impact on the criminal justice system (or other systems of interest such as health care and child welfare) of participation in drug court compared to the impact without drug court?
4. Is there a cost benefit in terms of monetary or resource savings due to participation in the program?

A cost-benefit methodology developed specifically for drug courts is called is called Transactional and Institutional Cost Analysis (TICA). The TICA approach views an individual's interaction with publicly funded agencies as a set of transactions in which the individual utilizes resources contributed from multiple agencies. Transactions are those points within a system where resources are consumed and/or change hands. In the case of drug courts, when a drug court participant appears in court or has a drug test, resources such as judge time, defense attorney time, court facilities, and urine sample cups are used. Court appearances and drug tests are transactions. In addition, the TICA approach recognizes that these transactions take place within multiple organizations and institutions that work together to create the program of interest. These organizations and institutions contribute to the cost of each transaction that

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[1] See drug court cost-benefit studies at http://www.npcresearch.com/projects_drug_courts.php

occurs for program participants. TICA is an intuitively appropriate approach to conducting costs assessment in an environment such as a drug court, which involves complex interactions among multiple taxpayer-funded organizations.

In order to maximize a cost evaluation's benefit to policymakers, a "cost-to-taxpayer" approach is used. This focus helps define which cost data should be collected (costs and avoided costs involving public funds) and which cost data should be omitted from the analyses (e.g., costs to the individual participating in the program).

The central core of the cost-to-taxpayer approach in calculating benefits (avoided costs) for drug courts specifically is the fact that untreated substance abuse will cost tax dollar-funded systems money that could be avoided or diminished if substance abuse were treated. In this approach, any cost that is the result of untreated substance abuse and that directly impacts a citizen (through tax-related expenditures) is used in calculating the benefits of substance abuse treatment.

The TICA cost approach looks at publicly funded costs as "opportunity resources." The concept of opportunity cost from the economic literature suggests that system resources are available to be used in other contexts if they are not spent on a particular transaction. The term opportunity resource describes these resources that are now available for different use. For example, if substance abuse treatment reduces the number of times that a client is subsequently incarcerated, the local sheriff may see no change in his or her budget, but an opportunity resource will be available to the sheriff in the form of a jail bed that can now be filled by another person, who, perhaps, possesses a more serious criminal justice record than does the individual who has received treatment and successfully avoided subsequent incarceration. Therefore, any "cost savings" reported in this type of cost evaluation may not be in the form of actual monetary amounts, but may be available in the form of a resource (such as a jail bed, or a police officer's time) that is available for other uses.

A cost evaluation involves calculating the costs of the program and the costs of outcomes (or impacts) after program entry (or the equivalent for the comparison group). To determine if there are any benefits (or avoided costs) due to program participation, it is necessary to determine what the participants' outcome costs would have been had they not participated in the drug court. One of the best ways to do this is to compare the costs of outcomes for drug court participants to the outcome costs for similar individuals who were eligible for the drug court but did not participate.

There are six key steps in the TICA methodology. Step 1 is to determine the program process through process evaluation; Step 2 is to identify the program transactions such as court hearings, various types of services, drug tests and case management; Step 3 is to identify the agencies involved with each transaction; Step 4 is to determine the resources used (such as staff time and materials) by each agency in performing each transaction; Step 5 is to determine

the cost of the resources (e.g., staff salaries, the cost of urine cups for drug testing); and Step 6 is to calculate the cost results which involves calculating the cost of each transaction and multiplying this cost by the number of transactions. For example, to calculate the cost of drug testing the unit cost per drug test is multiplied by the average number of drug tests per person. All the transactional costs for each individual are added to determine the overall cost per drug court participant/comparison group individual. This is reported as an average cost per person for the program, and outcome/impact costs due to re-arrests, jail time and other recidivism costs, as well as any other service usage, such as substance abuse treatment. Cost data is divided into program costs and outcome costs. The program costs, calculated only for those in drug court, are those associated with activities performed within the program such as court hearings, case management, drug tests, substance abuse treatment, and any other unique services provided by the program to participants. The outcome costs, calculated for both drug court and comparison groups, include criminal justice involvement (e.g., new arrests, subsequent court cases, jail/prison days, probation/parole days), treatment events that were not specifically a part of the drug court program, as well as other events that occur such as victimizations or emergency room visits. Finally, the outcome costs for the drug court group are subtracted from the cost of the comparison group, the resulting difference shows either the savings (if the drug court group costs less than the comparison) or the loss (if the drug court group costs more.

For more information on drug court evaluation, please see NADCP's best practice Standards Volume II Standard X.

Research Based Best Practices of Drug Court

The standards developed by NADCP combine the vast majority of existing good quality drug court research into some clear best practices (see attached documents – Volume I and II of the Adult Best Practice Standards). In addition, studies conducted by a private research and evaluation firm called NPC Research examined differences in practice across 100 different drug courts and determined over 50 best practices that were correlated with reduced recidivism and reduced cost (i.e., cost savings) in drug court programs (see two documents attached – the article describing the best practice research and a table listing the majority of known best practices).

The judge's role is key in the drug court process. Indeed, if no judge is presiding over a drug court program, then by definition, it cannot be considered a "drug court." Best practice research has shown that when judges preside over a drug court program for longer periods, participant recidivism decreases. Indeed, more than one study has shown that when a new judge takes the bench in a drug court program, participant recidivism increases significantly, and then recidivism decreases in the second year, as the judge learns the myriad amount of information to effectively run a drug court program. For this reason, best practice is that judges should be assigned to the a drug court for at least two years if not indefinitely. There is a steep

learning curve for new drug court team members, including the judge. To effectively participate in these program the judge and other team members need to understand addiction and the impact it has on individuals' brains. They need to understand behavior modification as the main purpose of a drug court program is to change participant behavior away from drug use and criminal activities to behaving as a law abiding, contributing citizen. The judge needs to learn about drug testing, substance abuse treatment, social services available in the community and motivational interviewing. Best practice research shows that when drug court team members receive training in all these areas, participant recidivism decreases and taxpayer savings increase.

Best practices also show that participant outcomes are significantly better when judges spend at least three minutes talking with each participant in court hearings, when the judge sees the participant in court at least once every two weeks, and when the judge chooses to sit on the drug court bench voluntarily rather than being assigned the role.

Research on Federal Problem Solving Courts

There have been a small number of research or evaluation studies in federal problem solving courts in both "front-end" drug courts (where participant go directly into the drug court without being incarcerated) and reentry courts (where participants are released from federal prison into the program).

Two outcome studies have been completed in the last few years:

1. A 2014 study of the federal drug court in the Eastern District of N.Y. about federal problem-solving courts: https://img.nyed.uscourts.gov/files/local_rules/EDNY-TWOYEARREPORT-ATI_Programs_April-2014.pdf and;
2. A 2016 study by the Federal Judicial Center (Rauma, 2016) of federal reentry courts in various districts.

Both studies found little impact of the programs on participant outcomes. Unfortunately, both studies were also poorly designed and there was little evidence that the programs involved were following known research based best practices and therefore, these studies cannot be used to make any definitive decisions around whether problem-solving courts (when properly implemented) can be effective in the federal system.

There are two studies currently underway on federal problem-solving courts, both scheduled to be completed before the end of 2017 and both being conducted by NPC Research. One is an outcome study of two reentry courts in the District of Oregon, one of which is following best practices for drug courts (i.e., adhering to the drug court model) and one that is using other reentry practices but not following many drug court specific best practices. This study should provide some evidence for whether the use of the drug court model in reentry courts in the federal system is effective. The second study is an outcome and cost study of a "front end" drug court in the District of Columbia operated by Pre-Trial Services (so participants are referred to and enter the program before conviction). This program was operating for several years

without adhering to the drug court model and following best practices. In more recent years the program implemented many of the drug court best practices and is now adhering fairly well to the drug court model. This study will examine participant outcomes both before and after the program implemented best practices. This study should provide some information on whether "front end" drug courts are effective in the federal system as an alternative to incarceration, and whether adherence to the model is important for positive outcomes to occur.

Adult Drug Court Best Practice Standards

Volume I

National Association of Drug Court Professionals
Alexandria, Virginia

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THE NATIONAL ASSOCIATION OF DRUG COURT PROFESSIONALS

It takes innovation, teamwork, and strong judicial leadership to achieve success when addressing drug-using offenders in a community. That's why since 1994 the National Association of Drug Court Professionals (NADCP) has worked tirelessly at the national, state, and local levels to create and enhance Drug Courts, which use a combination of accountability and treatment to support and compel drug-using offenders to change their lives.

Now an international movement, Drug Courts are the shining example of what works in the justice system. Today, there are over 2,700 Drug Courts operating in the U.S., and another thirteen countries have implemented the model. Drug Courts are widely applied to adult criminal cases, juvenile delinquency and truancy cases, and family court cases involving parents at risk of losing custody of their children due to substance abuse.

Drug Court improves communities by successfully getting offenders clean and sober and stopping drug-related crime, reuniting broken families, intervening with juveniles before they embark on a debilitating life of addiction and crime, and reducing impaired driving.

In the 24 years since the first Drug Court was founded in Miami/Dade County, Florida, more research has been published on the effects of Drug Court than on virtually all other criminal justice programs combined. The scientific community has put Drug Courts under a microscope and concluded that Drug Courts significantly reduce drug abuse and crime and do so at far less expense than any other justice strategy.

Such success has empowered NADCP to champion new generations of the Drug Court model. These include Veterans Treatment Courts, Reentry Courts, and Mental Health Courts, among others. Veterans Treatment Courts, for example, link critical services and provide the structure needed for veterans who are involved in the justice system due to substance or mental illness to resume life after combat. Reentry Courts assist individuals leaving our nation's jails and prisons to succeed on probation or parole and avoid a recurrence of drug abuse and crime. And Mental Health Courts monitor those with mental illness who find their way into the justice system, many times only because of their illness.

Today, the award-winning NADCP is the premier national membership, training, and advocacy organization for the Drug Court model, representing over 27,000 multidisciplinary justice professionals and community leaders. NADCP hosts the largest annual training conference on drugs and crime in the nation and provides 130 training and technical assistance events each year through its professional service branches, the National Drug Court Institute, the National Center for DWI Courts, and Justice for Vets: The National Veterans Treatment Court Clearinghouse. NADCP publishes numerous scholastic and practitioner publications critical to the growth and fidelity of the Drug Court model and works tirelessly in the media, on Capitol Hill, and in state legislatures to improve the response of the American justice system to substance-abusing and mentally ill offenders through policy, legislation, and appropriations.

Acknowledgements

The ***Adult Drug Court Best Practice Standards*** has been a tremendous undertaking, which would have been impossible but for the dedication and contributions of so many. This project has been continuing for more than two years, and the five standards included in Volume I are the result of countless hours of effort.

First, I thank the committee of volunteer practitioners, researchers, and subject-matter experts who gave of their time and expertise to develop the topics and materials contained in these standards. Second, I thank the peer reviewers who provided valuable feedback on each of the standards. Finally, I thank the NADCP Board of Directors for their leadership and vision in supporting this tremendous endeavor. I reserve special thanks to Dr. Douglas Marlowe, whose unwavering passion and diligence went into each word, line, and sentence of this document.

As we approach a quarter century of Drug Courts, my firm belief is these standards will move our field to an even higher level of professionalism and success. I know this document will be utilized for years to come and improve the life-saving work done every day by Drug Court practitioners across the nation.

C. West Huddleston,
Chief Executive Officer
National Association of Drug Court Professionals

Adult Drug Court Best Practice Standards

Introduction 1

I Target Population 5

Eligibility and exclusion criteria for the Drug Court are predicated on empirical evidence indicating which types of offenders can be treated safely and effectively in Drug Courts. Candidates are evaluated for admission to the Drug Court using evidence-based assessment tools and procedures.

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Citizens who have historically experienced sustained discrimination or reduced social opportunities because of their race, ethnicity, gender, sexual orientation, sexual identity, physical or mental disability, religion, or socioeconomic status receive the same opportunities as other citizens to participate and succeed in the Drug Court.

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The Drug Court judge stays abreast of current law and research on best practices in Drug Courts, participates regularly in team meetings, interacts frequently and respectfully with participants, and gives due consideration to the input of other team members.

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Consequences for participants' behavior are predictable, fair, consistent, and administered in accordance with evidence-based principles of effective behavior modification.

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Participants receive substance abuse treatment based on a standardized assessment of their treatment needs. Substance abuse treatment is not provided to reward desired behaviors, punish infractions, or serve other nonclinically indicated goals. Treatment providers are trained and supervised to deliver a continuum of evidence-based interventions that are documented in treatment manuals.

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Adult Drug Court
Best Practice Standards

Introduction

This expansion of drug courts throughout the country makes it critical to ensure that the standards for drug court implementation and operations are effectively disseminated to the field. With funding and technical assistance provided through [NADCP's] National Drug Court Institute, the Administration supports the dissemination of these standards and related training for new and existing drug courts…

—White House, Office of National Drug Control Policy (2012; p. 20)

In 1996, a small group of Drug Court professionals convened to describe the key ingredients of the Drug Court model. Published early the following year, *Defining Drug Courts: The Key Components* (NADCP, 1997) [hereafter the *Ten Key Components*] became the core framework not only for Drug Courts but for most types of problem-solving court programs.

At the time, these farsighted practitioners had little more to go on than their instincts, personal observations, and professional experiences. The research literature was still equivocal about whether Drug Courts worked and was virtually silent on the questions of how they worked, for whom, and why. Now more than fifteen years since the *Ten Key Components* was published, science has caught up with professional wisdom. Research confirms that how well Drug Courts accomplish their goals depends largely on how faithfully they adhere to the *Ten Key Components*. Drug Courts that watered down or dropped core ingredients of the model paid dearly for their actions in terms of lower graduation rates, higher criminal recidivism, and lower cost savings. Failing to apply the *Ten Key Components* has been shown to reduce the effectiveness and cost-effectiveness of Drug Courts by as much as one half (Carey et al., 2012; Downey & Roman, 2010; Gutierrez & Bourgon, 2012; Shaffer, 2010; Zweig et al., 2012).

From Principles to Standards

Science has accomplished considerably more than simply validating the *Ten Key Components*. It is putting meat on the bones of these broad principles, in effect transforming them into practice standards (Marlowe, 2010). Armed with specific guidance about how to operationalize the *Ten Key Components*, Drug Courts can be more confident in the quality of their operations, researchers can measure program quality in their evaluations, and trainers can identify areas needing further improvement and technical assistance.

Until Drug Courts define appropriate standards of practice, they will be held accountable, fairly or unfairly, for the worst practices in the field. Scientists will continue to analyze the effects of weak Drug Courts alongside those of exceptional Drug Courts, thus diluting the benefits of Drug Courts. Critics will continue to tarnish the reputation of Drug Courts by attributing to them the most noxious practices of the feeblest programs. Only by defining the bounds of acceptable and exceptional practices will Drug Courts be in a position to disown poor-quality or harmful programs and set effective benchmarks for new and existing programs to achieve.

Procedures

A little more than two years ago, the NADCP embarked on an ambitious project to develop these *Adult Drug Court Best Practice Standards*. The standards were drafted by a diverse and multidisciplinary committee comprising Drug Court practitioners, subject matter experts, researchers, and state and federal policymakers. Each draft standard was peer reviewed subsequently by between thirty and forty practitioners and researchers with expertise in the relevant subject matter. The peer reviewers rated the standards anonymously along the dimensions of clarity (what specific practices were required), justification (why those practices were required), and feasibility (how difficult it would be for Drug Courts to accomplish the practices). All of the standards received ratings from good to excellent and were viewed as being achievable by most Drug Courts within a reasonable period of time.

None of the requirements contained in these standards should come as a surprise to Drug Court professionals who have attended a training workshop or conference within the past five years. The research supporting the standards has been disseminated widely to the Drug Court field via conference presentations, webinars, practitioner fact sheets, and NDCI's scholarly journal, the *Drug Court Review* (Marlowe, 2012). This document is simply the first to compile and distill that research into concrete and measurable practice recommendations.

Scope

The standards contained herein do not address every practice performed in a Drug Court. Unless there was reliable and convincing evidence demonstrating that a practice significantly improves outcomes, it was not incorporated into a best practice standard. This should, in no way, be interpreted as suggesting that omitted practices were viewed as unimportant or as less important than the practices that were included. Practices were omitted simply because the current state of the research was insufficient for the Committee to impose an affirmative obligation on the field to alter its operations. New practices will be added to the standards as additional studies are completed.

These standards were developed specifically for adult Drug Courts. This is not to suggest that adult Drug Courts are more effective or valued than other types of Drug Courts, such as juvenile Drug Courts, DWI courts, family Drug Courts, or veterans treatment courts. Adult Drug Courts simply have far more research on them than other types of problem-solving courts. When a sufficient body of research has identified best practices for other problem-solving court programs, NADCP will release best practice standards for those programs as well.

This document represents the first of two parts. Contained herein are best practice standards related to the following five topics:

I. Target Population
II. Historically Disadvantaged Groups
III. Roles and Responsibilities of the Judge
IV. Incentives, Sanctions, and Therapeutic Adjustments
V. Substance Abuse Treatment

Volume II, scheduled to be released in mid-2014, will contain five to seven additional standards focusing on drug and alcohol testing, ancillary services, census and caseloads, team functioning, professional training, and research and evaluation.

Standard I begins by addressing the appropriate target population for a Drug Court. It is essential to recognize that every standard that follows assumes the Drug Court is treating the intended participants. If this precondition is not met, then the ensuing standards might, or might not, be applicable. It is not possible to prescribe an effective course of action for a Drug Court until and unless its participant population has been carefully defined.

Aspirational and Obligatory

The terms *best practices* and *standards* are rarely used in combination. Best practices are aspirational whereas standards are obligatory and enforceable. Many professions choose instead to use terms such as *guidelines* or *principles* to allow for latitude in interpreting and applying the indicated practices (e.g., American Psychological Association, 2013). Other professions have focused on enforcing minimum standards for competent practice rather than defining best practices for the field. In other words, they have focused on defining the floor of acceptable practices rather than the ceiling of optimal practices.

The NADCP chooses to combine aspirational and obligatory language because best practice standards may be ambitious at present, but they are expected to become obligatory and enforceable within a reasonable period of time. Once best practices have been defined clearly for the field, it is assumed that Drug Courts will comport their operations accordingly. How long this process should take will vary from standard to standard. Drug Courts should be able to comply with some of the standards within a few months, if they are not already doing so; however, other standards might require three to five years to satisfy.

Conclusion

In an era of shrinking public resources and accelerating demands for community-based alternatives to incarceration, why would the NADCP put even greater responsibilities on Drug Courts to improve their services and operations? Shouldn't NADCP instead focus on serving more and more offenders with fewer resources?

The truth is that Drug Courts have always placed inordinate demands on themselves. Dissatisfied with what was currently being done and had always been done, Drug Courts pushed through the envelope and redesigned the criminal justice system. They brushed aside old paradigms and changed the very language of justice reform. Old terms such as *accountability* were redefined and reconceptualized, and new terms such as *therapeutic jurisprudence* and *proximal behaviors* were introduced into the criminal justice lexicon. Asking a lot of Drug Courts is nothing more than business as usual.

Best practice standards reflect the hard-won knowledge of the Drug Court field garnered from nearly a quarter century of earnest labor and honest self-appraisal. As more and more programs come on line, Drug Courts must take advantage of this institutional memory and avoid relearning the painful lessons of the past. Drug Courts cannot allow new programs to drift from the original

model or dilute its powerful effects. The price of membership in the Drug Court field is excellence.

The goal of these Best Practice Standards is not to constrain ingenuity or penalize divergence. Rather, the goal is to provide education and practice pointers for a maturing field, which the NADCP has always done for the benefit of Drug Court professionals, participants, and their communities.

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I. TARGET POPULATION

Eligibility and exclusion criteria for the Drug Court are predicated on empirical evidence indicating which types of offenders can be treated safely and effectively in Drug Courts. Candidates are evaluated for admission to the Drug Court using evidence-based assessment tools and procedures.

A. Objective Eligibility & Exclusion Criteria

B. High-Risk and High-Need Participants

C. Validated Eligibility Assessments

D. Criminal History Disqualifications

E. Clinical Disqualifications

A. Objective Eligibility and Exclusion Criteria

Eligibility and exclusion criteria are defined objectively, specified in writing, and communicated to potential referral sources including judges, law enforcement, defense attorneys, prosecutors, treatment professionals, and community supervision officers. The Drug Court team does not apply subjective criteria or personal impressions to determine participants' suitability for the program.

B. High-Risk and High-Need Participants

The Drug Court targets offenders for admission who are addicted[1] to illicit drugs[2] or alcohol and are at substantial risk for reoffending or failing to complete a less intensive disposition, such as standard probation or pretrial supervision. These individuals are commonly referred to as high-risk and high-need offenders. If a Drug Court is unable to target only high-risk and high-need offenders, the program develops alternative tracks with services that are modified to meet the risk and need levels of its participants. If a Drug Court develops alternative tracks, it does not mix participants with different risk or need levels in the same counseling groups, residential treatment milieu, or housing unit.

C. Validated Eligibility Assessments

Candidates for the Drug Court are assessed for eligibility using validated risk-assessment and clinical-assessment tools. The risk-assessment tool has been demonstrated empirically to predict criminal recidivism or failure on community supervision and is

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[1] Diagnostic terminology is in flux in light of recent changes to the 5th edition of the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5). The terms *addiction* and *dependence* are defined herein in accordance with the American Society of Addiction Medicine (ASAM), which focuses on a compulsion to use or inability to abstain from alcohol or other drugs: "Addiction is characterized by inability to consistently abstain, impairment in behavioral control, craving, diminished recognition of significant problems with one's behaviors and interpersonal relationships, and a dysfunctional emotional response." Available at http://www.asam.org/for-the-public/definition-of-addiction.

[2] Illicit drugs include addictive or intoxicating prescription medications that are taken for a nonprescribed or nonmedically indicated purpose.

equivalently predictive for women and racial or ethnic minority groups that are represented in the local arrestee population. The clinical-assessment tool evaluates the formal diagnostic symptoms of substance dependence or addiction. Evaluators are trained and proficient in the administration of the assessment tools and interpretation of the results.

D. Criminal History Disqualifications

Current or prior offenses may disqualify candidates from participation in the Drug Court if empirical evidence demonstrates offenders with such records cannot be managed safely or effectively in a Drug Court. Barring legal prohibitions, offenders charged with drug dealing or those with violence histories are not excluded automatically from participation in the Drug Court.

E. Clinical Disqualifications

If adequate treatment is available, candidates are not disqualified from participation in the Drug Court because of co-occurring mental health or medical conditions or because they have been legally prescribed psychotropic or addiction medication.

COMMENTARY

A. Objective Eligibility and Exclusion Criteria

Studies have found that the admissions process in many Drug Courts included informal or subjective selection criteria, multiple gatekeepers, and numerous opportunities for candidates to be rejected from the programs (Belenko et al., 2011). Removing subjective eligibility restrictions and applying evidence-based selection criteria significantly increases the effectiveness and cost-effectiveness of Drug Courts by allowing them to serve the most appropriate target population (Bhati et al., 2008; Sevigny et al., 2013).

Some Drug Courts may screen candidates for their *suitability* for the program based on the team's subjective impressions of the offender's motivation for change or readiness for treatment. Suitability determinations have been found to have no impact on Drug Court graduation rates or postprogram recidivism (Carey & Perkins, 2008; Rossman et al., 2011). Because they have the potential to exclude individuals from Drug Courts for reasons that are empirically invalid, subjective suitability determinations should be avoided.

B. High-Risk And High-Need Participants

A substantial body of research indicates which types of offenders are most in need of the full range of interventions embodied in the *Ten Key Components of Drug Courts* (NADCP, 1997). These are the offenders who are (1) addicted to or dependent on illicit drugs or alcohol and (2) at high risk for criminal recidivism or failure in less intensive rehabilitative dispositions. Drug Courts that focus their efforts on these individuals—commonly referred to as high-risk/high-need offenders — reduce crime approximately twice as much as those serving less serious offenders (Cissner et al., 2013; Fielding et al., 2002; Lowenkamp et al., 2005) and return approximately 50% greater cost savings to their communities (Bhati et al., 2008; Carey et al., 2008, 2012; Downey & Roman, 2010).

It may not always be feasible for Drug Courts to target high-risk and high-need offenders. To gain the cooperation of prosecutors or other stakeholders, some Drug Courts may need to begin by treating less serious offenders and then expand their eligibility criteria after they have proven the safety and effectiveness of their programs. In addition, some Drug Courts may not have statutory authorization or

adequate resources to treat high-risk or high-need offenders. Under such circumstances, research indicates the programs should modify their services to provide a lower intensity of supervision, substance abuse treatment, or both. Otherwise, the programs risk wasting resources or making outcomes worse for some of their participants (Lowenkamp & Latessa, 2004). Providing substance abuse treatment for nonaddicted substance abusers can lead to higher rates of reoffending or substance abuse or a greater likelihood of these individuals eventually becoming addicted (Lovins et al., 2007; Lowenkamp & Latessa, 2005; Szalavitz, 2010; Wexler et al., 2004). In particular, mixing participants with different risk or need levels together in treatment groups or residential facilities can make outcomes worse for the low-risk or low-need participants by exposing them to antisocial peers or interfering with their engagement in productive activities, such as work or school (DeMatteo et al., 2006; Lowenkamp & Latessa, 2004; McCord, 2003; Petrosino et al., 2000). A free publication from the NDCI provides evidence-based recommendations for developing alternative tracks in Drug Courts for low-risk and low-need participants.[3]

Some evidence suggests Drug Courts may have better outcomes if they target offenders either on a pre- or postadjudication basis and do not mix these populations (Shaffer, 2006). Other studies have found no differences in outcomes regardless of whether these populations were served alone or in combination (Carey et al., 2012). It is premature to conclude whether it is appropriate to mix pre- and postadjudication populations in Drug Courts; however, Drug Courts must be mindful of the fact that the populations may differ significantly in terms of their risk or need levels. They should not be treated in the same counseling groups or residential facilities if their treatment needs or criminal propensities are significantly different.

C. Validated Eligibility Assessments

Standardized assessment tools are significantly more reliable and valid than professional judgment for predicting success in correctional supervision and matching offenders to appropriate treatment and supervision services (Andrews et al., 2006; Miller & Shutt, 2001; Wormith & Goldstone, 1984). Drug Courts that employ standardized assessment tools to determine candidates' eligibility for the program have significantly better outcomes than Drug Courts that do not use standardized tools (Shaffer, 2010).

Eligibility assessments should be performed along the dimensions of both risk and need to match offenders to appropriate levels of criminal justice supervision and treatment services, respectively (Andrews & Bonta, 2010; Casey et al., 2011; Marlowe, 2009). Most substance abuse screening tools are not sufficient for this purpose because they do not accurately differentiate substance dependence or addiction from lesser degrees of substance abuse or substance involvement (Greenfield & Hennessy, 2008; Stewart, 2009). A structured psychiatric interview is typically required to make a valid diagnosis of substance dependence or addiction and thus to ensure that a Drug Court is serving the target population. Appendix A provides information on how to obtain risk and need assessment tools that have been validated for use with addicted individuals in substance abuse treatment or the criminal justice system.

D. Criminal History Disqualifications

Some Drug Courts serve only individuals charged with drug-possession offenses or may disqualify offenders who are charged with or have a history of a serious felony. Research reveals, however, that Drug Courts yielded nearly twice the cost savings when they served addicted individuals charged with felony theft and property crimes (Carey et al., 2008, 2012). Drug Courts that served only drug-possession cases typically offset crimes that did not involve high victimization or incarceration costs, such as petty theft, drug possession, trespassing, and traffic offenses (Downey & Roman, 2010). As a result, the investment costs of the programs were not recouped by the modest cost savings that were achieved from reduced recidivism. The most cost-effective Drug Courts focused their efforts on reducing serious felony offenses that are most costly to their communities.

Mixed outcomes have been reported for violent offenders in Drug Courts. Several studies found that participants who were charged with violent crimes or had histories of violence performed as well or better

[3] Alternative Tracks in Adult Drug Courts: Matching Your Program to the Needs of Your Clients. Available at http://www.ndci.org/sites/default/files/nadcp/AlternativeTracksInAdultDrugCourts.pdf.

than nonviolent participants in Drug Courts (Carey et al., 2008, 2012; Saum & Hiller, 2008; Saum et al., 2001). However, two meta-analyses reported significantly smaller effects for Drug Courts that admitted violent offenders (Mitchell et al., 2012; Shaffer, 2010). The most likely explanation for this discrepancy is that some of the Drug Courts might not have provided adequate services to meet the need and risk levels of violent offenders. If adequate treatment and supervision are available, there is no empirical justification for routinely excluding violent offenders from participation in Drug Courts.

Although research is sparse on this point, there also appears to be no justification for routinely excluding individuals charged with drug dealing from participation in Drug Courts, providing they are drug addicted. Evidence suggests such individuals can perform as well (Marlowe et al., 2008) or better (Cissner et al., 2013) than other participants in Drug Court programs. An important factor to consider in this regard is whether the offender was dealing drugs to support an addiction or solely for purposes of financial gain. If drug dealing serves to support an addiction, the participant might be a good candidate for a Drug Court.

E. Clinical Disqualifications

Appellate cases in some jurisdictions permit Drug Courts to exclude offenders who require more intensive psychiatric or medical services than the program is capable of delivering (Meyer, 2011). Assuming, however, that adequate services are available, there is no empirical justification for excluding addicted offenders with co-occurring mental health or medical problems from participation in Drug Courts. A national study of twenty-three adult Drug Courts, called the Multisite Adult Drug Court Evaluation (MADCE), found that Drug Courts were equivalently effective for a wide range of participants regardless of their mental health conditions (Rempel et al., 2012; Zweig et al., 2012). Another study of approximately seventy Drug Courts found that programs that excluded offenders with serious mental health issues were significantly less cost-effective and had no better impact on recidivism than Drug Courts that did not exclude such individuals (Carey et al., 2012). Because mentally ill offenders are likely to cycle in and out of the criminal justice system and to utilize expensive emergency room and crisis-management resources, intervening with these individuals in Drug Courts (assuming they are drug addicted and at high risk for treatment failure) has the potential to produce substantial cost savings (Rossman et al., 2012; Skeem et al., 2011).

It is unclear how severe the mental health problems were in the above-referenced studies because psychiatric diagnoses were not reported. A Mental Health Court, Co-Occurring Disorder Court or other psychiatric specialty program might be preferable to a Drug Court for treating an individual with a major psychiatric disorder, such as a psychotic or bipolar disorder. Research does not provide a clear indication of how to make this determination. The best course of action is to carefully assess offenders along the dimensions of risk and need and match them to the most suitable programs that are available in their community. It is not justifiable to have an across-the-board exclusion from Drug Court for addicted offenders who are suffering from mental health problems or conditions.

Finally, numerous controlled studies have reported significantly better outcomes when addicted offenders received medically assisted treatments including opioid antagonist medications such as naltrexone, opioid agonist medications such as methadone, and partial agonist medications such as buprenorphine (Chandler et al., 2009; Finigan et al., 2011; National Institute of Drug Abuse, 2006). Therefore, a valid prescription for such medications should not serve as the basis for a blanket exclusion from a Drug Court (Parrino, 2002). A unanimous resolution of the NADCP Board of Directors[4] provides that Drug Courts should engage in a fact-sensitive inquiry in each case to determine whether and under what circumstances to permit the use of medically assisted treatments. This inquiry should be guided in large measure by input from physicians with expertise in addiction psychiatry or addiction medicine [see also Standard V, Substance Abuse Treatment].

[4] Available at http://www.nadcp.org/sites/default/files/nadcp/NADCP%20Board%20Statement%20on%20MAT.pdf.

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II. HISTORICALLY DISADVANTAGED GROUPS

Citizens who have historically experienced sustained discrimination or reduced social opportunities because of their race, ethnicity, gender, sexual orientation, sexual identity, physical or mental disability, religion, or socioeconomic status receive the same opportunities as other citizens to participate and succeed in the Drug Court.

- **A. Equivalent Access**
- **B. Equivalent Retention**
- **C. Equivalent Treatment**
- **D. Equivalent Incentives & Sanctions**
- **E. Equivalent Dispositions**
- **F. Team Training**

A. Equivalent Access

Eligibility criteria for the Drug Court are nondiscriminatory in intent and impact. If an eligibility requirement has the unintended effect of differentially restricting access for members of a historically disadvantaged group, the requirement is adjusted to increase the representation of such persons unless doing so would jeopardize public safety or the effectiveness of the Drug Court. The assessment tools that are used to determine candidates' eligibility for the Drug Court are valid for use with members of historically disadvantaged groups represented in the respective arrestee population.

B. Equivalent Retention

The Drug Court regularly monitors whether members of historically disadvantaged groups complete the program at equivalent rates to other participants. If completion rates are significantly lower for members of a historically disadvantaged group, the Drug Court team investigates the reasons for the disparity, develops a remedial action plan, and evaluates the success of the remedial actions.

C. Equivalent Treatment

Members of historically disadvantaged groups receive the same levels of care and quality of treatment as other participants with comparable clinical needs. The Drug Court administers evidence-based treatments that are effective for use with members of historically disadvantaged groups represented in the Drug Court population.

D. Equivalent Incentives and Sanctions

Except where necessary to protect a participant from harm, members of historically disadvantaged groups receive the same incentives and sanctions as other participants for comparable achievements or infractions. The Drug Court regularly monitors the delivery of incentives and sanctions to ensure they are administered equivalently to all participants.

E. Equivalent Dispositions

Members of historically disadvantaged groups receive the same legal dispositions as other participants for completing or failing to complete the Drug Court program.

F. Team Training

Each member of the Drug Court team attends up-to-date training events on recognizing implicit cultural biases and correcting disparate impacts for members of historically disadvantaged groups.

COMMENTARY

Drug Courts are first and foremost courts, and the fundamental principles of due process and equal protection apply to their operations (Meyer, 2011). Drug Courts have an affirmative legal and ethical obligation to provide equal access to their services and equivalent treatment for all citizens.

In June of 2010, the Board of Directors of the NADCP passed a unanimous resolution (hereafter minority resolution)[5] directing Drug Courts to examine whether unfair disparities exist in their programs for racial or ethnic minority[6] participants; and if so, to take reasonable corrective measures to eliminate those disparities (NADCP, 2010). The minority resolution places an affirmative obligation on Drug Courts to continually monitor whether minority participants have equal access to the programs, receive equivalent services in the programs, and successfully complete the programs at rates equivalent to nonminorities. It further instructs Drug Courts to adopt evidence-based assessment tools and clinical interventions, where they exist, that are valid and effective for use with minority participants and requires staff members to attend up-to-date training events on the provision of culturally sensitive and culturally proficient services.

The NADCP minority resolution focuses on racial and ethnic minority participants for two reasons. First, these groups are *suspect classes* pursuant to constitutional law and therefore receive heightened scrutiny and protections from the courts. Second, most of the available research on disproportionate impacts in Drug Courts has focused on African-American and Hispanic or Latino individuals because these individuals were represented in sufficient numbers in the studies for the evaluators to conduct separate analyses on their behalf. Nevertheless, the same principles of fundamental fairness apply to all historically disadvantaged groups that have experienced sustained periods of discrimination or reduced social opportunities. As a practical matter, Drug Courts can only be required to take remedial actions based on characteristics of participants that are readily observable or have been brought to the attention of the court. Such observable characteristics will typically include participants' gender, race or ethnicity.

A. Equivalent Access

Evidence suggests African-American and Hispanic or Latino citizens may be underrepresented by approximately 3% to 7% in Drug Courts. National studies have estimated that approximately 21% of Drug Court participants are African-American and 10% are Hispanic or Latino (Bureau of Justice Assistance, 2012; Huddleston & Marlowe, 2011). In contrast, approximately 28% of arrestees and probationers were African-American and approximately 13% of probationers were Hispanic or Latino. Additional research is needed to examine the representation of other historically disadvantaged groups in Drug Courts.

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[5] Resolution of the Board of Directors on the Equivalent Treatment of Racial and Ethnic Minority Participants in Drug Courts, *available at* http://www.nadcp.org/sites/default/files/nadcp/NADCP%20Board%20Resolution%20-%20The%20Equivalent%20Treatment%20of%20Racial%20and%20Ethnic%20Minority%20Participants%20in%20Drug%20Courts%2006-01-10.pdf.

[6] The term *minority* refers here to racial or ethnic groups that historically were numerically in the minority within the U.S. population. Some of these racial or ethnic groups currently constitute a majority in certain communities and may be approaching a plurality of the U.S. population.

Some commentators have suggested that unduly restrictive eligibility criteria might be partly responsible for the lower representation of minority persons in Drug Courts (Belenko et al., 2011; O'Hear, 2009). It has been suggested, for example, that African-Americans or Hispanics may be more likely than Caucasians to have prior felony convictions or other entries in their criminal records that disqualify them from participation in Drug Court (National Association of Criminal Defense Lawyers [NACDL], 2009; O'Hear, 2009). Although there is no empirical evidence to confirm this hypothesis, Drug Courts must ensure that their eligibility criteria do not unnecessarily exclude minorities or members of other historically disadvantaged groups. If an eligibility criterion has the unintended impact of differentially restricting access to the Drug Court for such persons, then extra assurances are required that the criterion is necessary for the program to achieve effective outcomes or protect public safety. If less restrictive adjustments can be made to an eligibility requirement to increase the representation of members of a historically disadvantaged group without jeopardizing public safety or efficacy, the Drug Court is obligated to make those adjustments. Although an unintended discriminatory impact may not always be constitutionally objectionable (Washington v. Davis, 1976), it is nevertheless inconsistent with best practices in Drug Courts and with the NADCP minority resolution.

Drug Courts cannot assume that the assessment tools they use to determine candidates' eligibility for the program—which are often validated on samples comprising predominantly Caucasian males—are valid for use with minorities, females, or members of other demographic subgroups (Burlew et al., 2011; Huey & Polo, 2008). Studies have found that women and racial or ethnic minorities interpreted test items differently than other test respondents, making the test items less valid for the women or minorities (Carle, 2009; Perez & Wish, 2011; Wu et al., 2010). Therefore, where available, Drug Courts have a responsibility to select tools that have been validated for use with members of historically disadvantaged groups that are represented among the candidates for the program. If such tools do not exist, then at a minimum the Drug Court should elicit feedback from the participants about the clarity, relevance, and cultural sensitivity of the tools it is using. Ideally, the Drug Court should engage an evaluator to empirically validate the tools among the candidates for the program.

The Alcohol and Drug Abuse Institute Library at the University of Washington has an online catalog of screening and assessment tools created for use in substance abuse treatment.[7] Each instrument can be searched for research studies, if any, that have examined its validity and reliability among women and racial or ethnic minorities.

B. Equivalent Retention

Numerous studies have reported that a significantly smaller percentage of African-American or Hispanic participants graduated successfully from Drug Court as compared to non-Hispanic Caucasians (Finigan, 2009; Marlowe, 2013). In several of the studies, the magnitude of the discrepancy was as high as 25% to 40% (Belenko, 2001; Sechrest & Shicor, 2001; Wiest et al., 2007). These findings are not universal, however. A smaller but growing number of evaluations has found no differences in outcomes or even superior outcomes for racial minorities as compared to Caucasians (Brown, 2011; Cissner et al., 2013; Fulkerson, 2012; Saum et al., 2001; Somers et al., 2012; Vito & Tewksbury, 1998). Nevertheless, African-Americans appear less likely to succeed in a plurality of Drug Courts as compared to their nonracial minority peers.

To the extent such disparities exist, evidence suggests they might not be a function of race or ethnicity per se, but rather might be explained by broader societal burdens that are often borne disproportionately by minorities, such as lesser educational or employment opportunities or a greater infiltration of crack cocaine into some minority communities (Belenko, 2001; Dannerbeck et al., 2006; Fosados, et al., 2007; Hartley & Phillips, 2001; Miller & Shutt, 2001). When evaluators accounted statistically for these confounding factors, the influence of race or ethnicity disappeared (Dannerbeck et al., 2006). Interviews and focus groups conducted with racial minority participants have suggested that Drug Courts may be paying insufficient attention to employment and educational problems that are experienced disproportionately by

[7] Available at http://lib.adai.washington.edu/instruments/.

minority participants (Cresswell & Deschenes, 2001; DeVall & Lanier, 2012; Gallagher, 2013; Leukefeld et al., 2007).

These findings require Drug Courts to determine whether racial or ethnic minorities or members of other historically disadvantaged groups are experiencing poorer outcomes in their programs as compared to other participants and to investigate and remediate any disparities that are detected. One low-cost and effective strategy is to confidentially survey participants and staff members about their perceptions of disparate treatment and outcomes in the program (Casey et al., 2012; Sentencing Project, 2008). Programs that continually solicit feedback about their performance in the areas of cultural competence and cultural sensitivity learn creative ways to address the needs of their participants and produce better outcomes as a result (Szapocznik et al., 2007). Drug Courts are further encouraged to engage independent evaluators to objectively identify areas requiring improvement to meet the needs of minorities and members of other historically disadvantaged groups (Carey et al., 2012; Rubio et al., 2008).

C. Equivalent Treatment

Racial and ethnic minorities often receive lesser quality treatment than nonminorities in the criminal justice system (Brocato, 2013; Janku & Yan, 2009; Fosados et al., 2007; Guerrero et al., 2013; Huey & Polo, 2008; Lawson & Lawson, 2013; Marsh et al., 2009; Schmidt et al., 2006). A commonly cited example of this phenomenon relates to California Proposition 36, the Substance Abuse and Crime Prevention Act of 2000, a statewide diversion initiative for nonviolent drug possession offenders. A several-year study of Proposition 36 (Nicosia et al., 2012; Integrated Substance Abuse Programs, 2007) found that Hispanic participants were significantly less likely than Caucasians to be placed in residential treatment for similar patterns of drug abuse, and African-Americans were less likely to receive medically assisted treatment for addiction. To date, no empirical studies have determined whether there are such disparities in the quality of treatment in Drug Courts. The NADCP minority resolution directs Drug Courts to remain vigilant to potential differences in the quality or intensity of services provided to minority participants and to institute corrective measures where indicated.

Drug Courts must also ensure that the treatments they provide are valid and effective for members of historically disadvantaged groups in their programs. Because women and racial minorities are often underrepresented in clinical trials of addiction treatments, the treatments are frequently less beneficial for these individuals (Burlew et al., 2011; Calsyn et al., 2009). The Substance Abuse and Mental Health Services Administration (SAMHSA) maintains an internet directory of evidence-based treatments called the National Registry of Evidence-Based Programs and Practices (NREPP). The NREPP Web site may be searched specifically for interventions that have been evaluated among substantial numbers of racial and ethnic minority participants, women, and members of some other historically disadvantaged groups.[8]

A small but growing number of treatments have been tailored specifically to meet the needs of women or racial minority participants in Drug Courts. In one study, outcomes were improved significantly for young African-American male participants when an experienced African-American clinician delivered a curriculum that addressed issues commonly confronting these young men, such as negative racial stereotypes (Vito & Tewksbury, 1998). Efforts are underway to examine the intervention used in that study—habilitation, empowerment & accountability therapy (HEAT)—in a controlled experimental study.

Substantial evidence shows that women, particularly those with histories of trauma, perform significantly better in gender-specific substance abuse treatment groups (Dannerbeck et al., 2002; Grella, 2008; Liang & Long, 2013; Powell et al., 2012). This gender-specific approach has been demonstrated to improve outcomes for female Drug Court participants in at least one randomized controlled trial (Messina et al., 2012). Similarly, a study of approximately seventy Drug Courts found that programs offering gender-specific services reduced criminal recidivism significantly more than those that did not (Carey et al., 2012).

Studies indicate the success of culturally tailored treatments depends largely on the training and skills of the clinicians delivering the services (Castro et al., 2010; Hwang, 2006). Unless the clinicians attend

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[8] NREPP, Find an Intervention: http://www.nrepp.samhsa.gov/AdvancedSearch.aspx.

comprehensive training workshops and receive ongoing supervision on how to competently deliver the interventions, outcomes are unlikely to improve for women and minority participants.

D. Equivalent Incentives and Sanctions

Some commentators have questioned whether racial or ethnic minority participants are sanctioned more severely than nonminorities in Drug Courts for comparable infractions. Anecdotal observations have been cited to support this concern (NACDL, 2009) and minority participants in at least one focus group did report feeling more likely than other participants to be ridiculed or laughed at during court sessions in response to violations (Gallagher, 2013). No empirical study, however, has borne out the assertion. To the contrary, what little research has been conducted suggests Drug Courts and other problem-solving courts appear to administer sanctions in a racially and ethnically even-handed manner (Arabia et al., 2008; Callahan et al., 2013; Frazer, 2006; Guastaferro & Daigle, 2012; Jeffries & Bond, 2012). Considerably more research is required to study this important issue in a systematic manner and in a representative range of Drug Courts. The NADCP minority resolution places an affirmative obligation on Drug Courts to continually monitor whether sanctions and incentives are being applied equivalently for minority participants and to take corrective actions if discrepancies are detected.

E. Equivalent Dispositions

Concerns have similarly been expressed that racial or ethnic minority participants might be sentenced more harshly than nonminorities for failing to complete Drug Court (Drug Policy Alliance, 2011; Justice Policy Institute, 2011; O'Hear, 2009). This is an important matter because, as discussed previously, minorities may be more likely than nonminorities to be terminated from Drug Courts. Although the matter is far from settled, evidence from at least one study suggests that participants who were terminated from Drug Court did receive harsher sentences than traditionally adjudicated defendants who were charged with comparable offenses (Bowers, 2008). There is no evidence, however, to indicate whether this practice differentially impacts minorities or members of other historically disadvantaged groups. In fact, one study in Australia found that indigenous minority Drug Court participants were *less* likely than nonminorities to be sentenced to prison (Jeffries & Bond, 2012). Nevertheless, due process and equal protection require Drug Courts to remain vigilant to the possibility of sentencing disparities in their programs and to take corrective actions where indicated.

F. Team Training

One of the most significant predictors of positive outcomes for racial and ethnic minority participants in substance abuse treatment is culturally sensitive attitudes on the part of the treatment staff, especially managers and supervisors (Ely & Thomas, 2001; Guerrero, 2010). When managerial staff value diversity and respect their clients' cultural backgrounds, the clients are retained significantly longer in treatment and services are delivered more efficiently (Guerrero & Andrews, 2011). Cultural-sensitivity training can enhance counselors' and supervisors' beliefs about the importance of diversity and the need to understand their clients' cultural backgrounds and influences (Cabaj, 2008; Westermeyer, & Dickerson, 2008).

Effective cultural-sensitivity curricula focus, in part, on identifying and examining the (often implicit or unconscious) biases that may be held by staff members about their clients (Greenwald & Banaji, 1995; Kang, 2005). Although the issue of implicit bias has not been studied in Drug Courts, it has been shown to negatively affect judicial decision-making in traditional criminal courts (Marsh, 2009; Rachlinski et al., 2009; Seamone, 2009). Cultural-sensitivity training can assist court staff to recognize and resolve prejudicial thoughts or beliefs they might hold but might not be aware of.

Merely sensitizing court staff to cultural concerns is not sufficient. Drug Courts need to go considerably further and teach staff concrete strategies to correct any problems that are identified and remediate disparities in services and outcomes. This includes teaching staff members how to apply research-based performance-monitoring procedures to identify and rectify disparate impacts (Casey et al., 2012; Rubio et al., 2008; Yu et al., 2009). One goal of cultural-sensitivity training is to underscore the importance of recognizing implicit bias; however, unless Drug Courts focus equally on finding concrete and feasible solutions to biases that are identified, little positive change is likely to occur.

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III. Roles and Responsibilities of the Judge

The Drug Court judge stays abreast of current law and research on best practices in Drug Courts, participates regularly in team meetings, interacts frequently and respectfully with participants, and gives due consideration to the input of other team members.[9]

A. **Professional Training**
B. **Length of Term**
C. **Consistent Docket**
D. **Participation in Pre-Court Staff Meetings**
E. **Frequency of Status Hearings**
F. **Length of Court Interactions**
G. **Judicial Demeanor**
H. **Judicial Decision Making**

A. Professional Training

The Drug Court judge attends current training events on legal and constitutional issues in Drug Courts, judicial ethics, evidence-based substance abuse and mental health treatment, behavior modification, and community supervision. Attendance at annual training conferences and workshops ensures contemporary knowledge about advances in the Drug Court field.

B. Length of Term

The judge presides over the Drug Court for no less than two consecutive years to maintain the continuity of the program and ensure the judge is knowledgeable about Drug Court policies and procedures.

C. Consistent Docket

Participants ordinarily appear before the same judge throughout their enrollment in the Drug Court.

D. Participation in Pre-Court Staff Meetings

The judge regularly attends pre-court staff meetings during which each participant's progress is reviewed and potential consequences for performance are discussed by the Drug Court team.

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[9] Studies in Drug Courts have not compared outcomes between judges and other judicial officers such as magistrates or commissioners. Barring evidence to the contrary, the standards contained herein are assumed to apply to all judicial officers working in Drug Courts.

E. Frequency of Status Hearings

Participants appear before the judge for status hearings no less frequently than every two weeks during the first phase of the program.[10] The frequency of status hearings may be reduced gradually after participants have initiated abstinence from alcohol and illicit drugs[11] and are regularly engaged in treatment. Status hearings are scheduled no less frequently than every four weeks until participants are in the last phase of the program.

F. Length of Court Interactions

The judge spends sufficient time during status hearings to review each participant's progress in the program. Evidence suggests judges should spend a minimum of approximately three minutes interacting with each participant in court.

G. Judicial Demeanor

The judge offers supportive comments to participants, stresses the importance of their commitment to treatment and other program requirements, and expresses optimism about their abilities to improve their health and behavior. The judge does not humiliate participants or subject them to foul or abusive language. The judge allows participants a reasonable opportunity to explain their perspectives concerning factual controversies and the imposition of sanctions, incentives, and therapeutic adjustments [see also Standard IV].

H. Judicial Decision Making

The judge is the ultimate arbiter of factual controversies and makes the final decision concerning the imposition of incentives or sanctions that affect a participant's legal status or liberty. The judge makes these decisions after taking into consideration the input of other Drug Court team members and discussing the matter in court with the participant or the participant's legal representative. The judge relies on the expert input of duly trained treatment professionals when imposing treatment-related conditions.

COMMENTARY

A. Professional Training

All team members in Drug Courts should attend annual training workshops on best practices in Drug Courts. The importance of training is emphasized specifically for judges because research indicates the judge exerts a unique and substantial impact on outcomes in Drug Courts (Carey et al., 2012; Jones, 2013; Jones & Kemp, 2013; Marlowe et al., 2006; Zweig et al., 2012).

Judges in Drug Courts have a professional obligation to remain abreast of legal, ethical and constitutional requirements related to Drug Court practices (Meyer, 2011; Meyer & Tauber, 2011). In addition, outcomes

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[10] This assumes the Drug Court is treating the appropriate target population of high-risk and high-need participants [see Standard I, Target Population].

[11] Illicit drugs include addictive or intoxicating prescription medications taken for a nonprescribed or nonmedically indicated purpose.

are significantly better when the Drug Court judge attends annual training conferences on evidence-based practices in substance abuse and mental health treatment and community supervision (Carey et al., 2008, 2012; Shaffer, 2010). A national study of twenty-three adult Drug Courts, called the Multisite Adult Drug Court Evaluation (MADCE), found that Drug Courts produced significantly greater reductions in crime and substance abuse when the judges were rated by independent observers as being knowledgeable about substance abuse treatment (Zweig et al., 2012). Similarly, a statewide study in New York reported significantly better outcomes when Drug Court judges were perceived by the participants as being open to learning about the disease of addiction (Farole & Cissner, 2007).

The increasing availability of webinars and other distance-learning programs has made it considerably more affordable and feasible for judges to stay abreast of evidence-based practices. Organizations including the NDCI, Center for Court Innovation, National Center for State Courts, and American University offer, free of charge, live and videotaped webinars on various topics related to best practices in Drug Courts. Appendix B provides further information about these webinars.

B. Length of Term

A study of approximately seventy Drug Courts found nearly three times greater cost savings and significantly lower recidivism when the judges presided over the Drug Courts for at least two consecutive years (Carey et al., 2008, 2012). Significantly greater reductions in crime were also found when the judges were assigned to the Drug Courts on a voluntary basis and their term on the Drug Court bench was indefinite in duration (Carey et al., 2012). Evidence suggests many Drug Court judges are significantly less effective at reducing crime during their first year on the Drug Court bench than during ensuing years (Finigan et al., 2007). Presumably, this is because judges, like most professionals, require time and experience to learn how to perform their jobs effectively. For this reason, annually rotating assignments appear to be contraindicated for judges in Drug Courts.

C. Consistent Docket

Drug Courts that rotated their judicial assignments or required participants to appear before alternating judges had the poorest outcomes in several research studies (Finigan et al., 2007; National Institute of Justice, 2006). Participants in Drug Courts commonly lead chaotic lives, and they often require substantial structure and consistency in order to change their maladaptive behaviors. Unstable staffing patterns, especially when they involve the central figure of the judge, are apt to exacerbate rather than ameliorate the disorganization in participants' lives.

D. Participation in Pre-Court Staff Meetings

Studies have found that outcomes were significantly better in Drug Courts where the judges regularly attended pre-court staff meetings (Carey et al., 2008, 2012). Pre-court staff meetings are where team members share their observations and impressions about each participant's performance in the program and propose consequences for the judge to consider (McPherson & Sauder, 2013). The judge's presence at the staff meetings ensures that each team member's perspective is taken into consideration when important decisions are made in the case. Observational studies suggest that when judges do not attend pre-court staff meetings, they are less likely to be adequately informed or prepared when they interact with the participants during court hearings (Baker, 2012; Portillo et al., 2013).

E. Frequency of Status Hearings

A substantial body of experimental and quasi-experimental research establishes the importance of scheduling status hearings no less frequently than every two weeks (biweekly) during the first phase of a Drug Court. In a series of experiments, researchers randomly assigned Drug Court participants to either appear before the judge every two weeks for status hearings or to be supervised by their clinical case managers and brought into court only in response to repetitive rule violations. The results revealed that high-risk participants[12] had significantly better counseling attendance, drug abstinence, and graduation rates

[12] See Standard I indicating that high-risk offenders are the appropriate target population for a Drug Court.

when they were required to appear before the judge every two weeks (Festinger et al., 2002). This finding was replicated in misdemeanor and felony Drug Courts serving urban and rural communities (Jones, 2013; Marlowe et al., 2004a, 2004b). It was subsequently confirmed in prospective matching studies in which the participants were assigned at entry to biweekly hearings if they were determined to be high risk (Marlowe et al., 2006, 2007, 2008, 2009, 2012).

Similarly, a meta-analysis involving ninety-two adult Drug Courts (Mitchell et al., 2012) and another study of nearly seventy Drug Courts (Carey et al., 2012) found significantly better outcomes for Drug Courts that scheduled status hearings every two weeks during the first phase of the program. Scheduling status hearings at least once per month until the last phase of the program was also associated with significantly better outcomes and nearly three times greater cost savings (Carey et al., 2008, 2012).

F. Length of Court Interactions

In a study of nearly seventy adult Drug Courts, outcomes were significantly better when the judges spent an average of at least three minutes, and as much as seven minutes, interacting with the participants during court sessions (Carey et al., 2008, 2012). Shorter interactions may not allow the judge sufficient time to gauge each participant's performance in the program, intervene on the participant's behalf, impress upon the participant the importance of compliance with treatment, or communicate that the participant's efforts are recognized and valued by staff.

G. Judicial Demeanor

Studies have consistently found that Drug Court participants perceived the quality of their interactions with the judge to be among the most influential factors for success in the program (Farole & Cissner, 2007; Goldkamp et al., 2002; Jones & Kemp, 2013; National Institute of Justice, 2006; Satel, 1998; Saum et al., 2002; Turner et al., 1999). The MADCE study found that significantly greater reductions in crime and substance use were produced by judges who were rated by independent observers as being more respectful, fair, attentive, enthusiastic, consistent and caring in their interactions with the participants in court (Zweig et al., 2012). Similarly, a statewide study in New York reported significantly better outcomes for judges who were perceived by the participants as being fair, sympathetic, caring, concerned, understanding and open to learning about the disease of addiction (Farole & Cissner, 2007). In contrast, outcomes were significantly poorer for judges who were perceived as being arbitrary, jumping to conclusions, or not giving participants an opportunity to explain their sides of the controversies (Farole & Cissner, 2007; Zweig et al., 2012). Program evaluations have similarly reported that supportive comments from the judge were associated with significantly better outcomes in Drug Courts (Senjo & Leip, 2001) whereas stigmatizing, hostile, or shaming comments from the judge were associated with significantly poorer outcomes (Miethe et al., 2000).

These findings are consistent with a body of research on procedural fairness or procedural justice. The results of those studies indicated that criminal defendants and other litigants were more likely to have successful outcomes and favorable attitudes towards the court system when they were treated with respect by the judge, given an opportunity to explain their sides of the controversies, and perceived the judge as being unbiased and benevolent in intent (Burke, 2010; Burke & Leben, 2007; Frazer, 2006). This in no way prevents judges from holding participants accountable for their actions, or from issuing stern warnings or punitive sanctions when they are called for. The dispositive issue is not the outcome of the judge's decision, but rather how the decision was reached and how the participant was treated during the interaction.

H. Judicial Decision Making

Due process and judicial ethics require judges to exercise independent discretion when resolving factual controversies, administering sanctions or incentives that affect a participant's fundamental liberty interests, or ordering the conditions of supervision (Meyer, 2011). A Drug Court judge may not delegate these responsibilities to other members of the Drug Court team. For example, it is not permissible for a Drug Court team to vote on what consequences to impose on a participant unless the judge considers the results of the vote to be merely advisory. Judges are, however, required to consider probative evidence or relevant

information when making these determinations. Because judges are not trained to make clinical diagnoses or select treatment interventions, they ordinarily require expert input from treatment professionals to make treatment-related decisions. The collaborative nature of the Drug Court model brings together experts from several professional disciplines, including substance abuse treatment, to share their knowledge and observations with the judge, thus enabling the judge to make rational and informed decisions (Hora & Stalcup, 2008).

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IV. Incentives, Sanctions, and Therapeutic Adjustments

Consequences for participants' behavior are predictable, fair, consistent, and administered in accordance with evidence-based principles of effective behavior modification.[13]

A. **Advance Notice**
B. **Opportunity to Be Heard**
C. **Equivalent Consequences**
D. **Professional Demeanor**
E. **Progressive Sanctions**
F. **Licit Addictive or Intoxicating Substances**
G. **Therapeutic Adjustments**
H. **Incentivizing Productivity**
I. **Phase Promotion**
J. **Jail Sanctions**
K. **Termination**
L. **Consequences of Graduation & Termination**

A. Advance Notice

Policies and procedures concerning the administration of incentives, sanctions, and therapeutic adjustments are specified in writing and communicated in advance to Drug Court participants and team members. The policies and procedures provide a clear indication of which behaviors may elicit an incentive, sanction, or therapeutic adjustment; the range of consequences that may be imposed for those behaviors; the criteria for phase advancement, graduation, and termination from the program; and the legal and collateral consequences that may ensue from graduation and termination. The Drug Court team reserves a reasonable degree of discretion to modify a presumptive consequence in light of the circumstances presented in each case.

B. Opportunity to Be Heard

Participants are given an opportunity to explain their perspectives concerning factual controversies and the imposition of incentives, sanctions, and therapeutic adjustments. If

[13] Herein, *incentives* refer to consequences for behavior that are desired by participants, such as verbal praise, phase advancement, social recognition, tangible rewards, or graduation. *Sanctions* refer to consequences that are disliked by participants, such as verbal reprimands, increased supervision requirements, community service, jail detention, or termination. *Therapeutic adjustments* refer to alterations to participants' treatment requirements that are intended to address unmet clinical or social service needs, and are not intended as an incentive or sanction. The generic term *consequence* encompasses incentives, sanctions and therapeutic adjustments.

a participant has difficulty expressing him or herself because of such factors as a language barrier, nervousness, or cognitive limitation, the judge permits the participant's attorney or legal representative to assist in providing such explanations. Participants receive a clear justification for why a particular consequence is or is not being imposed.

C. Equivalent Consequences

Participants receive consequences that are equivalent to those received by other participants in the same phase of the program who are engaged in comparable conduct.[14] Unless it is necessary to protect the individual from harm, participants receive consequences without regard to their gender, race, ethnicity, nationality, socioeconomic status, or sexual orientation [see Standard II, Historically Disadvantaged Groups].

D. Professional Demeanor

Sanctions are delivered without expressing anger or ridicule. Participants are not shamed or subjected to foul or abusive language.

E. Progressive Sanctions

The Drug Court has a range of sanctions of varying magnitudes that may be administered in response to infractions in the program. For goals that are difficult for participants to accomplish, such as abstaining from substance use[15] or obtaining employment, the sanctions increase progressively in magnitude over successive infractions. For goals that are relatively easy for participants to accomplish, such as being truthful or attending counseling sessions, higher magnitude sanctions may be administered after only a few infractions.

F. Licit Addictive or Intoxicating Substances

Consequences are imposed for the nonmedically indicated use of intoxicating or addictive substances, including alcohol, cannabis (marijuana) and prescription medications, regardless of the licit or illicit status of the substance. The Drug Court team relies on expert medical input to determine whether a prescription for an addictive or intoxicating medication is medically indicated and whether nonaddictive, nonintoxicating, and medically safe alternative treatments are available.

G. Therapeutic Adjustments

Participants do not receive punitive sanctions if they are otherwise compliant with their treatment and supervision requirements but are not responding to the treatment interventions. Under such circumstances, the appropriate course of action may be to reassess the individual and adjust the treatment plan accordingly. Adjustments to

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[14] This assumes all participants have been assessed comparably as high risk and high need [see Standard I, Target Population].

[15] This assumes participants are addicted to or dependent on illicit drugs or alcohol [see Standard I, Target Population]. Individuals who do not have a serious drug or alcohol addiction have less difficulty achieving abstinence, and may receive higher magnitude sanctions for substance abuse during the early phases of the program.

treatment plans are based on the recommendations of duly trained treatment professionals.

H. Incentivizing Productivity

The Drug Court places as much emphasis on incentivizing productive behaviors as it does on reducing crime, substance abuse, and other infractions. Criteria for phase advancement and graduation include objective evidence that participants are engaged in productive activities such as employment, education, or attendance in peer support groups.

I. Phase Promotion

Phase promotion is predicated on the achievement of realistic and defined behavioral objectives, such as completing a treatment regimen or remaining drug-abstinent for a specified period of time. As participants advance through the phases of the program, sanctions for infractions may increase in magnitude, rewards for achievements may decrease, and supervision services may be reduced. Treatment is reduced only if it is determined clinically that a reduction in treatment is unlikely to precipitate a relapse to substance use. The frequency of drug and alcohol testing is not reduced until after other treatment and supervisory services have been reduced and relapse has not occurred. If a participant must be returned temporarily to the preceding phase of the program because of a relapse or related setback, the team develops a remedial plan together with the participant to prepare for a successful phase transition.

J. Jail Sanctions

Jail sanctions are imposed judiciously and sparingly. Unless a participant poses an immediate risk to public safety, jail sanctions are administered after less severe consequences have been ineffective at deterring infractions. Jail sanctions are definite in duration and typically last no more than three to five days. Participants are given access to counsel and a fair hearing if a jail sanction might be imposed because a significant liberty interest is at stake.

K. Termination

Participants may be terminated from the Drug Court if they no longer can be managed safely in the community or if they fail repeatedly to comply with treatment or supervision requirements. Participants are not terminated from the Drug Court for continued substance use if they are otherwise compliant with their treatment and supervision conditions, unless they are nonamenable to the treatments that are reasonably available in their community. If a participant is terminated from the Drug Court because adequate treatment is not available, the participant does not receive an augmented sentence or disposition for failing to complete the program.

L. Consequences of Graduation and Termination

Graduates of the Drug Court avoid a criminal record, avoid incarceration, or receive a substantially reduced sentence or disposition as an incentive for completing the program. Participants who are terminated from the Drug Court receive a sentence or disposition for

the underlying offense that brought them into the Drug Court. Participants are informed in advance of the circumstances under which they may receive an augmented sentence for failing to complete the Drug Court program.

COMMENTARY

A. Advance Notice

Numerous studies reported significantly better outcomes when Drug Courts developed a coordinated sanctioning strategy that was communicated in advance to team members and participants. A national study of twenty-three adult Drug Courts, called the Multisite Adult Drug Court Evaluation (MADCE), found significantly better outcomes for Drug Courts that had a written schedule of predictable sanctions that was shared with participants and staff members (Zweig et al., 2012). Another study of approximately forty-five Drug Courts found 72% greater cost savings for Drug Courts that shared their sanctioning regimen with all team members (Carey et al., 2008a, 2012). A meta-analysis of approximately sixty studies involving seventy Drug Courts found significantly better outcomes for Drug Courts that had a formal and predictable system of sanctions (Shaffer, 2010). Finally, statewide studies of eighty-six adult Drug Courts in New York (Cissner et al., 2013) and twelve adult Drug Courts in Virginia (Cheesman & Kunkel, 2012) found significantly better outcomes for Drug Courts that provided participants with written sanctioning guidelines and followed the procedures in the guidelines.

Meta-analyses of voucher-based positive reinforcement programs have similarly reported superior outcomes for programs that communicated their policies and procedures to participants and staff members (Griffith et al., 1999; Lussier et al., 2006). To be most effective, Drug Courts should describe to participants the expectations for earning positive reinforcement and the manner in which rewards will be administered (Burdon et al., 2001; Stitzer, 2008).

Evidence from the MADCE also suggests that Drug Courts should remind participants frequently about what is expected of them in the program and the likely consequences of success or failure (Zweig et al., 2012). Significantly higher retention rates were produced in another study when staff members in Drug Courts consistently reminded participants about their responsibilities in treatment and the consequences that would ensue from graduation or termination (Young & Belenko, 2002).

Drug Courts should not, however, apply a rigid template when administering sanctions and incentives. Two of the above studies reported significantly better outcomes when the Drug Court team reserved a reasonable degree of discretion to modify a presumptive consequence in light of the facts presented in each case (Carey et al., 2012; Zweig et al., 2012). This empirical finding is consistent with legal and ethical requirements that Drug Court judges must exercise independent discretion when resolving factual controversies and imposing punitive consequences [See Standard III, Roles and Responsibilities of the Judge].

Because certainty is a critical factor in behavior modification programs (Marlowe & Kirby, 1999), discretion should generally be limited to modifying the magnitude of the consequence as opposed to withholding a consequence altogether. Drug Courts that intermittently failed to impose sanctions for infractions had significantly poorer outcomes in at least one large statewide study (Cissner et al., 2013). Withholding a consequence is appropriate only if subsequent information suggests an infraction or achievement did not in fact occur. For example, a sanction should be withheld if a participant's absence from treatment had been excused in advance by staff.

B. Opportunity to Be Heard
Equivalent Consequences
Professional Demeanor

A substantial body of research on procedural justice or procedural fairness reveals that criminal defendants are most likely to react favorably to an adverse judgment or punitive sanction if they believe fair procedures were followed in reaching the decision. The best outcomes were achieved when defendants were (1) given a reasonable opportunity to explain their side of the dispute, (2) treated in an equivalent manner to similar people in similar circumstances and (3) accorded respect and dignity throughout the process (Burke & Leben, 2007; Frazer, 2006; Tyler, 2007).

In the MADCE study, outcomes were significantly better when participants perceived the judge as fair and when independent observers rated the judge's interactions with the participants as respectful, fair, consistent, and predictable (Rossman et al., 2011). In contrast, outcomes were significantly poorer for judges who were rated as being arbitrary or not giving participants an opportunity to explain their side of the controversy (Farole & Cissner, 2007; Rossman et al., 2011). Stigmatizing, hostile, and shaming comments from the judge have also been associated with significantly poorer outcomes in Drug Courts (Gallagher, 2013; Miethe et al., 2000).

C. Equivalent Consequences

See Commentary B above.

D. Professional Demeanor

See Commentary B above.

E. Progressive Sanctions

Sanctions are less effective at low and high magnitudes than in the intermediate range (Marlowe & Kirby, 1999; Marlowe & Wong, 2008). Sanctions that are weak in magnitude can cause *habituation* in which the individual becomes accustomed, and thus less responsive, to punishment. Sanctions that are severe in magnitude can lead to *ceiling effects* in which the program runs out of sanctions before treatment has had a chance to take effect. The most effective Drug Courts develop a wide and creative range of intermediate-magnitude sanctions that can be ratcheted upward or downward in response to participants' behaviors (Marlowe, 2007). The NDCI publishes, free of charge, lists of sanctions and incentives of varying magnitudes that have been collected from hundreds of Drug Courts around the country.[16]

Significantly better outcomes are achieved when the sanctions for failing to meet difficult goals increase progressively in magnitude over successive infractions (Harrell & Roman, 2001; Harrell et al., 1999; Hawken & Kleiman, 2009; Kilmer et al., 2012; National Institute on Drug Abuse, 2006). Providing gradually escalating sanctions for difficult goals gives treatment a chance to take effect and prepares participants to meet steadily increasing responsibilities in the program. In contrast, applying high-magnitude sanctions for failing to meet easy goals avoids habituation (Marlowe, 2011).

F. Licit Addictive or Intoxicating Substances

Consequences should be imposed for the nonmedically indicated use of intoxicating and addictive substances, including alcohol, cannabis (marijuana), and prescription medications, regardless of the licit or illicit status of the substance. Ingestion of alcohol and cannabis gives rise to further criminal activity (Bennett et al., 2008; Boden et al., 2013; Friedman et al., 2001; Pedersen & Skardhamar, 2010; Reynolds et al., 2011), precipitates relapse to other drugs of abuse (Aharonovich et al., 2005), increases the likelihood that participants will fail out of Drug Court (Sechrest & Shicor, 2001), and reduces the efficacy of rewards and sanctions that are used in Drug Courts to improve participants' behaviors (Lane et al., 2004; Thompson et al., 2012). Permitting the continued use of these substances is contrary to evidence-based practices in

[16] List of Incentives and Sanctions, available at http://www.ndcrc.org/content/list-incentives-and-sanctions.

substance abuse treatment and interferes with the central goals of a Drug Court. The use of any addictive or intoxicating substance should be authorized only if it is determined by competent medical evidence to be medically indicated, if safe and effective alternative treatments are not reasonably available, and if the participant is carefully monitored by a physician with training in addiction psychiatry or addiction medicine. There is a serious risk of morbidity, mortality, or illegal diversion of medications when addiction medications are prescribed by general medical practitioners for addicted patients (Bazazi et al., 2011; Bohnert et al., 2011; Daniulaityte et al., 2012; Johanson et al., 2012).

G. Therapeutic Adjustments

Individuals who are addicted to alcohol or other drugs commonly experience severe cravings to use the substance and may suffer from painful or uncomfortable withdrawal symptoms when they discontinue use (American Psychiatric Association, 2000; American Society of Addiction Medicine, 2011). These symptoms often reflect neurological or neurochemical impairment in the brain (Baler & Volkow, 2006; Dackis & O'Brien, 2005; NIDA, 2006). If a Drug 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. Therefore, Drug Courts should ordinarily adjust participants' treatment requirements in response to positive drug tests during the early phases of the program. Participants might, for example, require medication, residential treatment, or motivational-enhancement therapy to improve their commitment to abstinence (Chandler et al., 2009). Because judges are not trained to make such decisions, they must rely on the expertise of duly trained clinicians when adjusting treatment conditions [see also Standard III, Roles and Responsibilities of the Judge]. After participants have received adequate treatment and have stabilized, it becomes appropriate to apply progressively escalating sanctions for illicit drug or alcohol use.

The question might arise about what to do for a participant who is complying with most of his or her obligations in the program, but is continuing to abuse substances over an extended period. If multiple adjustments to the treatment plan have been inadequate to initiate abstinence, it is possible the participant might not be amenable to the treatments that are available in the Drug Court. Under such circumstances, it may become necessary to discharge the participant; however, the participant should not be punished or receive an augmented sentence for trying, but failing, to respond to treatment (see subsection K below). Alternatively, the team might discover that the participant was willfully failing to apply him or herself in treatment. Under those circumstances, it would be appropriate to apply punitive sanctions for the willful failure to comply with treatment.

H. Incentivizing Productivity

Drug Courts achieve significantly better outcomes when they focus as much on incentivizing productive behaviors as they do on reducing undesirable behaviors. In the MADCE, significantly better outcomes were achieved by Drug Courts that offered higher and more consistent levels of praise and positive incentives from the judge (Zweig et al., 2012). Several other studies found that a 4:1 ratio of incentives to sanctions was associated with significantly better outcomes among drug offenders (Gendreau, 1996; Senjo & Leip, 2001; Wodahl et al., 2011). Support for the 4:1 ratio must be viewed with caution because it was derived from post hoc (after the fact) correlations rather than from controlled studies. By design, sanctions are imposed for poor performance and incentives are provided for good performance; therefore, a greater proportion of incentives might not have caused better outcomes, but rather better outcomes might have elicited a greater proportion of incentives. Nevertheless, although this correlation does not prove causality, it does suggest that Drug Courts are more likely to be successful if they make positive incentives readily available to their participants.

It is essential to recognize that punishment and positive reinforcement serve different, but complementary, functions. Punishment is used to reduce undesirable behaviors, such as substance abuse and crime, whereas positive reinforcement is used to increase desirable behaviors, such as treatment attendance and employment. Therefore, they are most likely to be effective when administered in combination (DeFulio et al., 2013). The effects of punishment typically last only as long as the sanctions are forthcoming, and undesirable behaviors often return precipitously after the sanctions are withdrawn (Marlowe & Kirby,

1999; Marlowe & Wong, 2008). For this reason, Drug Courts that rely exclusively on punishment to reduce drug abuse and crime will rarely produce lasting gains after graduation.

Treatment gains are most likely to be sustained if positive reinforcement is used to increase participant involvement in productive activities, such as employment or recreation, which can compete against drug abuse and crime after graduation. Studies have revealed that Drug Courts achieved significantly greater reductions in recidivism and greater cost savings when they required their participants to have a job, enroll in school, or live in sober housing as a condition of graduation from the program (Carey et al., 2012). How high a Drug Court should set the bar for graduation depends on the level of functioning of its participants. For seriously impaired participants, finding a safe place to live might be the most that can reasonably be expected after only a year or so of treatment. Other participants, however, might be capable of obtaining a job or a GED after a year. At a minimum, Drug Courts must ensure that their participants are engaged in a sufficient level of prosocial activities to keep them stable and abstinent after they have left the structure of the Drug Court program. The community reinforcement approach (CRA; Budney et al., 1998; Godley & Godley, 2008) is one example of an evidence-based counseling intervention that Drug Courts can use to incentivize participant involvement in prosocial activities.

I. Phase Promotion

Drug Courts have significantly better outcomes when they have a clearly defined phase structure and concrete behavioral requirements for advancement through the phases (Carey et al., 2012; Shaffer, 2006; Wolfer, 2006). The purpose of phase advancement is to reward participants for their accomplishments and put them on notice that the expectations for their behavior have been raised accordingly (Marlowe, 2011). Therefore, phase advancement should be predicated on the achievement of clinically important milestones that mark substantial progress towards recovery. Phase advancement should not be based simply on the length of time that participants have been enrolled in the program.

As participants make progress in treatment, they become better equipped to resist illicit drugs and alcohol and to engage in productive activities. Therefore, as they move through the phases of the program, the consequences for infractions should increase accordingly and supervision services may be reduced. Because addiction is a chronic and relapsing medical condition (McLellan et al., 2000), treatment must be reduced only if it is determined clinically that doing so would be unlikely to precipitate a relapse. Finally, a basic tenet of behavior modification provides that the effects of treatment should be assessed continually until all components of the intervention have been withdrawn (Rusch & Kazdin, 1981). Therefore, drug and alcohol testing should be the last supervisory obligation that is lifted to ensure relapse does not occur as other treatment and supervision services are withdrawn.

Reducing treatment or supervision before participants have been stabilized sufficiently puts the participants at serious risk for relapse or other behavioral setbacks. A relapse occurring soon after a phase promotion is often a sign that services were reduced too abruptly. The appropriate course of action is to return the participant temporarily to the preceding phase and plan for a more effective phase transition. Returning the participant to the beginning of the first phase of treatment is usually not appropriate because this may exacerbate what is referred to as the *abstinence violation effect* (AVE) (Marlatt, 1985). When addicted individuals experience a lapse after an extended period of abstinence, they may conclude, wrongly, that they have accomplished nothing in treatment and will never be successful at recovery. This counterproductive all-or-nothing thinking may put them at further risk for a full relapse or for dropping out of treatment (Collins & Lapp, 1991; Marlatt & Witkiewitz, 2005; Stephens et al., 1994). Returning the participant to the first phase of treatment could be misinterpreted as corroborating this erroneous thinking. The goal of the Drug Court should be to counteract the AVE and help the participant learn from the experience and avoid making the same mistake again.

J. Jail Sanctions

The certainty and immediacy of sanctions are far more influential to outcomes than the magnitude or severity of the sanctions (Harrell & Roman, 2001; Marlowe et al., 2005; Nagin & Pogarsky, 2011). As was noted earlier, sanctions that are too high in magnitude can lead to ceiling effects in which outcomes may become stagnant or may even be made worse.

Drug Courts are significantly more effective and cost-effective when they use jail sanctions sparingly (Carey et al., 2008b; Hepburn & Harvey, 2007). Research in Drug Courts indicates that jail sanctions produce diminishing returns after approximately three to five days (Carey et al., 2012; Hawken & Kleiman, 2009). A multisite study found that Drug Courts that had a policy of applying jail sanctions of longer than one week were associated with increased recidivism and negative cost-benefits (Carey et al., 2012). Drug Courts that relied on jail sanctions of longer than two weeks were two and a half times less effective at reducing crime and 45% less cost-effective than Drug Courts that tended to impose shorter jail sanctions.

Because jail sanctions involve the loss of a fundamental liberty interest, Drug Courts must ensure that participants receive a fair hearing on the matter (Meyer, 2011). Given that many controversies in Drug Courts involve uncomplicated questions of fact, such as whether a drug test was positive or whether the participant missed a treatment session, truncated hearings can often be held on the same day and provide adequate procedural due process protections.

K. Termination

Participants may be terminated from the Drug Court if they pose an immediate risk to public safety, are unwilling or unable to engage in treatment, or are too impaired to benefit from the treatments that are available in their community. If none of these conditions are met, then in most cases the most effective course of action will be to adjust a nonresponsive participant's treatment or supervision requirements or apply escalating sanctions.

Drug Courts have significantly poorer outcomes and are considerably less cost-effective when they terminate participants for drug or alcohol use. In a multisite study, Drug Courts that had a policy of terminating participants for positive drug tests or new arrests for drug possession offenses had 50% higher criminal recidivism and 48% lower cost savings than Drug Courts that responded to new drug use by increasing treatment or applying sanctions of lesser severity (Carey et al., 2012). The results of another meta-analysis similarly revealed significantly poorer outcomes for Drug Courts that had a policy of terminating participants for positive drug tests (Shaffer, 2010). Because termination from Drug Court for continued substance use is costly and does not improve outcomes, participants should be terminated only when necessary to protect public safety or if continued efforts at treatment are unlikely to be successful.

If a participant is terminated from Drug Court because adequate treatment was unavailable to meet his or her clinical needs, fairness dictates the participant should receive credit for the efforts in the program and should not receive an augmented sentence or disposition for the unsuccessful termination. To do otherwise is likely to dissuade addicted offenders and their defense attorneys from choosing the Drug Court option. Defense attorneys are understandably reluctant to advise their clients to enter Drug Court when there is a serious risk their client could receive an enhanced sentence despite his or her best efforts in treatment (Bowers, 2007; Justice Policy Institute, 2011; National Association of Criminal Defense Lawyers, 2009).

L. Consequences of Graduation and Termination

Studies consistently find that Drug Courts have better outcomes when they exert *leverage* over their participants, meaning the participants can avoid a serious sentence or disposition if they complete the program (Cissner et al., 2013; Goldkamp et al., 2001; Longshore et al., 2001; Mitchell et al., 2012; Rempel & DeStefano, 2001; Rossman et al., 2011; Shaffer, 2010; Young & Belenko, 2002). Conversely, outcomes are typically poor if minimal consequences are enacted for withdrawing from or failing to complete the program (Cissner et al., 2013; Burns & Peyrot, 2008; Carey et al., 2008b; Gottfredson et al., 2003; Rempel & DeStefano, 2001; Rossman et al., 2011; Young & Belenko, 2002). If it is the policy of a Drug Court to resume traditional legal proceedings as if terminated participants had never attempted Drug Court, the odds are substantially diminished that the program will be successful.

Legal precedent and empirical research offer little guidance for deciding when to impose more than the presumptive sentence for the underlying offense if an offender fails a diversion program such as a Drug Court. At a minimum, participants and their legal counsel must be informed of the possibility that an augmented sentence could be imposed when they execute a waiver to enter the Drug Court (Meyer, 2011). Drug Courts should make every effort to spell out in the waiver agreement what factors the judge is likely

to take into account when deciding whether to augment the presumptive sentence if a participant is terminated or withdraws from the program.

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V. SUBSTANCE ABUSE TREATMENT

Participants receive substance abuse treatment based on a standardized assessment of their treatment needs.[17] Substance abuse treatment is not provided to reward desired behaviors, punish infractions, or serve other nonclinically indicated goals. Treatment providers[18] are trained and supervised to deliver a continuum of evidence-based interventions that are documented in treatment manuals.

A. Continuum of Care
B. In-Custody Treatment
C. Team Representation
D. Treatment Dosage & Duration
E. Treatment Modalities
F. Evidence-Based Treatments
G. Medications
H. Provider Training & Credentials
I. Peer Support Groups
J. Continuing Care

A. Continuum of Care

The Drug Court offers a continuum of care for substance abuse treatment including detoxification, residential, sober living, day treatment, intensive outpatient and outpatient services. Standardized patient placement criteria govern the level of care that is provided. Adjustments to the level of care are predicated on each participant's response to treatment and are not tied to the Drug Court's programmatic phase structure. Participants do not receive punitive sanctions or an augmented sentence if they fail to respond to a level of care that is substantially below or above their assessed treatment needs.

B. In-Custody Treatment

Participants are not incarcerated to achieve clinical or social service objectives such as obtaining access to detoxification services or sober living quarters.

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[17] The provisions of this Standard assume participants have been reliably diagnosed as dependent on or addicted to illicit drugs, alcohol or prescription medications that are taken for a nonprescribed or nonmedically indicated purpose [see Standard I, Target Population]. If a Drug Court is unable to provide the level of services specified herein, it may need to alter its eligibility criteria to serve a nonaddicted population.

[18] The terms *treatment provider* or *clinician* refer to any professional administering substance abuse treatment in a Drug Court, including licensed or certified addiction counselors, social workers, nurses, psychologists, and psychiatrists. The term *clinical case manager* refers to a clinically trained professional who may perform substance abuse assessments, make referrals for substance abuse treatment, or report on participant progress in treatment during court hearings or staff meetings, but does not provide substance abuse treatment.

C. Team Representation

One or two treatment agencies are primarily responsible for managing the delivery of treatment services for Drug Court participants. Clinically trained representatives from these agencies are core members of the Drug Court team and regularly attend team meetings and status hearings. If more than two agencies provide treatment to Drug Court participants, communication protocols are established to ensure accurate and timely information about each participant's progress in treatment is conveyed to the Drug Court team.

D. Treatment Dosage and Duration

Participants receive a sufficient dosage and duration of substance abuse treatment to achieve long-term sobriety and recovery from addiction. Participants ordinarily receive six to ten hours of counseling per week during the initial phase of treatment and approximately 200 hours of counseling over nine to twelve months; however, the Drug Court allows for flexibility to accommodate individual differences in each participant's response to treatment.

E. Treatment Modalities

Participants meet with a treatment provider or clinical case manager for at least one individual session per week during the first phase of the program. The frequency of individual sessions may be reduced subsequently if doing so would be unlikely to precipitate a behavioral setback or relapse. Participants are screened for their suitability for group interventions, and group membership is guided by evidence-based selection criteria including participants' gender, trauma histories and co-occurring psychiatric symptoms. Treatment groups ordinarily have no more than twelve participants and at least two leaders or facilitators.

F. Evidence-Based Treatments

Treatment providers administer behavioral or cognitive-behavioral treatments that are documented in manuals and have been demonstrated to improve outcomes for addicted persons involved in the criminal justice system. Treatment providers are proficient at delivering the interventions and are supervised regularly to ensure continuous fidelity to the treatment models.

G. Medications

Participants are prescribed psychotropic or addiction medications based on medical necessity as determined by a treating physician with expertise in addiction psychiatry, addiction medicine, or a closely related field.

H. Provider Training and Credentials

Treatment providers are licensed or certified to deliver substance abuse treatment, have substantial experience working with criminal justice populations, and are supervised regularly to ensure continuous fidelity to evidence-based practices.

I. Peer Support Groups

Participants regularly attend self-help or peer support groups in addition to professional counseling. The peer support groups follow a structured model or curriculum such as the 12-step or Smart Recovery models.[19] Before participants enter the peer support groups, treatment providers use an evidence-based preparatory intervention, such as 12-step facilitation therapy, to prepare the participants for what to expect in the groups and assist them to gain the most benefits from the groups.

J. Continuing Care

Participants complete a final phase of the Drug Court focusing on relapse prevention and continuing care. Participants prepare a continuing-care plan together with their counselor to ensure they continue to engage in prosocial activities and remain connected with a peer support group after their discharge from the Drug Court. For at least the first ninety days after discharge from the Drug Court, treatment providers or clinical case managers attempt to contact previous participants periodically by telephone, mail, e-mail, or similar means to check on their progress, offer brief advice and encouragement, and provide referrals for additional treatment when indicated.

COMMENTARY

A. Continuum of Care

Outcomes are significantly better in Drug Courts that offer a continuum of care for substance abuse treatment which includes residential treatment and recovery housing in addition to outpatient treatment (Carey et al., 2012; Koob et al., 2011; McKee, 2010). Participants who are placed initially in residential treatment should be stepped down gradually to day treatment or intensive outpatient treatment and subsequently to outpatient treatment (Krebs et al., 2009). Moving patients directly from residential treatment to a low frequency of standard outpatient treatment has been associated with poor outcomes in substance abuse treatment studies (McKay, 2009a; Weiss et al., 2008). Broadly speaking, standard outpatient treatment is typically less than nine hours per week of services, intensive outpatient treatment is typically between nine and nineteen hours, and day treatment is typically over twenty hours but does not include overnight stays (Mee-Lee & Gastfriend, 2008).

Significantly better results are achieved when substance abuse patients are assigned to a level of care based on a standardized assessment of their treatment needs as opposed to relying on professional judgment or discretion (Andrews & Bonta, 2010; Babor & Del Boca, 2002; Karno & Longabaugh, 2007; Vieira et al., 2009). The most commonly used placement criteria are the *American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders* (ASAM-PPC; Mee-Lee et al., 2001). Studies have confirmed that patients who received the indicated level of care according to the ASAM-PPC had significantly higher treatment completion rates and fewer instances of relapse to substance use than patients who received a lower level of care than was indicated by the ASAM-PPC (for example, patients who received outpatient treatment when the ASAM-PPC indicated a need for residential treatment; De Leon et al., 2010; Gastfriend et al., 2000; Gregoire, 2000; Magura et al., 2003; Mee-Lee & Gastfriend, 2008). Patients who received a higher level of care than was indicated by the ASAM-PPC had equivalent or

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[19] Drug Courts must offer a secular alternative to 12-step programs such as Narcotics Anonymous because appellate courts have interpreted these programs to be deity-based, thus implicating the First Amendment (Meyer, 2011).

worse outcomes than those receiving the indicated level of care, and the programs were rarely cost-effective (Magura et al., 2003).

In the criminal justice system, mismatching offenders to a higher level of care than they require has been associated frequently with negative or iatrogenic effects in which outcomes were made worse. In several studies, offenders who received residential treatment when a lower level of care would have sufficed had significantly higher rates of treatment failure and criminal recidivism than offenders with comparable needs who were assigned to outpatient treatment (Lovins et al., 2007; Lowenkamp & Latessa, 2005; Wexler et al., 2004). The negative impact of receiving an excessive level of care appears to be most pronounced for offenders below the age of twenty-five years, perhaps because youthful offenders are more vulnerable to antisocial peer influences (DeMatteo et al., 2006; Lowenkamp & Latessa, 2004; McCord, 2003; Petrosino et al., 2000; Szalavitz, 2010). Particular caution is required, therefore, to ensure younger Drug Court participants are not placed erroneously into residential substance abuse treatment.

As was discussed earlier, evidence suggests racial and ethnic minority offenders may be more likely than nonminorities to receive a lower level of care than is warranted from their assessment results (Integrated Substance Abuse Programs, 2007; Janku & Yan, 2009). To prevent this from occurring in Drug Courts, a unanimous resolution of the NADCP Board of Directors requires Drug Courts to monitor whether minorities and members of other historically disadvantaged groups are receiving services equivalent to other participants in the program and to take remedial measures, where indicated, to correct any discrepancies [see Standard II, Historically Disadvantaged Groups].

Some Drug Courts may begin all participants in the same level of care, or may routinely taper down the level of care as participants move through the phases of the program. The research cited above shows clearly that such practices are not justified on the bases of clinical necessity or cost. Participants should not be assigned to a level of care without first confirming through a standardized and validated assessment that their clinical needs warrant that level of care.

If a Drug Court is unable to provide adequate levels of care to meet the needs of addicted individuals, then the program might consider adjusting its eligibility criteria to serve a less clinically disordered population, such as offenders who abuse but are not addicted to drugs or alcohol. At a minimum, participants should not be punished for failing to respond to a level of care that research indicates is insufficient to meet their treatment needs. If a participant is terminated from Drug Court for failing to respond to an inadequate level of treatment, fairness dictates the participant should receive credit for his or her efforts in the program and should not receive an augmented sentence or disposition for the unsuccessful termination. To do otherwise is likely to dissuade addicted offenders and their defense attorneys from choosing the Drug Court option. As was noted earlier, evidence suggests defense attorneys are reluctant to advise their clients to enter Drug Court when there is a serious chance the client could receive an enhanced sentence despite his or her best efforts in treatment (Bowers, 2007; Justice Policy Institute, 2011; National Association of Criminal Defense Lawyers, 2009).

B. In-Custody Treatment

Relying on in-custody substance abuse treatment can reduce the cost-effectiveness of a Drug Court by as much as 45% (Carey et al., 2012). Most studies have reported minimal gains from providing substance abuse treatment within jails or prisons (Pearson & Lipton, 1999; Pelissier et al., 2007; Wilson & Davis, 2006). Although specific types of in-custody programs, such as therapeutic communities (TCs), have been shown to improve outcomes for jail or prison inmates (Mitchell et al., 2007), most of the benefits of those programs were attributable to the fact that they increased the likelihood the offenders would complete outpatient treatment after their release from custody (Bahr et al., 2012; Martin et al., 1999; Wexler et al., 1999). The long-term benefits of the TCs were accounted for primarily by the offender's subsequent exposure to community-based treatment. Once an offender has engaged in community-based treatment, rarely will there be a clinical rationale for transferring him or her to in-custody treatment. Placing a participant in custody might be appropriate to protect public safety or to punish willful infractions such as intentionally failing to attend treatment sessions; however, in-custody treatment will rarely serve the goals of treatment effectiveness or cost-effectiveness.

Some Drug Courts may place participants in jail as a means of providing detoxification services or to keep them "off the streets" when adequate treatment is unavailable in the community. Although this practice may be necessary in rare instances to protect participants from immediate self-harm, it is inconsistent with best practices, unduly costly, and unlikely to produce lasting benefits. As soon as a treatment slot becomes available, the participant should be released immediately from custody and transferred to the appropriate level of care in the community.

C. Team Representation

Outcomes are significantly better in Drug Courts that rely on one or two primary treatment agencies to manage the provision of treatment services for participants (Carey et al., 2008, 2012; Shaffer, 2006; Wilson et al., 2006). Criminal recidivism may be reduced by as much as two fold when representatives from these primary agencies are core members of the Drug Court team and regularly attend staff meetings and court hearings (Carey et al., 2012). This arrangement helps to ensure that timely information about participants' progress in treatment is communicated to the Drug Court team and treatment-related issues are taken into consideration when decisions are reached in staff meetings and status hearings.

For practical reasons, large numbers of treatment providers cannot attend staff meetings and court hearings on a routine basis. Therefore, for Drug Courts that are affiliated with large numbers of treatment agencies, communication protocols must be established to ensure timely treatment information is reported to the Drug Court team. Clinical case managers from the primary treatment agencies are often responsible for ensuring that this process runs efficiently and timely information is conveyed to fellow team members. Particularly when Drug Courts are affiliated with large numbers of treatment providers, outcomes may be enhanced by having those treatment providers communicate frequently with the court via e-mail or similar electronic means (Carey et al., 2012).

D. Treatment Dosage and Duration

The success of Drug Courts is attributable, in part, to the fact that they significantly increase participant exposure to substance abuse treatment (Gottfredson et al., 2007; Lindquist et al., 2009). The longer participants remain in treatment and the more sessions they attend, the better their outcomes (Banks & Gottfredson, 2003; Gottfredson et al., 2007; Gottfredson et al., 2008; Peters et al., 2002; Shaffer, 2010; Taxman & Bouffard, 2005). The best outcomes are achieved when addicted offenders complete a course of treatment extending over approximately nine to twelve months (270 to 360 days; Peters et al., 2002; Huebner & Cobbina, 2007).[20] On average, participants will require approximately six to ten hours of counseling per week during the first phase of the program (Landenberger & Lipsey, 2005) and 200 hours of counseling over the course of treatment (Bourgon & Armstrong, 2005; Sperber et al., 2013).[21] The most effective Drug Courts publish general guidelines concerning the anticipated length and dosage of treatment; however, they retain sufficient flexibility to accommodate individual differences in each participant's response to treatment (Carey et al., 2012).

E. Treatment Modalities

Outcomes are significantly better in Drug Courts that require participants to meet with a treatment provider or clinical case manager for at least one individual session per week during the first phase of the program (Carey et al., 2012; Rossman et al., 2011). Most participants are unstable clinically and in a state of crisis when they first enter a Drug Court. Group sessions may not provide sufficient time and opportunities to address each participant's clinical and social service needs. Individual sessions reduce the likelihood that participants will fall through the cracks during the early stages of treatment when they are most vulnerable to cravings, withdrawal symptoms, and relapse.

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[20] This is a separate matter from the average term of enrollment in a Drug Court, which evidence suggests should be approximately twelve to eighteen months (Carey et al., 2012; Shaffer, 2010).

[21] This assumes the Drug Court is treating individuals who are addicted to drugs or alcohol and at high risk for criminal recidivism or treatment failure [see Standard I, Target Population].

Group counseling may also improve outcomes in Drug Courts, but only if the groups apply evidence-based practices and participants are screened for their suitability for group-based services. Research indicates counseling groups are most effective with six to twelve participants and two facilitators (Brabender, 2002; Sobell & Sobell, 2011; Velasquez et al., 2001; Yalom, 2005). Groups with more than twelve members have fewer verbal interactions, spend insufficient time addressing individual members' concerns, are more likely to fragment into disruptive cliques or subgroups, and are more likely to be dominated by antisocial, forceful or aggressive members (Brabender, 2002; Yalom, 2005). Groups with fewer than four members commonly experience excessive attrition and instability (Yalom, 2005). If a Drug Court cannot form stable groups with at least four members, relying on individual counseling rather than groups to deliver treatment services may be preferable.

For groups that are treating externalizing or acting-out behaviors, such as crime and substance abuse, two facilitators are often needed to monitor and control the group interactions (Sobell & Sobell, 2011). The main facilitator can direct the format and flow of the sessions, while the cofacilitator may set limits on disruptive participants, review participants' homework assignments, or take part in role-plays such as illustrating effective drug-refusal strategies. Although the main facilitator should be a trained and certified treatment professional, the cofacilitator may be a trainee or recent hire to the program. Using trainees or inexperienced staff members as cofacilitators can reduce the costs of having two facilitators and provides an excellent training opportunity for the new staff members.

Evidence reveals group interventions may be contraindicated for certain types of participants, such as those suffering from serious brain injury, paranoia, sociopathy, major depression, or traumatic disorders (Yalom, 2005). Individuals with these characteristics may need to be treated on an individual basis or in specialized groups that can focus on their unique needs and vulnerabilities (Drake et al., 2008; Ross, 2008). Better outcomes have been achieved, for example, in Drug Courts (Messina et al., 2012; Liang & Long, 2013) and other substance abuse treatment programs (Grella, 2008; Mills et al., 2012) that developed specialized groups for women with trauma histories. Researchers have identified substantial percentages of Drug Court participants who may require specialized group services for comorbid mental illness (Mendoza et al., 2013; Peters, 2008; Peters et al., 2012) or trauma histories (Sartor et al., 2012).

Not all substance abuse treatment participants may benefit from group counseling. Interviews with participants who were terminated from Drug Courts found that many of them attributed their failure, in part, to their dissatisfaction with group-based services (Fulkerson et al., 2012). This theme has arisen frequently in focus groups with young, African-American, male Drug Court participants (Gallagher, 2013). Although there is no proof that dissatisfaction with group counseling was the actual cause of these individuals' failure in the programs, the findings do suggest that Drug Courts should consider whether participants are suited for group-based services and prepare them for what to expect in the groups before assigning them to the interventions.

F. Evidence-Based Treatments

A substantial body of research spanning several decades reveals that outcomes from correctional rehabilitation are significantly better when (1) offenders receive behavioral or cognitive-behavioral counseling interventions, (2) the interventions are carefully documented in treatment manuals, (3) treatment providers are trained to deliver the interventions reliably according to the manual, and (4) fidelity to the treatment model is maintained through continuous supervision of the treatment providers (Andrews et al., 1990; Andrews & Bonta, 2010; Gendreau, 1996; Hollins, 1999; Landenberger & Lipsey, 2005; Lowenkamp et al., 2006; Lowenkamp et al., 2010; Smith et al., 2009). Adherence to these principles has been associated with significantly better outcomes in Drug Courts (Gutierrez & Bourgon, 2012) and in other drug abuse treatment programs (Prendergast et al., 2013).

Behavioral treatments reward offenders for desirable behaviors and sanction them for undesirable behaviors. The systematic application of graduated incentives and sanctions in Drug Courts is an example of a behavior therapy technique (Defulio et al., 2013; Marlowe & Wong, 2008). Cognitive-behavioral therapies (CBT) take an active problem-solving approach to managing drug- and alcohol-related problems. Common CBT techniques include correcting participants' irrational thoughts related to substance abuse (e.g., "I will never amount to anything anyway, so why bother?"), identifying participants' triggers or risk

factors for drug use, scheduling participants' daily activities to avoid coming into contact with their triggers, helping participants to manage cravings and other negative affects without recourse to substance abuse, and teaching participants effective problem-solving techniques and drug-refusal strategies.

Examples of manualized CBT curricula that have been proven to reduce criminal recidivism among offenders include Moral Reconation Therapy (MRT), Reasoning and Rehabilitation (R&R), Thinking for a Change (T4C), relapse prevention therapy (RPT) and the Matrix Model (Cullen et al., 2012; Dowden et al., 2003; Ferguson & Wormith, 2012; Landenberger & Lipsey, 2005; Lipsey et al., 2001; Lowenkamp et al., 2009; Marinelli-Casey et al., 2008; Milkman & Wanberg, 2007; Pearson et al., 2002; Wilson et al., 2005). Some of these CBT curricula were developed to address criminal offending generally and were not developed specifically to treat substance abuse or addiction. However, the Matrix Model and RPT were developed for the treatment of addiction and MRT has been adapted successfully to treat drug-abusing offenders (Bahr et al., 2012; Wanberg & Milkman, 2006) and Drug Court participants (Cheesman & Kunkel, 2012; Heck, 2008; Kirchner & Goodman, 2007). The Substance Abuse and Mental Health Services Administration (SAMHSA) maintains an Internet directory of evidence-based treatments called the *National Registry of Evidence-Based Programs and Practices* (NREPP).[22] Drug Court professionals can search the NREPP Web site, free of charge, to identify substance abuse treatments that have been demonstrated to improve outcomes for addicted offenders.

Outcomes from CBT are enhanced significantly when counselors are trained to deliver the curriculum in a reliable manner as specified in the manual (Goldstein et al., 2013; Southam-Gerow & McLeod, 2013). A minimum of three days of preimplementation training, periodic booster sessions, and monthly individualized supervision and feedback are required for probation officers and treatment providers to administer evidence-based practices reliably (Bourgon et al., 2010; Edmunds et al., 2013; Robinson et al., 2012; Schoenwald et al., 2013). In addition, outcomes are better when counselors give homework assignments to the participants that reinforce the material covered in the sessions (Kazantzis et al., 2000; McDonald & Morgan, 2013). Examples of homework assignments include having participants keep a journal of their thoughts and feelings related to substance abuse, requiring participants to develop and follow through with a preplanned activity schedule, or having them write an essay on a drug-related topic (Sobell & Sobell, 2011).

G. Medications

Medically assisted treatment (MAT) can significantly improve outcomes for addicted offenders (Chandler et al., 2009; National Center on Addiction & Substance Abuse, 2012; National Institute on Drug Abuse, 2006). Buprenorphine or methadone maintenance administered prior to and immediately after release from jail or prison has been shown to significantly increase opiate-addicted inmates' engagement in treatment; reduce illicit opiate use; reduce rearrests, technical parole violations, and reincarceration rates; and reduce mortality and hepatitis C infections (Dolan et al., 2005; Gordon et al., 2008; Havnes et al., 2012; Kinlock et al., 2008; Magura et al., 2009). These medications are referred to as agonists or partial agonists because they stimulate the central nervous system (CNS) in a similar manner to illicit drugs. Because they can be addictive and may produce euphoria in nontolerant individuals, they may be resisted by some criminal justice professionals. Positive outcomes have also been reported for antagonist medications, such as naltrexone, which are nonaddictive and nonintoxicating. Naltrexone blocks the effects of opiates and partially blocks the effects of alcohol without producing psychoactive effects of its own. Studies have reported significant reductions in heroin use and rearrest rates for opiate-addicted probationers and parolees who received naltrexone (Cornish et al., 1997; Coviello et al., 2012; O'Brien & Cornish, 2006). In addition, at least two small-scale studies reported better outcomes in DWI Drug Courts or DWI probation programs for alcohol-dependent participants who received an injectable form of naltrexone called Vivitrol (Finigan et al., 2011; Lapham & McMillan, 2011).

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[22] Simply being listed on the NREPP does not guarantee an intervention is effective. Drug Courts need to review the studies and ratings on the Web site to determine how reliable and powerful the effects were, and whether the intervention was examined in a similar context to that of a Drug Court. Registry available at http://www.samhsa.gov/newsroom/advisories/1012071342.aspx.

A recent national survey found that nearly half of Drug Courts do not use medications in their programs (Matusow et al., 2013). One of the primary barriers to using medications was reportedly a lack of awareness of or familiarity with medical treatments. For this reason, the NADCP Board of Directors issued a unanimous resolution directing Drug Courts to learn the facts about MAT and obtain expert consultation from duly trained addiction psychiatrists or addiction physicians.[23] Drug Courts should ordinarily discourage their participants from obtaining addictive or intoxicating medications from general medical practitioners, because this practice can pose an unacceptable risk of morbidity, mortality, or illegal diversion of the medications (Bazazi et al., 2011; Bohnert et al., 2011; Daniulaityte et al., 2012; Johanson et al., 2012).

H. Provider Training and Credentials

Treatment providers are significantly more likely to administer evidence-based assessments and interventions when they are professionally credentialed and have an advanced educational degree in a field directly related to substance abuse treatment (Kerwin et al., 2006; McLellan et al., 2003; National Center on Addiction & Substance Abuse, 2012; Olmstead et al., 2012). Studies have found that clinicians with higher levels of education and clinical certification were more likely to hold favorable views toward the adoption of evidence-based practices (Arfken et al., 2005) and to deliver culturally competent treatments (Howard, 2003). A large-scale study found that clinically certified professionals significantly outperformed noncertified staff members in conducting standardized clinical assessments (Titus et al., 2012). Clinicians are also more likely to endorse treatment philosophies favorable to client outcomes if they are educated about the neuroscience of addiction (Steenbergh et al., 2012).

As was previously discussed, treatment providers must be supervised regularly to ensure continuous fidelity to evidence-based treatments. Providers are better able to administer evidence-based practices when they receive three days of preimplementation training, periodic booster trainings, and monthly individualized supervision and feedback (Bourgon et al., 2010; Edmunds et al., 2013; Robinson et al., 2012). Finally, research suggests treatment providers are more likely to be effective if they have substantial experience working with criminal offenders and are accustomed to functioning in a criminal justice environment (Lutze & van Wormer, 2007).

I. Peer Support Groups

Participation in self-help or peer-support groups is consistently associated with better long-term outcomes following a substance abuse treatment episode (Kelly et al., 2006; Moos & Timko, 2008; Witbrodt et al., 2012). Contrary to some beliefs, individuals who are court mandated to attend self-help groups perform as well or better than nonmandated individuals (Humphreys et al., 1998). The critical variable appears to be how long the participants were exposed to the self-help interventions and not their original level of intrinsic motivation (Moos & Timko, 2008). Many people (more than 40%) drop out prematurely from self-help groups, in part because they are unmotivated or insufficiently motivated to maintain sobriety (Kelly & Moos, 2003). Therefore, Drug Courts need to find effective ways to leverage continued participant involvement in self-help groups.

Simply attending self-help groups is not sufficient to achieve successful outcomes. Sustained benefits are more likely to be attained if participants engage in recovery-relevant activities such as developing a sober-support social network (Kelly et al., 2011a), engaging in spiritual practices (Kelly et al., 2011b; Robinson et al., 2011), and learning effective coping skills from fellow group members (Kelly et al., 2009). Because it is very difficult for Drug Courts to mandate and monitor compliance with these types of recovery activities, they must find other means of encouraging and reinforcing participant engagement in recovery-related exercises. Evidence-based interventions have been developed, documented in treatment manuals, and proven to improve participant engagement in self-help groups and recovery activities. Examples of validated interventions include 12-step facilitation therapy (Ries et al., 2008), which teaches participants about what to expect and how to gain the most benefits from 12-step meetings. In addition, *intensive referrals* improve outcomes by assertively linking participants with support-group volunteers who may

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[23] Available at http://www.nadcp.org/sites/default/files/nadcp/NADCP%20Board%20Statement%20on%20MAT.pdf.

escort them to the groups, answer any questions they might have, and provide them with support and camaraderie (Timko & DeBenedetti, 2007).

J. Continuing Care

Vulnerability to relapse remains high for at least three to six months after completion of substance abuse treatment (Marlatt, 1985; McKay, 2005). One year after treatment, an average of 40% to 60% of treatment graduates will have relapsed to substance abuse (McLellan et al., 2000). Therefore, preparation for aftercare or continuing care is a critical component of Drug Courts.

In one multisite study, Drug Courts that included a formal phase focusing on relapse prevention and aftercare preparation had more than three times greater cost-benefits and significantly greater reductions in recidivism than those that offered minimal services during the last phase of the program or neglected aftercare preparation (Carey et al., 2008). Drug Courts that required their participants to plan for engaging in prosocial activities after graduation, such as employment or schooling, were found to be more effective and significantly more cost effective than those that did not plan for postgraduation activities (Carey et al., 2012). Another study found that drug-abusing probationers who received aftercare services were nearly three times more likely to be abstinent from all drugs of abuse after six months than those who did not receive aftercare services (Brown et al, 2001).

As was described earlier, RPT is a manualized, cognitive-behavioral counseling intervention that has been demonstrated to extend the effects of substance abuse treatment (Dowden et al., 2003; Dutra et al, 2008). Participants in RPT learn to identify their personal triggers or risk factors for relapse, take measures to avoid coming into contact with those triggers, and rehearse strategies to deal with high-risk situations that arise unavoidably. Drug Courts that teach formal RPT skills are likely to significantly extend the effects of their program beyond graduation (Carey et al., 2012).

Studies have also examined ways to remain in contact with participants after they have been discharged from a treatment program. For example, researchers have extended the benefits of substance abuse treatment by making periodic telephone calls to participants (McKay, 2009a), although not all studies have reported success with this approach (McKay et al., 2013). In addition, treatment benefits have been extended by inviting participants back to the program for brief recovery management check-ups (Scott & Dennis, 2012), providing assertive case management involving periodic home visits (Godley et al., 2006), and reinforcing participants with praise or small gifts for continuing to attend aftercare sessions (Lash et al., 2004). The aftercare strategies that have been successful typically continued for at least 90 days and had trained counselors, nurses, or case managers contact the participants briefly to check on their progress, probe for potential warning signs of an impending relapse, offer advice and encouragement, and make suitable referrals if a return to treatment appeared warranted (McKay, 2009b).

Although some of these measures might be cost-prohibitive for many Drug Courts, and participants might be reluctant to remain engaged with the criminal justice system after graduation, research suggests brief telephone calls, letters, or e-mails can be helpful in extending the effects of a Drug Court at minimal cost to the program and with minimal inconvenience to the participants. Anecdotal reports from Drug Court graduates and staff members have also suggested that involving graduates in alumni groups might be another promising, yet understudied, method for extending the benefits of Drug Courts (Burek, 2011; McLean, 2012).

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APPENDIX A

VALIDATED RISK AND NEED ASSESSMENT TOOLS

This list provides examples of risk and need assessment tools that have been validated for use with addicted individuals in substance abuse treatment or the criminal justice system. It is not an exhaustive list. Further information about these and other assessment tools can be obtained online from the Alcohol and Drug Abuse Institute Library at the University of Washington at http://lib.adai.washington.edu/instruments/.

RISK ASSESSMENT TOOLS

Level of Service Inventory—Revised (LSI-R)

https://ecom.mhs.com/(S(zhkd5d55qlwc3lr2gzqq5w55))/product.aspx?gr=saf&prod=lsi-r&id=overview

Wisconsin Risk and Need Assessment Scale (WRN)

http://www.j-satresources.com/Toolkit/Adult/adf6e846-f4dc-4b1e-b7b1-2ff28551ce85

Risk and Needs Triage (RANT)

http://www.trirant.org/

Correctional Offender Management Profiling for Alternative Sanctions (COMPAS)

http://www.northpointeinc.com/products/northpointe-software-suite

Ohio Risk Assessment System (ORAS)

http://www.uscourts.gov/uscourts/FederalCourts/PPS/Fedprob/2010-06/02_creation_validation_of_oras.html

Federal Post Conviction Risk Assessment (PCRA)

http://www.uscourts.gov/FederalCourts/ProbationPretrialServices/Supervision/PCRA.aspx

Risk Prediction Index (RPI)

http://www.fjc.gov/public/pdf.nsf/lookup/0013.pdf/$file/0013.pdf

Risk-Need-Responsivity Simulation Tool

http://www.gmuace.org/tools/

CLINICAL DIAGNOSTIC TOOLS

Global Appraisal of Individual Needs (GAIN)

http://www.gaincc.org/

Texas Christian University (TCU) Drug Screen II

http://www.ibr.tcu.edu/pubs/datacoll/Forms/ddscreen-95.pdf

Structured Clinical Interview for the DSM-IV (SCID)

http://www.scid4.org/

Psychiatric Research Interview for Substance and Mental Disorders (PRISM)

http://www.columbia.edu/~dsh2/prism/

Diagnostic Interview Schedule (DIS)

http://www.enotes.com/drugs-alcohol-encyclopedia/diagnostic-interview-schedule-dis

Drug Abuse Screening Test (DAST-20)

http://www.camh.ca/en/education/about/camh_publications/Pages/drug_abuse_screening_test.aspx

Appendix B

On-Line Webinars on Best Practices in Drug Courts

National Drug Court Institute (NDCI)

http://www.ndci.org/training/online-trainings-webinars

National Drug Court Resource Center (NDCRC)

http://www.ndcrc.org/

Center for Court Innovation (CCI)

http://drugcourtonline.org/

National Center for State Courts (NCSC) &
Justice Programs Office at American University
Translating Drug Court Research into Practice (R2P)

http://research2practice.org/

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ADULT DRUG COURT BEST PRACTICE STANDARDS

VOLUME II

NATIONAL ASSOCIATION OF DRUG COURT PROFESSIONALS
ALEXANDRIA, VIRGINIA

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The National Association of Drug Court Professionals

It takes innovation, passion, teamwork, and strong judicial leadership for a community to achieve success in rehabilitating persons with severe substance use disorders and concurrent criminal involvement. That is why since 1994, the National Association of Drug Court Professionals (NADCP) has worked tirelessly at the national, state, and local levels to develop and enhance Drug Courts, which combine treatment and accountability to support and compel drug-addicted persons charged with serious crimes to change their lives.

Now an international movement, Drug Courts are the shining example of what works in the criminal justice system. Today over 2,900 Drug Courts operate in the U.S. and another thirteen countries have also implemented the model. Drug Courts are applied widely to adult criminal cases, juvenile delinquency and truancy cases, and family court cases involving parents at risk of losing custody of their children as a result of substance use problems.

In the twenty-six years since the first Drug Court was founded in Miami/Dade County, Florida, more research has been published on the effects of Drug Courts than virtually all other criminal justice programs combined. The scientific community has put Drug Courts under a microscope and concluded that Drug Courts significantly reduce drug abuse and crime and do so at far less cost than any other justice strategy. Drug Courts improve communities by successfully getting justice-involved individuals clean and sober, stopping drug-related crime, reuniting broken families, intervening with juveniles before they embark on a debilitating life of addiction and crime, and preventing impaired driving.

This success has motivated NADCP to champion new generations of the Drug Court model, including but not limited to Veterans Treatment Courts, Reentry Courts, and Mental Health Courts. Veterans Treatment Courts link critical services and provide the structure needed for military veterans who are involved in the justice system as a result of substance abuse or mental illness to resume productive lives after combat. Reentry Courts assist individuals leaving our nation's jails and prisons to succeed on probation or parole and avoid a recurrence of drug abuse and crime. And Mental Health Courts treat and monitor those with severe and persistent mental illness who often find their way into the justice system because of their illness.

Today the award-winning NADCP is the premier national membership, training, and advocacy organization for the Drug Court model, representing over 27,000 multidisciplinary justice professionals and community leaders. NADCP hosts the largest annual training conference on drugs and crime in the nation and provides 130 training and technical assistance events each year through its professional service branches, the National Drug Court Institute, the National Center for DWI Courts, and Justice for Vets: The National Veterans Treatment Court Clearinghouse. NADCP publishes numerous scholastic and practitioner publications critical to the growth and fidelity of the Drug Court model, and works tirelessly on Capitol Hill, in the media, and in state legislatures to improve the response of the American justice system to help persons suffering from drug addiction and mental illness through effective policy, legislation, appropriations, and public education.

ACKNOWLEDGMENTS

Producing the first two volumes of the ***Adult Drug Court Best Practice Standards*** has been a tremendous undertaking, which would not have been possible but for the dedication and contributions of so many seasoned and generous professionals. This exhaustive project has been continuing for more than six years. The five standards contained in Volume II and the five preceding standards in Volume I are the products of countless hours of effort from a host of dedicated professionals who volunteered their time, energy, and intellects to the endeavor.

First, I want to thank the committee of volunteer practitioners, researchers, and subject-matter experts who developed the topics and materials contained in these standards. Second, I thank the peer reviewers who provided invaluable and meticulous feedback on each standard. Finally, I thank the NADCP Board of Directors for its leadership and vision in supporting this time- and labor-intensive effort. I reserve special recognition for Dr. Douglas Marlowe, who, as he did with Volume I, labored over every aspect of the document to ensure that it provides guidance that is clear, rooted convincingly in scientific research, and as practical as possible for Drug Court professionals.

I could not be more excited as we release this next volume. In the twenty-six years since the first Drug Court was founded, a vast body of research has proven not only that Drug Courts work, but also how they work and for whom. We now know how to structure and implement our Drug Courts to achieve the best outcomes, and it is a great privilege and honor to share this hard-won knowledge with the Drug Court field. With science guiding the hands of a compassionate and dedicated field of educated professionals, Drug Courts are poised to give hope and the gift of recovery to millions of deserving citizens, enhance public safety in our communities, and make the best use of taxpayer dollars.

Clearly the work is not done. The material contained herein must be disseminated widely to the Drug Court field and translated into day-to-day Drug Court operations. Much effort lies ahead to train practitioners on the content of the standards and put the recommended procedures into effect. In addition, future volumes of the standards will address other aspects of Drug Court procedures as new research findings become available. NADCP stands ready to deliver the requisite training, technical assistance, and knowledge development needed to enact the standards, expand the field's knowledge of best practices, and produce the best possible results for our participants and our communities.

Carolyn D. Hardin
Interim Chief Executive Officer
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Adult Drug Court Best Practice Standards

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Participants receive complementary treatment and social services for conditions that co-occur with substance abuse and are likely to interfere with their compliance in Drug Court, increase criminal recidivism, or diminish treatment gains.

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ADULT DRUG COURT
BEST PRACTICE STANDARDS

INTRODUCTION

Until Drug Courts define appropriate standards of practice, they will be held accountable, fairly or unfairly, for the worst practices in the field. Scientists will continue to analyze the effects of weak Drug Courts alongside those of exceptional Drug Courts, thus diluting the benefits of Drug Courts. Critics will continue to tarnish the reputation of Drug Courts by attributing to them the most noxious practices of the feeblest programs. Only by defining the bounds of acceptable and exceptional practices will Drug Courts be in a position to disown poor-quality or harmful programs and set effective benchmarks for new and existing programs to achieve.

—Adult Drug Court Best Practice Standards, Volume I (NADCP, 2013; p. 1)

Volume I

In 2013, NADCP released Volume I of the *Adult Drug Court Best Practice Standards* (Standards). This landmark document was the product of more than four years of exhaustive work reviewing scientific research on best practices in substance abuse treatment and correctional rehabilitation and distilling that vast literature into measurable and enforceable practice recommendations for Drug Court professionals.

The response from the Drug Court field was immediate and profound. In the ensuing two years, twenty out of twenty-five states (80%) responding to a national survey indicated they have adopted the Standards for purposes of credentialing, funding, or training new and existing Drug Courts in their jurisdictions. The parlance of the field is literally evolving as evidence-based terminology permeates Drug Court policies and procedures. Drug Court professionals now speak routinely about targeting high-risk and high-need participants [Standard I], ensuring equivalent access and services for members of historically disadvantaged groups [Standard II], enhancing perceptions of procedural fairness during court hearings [Standard III], distinguishing proximal from distal behavioral goals and responding to participant conduct accordingly [Standard IV], and delivering evidence-based treatments matched to participants' clinical needs and prognoses for success in treatment [Standard V].

Any concerns that the Standards might sit on a shelf and collect dust vanished rapidly. Drug Courts are changing their policies and procedures in accordance with scientific findings and improving their outcomes as a result.

Volume II

Volume I marked the beginning of an ongoing process of self-evaluation and self-correction initiated by and for the Drug Court field. Before the ink dried on Volume I, NADCP launched subsequent efforts to bring Volume II to print, and those efforts have now reached fruition. Volume II picks up seamlessly where Volume I left off and describes best practices for Drug Courts on the following topics:

VI. Complementary Treatment and Social Services. Drug Court participants often have a range of service needs extending well beyond substance abuse treatment. Standard VI addresses an array of co-occurring needs encountered frequently in Drug Courts, including best practices for delivering mental health treatment, trauma-informed services, criminal thinking interventions, family counseling, vocational or educational counseling, and prevention education to reduce health-risk behaviors.

VII. Drug and Alcohol Testing. Unless Drug Courts have accurate and timely information as to whether participants are maintaining abstinence from illicit drugs and alcohol, they have no way to apply incentives, sanctions, or treatment adjustments effectively. Standard VII describes best practices for detecting unauthorized substance use in a population that is often highly motivated and surprisingly adept at avoiding detection by standard testing methods.

VIII. Multidisciplinary Team. Recent studies have shed considerable light on the workings of the Drug Court team. Standard VIII reviews the latest research indicating which professional disciplines should be represented on the team, how team members should share information and expertise, and how often and under what circumstances team members should receive preparatory instruction and continuing-education training on Drug Court best practices.

IX. Census and Caseloads. Drug Courts need to "go to scale" and treat all eligible individuals involved in the criminal justice system. Yet studies suggest outcomes may decline if caseloads increase without ensuring that programs have sufficient resources to maintain fidelity to best practices. Standard IX identifies milestones related to the size of the Drug Court census and caseloads for supervision officers and clinicians that should trigger a reexamination of a Drug Court's resources and adherence to best practices.

X. Monitoring and Evaluation. Drug Courts are successful in large measure because they recognized the importance of research and evaluation from their inception. Not all studies, however, employ adequate scientific methodology, thus contributing a good deal of "noise" and confusion to the scientific literature on Drug Courts. Standard X describes best practices for monitoring a Drug Court's adherence to best practices and evaluating its impacts on substance abuse, crime, participants' emotional health, and other important outcomes.

Procedures

NADCP employed the same procedures for developing Volume II as were employed for Volume I. The standards were drafted by a diverse and multidisciplinary committee comprising Drug Court practitioners, subject-matter experts, researchers, and state and federal policymakers. Each draft standard was peer-reviewed subsequently by at least thirty practitioners and researchers with expertise in the relevant subject matter. The peer reviewers rated the standards on the dimensions of *clarity* (what specific practices were required), *justification* (why those practices were required), and *feasibility* (how difficult it would be for Drug Courts to implement the practices). All of the standards received ratings from good to excellent and were viewed as achievable by most Drug Courts within a reasonable period of time. How long this process should take will vary from standard to standard. Drug Courts should be able to comply with some of the standards within a few months if they are not already doing so; however, other standards may require three to five years to satisfy.

None of the requirements contained in the Standards will come as a surprise to Drug Court professionals who have attended a training workshop or conference within the past five years. The research supporting these standards has been disseminated widely to the Drug Court field via conference presentations, webinars, practitioner fact sheets, and NDCI's scholarly journal, the *Drug Court Review*. Volumes I and II of the Standards are simply the first documents to compile and distill that research into concrete and measurable practice recommendations.

Future Volumes

The standards contained in Volumes I and II do not come close to addressing every practice performed in a Drug Court. Unless reliable and convincing evidence demonstrated that a practice significantly improves outcomes, it was not incorporated (yet) into a best practice standard. This should in no way be interpreted to suggest that omitted practices are unimportant or less important than the practices that were included. Practices were omitted simply because the current state of research is insufficient at this time to provide dependable guidance to the field or to impose an obligation on Drug Courts to alter their operations. Additional practices will be added to the Standards in future volumes as new studies are completed. Future standards are expected to address topics including best practices for community-supervision officers in Drug Courts; restorative-justice interventions such as community service or victim restitution; payment of fines, fees, and costs; peer and vocational mentoring; and recovery-oriented systems of care. NADCP is working actively with researchers and funders to fill these gaps in the literature and is committed to publishing related practice guidance as soon as a sufficient body of evidence is compiled.

To date, best practice standards have only been developed for Adult Drug Courts. This fact does not suggest that Adult Drug Courts are more effective or valued than other types of problem-solving courts such as Juvenile Drug Courts, DWI Courts, Family Drug Courts, or Veterans Treatment Courts. Adult Drug Courts simply have far more research on them than other types of problem-solving courts. When a sufficient body of research identifies best practices for other problem-solving court programs, NADCP will develop and release best practice standards for those programs as well.

Implementation

Putting science into practice is the greatest challenge facing the substance abuse treatment and criminal justice fields (Damschroder et al., 2009; Rudes et al., 2013; Taxman & Belenko, 2013). So far, Drug Courts are doing considerably better than most programs at following best practice standards; however, more work is needed. Programs that ignore best practices and fail to attend training conferences are the ones most likely to produce ineffective or harmful results (Carey et al., 2012; Shaffer, 2006; van Wormer, 2010) and thus to diminish the effects of Drug Courts and tarnish the reputation of the field. There is no escaping the need to redouble our efforts to disseminate best practice information widely, provide needed technical assistance to help Drug Courts bring themselves into compliance with the standards, and hold outlier programs accountable for refusing to align their practices with what works.

Responsibility for enforcing best practices is the province of state and local court and treatment systems; however, NADCP and other national organizations can and will play a critical role in

training, consulting, and evaluating program adherence to best practices. Coordinated efforts at the state, local, and national levels will teach Drug Courts what they should be doing, why they should be doing it, and how to do it. Programs that turn a blind eye to this assistance will be readily identifiable and will ultimately face the same consequences as any other program or professional that provides deficient services below the recognized standard of care for their field.

Drug Courts have always set the highest standards for themselves. Dissatisfied with what was being done in the past, Drug Courts pushed the envelope and redesigned the criminal justice system. They brushed aside old paradigms and changed the language of justice reform. The large majority of Drug Courts can be expected to follow best practices once those practices have been identified and to save innumerable lives in the process. With a critical mass of effective programs crowding out ineffective alternatives, Drug Courts will continue to lead the way toward improved public health, public safety, and higher financial benefits for taxpayers.

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VI. COMPLEMENTARY TREATMENT AND SOCIAL SERVICES

Participants receive complementary treatment and social services[1] for conditions that co-occur with substance abuse and are likely to interfere with their compliance in Drug Court, increase criminal recidivism, or diminish treatment gains.

A. Scope of Complementary Services

B. Sequence and Timing of Services

C. Clinical Case Management

D. Housing Assistance

E. Mental Health Treatment

F. Trauma-Informed Services

G. Criminal Thinking Interventions

H. Family and Interpersonal Counseling

I. Vocational and Educational Services

J. Medical and Dental Treatment

K. Prevention of Health-Risk Behaviors

L. Overdose Prevention and Reversal

A. Scope of Complementary Services

The Drug Court provides or refers participants for treatment and social services to address conditions that are likely to interfere with their response to substance abuse treatment or other Drug Court services (*responsivity needs*), to increase criminal recidivism (*criminogenic needs*), or to diminish long-term treatment gains (*maintenance needs*). Depending on participant needs, complementary services may include housing assistance, mental health treatment, trauma-informed services, criminal-thinking interventions, family or interpersonal counseling, vocational or educational services, and medical or dental treatment. Participants receive only those services for which they have an assessed need.

B. Sequence and Timing of Services

In the first phase of Drug Court, participants receive services designed primarily to address responsivity needs such as deficient housing, mental health symptoms, and substance-related cravings, withdrawal, or anhedonia (diminished ability to experience pleasure). In the interim phases of Drug Court, participants receive services designed to resolve criminogenic needs that co-occur frequently with substance abuse, such as

[1] The term *complementary treatment and social services* refers to interventions other than substance abuse treatment that ameliorate symptoms of distress, provide for participants' basic living needs, or improve participants' long-term adaptive functioning. The term does not include restorative-justice interventions such as victim restitution, supervisory interventions such as probation home visits, or recovery-oriented services such as peer mentoring.

criminal-thinking patterns, delinquent peer interactions, and family conflict. In the later phases of Drug Court, participants receive services designed to maintain treatment gains by enhancing their long-term adaptive functioning, such as vocational or educational counseling.

C. Clinical Case Management

Participants meet individually with a clinical case manager or comparable treatment professional at least weekly during the first phase of Drug Court. The clinical case manager administers a validated assessment instrument to determine whether participants require complementary treatment or social services, provides or refers participants for indicated services, and keeps the Drug Court team apprised of participants' progress.

D. Housing Assistance

Where indicated, participants receive assistance finding safe, stable, and drug-free housing beginning in the first phase of Drug Court and continuing as necessary throughout their enrollment in the program. If professional housing services are not available to the Drug Court, clinical case managers or other staff members help participants find safe and sober housing with prosocial and drug-free relatives, friends, or other suitable persons. Participants are not excluded from participation in Drug Court because they lack a stable place of residence.

E. Mental Health Treatment

Participants are assessed using a validated instrument for major mental health disorders that co-occur frequently in Drug Courts, including major depression, bipolar disorder (manic depression), posttraumatic stress disorder (PTSD), and other major anxiety disorders. Participants suffering from mental illness receive mental health services beginning in the first phase of Drug Court and continuing as needed throughout their enrollment in the program. Mental illness and addiction are treated concurrently using an evidence-based curriculum that focuses on the mutually aggravating effects of the two conditions. Participants receive psychiatric medication based on a determination of medical necessity or medical indication by a qualified medical provider. Applicants are not denied entry to Drug Court because they are receiving a lawfully prescribed psychiatric medication [see Standard I, Target Population], and participants are not required to discontinue lawfully prescribed psychiatric medication as a condition of graduating from Drug Court [see Standard V, Substance Abuse Treatment].

F. Trauma-Informed Services

Participants are assessed using a validated instrument for trauma history, trauma-related symptoms, and posttraumatic stress disorder (PTSD). Participants with PTSD receive an evidence-based intervention that teaches them how to manage distress without resorting to substance abuse or other avoidance behaviors, desensitizes them gradually to symptoms of panic and anxiety, and encourages them to engage in productive actions that reduce the risk of retraumatization. Participants with PTSD or severe trauma-related symptoms are evaluated for their suitability for group interventions and are treated on an individual basis or in small groups when necessary to manage panic, dissociation, or

severe anxiety. Female participants receive trauma-related services in gender-specific groups. All Drug Court team members, including court personnel and other criminal justice professionals, receive formal training on delivering trauma-informed services.

G. Criminal Thinking Interventions

Participants receive an evidence-based criminal-thinking intervention after they are stabilized clinically and are no longer experiencing acute symptoms of distress such as cravings, withdrawal, or depression. Staff members are trained to administer a standardized and validated cognitive-behavioral criminal-thinking intervention such as Moral Reconation Therapy, the Thinking for a Change program, or the Reasoning & Rehabilitation program.

H. Family and Interpersonal Counseling

When feasible, at least one reliable and prosocial family member, friend, or daily acquaintance is enlisted to provide firsthand observations to staff about participants' conduct outside of the program, to help participants arrive on time for appointments, and to help participants satisfy other reporting obligations in the program. After participants are stabilized clinically, they receive an evidence-based cognitive-behavioral intervention that focuses on improving their interpersonal communication and problem-solving skills, reducing family conflicts, and eliminating associations with substance-abusing and antisocial peers and relatives.

I. Vocational and Educational Services

Participants with deficient employment or academic histories receive vocational or educational services beginning in a late phase of Drug Court. Vocational or educational services are delivered after participants have found safe and stable housing, their substance abuse and mental health symptoms have resolved substantially, they have completed a criminal-thinking intervention, and they are spending most or all of their time interacting with prosocial and sober peers. Vocational interventions are standardized and cognitive-behavioral in orientation and teach participants to find a job, keep a job, and earn a better or higher-paying job in the future though continuous self-improvement. Participants are required to have a stable job, be enrolled in a vocational or educational program, or be engaged in comparable prosocial activity as a condition of graduating from Drug Court. Continued involvement in work, education, or comparable prosocial activity is a component of each participant's continuing-care plan.

J. Medical and Dental Treatment

Participants receive immediate medical or dental treatment for conditions that are life-threatening, cause serious pain or discomfort, or may lead to long-term disability or impairment. Treatment for nonessential or nonacute conditions that are exacerbated by substance abuse may be provided in a late phase of Drug Court or included in the participant's continuing-care plan.

K. Prevention of Health-Risk Behaviors

Participants complete a brief evidence-based educational curriculum describing concrete measures they can take to reduce their exposure to sexually transmitted and other communicable diseases.

L. Overdose Prevention and Reversal

Participants complete a brief evidence-based educational curriculum describing concrete measures they can take to prevent or reverse drug overdose.

COMMENTARY

A. Scope of Complementary Services

Drug Court participants frequently have needs for treatment and social services that extend well beyond substance abuse treatment. National and statewide studies have found that substantial proportions of Drug Court participants suffered from a serious co-occurring mental health or medical disorder, were chronically unemployed, had low educational achievement, were homeless, or had experienced physical or sexual abuse or other trauma (see Table 1).

TABLE 1	COMPLEMENTARY NEEDS IDENTIFIED IN NATIONAL AND STATEWIDE STUDIES OF DRUG COURTS
Complementary Need	**Percentage of Participants**
Any mental health problem/disorder	63%
Major depression	16%–39%
Posttraumatic stress disorder (PTSD)	10%
Anxiety disorder other than PTSD	9%
Bipolar disorder	8%
Chronic medical condition	26%
Unemployed	54%–72%
Less than a high school diploma or GED	32%–38%
Homeless	11%–47%
Abuse or trauma history	27%–29%

Sources: Cissner et al. (2013); Green & Rempel (2012); Peters et al. (2012).

Drug Courts are more effective and cost-effective when they offer complementary treatment and social services to address these co-occurring needs. A multisite study of approximately seventy Drug Courts found that programs were significantly more effective at reducing crime when they offered mental health treatment, family counseling, and parenting classes and were marginally more effective when they offered medical and dental services (Carey et al., 2012). The same study determined that Drug Courts were more cost-effective when they helped participants find a job, enroll in an educational program, or obtain sober and supportive housing. Similarly, a statewide study of eighty-six Drug Courts in New York found that programs were significantly more effective at reducing crime when they assessed participants for trauma and other mental health treatment needs, and delivered mental health, medical, vocational, or educational services where indicated (Cissner et al., 2013).

Studies do not, however, support a practice of delivering the same complementary services to all participants. Drug Courts that required all participants to receive educational or employment services were

determined in one meta-analysis to be less effective at reducing crime than Drug Courts that matched these services to the assessed needs of the participants (Shaffer, 2006). Requiring participants to receive unnecessary services wastes time and resources and can make outcomes worse by placing excessive demands on participants and interfering with the time they have available to engage in productive activities (Gutierrez & Bourgon, 2012; Lowenkamp et al., 2006; Prendergast et al., 2013; Smith et al., 2009; Vieira et al., 2009; Viglione et al., 2015). Evidence also suggests participants may become resentful, despondent, or anxious if they are sanctioned for failing to meet excessive or unwarranted demands, a phenomenon referred to as learned helplessness or ratio burden (Seligman, 1975). Under such circumstances, behavior fails to improve, and participants may leave treatment prematurely (Marlowe & Wong, 2008). If a Drug Court team cannot articulate a sound rationale for requiring a participant to receive a given service, then the team should reconsider requiring that service.

B. Sequence and Timing of Services

Timing is critical to the successful delivery of complementary treatment and social services. Outcomes are significantly better when rehabilitation programs address complementary needs in a specific sequence. This finding has important implications for designing the phase structure in a Drug Court. The first phase of Drug Court should focus primarily on resolving conditions that are likely to interfere with retention or compliance in treatment (responsivity needs). This process may include meeting participants' basic housing needs, stabilizing mental health symptoms if present, and ameliorating acute psychological or physiological symptoms of addiction, such as cravings, anhedonia, or withdrawal. Subsequently, the interim phases of Drug Court should focus on resolving needs that increase the likelihood of criminal recidivism and substance abuse (criminogenic needs). This process includes initiating sustained abstinence from drugs and alcohol, addressing dysfunctional or antisocial thought patterns, eliminating delinquent peer associations, and reducing family conflict. Finally, later phases of Drug Court should address remaining needs that are likely to undermine the maintenance of treatment gains (maintenance needs). This process may include providing vocational or educational assistance, parent training, or other interventions designed to enhance participants' activities of daily living (ADL) skills.[2]

Responsivity Needs. When participants first enter Drug Court, one of the most pressing goals is to ensure that they remain in treatment and comply with other reporting obligations. This objective requires Drug Courts to resolve symptoms or conditions that are likely to interfere with attendance or engagement in treatment. Such conditions are commonly referred to as responsivity needs because they interfere with a person's response to rehabilitation efforts (Andrews & Bonta, 2010; Smith et al., 2009). Although responsivity needs do not necessarily cause or exacerbate crime, they nevertheless must be addressed early in treatment to prevent participants from failing or dropping out of treatment prematurely (Hubbard & Pealer, 2009; Karno & Longabaugh, 2007).

Responsivity needs that are commonly encountered in Drug Courts include severe mental illness and homelessness or unstable housing (Cissner et al., 2013; Green & Rempel, 2012; Peters et al., 2012). Although these conditions usually do not cause crime (Andrews & Bonta, 2010; Bonta et al., 1998; Gendreau et al., 1996), they have a marked tendency to undermine the effectiveness of Drug Courts and other correctional rehabilitation programs (Gray & Saum, 2005; Hickert et al., 2009; Johnson et al., 2011; Mendoza et al., 2013; Young & Belenko, 2002). To avoid premature termination from Drug Court, these responsivity needs must be addressed, when present, beginning in the first phase of treatment and continuing as needed throughout participants' enrollment in the program.

Criminogenic Needs. Criminogenic needs refer to disorders or conditions that cause or exacerbate crime (Andrews & Bonta, 2010). Drug and alcohol dependence are highly criminogenic needs (Bennett et al., 2008; Walters, 2015), which explains why they are the primary focus of most interventions in Drug Courts. Other criminogenic needs that are encountered frequently in Drug Courts include criminal-thinking

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[2] This phase structure assumes a Drug Court is serving high-risk and high-need participants [see Standard I]. If a Drug Court serves individuals who are not addicted to drugs or alcohol or suffering from a serious mental illness, it may be advisable to deliver vocational, educational or other maintenance interventions beginning in an early phase of the program (Cresswell & Deschenes, 2001; Gallagher, 2013a; Vito & Tewksbury, 1998).

patterns, impulsivity, family conflict, and delinquent peer affiliations (Green & Rempel, 2012; Hickert et al., 2009; Jones et al., 2015).

Studies have reported improved outcomes when Drug Courts provided services to address these criminogenic needs. For example, superior outcomes have been reported when Drug Court participants learned to apply effective and prosocial decision-making skills, such as learning to think before they act, to consider the potential consequences of their actions, and to recognize their own role in interpersonal conflicts (Cheesman & Kunkel, 2012; Heck, 2008; Kirchner & Goodman, 2007; Lowenkamp et al., 2009; Vito & Tewksbury, 1998). Similarly, studies found that crime and substance abuse declined significantly when Drug Court participants spent less time interacting with delinquent peers, spent more time interacting with prosocial peers and relatives, and reported fewer conflicts with family members (Green & Rempel, 2012; Hickert et al., 2009; Shaeffer et al., 2010; Wooditch et al., 2013).

Maintenance Needs. Some needs, such as poor job skills, illiteracy, or low self-esteem, are often the result of living a nonproductive or antisocial lifestyle rather than the cause of that lifestyle (Hickert et al., 2009; Wooditch et al., 2013). Treating such noncriminogenic needs before one treats criminogenic needs is associated with increased criminal recidivism, treatment failure, and other undesirable outcomes (Andrews & Bonta, 2010; Andrews et al., 1990; Smith et al., 2009; Vieira et al., 2009). Nevertheless, if these needs are ignored over the long term, they are likely to interfere with the maintenance of treatment gains. Improvements in certain maintenance needs, such as improved educational achievement or job skills, predict better long-term persistence of treatment effects (Leukefeld et al., 2007).

The important point is that improvements in maintenance needs rarely occur until after the more pressing responsivity and criminogenic needs have been resolved. Participants are unlikely, for example, to improve their job performance until after they have stopped experiencing debilitating symptoms of addiction or mental illness, stopped associating with delinquent peers, and relinquished self-centered attitudes and impulsive behaviors (Guastaferro, 2012; Samenow, 2014). After participants are stabilized clinically and have achieved a reasonable period of sobriety, maintenance services designed to enhance their adaptive functioning and ADL skills help to ensure the gains are sustained. Outcomes are also significantly better when continued involvement in maintenance activities after discharge is a requirement for graduation and a component of each participant's continuing-care plan (Carey et al., 2012).

C. Clinical Case Management

Studies consistently find that Drug Courts are more effective and cost-effective when participants meet individually with a clinical case manager or comparable treatment professional at least weekly during the first phase of the program (Carey et al., 2012; Cissner et al., 2013; Zweig et al., 2012). As described previously, Drug Courts must identify a range of complementary needs among participants, refer participants for indicated services, and ensure the services are delivered in an effective sequence. To do otherwise risks wasting resources and making outcomes worse for some participants. These complicated tasks require input from a professionally trained clinical case manager or clinician who is competent to perform clinical and social service assessments, understands how services should be sequenced and matched to participant needs, and is skilled at monitoring and reporting on participant progress (Monchick et al., 2006; Rodriguez, 2011).

Typically, clinical case managers are addiction counselors, social workers, or psychologists who have received specialized training to assess participant needs, broker referrals for indicated services, coordinate care between partner agencies, and report progress information to other interested professionals (Monchick et al., 2006; Rodriguez, 2011). In some Drug Courts, probation officers or other criminal justice professionals may serve as court case managers, to be distinguished from clinical case managers. Typically, court case managers administer brief screening instruments designed to identify participants requiring more in-depth clinical assessments. Participants scoring above established thresholds on the screening instruments are referred for further evaluation by a clinically trained treatment professional.

Broadly speaking, there are four basic models of clinical case management (Hesse et al., 2007; Rapp et al., 2014):

- *Brokerage Model*—The least intensive form of case management, the brokerage model involves assessing participants and linking them to indicated services.
- *Generalist or Clinician Model*—In the most common form of case management, the Generalist case manager assesses participant needs and delivers some or all of the indicated services.
- *Assertive Community Treatment (ACT) Model*—The most intensive form of case management, the ACT Model provides around-the-clock access to a multidisciplinary team of professionals that delivers wrap-around services in the community designed to meet an array of treatment and social-service needs.
- *Strengths-Based Model*—A strengths-based philosophy may be applied in the context of any of the above models. It focuses on leveraging participants' natural resources and encouraging participants to take an active role in setting treatment goals and selecting treatment options.

Meta-analyses reveal that all four case management models significantly increase referrals for indicated services and retain participants longer in treatment; however, they have relatively small effects on substance abuse, crime, and other long-term outcomes (Hesse et al., 2007; Rapp et al., 2014). Whether a program produces long-term improvements depends ultimately on the quality and quantity of treatment and social services that are delivered. No evidence suggests any one case management model is superior to another; however, the models were developed for different types of programs serving individuals with different clinical and social service profiles. The generalist model was developed primarily for use in outpatient treatment settings where a primary therapist commonly delivers or coordinates the delivery of various components of a participant's care. Although few Drug Court studies have provided a clear description of the case management services that were provided, the generalist model appears to be used most frequently in adult Drug Courts (Carey et al., 2012; Cissner et al., 2013; Zweig et al., 2012).

The brokerage model was developed for participants who are served by more than one agency or system. For example, some substance abuse treatment programs may lack the required expertise to deliver mental health treatment or vocational rehabilitation. As a result, participants must be referred to another agency for a portion of their care. A clinical case manager is required to broker the referral, reconcile conflicting demands that may be placed on participants by different agencies, and report on participant progress to the Drug Court team.

A specific model of case management, called Treatment Accountability for Safer Communities or Treatment Alternatives to Street Crime (TASC), was designed to bridge gaps between the substance abuse, mental health, and criminal justice systems. TASC programs typically apply a brokerage or generalist model depending on whether treatment is available within the criminal justice system or must be brokered through another system or agency. Evidence is convincing that TASC programs increase participants' access to services and retention in treatment; however, impacts on substance abuse and crime have been mixed (Anglin et al., 1999; Ventura & Lambert, 2004). As was already noted, the key to successful outcomes depends on the quality and quantity of treatment and social services that are delivered (Clark et al., 2013; Cook, 2002; Rodriguez, 2011). Outcomes are more consistently favorable when TASC case management is delivered in conjunction with intensive evidence-based treatment as in Drug Courts (Monchick et al., 2006). Therefore, training on the TASC model or a comparable case management model is important for staff members providing clinical case management services in Drug Courts.

Finally, the ACT model was developed for use with seriously impaired individuals who have a wide range of mental health and social service needs (McLellan et al., 1998, 1999). This intensive model of case management has been applied successfully in the context of a mental health court (Braude, 2005) and a community court serving persons with serious and persistent mental illness or social service needs (Somers et al., 2014). Training on the ACT model of case management is advisable for Drug Courts serving seriously impaired individuals suffering from co-occurring mental illness, chronic homelessness, or other severe functional impairments.

Regardless of which model of case management is applied, outcomes are superior when case managers administer reliable and valid needs-assessment instruments (Andrews & Bonta, 2010; Andrews et al., 2006). [Appendix C provides examples of validated instruments designed to assess clinical and

criminogenic needs among persons in substance abuse treatment and the criminal justice system.] Whether needs assessments should be administered repeatedly during the course of treatment is an open question. Although evidence suggests changes in need scores correlate with progress in treatment (Greiner et al., 2015; Serin et al., 2013; Vose et al, 2013; Wooditch et al., 2013), little guidance is available to determine when or how to alter treatment conditions in light of changing scores (Serin et al., 2013). Until such guidance is available, Drug Courts are advised to rely on objective indices of participant progress, such as drug test results and treatment attendance rates, to make decisions about adjusting treatment and social services.

On a final note, a critical function of case management is linking participants to public benefits and other subsidies to which they are legally entitled. For example, under the Affordable Care Act (ACA), Drug Court participants may be eligible for medical or mental health care benefits pursuant to Medicaid expansion or newly created health-insurance exchanges (Frescoln, 2014). Court case managers or clinical case managers must leverage these financial resources and enroll participants for eligible benefits to meet participants' needs for substance abuse treatment and other complementary services.

D. Housing Assistance

Participants are unlikely to succeed in treatment if they do not have a safe, stable, and drug-free place to live (Morse et al., 2015; Quirouette et al., 2015). No study was identified that has examined the impact of housing assistance on Drug Court outcomes. However, studies in similar contexts have reported improved outcomes when housing assistance was provided for parolees reentering the community after prison (Clark, 2014; Lutze et al., 2014), in community courts for persons suffering from serious and persistent mental illness (Kilmer & Sussell, 2014; Lee et al., 2013), and in programs serving homeless military veterans (Elbogen et al., 2013; Winn et al., 2014).

Some Drug Courts may have a policy of denying entry to persons who do not have a stable place of residence. Such a policy is likely to have the unintended effect of excluding the highest-risk and highest-need individuals—those who need Drug Court the most—from participation in Drug Court (Morse et al., 2015; Quirouette et al., 2015). The preferable course of action is to provide housing assistance, where indicated, beginning in the first phase of Drug Court and continuing as needed throughout participants' enrollment in the program. If professional housing services are not available to a Drug Court, then clinical case managers or other staff members should make every effort to help participants find safe and stable housing with prosocial and drug-free relatives, friends, or other suitable individuals.

E. Mental Health Treatment

Approximately two-thirds of Drug Court participants report serious mental health symptoms and roughly one-quarter have a diagnosed Axis I psychiatric disorder, most commonly major depression, bipolar disorder, PTSD, or other anxiety disorder (Cissner et al., 2013; Green & Rempel, 2012; Peters et al., 2012). Mental illness, by itself, is ordinarily not a criminogenic need (Bonta et al., 1998; Elbogen & Johnson, 2009; Gendreau et al., 1996; Peterson et al., 2014; Phillips et al., 2005; Prins et al., 2014); however, it is a responsivity need that can interfere significantly with the effectiveness of Drug Courts and other rehabilitation programs (Gray & Saum, 2005; Hickert et al., 2009; Johnson et al., 2011; Manchak et al., 2014; Mendoza et al., 2013; Ritsher et al., 2002; Young & Belenko, 2002). Moreover, when mental illness is combined with substance abuse, the odds of recidivism increase significantly—although the magnitude of this effect is smaller than for most other criminogenic risk factors, such as a participant's criminal history or association with delinquent peers (Andrews & Bonta, 2010; Peters et al., 2015; Rezansoff et al., 2013).

Mental illness and substance abuse may co-occur in a given case for several reasons. Substance abuse may trigger or exacerbate mental illness, mentally ill individuals may abuse substances in a misguided effort to self-medicate psychiatric symptoms, or the two disorders may emerge independently in a person who has a generalized vulnerability to stress-related illness (Ross, 2008). Causality aside, treating either disorder alone without treating both disorders simultaneously is rarely, if ever, successful. Addiction and mental illness are reciprocally aggravating conditions, meaning that continued symptoms of one disorder are likely to precipitate relapse in the other disorder (Chandler et al., 2004; Drake et al., 2008). For example, a

formerly depressed person who continues to abuse drugs is likely to experience a resurgence of depressive symptoms. Conversely, a person recovering from addiction who continues to suffer from depression is at risk for relapsing to drug abuse. For this reason, best practice standards for Drug Courts and other treatment programs require mental illness and addiction to be treated concurrently as opposed to consecutively (Drake et al., 2004; Kushner et al., 2014; Mueser et al., 2003; Osher et al., 2012; Peters, 2008; Steadman et al., 2013). Whenever possible, both disorders should be treated in the same facility by the same professional(s) using an integrated treatment model that focuses on the mutually aggravating effects of the two conditions. The Substance Abuse and Mental Health Services Administration (SAMHSA, 2010) has published therapist toolkits to assist in delivering evidence-based integrated treatments for co-occurring substance-use and mental health disorders.

Participants should also have unhindered access to medical providers qualified to prescribe and monitor response to psychiatric medications (Kushner et al, 2014; Steadman et al., 2013). In one study, Drug Court participants who were prescribed psychiatric medications were seven times more likely to graduate successfully from the program than participants with psychiatric symptoms who did not receive psychiatric medications (Gray & Saum, 2005). Thus, for Drug Courts to deny participants access to psychiatric medication or require them to discontinue legally prescribed psychiatric medication as a condition of entering or graduating from Drug Court is not appropriate [see also Standard I, Target Population, and Standard V, Substance Abuse Treatment]. A participant should only be denied psychiatric medication if the decision is based on expert medical evidence from a qualified physician who has examined the participant and is adequately informed about the facts of the case (Peters & Osher, 2004; Steadman et al., 2013).

F. Trauma-Informed Services

More than one-quarter of Drug Court participants report having been physically or sexually abused in their lifetime or having experienced another serious traumatic event, such as a life-threatening car accident or work-related injury (Cissner et al., 2013; Green & Rempel, 2012). Among female Drug Court participants, studies have found that more than 80% experienced a serious traumatic event in their lifetime, more than half were in need of trauma-related services, and over a third met diagnostic criteria for PTSD (Messina et al., 2012; Powell et al., 2012; Sartor et al., 2012).

Unlike most types of mental illness which are typically noncriminogenic, individuals in the criminal justice system who have PTSD are approximately one and a half times more likely to reoffend than those without PTSD (Sadeh & McNiel, 2015). Moreover, as is true for many forms of mental illness, individuals with PTSD are significantly more likely to drop out or to be discharged prematurely from substance abuse treatment than individuals without PTSD (Mills et al., 2012; Read et al., 2004; Saladin et al., 2014). For these reasons, addressing trauma-related symptoms beginning in the first phase of Drug Court and continuing as necessary throughout participants' enrollment in the program is essential.

Most research on treatment of PTSD and other trauma-related syndromes has been conducted with military veterans or women in gender-specific treatment programs. For persons suffering from a diagnosed PTSD, evidence-based treatments are manualized, standardized, and cognitive-behavioral in orientation (Benish et al., 2008). Effective interventions focus on the following objectives (Benish et al., 2008; Bisson et al., 2007; Bradley et al., 2005; Mills et al., 2012):

- Creating a safe and dependable therapeutic relationship between the participant and therapist
- Helping participants deal with anger, anxiety, and other negative emotions without lashing out or engaging in avoidance behaviors such as substance abuse
- Assisting participants to construct a coherent "narrative" or understanding of the traumatic events that points toward productive actions (For example, many trauma victims believe they were to blame for past traumas or are helpless to prevent future traumas. Helping participants absolve themselves of guilt for past events and learn effective behavioral strategies to avoid future retraumatization is far more productive.)
- Exposing participants, in tolerable dosages, to memories or images of the event in a manner that gradually desensitizes them to associated feelings of panic and anxiety

Web sites providing additional information about evidence-based treatments for PTSD are listed in Appendix D.

In a randomized controlled experiment, female Drug Court participants with trauma histories who received manualized cognitive-behavioral PTSD treatments—Helping Women Recover (Covington, 2008) or Beyond Trauma (Covington, 2003)—in gender-specific groups were more likely to graduate from Drug Court, were less likely to receive a jail sanction in the program, and reported more than twice the reduction in PTSD symptoms than participants with trauma histories who did not receive PTSD treatment (Messina et al., 2012). In another study, female Drug Court participants who received similar interventions—trauma-focused cognitive-behavioral therapy or abuse-focused cognitive-behavioral therapy—reported substantial reductions in substance use and mental health symptoms as well as improvements in housing and employment (Powell et al., 2012). Given the design of these studies, separating the effects of the PTSD treatments from the effects of the gender-specific groups is not possible. Studies have reported superior outcomes when women in the criminal justice system received various types of substance abuse treatment in female-only groups (Grella, 2008; Kissin et al., 2013; Liang & Long, 2013; Morse et al., 2013). Given the current state of knowledge, the best practice is to deliver trauma-related services for women in female-only groups because this combination of services clearly enhances outcomes for these participants.

Not all individuals who experience trauma will develop PTSD or require PTSD treatment, nor can Drug Courts assume that past trauma was the cause of a participant's substance abuse problem or criminal history (Saladin et al., 2014). In some cases, trauma is the result rather than the cause of a participant's substance abuse problem or criminal involvement. Persons who engage in substance abuse or crime often expose themselves repeatedly to the potential for trauma; therefore, treating trauma symptoms without paying equivalent attention to substance abuse and other criminogenic needs is unlikely to produce sustainable improvements.

Although some participants with trauma histories do not require formal PTSD treatment, all staff members, including court personnel and other criminal justice professionals, need to be *trauma-informed* for all participants (Bath, 2008). Staff members should remain cognizant of how their actions may be perceived by persons who have serious problems with trust, are paranoid or unduly suspicious of others' motives, or have been betrayed, sometimes repeatedly, by important persons in their lives. Safety, predictability and reliability are critical for treating such individuals. Several practice recommendations should be borne in mind (Bath, 2008; Covington, 2003; Elliott et al., 2005; Liang & Long, 2013):

- Staff members should strive continually to avoid inadvertently retraumatizing participants. For example, responding angrily to participant infractions, ignoring participants' fears or concerns, maintaining a chaotic or noisy group-counseling environment, or performing urine drug testing in a public or disrespectful manner may reawaken feelings of shame, fear, guilt, or panic in formerly traumatized individuals.
- Staff should remain true to their word, including following policies and procedures as described in the program manual and applying incentives and sanctions as agreed. Too much flexibility, no matter how well-intentioned, may seem unfair and unpredictable to persons who have fallen victim to unexpected dangers in the past.
- Staff should provide clear instructions in advance to participants concerning behaviors that are expected and prohibited in the program. Individuals with trauma histories need to understand the rules and to be prepared for what will occur in the event of an accomplishment or infraction.
- Staff should start and end counseling sessions, court hearings, and other appointments on time, at the agreed-upon location, and according to an agreed-upon structure and format. If participants cannot rely on staff to follow a basic itinerary, relying on those same staff persons for trustworthy support, feedback, and counseling may prove difficult for participants.
- Participants with PTSD or severe trauma-related symptoms, such as panic or dissociation (feeling detached from one's surroundings), may not be suitable candidates for group interventions, especially in the early stages of treatment (Yalom & Leszcz, 2005). Such individuals may need to be treated on an individual basis or in small groups with carefully selected group members who are nonthreatening

and nonpredatory. As was noted earlier, female participants with trauma histories are especially well suited for gender-specific groups (Liang & Long, 2013; Messina et al., 2012).

- Participants with histories of childhood-onset abuse or neglect may be at risk for developing a severe personality disorder such as borderline personality disorder. These individuals may have considerable difficulty trusting others, controlling overwhelming feelings of anger or depression, and containing their impulses. Manualized cognitive-behavioral treatments, such as dialectical behavior therapy (Linehan, 1996), have been shown to improve outcomes in these difficult cases (Dimeff & Koerner, 2007; Linehan et al., 1999). These complicated treatments require specialized training and continuous supervision to help staff deal with uncomfortable and confusing reactions that are commonly engendered in these challenging cases.

G. Criminal Thinking Interventions

As stated earlier, criminal-thinking patterns are observed frequently among Drug Court participants (Jones et al., 2015) and may contribute to program failure (responsivity need) and criminal recidivism (criminogenic need) (Gendreau et al., 1996; Helmond et al., 2015; Knight et al., 2006; Walters, 2003). Some Drug Court participants have considerable difficulty seeing other people's perspectives, recognizing their role in interpersonal conflicts, or anticipating consequences before they act. Moreover, they may hold counterproductive attitudes or values, such as assuming that all people are untrustworthy and motivated to manipulate or dominant others. Given such antisocial sentiments, these participants are often viewed as suspicious or manipulative in character, get into repeated conflicts with others, and fail to learn from negative social interactions.

Several manualized cognitive-behavioral interventions address criminal-thinking patterns among individuals addicted to drugs or charged with crimes. Evidence-based curricula demonstrating improved outcomes in Drug Courts and similar programs include but are not limited to Moral Reconation Therapy (Cheesman & Kunkel, 2012; Heck, 2008; Kirchner & Goodman, 2007), Thinking for a Change (Lowenkamp et al., 2009), and Reasoning & Rehabilitation (Cullen et al., 2012; Tong & Farrington, 2006). Other curricula focused specifically on the needs of men in the criminal justice system, such as Habilitation, Empowerment and Accountability Therapy (Turpin & Wheeler, 2012; Vito & Tewksbury, 1998) and Helping Men Recover (Covington et al., 2011), are undergoing development and effectiveness testing in Drug Courts. Additional information about evidence-based criminal-thinking interventions is provided in Appendix D.

Studies have not determined when delivering criminal-thinking interventions is most beneficial. Clinical experience suggests the most beneficial time to introduce these interventions is after participants are stabilized in treatment and no longer experiencing acutely debilitating symptoms such as cravings, withdrawal, or anhedonia (Milkman & Wanberg, 2007). Until participants are no longer in acute distress, expecting them to benefit from a cognitive-behavioral intervention that requires them to maintain consistent attention and cognitive endurance is unrealistic. Participants should be stabilized clinically before a Drug Court can reasonably expect them to think flexibly about the motivations for their behaviors and the potential ramifications of continuing in their current behavioral patterns.

H. Family and Interpersonal Counseling

Reductions in substance abuse and crime go hand in hand with reduced family conflict, fewer interactions with delinquent relatives and peers, and increased interactions with sober and prosocial individuals (Berg & Huebner, 2011; Fergusson et al., 2002; Knight & Simpson, 1996; Wooditch et al., 2013; Wright & Cullen, 2004). These findings hold true in Drug Courts as they do in most correctional rehabilitation programs (Green & Rempel, 2012; Hickert et al., 2009).

Most studies of family treatments in Drug Courts have been conducted in the context of Family Drug Courts or Juvenile Drug Courts. Results have demonstrated consistently superior outcomes when manualized, cognitive-behavioral family interventions were added to the Drug Court curriculum, including Strengthening Families and Celebrating Families! (Brook et al., 2015) and modified versions of multidimensional family therapy (Dakof et al., 2009, 2010, 2015), multisystemic therapy (Henggeler et al., 2006), and functional family therapy (Datchi & Sexton, 2013). [Further information about these and other

evidence-based family treatments is provided in Appendix D.] Each of these treatments focuses on lessening familial conflict, reducing interactions with drug-using and antisocial peers and relatives, improving communication skills, and enhancing problem-solving skills. In the beginning of treatment, prosocial and drug-free family members, friends, or daily acquaintances are trained by staff to monitor participant behavior reliably, reinforce prosocial activities, respond appropriately and helpfully to problematic behaviors, reduce tension and conflict, and deescalate confrontations. As therapy progresses, treatment focuses on teaching all parties effective communication and problem-solving skills.

Studies have not determined when delivering family or interpersonal counseling in Drug Courts is most beneficial. Given the powerful association between family functioning and criminal justice outcomes, these services should be delivered as soon as practicable. Outcomes in substance abuse treatment are significantly better when at least one reliable and prosocial family member, friend, or close acquaintance is enlisted early in treatment to help the participant arrive on time for appointments and comply with other obligations in the program, such as following a curfew, adhering to prescribed medications, and avoiding forbidden locations like bars (Meyers et al., 1998; Roozen et al., 2010). The same individual may be enlisted to provide helpful observations to staff about the participant's conduct outside of treatment (Kirby et al., 1999). After participants are stabilized clinically, family interventions should focus on improving communication skills, altering maladaptive interactions, reinforcing prosocial behaviors, and reducing interpersonal conflicts.

I. Vocational and Educational Services

Approximately one-half to three-quarters of Drug Court participants have poor work histories or low educational achievement (Cissner et al., 2013; Deschenes et al., 2009; Green & Rempel, 2012; Hickert et al, 2009; Leukefeld et al., 2007). Being unemployed or having less than a high school diploma or general educational development (GED) certificate predicts poor outcomes in Drug Courts (DeVall & Lanier, 2012; Gallagher, 2013b; Gallagher et al., 2015; Mateyoke-Scrivener et al., 2004; Peters et al., 1999; Roll et al., 2005; Shannon et al., 2015) as it does in most other substance abuse treatment (Keefer, 2013) and correctional rehabilitation programs (Berg & Huebner, 2011; Wright & Cullen, 2004).

Unfortunately, few vocational or educational interventions have been successful at reducing crime (Aos et al., 2006; Cook et al., 2014; Farabee et al., 2014; Wilson et al., 2000) or substance abuse (Lidz et al., 2004; Magura et al., 2004; Platt, 1995). Disappointing results have commonly been attributable to poor quality and timing of the interventions. Many vocational programs amount to little more than job-placement services, which alert participants to job openings, place them in a job, or help them conduct a job search. Placing high-risk and high-need individuals in a job is unlikely to be successful if they continue to crave drugs or alcohol, experience serious mental health symptoms, associate with delinquent peers, or respond angrily or impulsively when they are criticized or receive negative feedback from others (Coviello et al., 2004; Lidz et al., 2004; Magura et al., 2004; Platt, 1995; Samenow, 2014). Improvements in education and employment rarely occur until after participants are stabilized clinically, cease interacting with delinquent peers, and learn to deal with frustration in a reasonably effective and mature manner.

At least two studies in Drug Courts have reported improved outcomes when unemployed or underemployed participants received a manualized, cognitive-behavioral vocational intervention. The effective interventions taught participants not only how to find a job, but also how to keep the job by behaving responsibly and dependably and how to land a better or higher-paying job in the future by continually honing their skills and productivity (Deschenes et al., 2009; Leukefeld et al., 2007). Comparable studies in drug abuse treatment reported improved outcomes when participants learned to interact effectively with coworkers and employers and resolve interpersonal conflicts on the job (Platt et al., 1993; Platt, 1995).

Studies have not determined when administering vocational or educational interventions is most beneficial. For high-risk and high-need individuals, these services are best introduced late in the course of Drug Court after participants have secured safe and stable housing, their addiction and mental health symptoms have resolved substantially, they have completed a criminal-thinking intervention, and they are spending most or all of their time interacting with prosocial, sober, and supportive peers (Magura et al., 2004; Platt, 1995). For many high-risk and high-need participants, this preparatory process may require at least six months of

treatment, and twelve months may be needed for individuals with serious substance use disorders or mental illness (Gottfredson et al., 2007; Peters et al., 2002).

J. Medical and Dental Treatment

Approximately one-quarter of Drug Court participants suffer from chronic medical or dental conditions that cause them serious discomfort, require ongoing medical attention, or interfere with their daily functioning (Green & Rempel, 2012). Medical and dental problems are typically maintenance needs, meaning they are most often a result rather than the cause of substance abuse and crime but can interfere with the maintenance of treatment gains. (An obvious exception is participants who become addicted to prescription medications during the course of medical or dental treatment.) Evidence suggests providing medical or dental treatment can improve outcomes for some Drug Court participants (Carey et al., 2012). Moreover, for humanitarian reasons, treating pain or discomfort regardless of the impact on criminal justice outcomes is always important.

No study has determined when addressing medical or dental concerns in Drug Courts is most appropriate. Needless to say, conditions that are life-threatening or may cause long-term disability should be treated immediately. However, waiting until later phases of Drug Court to treat nonessential or nonacute conditions that are exacerbated or maintained by substance abuse may be prudent. Outcomes may be better if medical or dental services are delivered after participants have achieved sobriety and relinquished other antisocial behaviors. For example, participants who abuse methamphetamine often have serious dental problems (American Dental Association, n.d.). If these dental problems are not causing acute distress, it might be appropriate to wait until the participant has stopped using methamphetamine before attempting dental repairs. Continued substance abuse risks undoing dental efforts and may cause a participant to discontinue dental treatment prematurely. A more efficient use of resources may be to address nonessential dental or medical treatment in a late phase of Drug Court or as part of a participant's continuing-care plan so as to maintain and extend the Drug Court's beneficial effects. A logical first step is to refer participants for routine medical and dental checkups to establish relationships with health care providers and begin a long-term process of preventive and routine medical and dental care.

K. Prevention of Health-Risk Behaviors

Alarmingly high percentages of Drug Court participants engage in behaviors which put them at serious risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases (STDs). In some studies, approximately 50% to 85% of Drug Court participants reported engaging in frequent unprotected sex with multiple sex partners (Festinger et al., 2012; Robertson et al., 2012; Tolou-Shams et al., 2012). Drug Court participants were found in one study to lack basic knowledge about simple self-protective measures they can take to reduce their health-risk exposure, such as using condoms and cleaning injection needles (Robertson et al., 2012).

A recent systematic review identified several brief educational interventions that are proven to reduce HIV risk behaviors among drug-addicted persons in the criminal justice system (Underhill et al., 2014). [Additional resources for identifying effective health-risk prevention programs are provided in Appendix D.] Most effective interventions are brief and inexpensive to administer, and some can be delivered via computer or videotape with minimal burden on staff. The criminal justice system is a major vector for the spread of HIV, STDs, and other serious communicable diseases (Belenko et al., 2004; Spaulding et al., 2009). Impacts on crime and substance abuse aside, Drug Courts have a responsibility to reduce the chances that participants will contract a life-threatening or incurable illness, especially in light of the fact that effective interventions can be delivered at minimal cost and burden to the program.

L. Overdose Prevention and Reversal

Unintentional overdose deaths from illicit and prescribed opiates have more than tripled in the past fifteen years (Meyer et al., 2014). Individuals addicted to opiates are at especially high risk for overdose death following release from jail or prison because tolerance to opiates decreases substantially during periods of incarceration (Dolan et al., 2005; Strang, 2015; Strang et al., 2014).

Drug Courts should educate participants, their family members, and close acquaintances about simple precautions they can take to avoid or reverse a life-threatening drug overdose. At a minimum, this should include providing emergency phone numbers and other contact information to use in the event of an overdose or similar medical emergency.

As permitted by law, Drug Courts should also support local efforts to train Drug Court personnel, probation officers, law enforcement, and other persons likely to be first responders to an overdose on the safe and effective administration of overdose-reversal medications such as naloxone hydrochloride (naloxone or Narcan). Naloxone is nonaddictive, nonintoxicating, poses a minimal risk of medical side effects, and can be administered intranasally by nonmedically trained laypersons (Barton et al., 2002; Kim et al., 2009). The Centers for Disease Control and Prevention (2012) estimates that more than 10,000 potentially fatal opiate overdoses have been reversed by naloxone administered by nonmedical laypersons. Studies in the U.S. and Scotland confirm that educating at-risk persons and their significant others about ways to prevent or reverse overdose, including the use of naloxone, significantly reduces overdose deaths (National Institute on Drug Abuse, 2014; Strang, 2015).

State laws vary in terms of who may administer naloxone. Some states shield professional first responders and nonprofessional Good Samaritans from criminal or civil liability if they administer naloxone or render comparable medical aid in the event of a drug overdose (Strang et al., 2006). Other states restrict administration of naloxone to licensed medical providers, trained law enforcement personnel, or other professional first responders.

Some Drug Court professionals may fear this practice could give the unintended message to participants that continued drug use is acceptable or anticipated. On the contrary, educating participants about drug overdose delivers a clear message about the potentially fatal consequences of continued drug abuse. Moreover, drug-abstinent participants may find themselves in the position of needing to save the life of a nonsober family member or acquaintance. Preparing participants to respond effectively in such circumstances delivers the prosocial message that they have a responsibility to help their fellow citizens.

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VII. DRUG AND ALCOHOL TESTING

Drug and alcohol testing provides an accurate, timely, and comprehensive assessment of unauthorized[3] substance use throughout participants' enrollment in the Drug Court.

A. Frequent Testing

B. Random Testing

C. Duration of Testing

D. Breadth of Testing

E. Witnessed Collection

F. Valid Specimens

G. Accurate and Reliable Testing Procedures

H. Rapid Results

I. Participant Contract

A. Frequent Testing

Drug and alcohol testing is performed frequently enough to ensure substance use is detected quickly and reliably. Urine testing is performed at least twice per week until participants are in the last phase of the program and preparing for graduation. Tests that measure substance use over extended periods of time, such as ankle monitors, are applied for at least ninety consecutive days followed by urine or other intermittent testing methods. Tests that have short detection windows, such as breathalyzers or oral fluid tests, are administered when recent substance use is suspected or when substance use is more likely to occur, such as during weekends or holidays.

B. Random Testing

The schedule of drug and alcohol testing is random and unpredictable. The probability of being tested on weekends and holidays is the same as on other days. Participants are required to deliver a test specimen as soon as practicable after being notified that a test has been scheduled. Urine specimens are delivered no more than eight hours after being notified that a urine test has been scheduled. For tests with short detection windows, such as oral fluid tests, specimens are delivered no more than four hours after being notified that a test was scheduled.

C. Duration of Testing

Drug and alcohol testing continues uninterrupted to determine whether relapse occurs as other treatment and supervision services are adjusted.

[3] Unauthorized substances include alcohol, illicit drugs, and addictive or intoxicating prescription medications that are taken without prior approval from the Drug Court and not during a medical emergency.

D. Breadth of Testing

Test specimens are examined for all unauthorized substances of abuse that are suspected to be used by Drug Court participants. Randomly selected specimens are tested periodically for a broader range of substances to detect new substances of abuse that might be emerging in the Drug Court population.

E. Witnessed Collection

Collection of test specimens is witnessed directly by a staff person who has been trained to prevent tampering and substitution of fraudulent specimens. Barring exigent circumstances, participants are not permitted to undergo independent drug or alcohol testing in lieu of being tested by trained personnel assigned to or authorized by the Drug Court.

F. Valid Specimens

Test specimens are examined routinely for evidence of dilution and adulteration.

G. Accurate and Reliable Testing Procedures

The Drug Court uses scientifically valid and reliable testing procedures and establishes a chain of custody for each specimen. If a participant denies substance use in response to a positive screening test, a portion of the same specimen is subjected to confirmatory analysis using an instrumented test, such as gas chromatography/mass spectrometry (GC/MS) or liquid chromatography/mass spectrometry (LC/MS). Barring staff expertise in toxicology, pharmacology, or a related discipline, drug or metabolite concentrations falling below industry- or manufacturer-recommended cutoff levels are not interpreted as evidence of new substance use or changes in participants' substance use patterns.

H. Rapid Results

Test results, including the results of confirmation testing, are available to the Drug Court within forty-eight hours of sample collection.

I. Participant Contract

Upon entering the Drug Court, participants receive a clear and comprehensive explanation of their rights and responsibilities related to drug and alcohol testing. This information is described in a participant contract or handbook and reviewed periodically with participants to ensure they remain cognizant of their obligations.

COMMENTARY

Certainty is one of the most influential factors for success in a behavior modification program (Harrell & Roman, 2001; Marlowe & Kirby, 1999). Outcomes improve significantly when detection of substance use is likely (Kilmer et al., 2012; Marques et al., 2014; Schuler et al., 2014), and participants receive incentives for abstinence and sanctions or treatment adjustments for positive test results (Hawken & Kleiman, 2009; Marlowe et al., 2005). Therefore, the success of any Drug Court will depend, in part, on the reliable monitoring of substance use. If a Drug

Court does not have accurate and timely information about whether participants are maintaining abstinence from alcohol and other drugs, the team has no way to apply incentives or sanctions correctly or to adjust treatment and supervision services accordingly. Drug and alcohol testing also serves other important therapeutic aims, such as helping to confirm clinicians' diagnostic impressions, providing objective feedback to participants about their progress or lack thereof in treatment, and assisting clinicians to challenge and resolve participant denial about the severity of their problems (American Society of Addiction Medicine (ASAM), 2010, 2013; DuPont & Selavka, 2008; DuPont et al., 2014; Srebnik et al., 2014).

Participants cannot be relied upon to self-disclose substance use accurately (Hunt et al., 2015). Studies consistently find that between 25% and 75% of participants in substance abuse treatment deny recent substance use when biological testing reveals a positive result (Auerbach, 2007; Harris et al., 2008; Hindin et al., 1994; Magura & Kang, 1997; Morral et al., 2000; Peters et al., 2015; Tassiopoulos et al., 2004). The accuracy of self-reporting is particularly low among individuals involved in the criminal justice system, presumably because they are likely to receive sanctions for substance use (Harrison, 1997; Peters et al., 2015). Although some clinicians may assume that the accuracy of self-report increases during the course of treatment, contrary evidence suggests participants may be *less* likely to acknowledge substance use after they have been enrolled in treatment for a period of time or have completed treatment (Wish et al., 1997). The longer participants are in treatment, the more staff come to expect and insist upon abstinence. For this reason, participants find it increasingly difficult to admit to substance abuse after they have been enrolled in treatment for several months (Davis et al., 2014; Nirenberg et al., 2013).

Best practices for conducting drug and alcohol testing vary considerably depending on whether a test is administered intermittently as opposed to continually, the length of the test's detection window, and the range of substances the test is capable of detecting. Some tests, such as urine or oral fluid tests, must be administered repeatedly, whereas others, such as sweat patches or ankle monitors, can measure substance use over extended periods of time. Most drug metabolites are detectable in urine for approximately two to four days, but are detectable in oral fluid for an average of twenty-four hours and in breath or blood for less than twelve hours (Auerbach, 2007; Cary, 2011; DuPont et al., 2014). Some tests, such as breathalyzers, can only assess for alcohol use, whereas urine tests can assess for a wide range of substances. These factors influence how the tests must be used to obtain useful results.

Urine testing is, by far, the most common methodology used in Drug Courts and probation programs. This is because urine is typically available in copious amounts, is relatively simple to collect, does not require elaborate sample preparation procedures, is inexpensive to analyze, and can be examined for many substances (Cary, 2011). Most studies, to date, have examined best practices for conducting urine testing with offenders; however, recent studies have begun to examine other testing methods in Drug Courts, including sweat patches and ankle monitors.

A. Frequent Testing

The more frequently Drug Courts and probation programs perform urine drug testing, the better their outcomes in terms of higher graduation rates and lower drug use and criminal recidivism (Banks & Gottfredson, 2003; Gottfredson et al., 2007; Griffith et al., 2000; Harrell et al., 1998; Hawken & Kleiman, 2009; Kinlock et al., 2013; National Institute on Drug Abuse, 2006). In focus groups, Drug Court participants consistently identified frequent drug and alcohol testing as being among the most influential factors for success in the program (Gallagher et al., 2015; Goldkamp et al., 2002; Saum et al., 2002; Turner et al., 1999; Wolfer, 2006).

The most effective Drug Courts perform urine drug testing at least twice per week for the first several months of the program (Carey et al., 2008). In a multisite study of approximately seventy Drug Courts, programs performing urine testing at least twice per week in the first phase produced 38% greater reductions in crime and were 61% more cost-effective than programs performing urine testing less frequently (Carey et al., 2012). Because the metabolites of most drugs of abuse are detectable in urine for approximately two to four days, testing less frequently leaves an unacceptable time gap during which participants can abuse substances and evade detection, thus leading to significantly poorer outcomes (Stitzer & Kellogg, 2008).

Recent studies have examined the impact of other testing methods in Drug Courts. The Secure Continuous Remote Alcohol Monitor (SCRAM) is an ankle device that can detect alcohol in sweat and transmits a wireless signal to a remote monitoring station. Preliminary evidence suggests the use of a SCRAM may

deter alcohol consumption and alcohol-impaired driving among recidivist driving-while-impaired (DWI) offenders if it is worn for at least ninety consecutive days (Flango & Cheesman, 2009; Tison et al., 2015). Another study found that adding sweat patches to urine testing did not improve outcomes in a Drug Court (Kleinpeter et al., 2010). However, that study did not examine the influence of sweat patches alone or as compared against urine testing. The study merely found that the addition of sweat patches did not improve outcomes beyond what was already being achieved from frequent urine drug testing.

Ethyl glucuronide (EtG) and ethyl sulfate (EtS) are metabolites of alcohol that can be detected in urine for longer periods of time than ethanol. The use of EtG or EtS can extend the time window for detecting alcohol consumption from several hours to several days (Cary, 2011). A recent randomized, controlled trial reported that participants completed the first two phases of a Drug Court significantly sooner when they were subjected to weekly EtG and EtS testing (Gibbs & Wakefield, 2014). The EtG and EtS testing enabled the Drug Court to respond more rapidly and reliably to instances of alcohol use, thus producing more efficient results. Importantly, EtG and EtS testing was determined in the same study to be superior to standard ethanol testing for detecting alcohol use occurring over weekends. Because some Drug Courts may not perform drug or alcohol testing on weekends, weekday tests capable of detecting weekend substance use are crucial.

As was noted previously, some drug or alcohol tests have short detection windows of twelve to twenty-four hours. This makes them generally unsuitable for use as the primary testing method in Drug Courts. Such tests can be used effectively, however, for spot-testing when recent use is suspected or during high-risk times, such as weekends or holidays. Evidence also suggests these tests can deter substance use effectively if they are administered on a daily basis. A statewide study in South Dakota found that daily breathalyzer testing significantly reduced failures to appear and rearrest rates among DWI offenders released on bail (Kilmer et al., 2012). In that study, daily breathalyzer testing appears to have been sufficient to deter alcohol consumption in the majority of cases without the need for additional services.

B. Random Testing

Drug and alcohol testing is most effective when performed on a random basis (ASAM, 2013; ASAM, 2010; Auerbach, 2007; Carver, 2004; Cary, 2011; Harrell & Kleiman, 2002; McIntire et al., 2007). If participants know in advance when they will be tested, they can adjust the timing of their usage or take other countermeasures, such as excessive fluid consumption, to defraud the tests (McIntire & Lessenger, 2007). Random drug testing elicits significantly higher percentages of positive tests than prescheduled testing, suggesting that many participants can evade detection if they have advance notice about when testing will occur (Harrison, 1997).

Random testing means the odds of being tested are the same on any given day of the week, including weekends and holidays. For example, if a participant is scheduled to be drug tested two times per week, then the odds of being tested should be two in seven (28%) on every day of the week. For this reason, Drug Courts should not schedule their testing regimens in seven-day or weekly blocks, which is a common practice. Assume, for example, that a participant is randomly selected for drug testing on Monday and Wednesday of a given week. If testing is scheduled in weekly blocks, then the odds of that same participant being selected again for testing on Thursday will be zero. In behavioral terms, this is referred to as a *respite* from detection, which can lead to increased drug or alcohol use owing to the absence of negative consequences (Marlowe & Wong, 2008).

The odds of being tested for drugs and alcohol should be the same on weekends and holidays as on any other day of the week (Marlowe, 2012). Weekends and holidays are high-risk times for drug and alcohol use (Kirby et al., 1995; Marlatt & Gordon, 1985). Providing a respite from detection during high-risk times reduces the randomness of testing and undermines the central aims of a drug-testing program (ASAM, 2013).

Limiting the time delay between notification of an impending drug or alcohol test and collection of the test specimen is essential (ASAM, 2013). If participants can delay provision of a specimen for even a day or two, they can rely on natural elimination processes to reduce drug and metabolite concentrations below cutoff levels. For participants who live in close proximity to the testing facility and do not have confirmed

scheduling conflicts, Drug Courts can reasonably expect samples to be delivered within a few hours of notification that a test has been scheduled (Cary, 2011). Barring exigent circumstances, participants should be required to deliver a urine specimen no more than eight hours after being notified that a urine test has been scheduled (Auerbach, 2007). This practice should give most participants ample time to meet their daily obligations and travel to the sample collection site, while also reducing the likelihood that metabolite concentrations will fall below cutoff levels. For tests with short detection windows of less than twenty-four hours, such as oral fluid tests, participants should be required to deliver a specimen no more than four hours after being notified that a test has been scheduled.

C. Duration of Testing

A basic tenet of behavior modification provides that the effects of any intervention should be assessed continually until all components of the intervention are completed (Rusch & Kazdin, 1981). This is the only way to know whether a participant is likely to relapse or regress after the program ends.

Drug Courts commonly decrease the intensity of treatment and supervision as participants make progress in the program. For example, the frequency of court hearings or case management sessions is commonly reduced as participants advance through successive phases. With a reduction of services comes the ever-present risk of relapse or other behavioral setback; therefore, drug and alcohol testing should continue uninterrupted to reveal any relapse as other components of the participants' treatment regimens are adjusted (Cary, 2011; Marlowe, 2011, 2012). Although research has not addressed the issue, logic dictates maintaining the frequency of drug and alcohol testing until participants are engaged in what will ultimately be their continuing-care or aftercare plan. This practice provides the greatest assurance that participants are likely to remain abstinent after program graduation.

D. Breadth of Testing

Drug Courts must test for the full range of substances that are likely to be used by participants in the program. Participants can easily evade detection of their substance use on many standard test panels—such as the National Institute on Drug Abuse five-panel test (NIDA-5) or a standard eight-panel test—simply by switching to other drugs of abuse that have similar psychoactive effects but are not detected by the test (ASAM, 2013). For example, heroin users can avoid detection by many standard test panels if they switch to pharmaceutical opioids, such as oxycodone or buprenorphine (Wish et al., 2012). Similarly, marijuana users can avoid detection by using synthetic cannabinoids, such as K2 or Spice, which were developed for the specific purpose of avoiding detection (Cary, 2014; Castaneto et al., 2014). Studies confirm that some marijuana users do switch to synthetic cannabinoids to evade detection by drug tests and then return to marijuana use after the testing regimen has been discontinued (Perrone et al., 2013). Because new substances of abuse are constantly being sought out by offenders to cheat drug tests, Drug Courts should select test specimens randomly and frequently and examine them for a wide range of potential drugs of abuse that might be emerging in their population (ASAM, 2013).

E. Witnessed Collection

Drug Court participants and probationers acknowledge engaging in widespread efforts to defraud drug and alcohol tests. These efforts include, but are not limited to, consuming excessive water to dilute the sample (dilution), adulterating the sample with chemicals intended to mask a positive result (adulteration), and substituting another person's urine or a look-alike sample that is not urine, such as apple juice (substitution) (Cary, 2011; McIntire & Lessenger, 2007). Collectively, these efforts are referred to as tampering. In focus groups, Drug Court participants reported being aware of several individuals in their program who tampered with drug tests on more than one occasion without being detected by staff (Goldkamp et al., 2002).

The most effective way to avoid tampering is to ensure that sample collection is witnessed directly by a trained and experienced staff person (ASAM, 2013; Cary, 2011). If substitution or adulteration is suspected, a new sample should be collected immediately under closely monitored conditions (McIntire et al., 2007). Staff members should be trained in how to implement countermeasures to avoid tampered test specimens. Examples of such countermeasures include searching participants' clothing for chemical adulterants or fraudulent samples, requiring participants to leave outerwear outside of the test-collection

room, and putting colored dye in the sink and toilet to prevent water from being used to dilute test specimens (McIntire & Lessenger, 2007).

If substitution or other efforts at tampering are suspected for a urine specimen, it may be useful to obtain an oral fluid specimen immediately as a secondary measure of substance use. Generally speaking, observing the collection of oral fluid closely is easier than for the collection of urine, and oral fluid tests are less susceptible to dilution than urine tests (Heltsley et al., 2012; Sample et al., 2010). However, because oral fluid testing has a shorter detection window than urine testing, a negative oral fluid test would not necessarily rule out recent drug use or the possibility of a tampered urine test.

Because specialized training is required to minimize tampering of test specimens, under most circumstances participants should be precluded from undergoing drug and alcohol testing by independent sources. In exigent circumstances, such as when participants live a long distance from the test collection site, the Drug Court might designate independent professionals or laboratories to perform drug and alcohol testing. As a condition of approval, these professionals should be required to complete formal training on the proper collection, handling, and analyses of drug and alcohol test samples among Drug Court participants or comparable criminal justice populations. Drug Courts are also required to follow generally accepted chain-of-custody procedures when handling test specimens (ASAM, 2013; Cary, 2011; Meyer, 2011). Therefore, if independent professionals or laboratories perform drug and alcohol testing, they must be trained carefully to follow proper chain-of-custody procedures.

F. Valid Specimens

Several low-cost analyses can be performed to detect adulterated or diluted test specimens (McIntire et al., 2007). The temperature of each urine specimen should be examined immediately upon collection to ensure it is consistent with an expected human body temperature. An unusual temperature might suggest the sample cooled down because it was collected at an earlier point in time, or was mixed with water that was too cold or too hot to be consistent with body temperature. Under normal conditions, urine specimens should be between 90^0 and 100^0 F within four minutes of collection, and a lower or higher temperature likely indicates a deliberate effort at deception (ASAM, 2013; Tsai et al., 1998).

Urine specimens should also be tested for creatinine and specific gravity. Creatinine is a metabolic product of muscle contraction that is excreted in urine at a relatively constant rate. A creatinine level below 20 mg/dL is rare and is a reliable indicator of an intentional effort at dilution or excessive fluid consumption barring unusual medical or metabolic conditions (ASAM, 2013; Cary, 2011; Jones & Karlsson, 2005; Katz et al., 2007). Specific gravity reflects the amount of solid substances that are dissolved in urine. The greater the specific gravity, the more concentrated the urine; and the lower the specific gravity, the closer its consistency to water. The normal range of specific gravity for urine is 1.003 to 1.030, and a specific gravity of 1.000 is essentially water. Some experts believe a specific gravity below 1.003 reflects a diluted sample (Katz et al., 2007). Although this analysis, by itself, may not be sufficient to prove excessive fluid consumption, dilution is likely to have occurred if the specific gravity is low and accompanies other evidence of tampering or invalidity, such as a low creatinine level or temperature. Several commercially available test strips, such as Adultacheck and Intect, have also been shown to reliably detect dilution or adulteration of urine test samples (Dasgupta et al., 2004; Mikkelsen & Ash, 1988).

G. Accurate and Reliable Testing Procedures

To be admissible as evidence in a legal proceeding, drug and alcohol test results must be derived from scientifically valid and reliable methods (Meyer, 2011). Appellate courts have recognized the scientific validity of several commonly used methods for analyzing urine, including gas chromatography/mass spectrometry (GC/MS), liquid chromatography/tandem mass spectrometry (LC/MS/MS), the enzyme multiple immunoassay technique (EMIT), and some sweat, oral fluid, hair, and ankle-monitor tests (Meyer, 2011).

Tests such as GC/MS and LC/MS/MS are referred to as instrumented tests, laboratory-based tests, or confirmation tests. These tests have a higher degree of scientific precision than immunoassay tests, point of collection tests (POCT), or screening tests, such as on-site test cups or instant test strips. If a participant

denies substance use in the face of a positive screening test, courts will typically require, and toxicology experts recommend, performing confirmation testing using GC/MS or a similar instrumented technique (ASAM, 2013; Cary, 2011). Confirmation with an instrumented test virtually eliminates the odds of a false-positive result, assuming the sample was collected and stored properly (Auerbach, 2007; Peat, 1988). Drug Courts commonly require participants to pay the cost of confirmation tests if the initial screening result is confirmed (Cary, 2011; Meyer, 2011). Confirmation testing should be performed on a portion of the original test specimen. If confirmation testing is performed on a different specimen that was collected at a later point in time, a conflicting result might not reflect a failure to confirm but rather differences in the detection windows for the tests or the metabolic processes of the participant.

Drug Courts must follow generally accepted chain-of-custody procedures when handling test specimens (ASAM, 2013; Cary, 2011; Meyer, 2011). They need to establish a reliable paper trail identifying each professional who handled the specimen from collection through laboratory analysis to reporting of the results. Establishing a proper chain of custody requires sufficient labeling and security measures to provide confidence the specimen belongs to the individual identified on the record and the specimen was transported and stored according to generally accepted laboratory procedures and manufacturer recommendations.

Some Drug Courts interpret changes in quantitative levels of drug metabolites as evidence that new substance use has occurred or a participant's substance use pattern has changed. Unless a Drug Court has access to an expert trained in toxicology, pharmacology, or a related discipline, such practices should be avoided. Quantitative metabolite levels can vary considerably based on a number of factors, including the total fluid content in urine or blood (Cary, 2004; Schwilke et al., 2010). Moderate changes in participants' fluid intake or fluid retention could lead Drug Courts to miscalculate substance use patterns. Most drug and alcohol tests used in Drug Courts were designed to be *qualitative*, meaning they were designed to determine whether a drug or drug metabolite is present at levels above a prespecified concentration level. The cutoff concentration level is calculated empirically to maximize the true-positive rate, true-negative rate, or classification rate. When Drug Courts engage in quantitative analyses, they are effectively altering the cut-off score and making the results less accurate.

Some Drug Courts have difficulty interpreting positive cannabinoid (marijuana) test results. Because cannabinoids are lipid-soluble (i.e., bind to fat molecules), they may be excreted more slowly than other substances of abuse. This has caused confusion about when a positive cannabinoid result may be interpreted as evidence of new use as opposed to residual use from an earlier episode. A participant is highly unlikely to produce a cannabinoid-positive urine result above 50 ng/mL after more than ten days following cessation of chronic usage or for more than three to four days following a single-use event (Cary, 2005). Therefore, a Drug Court would be justified in considering the first two weeks of enrollment to be a grace period during which there would be no sanctions for positive cannabinoid test results. However, subsequent positive tests may be interpreted as evidence of new cannabis use and dealt with accordingly. Moreover, once a participant has produced two consecutive cannabinoid-negative urine specimens (called an *abstinence baseline*), a subsequent cannabinoid-positive test may be interpreted as new use (Cary, 2005). Some Drug Courts or laboratories may employ a lower cutoff level of 20 ng/mL for cannabis metabolites. Using this lower cutoff, thirty days is sufficient to establish a presumptive abstinence baseline even for chronic users (Cary, 2005); in the majority of cases, twenty-one days should be sufficient.

Some participants may attempt to attribute a positive cannabinoid test to passive inhalation or second-hand smoke. This excuse should not be credited. The likelihood of passive inhalation triggering a positive cannabinoid test is negligible (Cone et al., 2014; Law et al., 1984; Katz et al., 2007; Niedbala et al., 2005). Moreover, because Drug Court participants are usually prohibited from associating with people who are engaged in substance use, passive inhalation may be viewed as a violation of this central prohibition, thus meriting an additional sanction (Marlowe, 2011).

H. Rapid Results

In addition to certainty, timing is one of the most influential factors for success in a behavior modification program (Harrell & Roman, 2001; Marlowe & Kirby, 1999). The sooner sanctions are delivered after an infraction and incentives delivered after an achievement, the better the results. Because sanctions and

incentives are imposed routinely on the basis of drug and alcohol test results, the Drug Court team needs test results before participants appear for status hearings.

A study of approximately seventy Drug Courts reported significantly greater reductions in criminal recidivism and significantly greater cost benefits when the teams received drug and alcohol test results within forty-eight hours of sample collection (Carey et al., 2012). Drug Courts that received test results within forty-eight hours were 73% more effective at reducing crime and 68% more cost-effective than Drug Courts receiving test results after longer delays. Ordinarily, negative test results should take no longer than one business day to produce, and positive results should require no more than two days if confirmation testing is requested (Cary, 2011; Robinson & Jones, 2000).

I. Participant Contract

Outcomes are significantly better when Drug Courts specify their policies and procedures clearly in a participant manual or handbook (Carey et al., 2012). Criminal defendants are significantly more likely to react favorably to an adverse judgment if they were given advance notice about how such judgments would be made (Burke & Leben, 2007; Frazer, 2006; Tyler, 2007). Drug Courts can enhance participants' perceptions of fairness substantially and reduce avoidable delays from contested drug and alcohol tests by describing their testing procedures and requirements in a participant contract or handbook.

Below are examples of provisions that should be included in a participant contract to address many of the best practices discussed above. For participants with limited educational histories, the language may need to be simplified and the requirements explained orally. Repeat the information periodically to ensure participants understand their rights and obligations.

- Drug and alcohol testing will be performed frequently and on a random basis throughout your enrollment in the Drug Court.
- Drug and alcohol testing will be performed on weekends and holidays.
- Drug and alcohol testing will be performed by a laboratory or program approved by the Drug Court.
- Because cannabinoids (a byproduct of marijuana) may persist in the body for several days, marijuana users have a two-week grace period following enrollment during which no sanctions will be given for positive cannabinoid test results. However, after two weeks positive cannabinoid tests will be presumed to reflect new marijuana use. Participants bear the burden of establishing a convincing alternative explanation for such results. After you have had two consecutive cannabinoid-negative urine specimens, the Drug Court will presume that subsequent positive cannabinoid results reflect new use.
- You must arrive at the testing facility as soon as possible after being notified that a test has been scheduled. You will be sanctioned for an unexcused failure to arrive within eight hours of being notified that a urine test has been scheduled or within four hours for tests that have short detection windows, such as breath or oral fluid tests.
- A staff person will directly observe the collection of test specimens. The staff person will be the same gender as you unless you, your defense attorney or your therapist request otherwise.
- Failure to provide a test specimen or providing an insufficient volume of fluid for analysis is an infraction of the rules of the program and will be sanctioned accordingly. You will be given a sufficient time (up to one hour) to deliver a urine specimen and allowed to drink up to one cup of water in the presence of staff.
- You may not drink any fluid excessively before testing and must avoid environmental contaminants, over-the-counter medications, or foods that can reduce the accuracy of the tests. Potential contaminants that you need to avoid are [provide list of contaminants].
- You may be subjected to immediate spot testing if the Drug Court has reason to suspect recent use or during high-risk times such as weekends or holidays.

- You have the right to challenge the results of a screening test and to request proof that an adequate chain of custody was established for your specimen. The Drug Court will rely on the results of an instrumented or laboratory-based test in confirming whether substance use has occurred. You may be charged the cost of the confirmation test if a screening test is confirmed.
- You will be sanctioned for providing diluted, adulterated, or substituted test specimens. Urine specimens below 90° F, above 100° F, or that have a creatinine level below 20 mg/dL will be presumed to be diluted or fraudulent. Participants bear the burden of establishing a convincing alternative explanation for such results. Under such circumstances, you may receive two sanctions, one for the substance use and one for the effort at deception.
- You will be sanctioned for using synthetic substances such as K2 or Spice that are designed to avoid detection by standard drug tests. Switching to a new substance of abuse (for example, switching from heroin to an unauthorized prescription opioid) will be presumed to be an effort to defraud the drug test. You may receive two sanctions in such circumstances, one for the substance use and one for the effort at deception.
- You will be sanctioned for associating with other people who are engaged in substance use or for exposing yourself to passive inhalation or secondhand smoke.

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VIII. MULTIDISCIPLINARY TEAM

A dedicated multidisciplinary team of professionals manages the day-to-day operations of the Drug Court, including reviewing participant progress during pre-court staff meetings and status hearings, contributing observations and recommendations within team members' respective areas of expertise, and delivering or overseeing the delivery of legal, treatment and supervision services.

A. Team Composition

B. Pre-Court Staff Meetings

C. Sharing Information

D. Team Communication and Decision Making

E. Status Hearings

F. Team Training

A. Team Composition

The Drug Court team comprises representatives from all partner agencies involved in the creation of the program, including but not limited to a judge or judicial officer, program coordinator, prosecutor, defense counsel representative, treatment representative, community supervision officer, and law enforcement officer.

B. Pre-Court Staff Meetings

Team members consistently attend pre-court staff meetings to review participant progress, determine appropriate actions to improve outcomes, and prepare for status hearings in court. Pre-court staff meetings are presumptively closed to participants and the public unless the court has a good reason for a participant to attend discussions related to that participant's case.

C. Sharing Information

Team members share information as necessary to appraise participants' progress in treatment and compliance with the conditions of the Drug Court. Partner agencies execute memoranda of understanding (MOUs) specifying what information will be shared among team members. Participants provide voluntary and informed consent permitting team members to share specified data elements relating to participants' progress in treatment and compliance with program requirements. Defense attorneys make it clear to participants and other team members whether they will share communications from participants with the Drug Court team.

D. Team Communication and Decision Making

Team members contribute relevant insights, observations, and recommendations based on their professional knowledge, training, and experience. The judge considers the perspectives of all team members before making decisions that affect participants'

welfare or liberty interests and explains the rationale for such decisions to team members and participants [see Standard III, Roles and Responsibilities of the Judge].

E. Status Hearings

Team members attend status hearings on a consistent basis. During the status hearings, team members contribute relevant information or recommendations when requested by the judge or as necessary to improve outcomes or protect participants' legal interests.

F. Team Training

Before starting a Drug Court, team members attend a formal preimplementation training to learn from expert faculty about best practices in Drug Courts and develop fair and effective policies and procedures for the program. Subsequently, team members attend continuing education workshops on at least an annual basis to gain up-to-date knowledge about best practices on topics including substance abuse and mental health treatment, complementary treatment and social services, behavior modification, community supervision, drug and alcohol testing, team decision making, and constitutional and legal issues in Drug Courts. New staff hires receive a formal orientation training on the Drug Court model and best practices in Drug Courts as soon as practicable after assuming their position and attend annual continuing education workshops thereafter.

COMMENTARY

The Drug Court team is a multidisciplinary group of professionals responsible for administering the day-to-day operations of a Drug Court, including reviewing participant progress during pre-court staff meetings and status hearings, contributing observations and recommendations within team members' respective areas of expertise, and delivering or overseeing the delivery of legal, treatment, and supervision services (Hardin & Fox, 2011). Some Drug Courts may have additional governing bodies such as Steering Committees that are not involved in the daily operations of the program, but provide oversight on policies and procedures, negotiate MOUs between partner agencies, garner political and community support for the Drug Court, or engage in fundraising. Researchers have examined the influence of the multidisciplinary Drug Court team on participant outcomes but have not addressed the influence of other governing bodies.

A. Team Composition

Studies reveal the composition of the Drug Court team has a substantial influence on outcomes. Drug Courts produce significantly greater reductions in criminal recidivism and are significantly more cost-effective when the following professionals are dedicated members of the Drug Court team and participate regularly in pre-court staff meetings and status hearings (Carey et al., 2008, 2012; Cissner et al., 2013; Rossman et al., 2011; Shaffer, 2010):

- *Judge*—Typically a trial court judge leads the Drug Court team; however, in some jurisdictions a nonjudicial officer such as a magistrate or commissioner may preside over the Drug Court. Nonjudicial officers usually report directly to a judge and require judicial authorization for actions that affect participants' liberty interests such as jail sanctions or discharge from the program. No study has compared outcomes between judges and nonjudicial officers.
- *Program Coordinator*—Typically a court administrator or clerk serves as the coordinator for the Drug Court program; however, some Drug Courts may employ a senior probation officer, case manager, or clinician as the coordinator. Among many other duties, the coordinator is responsible for maintaining

accurate and timely records and documentation for the program, overseeing fiscal and contractual obligations, facilitating communication between team members and partner agencies, ensuring policies and procedures are followed, overseeing collection of performance and outcome data, scheduling court sessions and staff meetings, and orienting new hires.

- *Prosecutor*—Typically an assistant district attorney serves on the team. Among other duties, the prosecutor advocates on behalf of public safety, victim interests, and holding participants accountable for meeting their obligations in the program. The prosecutor may also help to resolve other pending legal cases that impact participants' legal status or eligibility for Drug Court.

- *Defense Attorney*—Typically an assistant public defender or private defense attorney specializing in Drug Court cases serves on the team. Among other duties, the defense attorney ensures participants' constitutional rights are protected and advocates for participants' stated legal interests. Defendants are usually represented by a public defender or private defense attorney in proceedings leading up to their entry into Drug Court. After entry, participants may retain their previous defense counsel, provide informed consent to be represented by a defense representative serving on the Drug Court team, or consent to be represented jointly by private defense counsel and the defense representative. In cases of joint representation, the defense representative typically handles most day-to-day issues relating to Drug Court participation, but private counsel may step in if the participant faces a potential jail sanction or discharge from the program (Freeman-Wilson et al., 2003; Tobin, 2012).

  In postconviction Drug Courts, participation in the program is a condition of probation or part of a criminal sentence. Ordinarily, participants are not entitled to defense representation at the postconviction stage unless they face a potential jail sanction or revocation of probation (Meyer, 2011a). Nevertheless, postconviction Drug Courts should include a defense representative on their team because studies indicate defense involvement improves outcomes significantly (Carey et al., 2012; Cissner et al., 2013; National Association of Drug Court Professionals [NADCP], 2009). Evidence suggests participants may be more likely to perceive Drug Court procedures as fair when a dedicated defense attorney represents their interests in team meetings and status hearings (Frazer, 2006), and greater perceptions of fairness are consistently associated with better outcomes in Drug Courts and other problem-solving courts (Berman & Gold, 2012; Burke, 2010; Gottfredson et al., 2007; Rossman et al., 2011).

  Some Drug Courts require participants to waive defense representation as a condition of entry. Although no case has addressed this issue squarely in the context of Drug Court, the weight of legal authority suggests defendants and probationers are entitled to withdraw such waivers and reassert their right to counsel at critical stages in the proceedings such as when they face a potential jail sanction or probation revocation (McKaskle v. Wiggins, 1984; Menefield v. Borg, 1989; Robinson v. Ignacio, 2004; State v. Pitts, 2014). Regardless of the legality of such waivers, defense representation should be encouraged rather than discouraged in Drug Courts because doing so is associated with significantly better outcomes and ensures participants' due process rights are protected (Hora & Stalcup, 2008; NADCP, 2009).

- *Community Supervision Officer*—Typically a probation officer or pretrial services officer serves on the team; however, some Drug Courts may rely on law enforcement or specially trained case managers or social service professionals to provide community supervision. Duties of the community supervision officer may include performing drug and alcohol testing, conducting home or employment visits, enforcing curfews and travel restrictions, and delivering cognitive-behavioral interventions designed to improve participants' problem-solving skills and alter dysfunctional criminal-thinking patterns (Harberts, 2011).

- *Treatment Representative*—Typically an addiction counselor, social worker, psychologist, or clinical case manager serves on the team. In many Drug Courts, participants can be referred to multiple treatment agencies or providers for substance abuse treatment and other complementary services such as mental health counseling or vocational rehabilitation. Because it is unwieldy to have multiple providers attend pre-court staff meetings and status hearings, many Drug Courts will designate one or two treatment professionals to serve as treatment representatives on the Drug Court team (Carey et al., 2012). The treatment representatives receive clinical information from programs treating Drug Court

participants, report that information to the Drug Court team, and contribute clinical knowledge and expertise during team deliberations.

- *Law Enforcement Officer*—Typically a police officer, deputy sheriff, highway patrol officer, or jail official serves on the team. Law enforcement is often the eyes and ears of Drug Court on the street, observing participant behavior and interacting with participants in the community. Law enforcement may also assist with home and employment visits, and serves as a liaison between the Drug Court and the police department, sheriff's office, jail, and correctional system.

Drug Courts may include other community representatives on their team as well, such as peer mentors, vocational advisors, or sponsors from the self-help recovery community. Studies have not examined the impact of including such persons on the Drug Court team; however, anecdotal reports suggest this practice can enhance team decision making and effectiveness (Taylor, 2014). As a condition of federal grant funding and funding from many states, Drug Courts may also be required to include an evaluator on their team beginning in the planning stages for the program and continuing during implementation. This practice helps to ensure Drug Courts collect reliable performance data to report to grant-making authorities and is generally advisable for all Drug Courts to ensure good-quality program monitoring and evaluation [see Standard X, Monitoring and Evaluation]. Finally, Drug Courts may be advised to include a nurse or physician on their team if they treat substantial numbers of participants requiring medication-assisted treatment or suffering from co-occurring medical or mental health disorders.

B. Pre-Court Staff Meetings

The Drug Court model requires Drug Courts to hold pre-court staff meetings—commonly referred to as *staffings* or *case reviews*—to review participant progress, develop a plan to improve outcomes, and prepare for status hearings in court (Hardin & Fox, 2011; NADCP, 1997; Roper & Lessenger, 2007). Not every participant is discussed in every meeting; however, staffings are held frequently enough (typically weekly or at the same frequency as status hearings) to ensure the team has an opportunity to consider the needs of each case.

Consistent attendance by all team members at staffings is associated with significantly better outcomes (Carey et al., 2012; Cissner et al., 2013; Rossman et al., 2011; Shaffer, 2010). A multisite study of approximately seventy Drug Courts found that programs were 50% more effective at reducing recidivism when all team members—the judge, prosecutor, defense representative, program coordinator, treatment representative, law-enforcement representative, and community supervision officer—attended staffings on a consistent basis (Carey et al., 2008, 2012). Drug Courts were nearly twice as cost-effective when defense counsel attended staffings consistently, and were more than twice as effective at reducing recidivism when the program coordinator, treatment representative, and law enforcement representative attended staffings consistently (Carey et al., 2012).

In most Drug Courts, staffings are presumptively closed. Discussions are not transcribed or recorded and the meeting is not open to the public or to participants unless the court has a good reason to allow a participant to attend discussions related to his or her case. Few appellate opinions have addressed the constitutionality or legality of closing staffings. In a recent opinion, the Washington State Supreme Court—which traditionally holds a very dim view of off-the-record proceedings—ruled that staffings may be presumptively closed at the discretion of the Drug Court judge (State of Washington v. Sykes, 2014). The Court analogized staffings to *pre-court conferences* in which attorneys commonly meet with the judge in chambers to clarify what legal issues are under contention, determine which facts are in dispute, and address other practical or collateral matters necessary to achieve a fair and efficient resolution of the case, such as scheduling witnesses or issuing discovery orders. In line with this reasoning, staffings may be closed so long as no final decisions are reached concerning disputed facts or legal issues in the case, and the judge recites in open court what decisions, if any, were made during the staffing. A closed staffing may not result in a binding order or factual conclusion related to a contested matter (Meyer, 2011a). Contested matters must be addressed and resolved in open court during status hearings or related due process hearings such as termination hearings or probation violation hearings.

Studies have not determined whether closed staffings produce more favorable outcomes than open staffings. The rationale for closing staffings derives largely from empirical studies and ethical analyses conducted in the context of psychotherapy progress notes and case conferences. For example, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 grants broad access for patients to their health records, yet provides a lone exception for psychotherapy progress notes (45 C.F.R §§ 164.508(a)(2) & 164.524; U.S. Dept. of Health & Human Services [U.S. DHHS], 2003; Wooten v. Duane Reade, 2009). Psychotherapy notes receive heightened protection against patient access, in part, because they often contain sensitive information provided by collateral sources, such as family members and friends (U.S. DHHS, 2003). If participants could gain access to this information, collateral sources might not be forthright in providing sensitive information about matters which are critical for delivering effective treatment, such as providing accurate histories of participants' substance abuse patterns, criminality, or related conduct (Stasiewicz et al., 2008). Studies have also reported that patients can be harmed psychologically by receiving unfettered access to their therapists' diagnostic impressions and conclusions (Lajeunesse & Lussier, 2010; Ross & Lin, 2003; Sergeant, 1986; Short, 1986; Westin, 1977). Sensitive clinical information must be communicated to patients in a cautious, empathic, and understandable manner to avoid causing psychological distress, embarrassment, confusion, or other untoward reactions (McFarlane et al., 1980; Miller et al., 1987).

Participant attendance at staffings might also inhibit free flow of information among staff, which is necessary to achieve productive aims. Treatment representatives, for example, may be reluctant to discuss their concerns about a participant's prognosis in front of the participant. Probation officers might similarly be reticent to recommend sanctions for participants in response to infractions. It is one thing for sanctions to be imposed by the team as a whole, but quite another for an individual staff member to be identified as the person who first proposed the sanction. Closed staffings allow team members to freely consider alternative courses of action that may or may not be adopted ultimately by the team.

Although staffings are presumptively closed, the judge and team may conclude they have a good reason for a participant to attend discussions related to that participant's case. For example, the team might wish to discuss highly sensitive matters with a participant in private, such as a history of childhood sexual abuse or positive HIV test result. Drug Courts are encouraged to include participants in staffings when clinically indicated or necessary to protect a participant from serious harm resulting from public disclosure of highly sensitive treatment information.

C. Sharing Information

Participants and staff rate communication among team members as one of the most important factors for success in Drug Courts (Frazer, 2006; Gallagher et al., 2015; Lloyd et al., 2014). Participants complain frequently that they are forced to repeat the same information to different professionals and to comply with excessive and inconsistent mandates stemming from different agencies (Goldkamp et al., 2002; Saum et al., 2002; Turner et al., 1999). Ongoing communication among staff ensures participants receive consistent messages, reduces unwarranted burdens on participants, and prevents participants from falling through the cracks or eluding responsibility for their actions by providing different information selectively to different team members.

Contrary to some misconceptions, the HIPAA and other applicable confidentiality statutes (e.g., Confidentiality of Substance Abuse Patient Records, 42 C.F.R. Part 2) do *not* prohibit treatment professionals or criminal justice professionals from sharing information related to substance abuse and mental health treatment (Matz, 2014; Meyer, 2011b). Rather, these statutes control how and under what circumstances such information may be disclosed (U.S. DHHS, 2003). Treatment professionals are generally permitted to share confidential treatment information with criminal justice professionals pursuant to a voluntary, informed, and competent waiver of a patient's confidentiality and privacy rights (45 C.F.R. §164.502(a)) or pursuant to a court order (45 C.F.R. §164.512(e)).

The scope of the disclosure must be limited to the minimum information necessary to achieve the intended aims of the disclosure (45 C.F.R. §§164.502(b) & 164.514(d)). In Drug Courts, team members may ordinarily share information pursuant to a valid waiver to the degree necessary to ensure that participants are progressing adequately in treatment and complying with other conditions of the program (Meyer,

2011b). At a minimum, the following data elements are required by all Drug Court team members to appraise participant progress and compliance or noncompliance with the conditions of Drug Court:

- Assessment results pertaining to a participant's eligibility for Drug Court and treatment and supervision needs
- Attendance at scheduled appointments
- Drug and alcohol test results, including efforts to defraud or invalidate said tests
- Attainment of treatment plan goals, such as completion of a required counseling regimen
- Evidence of symptom resolution, such as reductions in drug cravings or withdrawal symptoms
- Evidence of treatment-related attitudinal improvements, such as increased insight or motivation for change
- Attainment of Drug Court phase requirements, such as obtaining and maintaining employment or enrolling in an educational program
- Compliance with electronic monitoring, home curfews, travel limitations, and geographic or association restrictions
- Adherence to legally prescribed and authorized medically assisted treatments
- Procurement of unauthorized prescriptions for addictive or intoxicating medications
- Commission of or arrests for new offenses
- Menacing, threatening, or disruptive behavior directed at staff members, participants or other persons

To be legally valid, an informed consent document must specify what data elements may be shared, with whom, and for what authorized period of time (Meyer, 2011b). Therefore, the above data elements and any other information that may be shared among team members should be listed in releases of information or confidentiality waivers executed by Drug Court participants (Meyer, 2011b). If the scope of the disclosure is not enumerated clearly, then the waiver may not be knowing or informed—and thus may be legally invalid. Consent documents must also indicate which professionals are authorized to receive the information, what steps participants must take to revoke consent, and when the consent expires. Expiration of consent may be predicated upon a specific event, such as discharge from Drug Court, as opposed to a specific date or time frame (Meyer, 2011b). Finally, recipients of confidential information must be put on notice that they are only permitted to redisclose information to additional parties under carefully specified and approved conditions. MOUs between partner agencies—referred to as business associate contracts pursuant to HIPAA—must state clearly that confidential information may not be redisclosed to additional parties outside of the Drug Court without the express written permission of the participant and may not be used to prosecute new charges against the participant.

Assuming a participant has executed a valid waiver of his or her privacy and confidentiality rights, Drug Court team members are permitted, and indeed may be required, to share covered information in the course of performing their professional duties. Confidentiality and privacy rights belong to the participant, not to staff, and may be waived freely and voluntarily in exchange for receiving anticipated benefits, such as gaining access to effective treatment or avoiding a criminal record or jail sentence (Melton et al., 2007). Failing to abide by a valid confidentiality waiver could, under some circumstances, be a breach of a staff person's professional responsibilities to the participant.

Staff persons also have ethical obligations to other Drug Court team members. If a staff person knowingly withholds relevant information about a participant from other team members, this omission could inadvertently interfere with the participant's treatment goals, endanger public safety, or undermine the functioning of the Drug Court team. All agencies involved in the administration of a Drug Court should, therefore, execute MOUs specifying what data elements will be shared among team members (Harden & Fox, 2011). The data elements listed above might be included in such MOUs to clarify the obligations of each professional on the team.

If a staff person questions the validity or legality of a consent waiver, that staff person should raise this concern with the Drug Court team and make it clear that he or she may withhold relevant progress information until the matter is resolved. This course of action puts the Drug Court team on notice that important information may not be forthcoming and reduces the likelihood that mistaken actions will be taken based on erroneous or incomplete information.

Controversy surrounds the question of whether defense representatives should report infractions by participants to the Drug Court team. In most instances, infractions come to the attention of the team from sources other than defense counsel, such as positive drug tests or progress reports from treatment providers or probation officers. In some instances, however, participants may self-disclose infractions to defense representatives which would otherwise go undetected by the program.

Some defense experts advise against disclosing such communications because doing so may violate the attorney's ethical duty to advocate for the participant's stated legal interests, which are to be distinguished from the participant's *best* interests (Boldt, 1998; National Association of Criminal Defense Lawyers [NACDL], 2009). Other defense experts take the contrary position that withholding such information may undermine the defense representative's trustworthiness and credibility with the team. If team members know or suspect that defense counsel is shielding important information from them, they may discount recommendations from that defense expert as one-sided or nonobjective or may withhold information of their own (Tobin, 2012). In the absence of empirical evidence or legal precedent to guide the decision, defense representatives should make clear their position and the rationale for that position to participants and team members from the outset of each case (Freeman-Wilson et al., 2003). Participants have a right to know whether some confidences shared with defense representatives may be disclosed to other staff members, and team members have a right to know whether some information may not be available to them for decision making.

D. Team Communication and Decision Making

Before the advent of Drug Courts, studies of *courtroom workgroups* raised concerns about relying on multidisciplinary teams to manage criminal and civil cases. In response to overwhelming court dockets in the 1980s, some jurisdictions appointed teams of professionals—commonly including a judge, defense attorney, prosecutor, court clerk, probation officer, and bailiff—to process certain types of cases more efficiently, such as drug possession cases and child maltreatment cases. Observational studies revealed these workgroups tended to routinize their procedures to speed case processing, often at the expense of applying evidence-based practices or adapting dispositions to the needs and risk levels of litigants (Haynes et al., 2010; Knepper & Barton, 1997; Lipetz, 1980). Teaming up as a group did not necessarily improve outcomes and in some cases may have undermined litigants' due process rights. Drug Courts must not, in the interest of expediency, allow assembly-line procedures or groupthink mindsets to interfere with their adherence to due process and best practices.

Drug Courts are properly characterized as nonadversarial programs, meaning participants waive some, but not all, adversarial trial rights as a condition of entry, including the right to a speedy trial and to refuse to provide self-incriminating information (Hora & Stalcup, 2008; NADCP, 1997). Moreover, unlike traditional adversarial proceedings, the Drug Court judge speaks directly to participants rather than through legal counsel and takes an active role in supervising cases. The term nonadversarial does *not*, however, imply that team members relinquish their professional roles or responsibilities (Holland, 2010; Hora & Stalcup, 2008). Prosecutors continue to advocate on behalf of public safety, victim interests, and participant accountability; defense counsel continue to advocate for participants' legal rights; and treatment providers continue to advocate for effective and humane treatment (Freeman-Wilson et al., 2003; Holland, 2010; Tobin, 2012). In other words, the term *nonadversarial* does not have the same meaning as *nonadvocacy*. The principal distinction in Drug Courts is that advocacy occurs primarily in staffings as opposed to court hearings, reserving the greater share of court time for intervening with participants rather than arbitrating uncontested facts or legal issues (Christie, 2014; Portillo et al., 2013).

How Drug Court teams make decisions in this nonadversarial climate has constitutional implications. Due process and judicial ethics require Drug Court judges to exercise independent discretion when resolving factual controversies, ordering conditions of treatment and supervision, and administering sanctions and

incentives that affect participants' liberty interests (Hora & Stalcup, 2008; Meyer, 2011c; Meyer & Tauber, 2011). The judge may not delegate these decisions to the Drug Court team or acquiesce to majority rule [see Standard III, Roles and Responsibilities of the Judge]. The judge must, however, consider arguments from all sides of a controversy (typically from the defense and prosecution) before rendering a decision and must hear evidence from scientific experts if the subject matter of the controversy is beyond the common knowledge of laypersons (Hora & Stalcup, 2008; Meyer, 2011a). Information relating to addiction science and substance abuse treatment is typically beyond the knowledge of laypersons; therefore, this information must usually be introduced or explained by a qualified expert (e.g., Federal Rule of Evidence 702, 2015).

In Drug Courts, the multidisciplinary team serves essentially as a panel of "expert witnesses" providing legal and scientific expertise for the judge (Bean, 2002; Hora & Stalcup, 2008). Team members have an obligation to contribute relevant observations and insights and to offer suitable recommendations based on their professional knowledge, experience, and training. A team member who remains silent in staffings or defers habitually to group consensus is violating his or her professional obligations to participants and to the administration of justice (Freeman-Wilson et al., 2003; Holland, 2010; NACDL, 2009; Tobin, 2012). The judge may ultimately overrule a team member's assertions, but this fact does not absolve the team member from articulating and justifying an informed opinion.

Studies have identified effective communication strategies that can enhance team decision making in Drug Courts. For example, researchers have improved team decision-making skills in several Drug Courts using the NIATx (Network for the Improvement of Addiction Treatment) Organizational Improvement Model (Melnick et al., 2014a, 2014b; Wexler et al., 2012). The NIATx model seeks to create a climate of psychological safety by teaching team members to articulate divergent views in a manner that is likely to be heeded by fellow team members. Examples of NIATx techniques include the following (Melnick et al., 2014b):

- *Avoid Ego-Centered Communications*—Focus statements on the substantive issue at hand rather than attempting to be "right" or win an argument.
- *Avoid Downward Communication*—Ensure that all team members, regardless of status or authority, have an equal opportunity to speak.
- *Practice Attentive Listening*—Hear all aspects of a team member's statements before thinking about or forming a response.
- *Reinforce Others' Statements*—Express appreciation for a team member's input before making counterarguments or changing the subject.
- *Find Common Ground*—Acknowledge areas of agreement among team members before making counterarguments.
- *Reframe Statements Neutrally*—Restate a position in a manner that minimizes counterproductive affect such as anger or frustration.
- *Ensure Inclusiveness*—Ensure that all team members weigh in on subjects within their area of expertise or experience.
- *Show Understanding*—Restate others' positions to demonstrate accurate understanding.
- *Engage in Empathic Listening*—Imagine oneself in other team members' positions to understand issues from their perspective.
- *Sum Up*—The judge should recap the various arguments and positions, assure the team that all positions were considered carefully, and explain his or her rationale for reaching a conclusion or tabling the matter pending further information.

Preliminary studies in more than ten Drug Courts found that training Drug Court teams on the NIATx model enhanced team communication skills (Melnick et al., 2014b), increased staff job satisfaction (Melnick et al., 2014a), and improved program efficiency, leading to higher admission rates, shorter wait times for treatment, and reduced no-show rates at scheduled appointments (Wexler et al., 2012).

E. Status Hearings

Status hearings are critical components of Drug Courts (NADCP, 1997). In status hearings, participants interact with all team members in the same proceeding, the judge speaks personally with each participant, and incentives, sanctions and treatment adjustments are administered in accordance with participants' progress or lack thereof in treatment (Roper & Lessenger, 2007). A substantial body of research establishes convincingly that better outcomes are achieved when status hearings are held biweekly (every two weeks) or more frequently at least during the first phase of Drug Court (Carey et al., 2012; Cissner et al., 2013; Festinger et al., 2002; Jones, 2013; Marlowe et al., 2006, 2007; Mitchell et al., 2012; Rossman et al., 2011).[4]

Studies further reveal that consistent attendance by all team members at status hearings is associated with significantly better outcomes. A study of approximately seventy Drug Courts found that programs were 35% more cost-effective and 35% more effective at reducing crime when all team members—the judge, program coordinator, defense representative, prosecutor, probation officer, treatment representative, and law enforcement representative—attended status hearings regularly (Carey et al., 2012). When a treatment representative attended status hearings regularly, Drug Courts were nearly twice as effective at reducing crime and 80% more cost-effective, and when a representative from law enforcement attended hearings regularly, Drug Courts were over 80% more effective at reducing crime and 60% more cost-effective (Carey et al., 2008, 2012).

Although the judge typically controls most of the interactions during status hearings, observational studies reveal that other team members play an important role as well. Team members may report on participant progress, share their observations of participants, fill in missing information for the judge, offer praise and encouragement to participants, challenge inaccurate statements by participants, or make recommendations for suitable consequences to impose (Baker, 2013; Christie, 2014; Mackinem & Higgins, 2008; McPherson & Sauder, 2013; Portillo et al., 2013; Roper & Lessenger, 2007). Colloquially referred to as *courtroom as theater*, these interactions are often planned in advance during staffings to illustrate treatment-relevant concepts, prevent participants from fomenting disagreement among staff members, and demonstrate unity of purpose for the team as a whole (Satel, 1998; Tauber, 2011). In focus groups, participants rated interactions among staff during court sessions as informative and helpful to improving their performance (Goldkamp et al., 2002).

F. Team Training

Drug Courts represent a fundamentally new way of treating persons charged with drug-related offenses (Roper & Lessenger, 2007). Specialized knowledge and skills are required to implement these multifaceted programs effectively (Carey et al., 2012; Shaffer, 2010; Van Wormer, 2010). To be successful in their new roles, staff members require at least a journeyman's knowledge of best practices in a wide range of areas, including substance abuse and mental health treatment, complementary treatment and social services, behavior modification, community supervision, and drug and alcohol testing. Staff must also learn to perform their duties in a multidisciplinary environment, consistent with constitutional due process and the ethical mandates of their respective professions. These skills and knowledge sets are not taught in traditional law school, graduate school, or most continuing education programs (Berman & Feinblatt, 2005; Holland, 2010). Ongoing specialized training and supervision are needed for staff to achieve the goals of Drug Court and conduct themselves in an ethical, professional, and effective manner.

Preimplementation Trainings—In preimplementation trainings, staff meet for several days as a team to, among other things, develop a mission statement and goals and objectives for their program, learn from expert faculty about best practices in Drug Courts, and develop effective policies and procedures to govern their day-to-day operations (Hardin & Fox, 2011). A multisite study found that Drug Courts were nearly two and a half times more cost-effective and over 50% more effective at reducing recidivism when the teams participated in formal training prior to implementation (Carey et al., 2008, 2012). Drug Courts that

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[4] This finding assumes the Drug Court is serving the appropriate target population of high-risk and high-need participants [see Standard I, Target Population].

did not receive preimplementation training produced outcomes that were negligibly different from traditional criminal justice approaches (Carey et al., 2008).

Continuing Education Workshops—Continuing education workshops are commonly delivered as part of national, regional, or state Drug Court training conferences or in stand-alone seminars. These workshops provide experienced Drug Court professionals with up-to-date knowledge about new research findings on best practices in Drug Courts. Studies consistently find that annual attendance by staff at training workshops is associated with significantly better outcomes. A multisite study involving more than sixty Drug Courts found that annual attendance at training conferences was the greatest predictor of program effectiveness (Shaffer, 2006, 2010). Another large-scale study found that regular participation in continuing education workshops was the greatest predictor of a program's adherence to the Drug Court model (Van Wormer, 2010). After taking continuing education into account, no other variable was independently or incrementally associated with adherence to the Drug Court model. This finding suggests that adherence to best practices may be mediated primarily through staff participation in continuing education workshops. The same study determined that regular attendance in continuing education workshops was also associated with better collaboration among Drug Court team members, increased job satisfaction by staff, greater perceived benefits of Drug Court, greater optimism about the effects of substance abuse treatment, and better perceived coordination between the criminal justice system and other social service and treatment systems (Van Wormer, 2010).

Tutorials for New Staff—Within five years, 30% to 60% of Drug Courts experience substantial turnover in key staff positions (Van Wormer, 2010). The highest turnover rates, commonly exceeding 50%, are among substance abuse and mental health treatment providers (Lutze & Van Wormer, 2007; McLellan et al., 2003; Taxman & Bouffard, 2003; Van Wormer, 2010). Evidence further reveals that staff turnover correlates significantly with downward drift in the quality of the services provided, meaning that services diverge increasingly from the Drug Court model as more staff positions turn over (Van Wormer, 2010).

Research has determined that Drug Courts are more effective when they provide introductory tutorials for new hires. A multisite study of approximately seventy Drug Courts found that programs were over 50% more effective at reducing recidivism when they routinely provided formal orientation training for new staff (Carey et al., 2012). Typically, the tutorials provide a *"Reader's Digest"* orientation to the Ten Key Components of Drug Courts (NADCP, 1997) and a synopsis of best practices associated with each component. The tutorials are not intended to take the place of formal continuing education workshops, but serve rather as a stopgap measure to prevent acute disruption in services and degradation of outcomes. To maintain effective outcomes over time, recent hires should attend formal training workshops as soon as practicable after assuming their new positions. Given the powerful influence of staff training on Drug Court outcomes (Carey et al., 2012; Shaffer, 2006, 2010; Van Wormer, 2010), a firm commitment to ongoing professional education is key to maintaining the success and integrity of Drug Courts.

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IX. CENSUS AND CASELOADS

The Drug Court serves as many eligible individuals as practicable while maintaining continuous fidelity to best practice standards.

A. Drug Court Census
B. Supervision Caseloads
C. Clinician Caseloads

A. Drug Court Census

The Drug Court does not impose arbitrary restrictions on the number of participants it serves. The Drug Court census is predicated on local need, obtainable resources, and the program's ability to apply best practices. When the census reaches 125 active[5] participants, program operations are monitored carefully to ensure they remain consistent with best practice standards. If evidence suggests some operations are drifting away from best practices, the team develops a remedial action plan and timetable to rectify the deficiencies and evaluates the success of the remedial actions.

B. Supervision Caseloads

Caseloads for probation officers or other professionals responsible for community supervision of participants must permit sufficient opportunities to monitor participant performance, apply effective behavioral consequences, and report pertinent compliance information during pre-court staff meetings and status hearings. When supervision caseloads exceed thirty active participants per supervision officer, program operations are monitored carefully to ensure supervision officers can evaluate participant performance accurately, share significant observations with team members, and complete other supervisory duties as assigned. Supervision caseloads do not exceed fifty active participants per supervision officer.

C. Clinician Caseloads

Caseloads for clinicians must permit sufficient opportunities to assess participant needs and deliver adequate and effective dosages of substance abuse treatment and indicated complementary services. Program operations are monitored carefully to ensure adequate services are delivered when caseloads exceed the following thresholds:

- 50 active participants for clinicians providing clinical case management[6]

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[5] Cases are considered to be active if participants are receiving treatment or supervision services from the Drug Court. Participants who have absconded from the program or are continuing on probation but no longer receiving Drug Court services are not considered active.

[6] Clinical case management includes assessing participant needs, brokering referrals for indicated services, coordinating care between partner agencies, and reporting progress information to the Drug Court team (Braude, 2005; Monchick et al., 2006; Rodriguez, 2011). Clinical case managers may also represent treatment concerns during pre-court staff meetings and status

- 40 active participants for clinicians providing individual therapy or counseling
- 30 active participants for clinicians providing both clinical case management and individual therapy or counseling

COMMENTARY

A. Drug Court Census

Drug Courts serve fewer than 10% of adults in the criminal justice system in need of their services (Bhati et al., 2008; Huddleston & Marlowe, 2011). An important goal for the Drug Court field is to take Drug Courts to scale and serve every drug-addicted person in the criminal justice system who meets evidence-based eligibility criteria for the programs (Fox & Berman, 2002). Putting arbitrary restrictions on the size of the Drug Court census unnecessarily reduces the program's impact on public health and public safety.

Not all Drug Courts, however, may have adequate resources to increase capacity while maintaining fidelity to best practices. Surveys of judges and other criminal justice professionals consistently identify insufficient personnel and other resources as the principal barrier preventing Drug Courts from expanding to serve more people (Center for Court Innovation, n.d.; Farole, 2006, 2009; Farole et al., 2005; Huddleston & Marlowe, 2011). Resource limitations may put some Drug Courts in the challenging position of needing to choose between diluting their services to treat more people or turning away deserving individuals.

Evidence suggests expanding Drug Court capacity without sufficient resources can interfere with adherence to best practices. A multisite study of approximately seventy Drug Courts found a significant inverse correlation between the size of the Drug Court census and effects on criminal recidivism (Carey et al., 2008, 2012a). On average, programs evidenced a steep decline in effectiveness when the census exceeded approximately 125 participants. Drug Courts with fewer than 125 participants were over five times more effective at reducing recidivism than Drug Courts with more than 125 participants (Carey et al., 2012a).

Further analyses uncovered a likely explanation for this finding: Drug Courts with more than 125 participants were less likely to follow best practices than Drug Courts with fewer participants. Specifically, when the census exceeded 125 participants, the following was observed (Carey et al., 2012b):[7]

- Judges spent approximately half as much time interacting with participants in court.
- Team members were less likely to attend pre-court staff meetings.
- Treatment and law enforcement representatives were less likely to attend status hearings.
- Drug and alcohol testing occurred less frequently.
- Treatment agencies were less likely to communicate with the court about participant performance via email or other electronic means.
- Participants were treated by a large number of treatment agencies with divergent practices and expectations.
- Team members were less likely to receive training on Drug Court best practices.

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hearings. Some court personnel or criminal justice professionals may be referred to as case managers or court case managers to be distinguished from clinical case managers. Court case managers may screen participants and refer them, when indicated, for more in-depth clinical assessments. These professionals do not provide clinical case management because they are not trained or qualified to administer clinical assessments, interpret assessment results, coordinate treatment delivery, or gauge treatment progress.

[7] All comparisons statistically significant at $p < .05$.

These findings are merely correlations and do not prove that a large census produces poor outcomes. Most Drug Courts in the study were staffed by a single judge and a small team of roughly four to five other professionals overseeing a single court docket. Drug Courts can serve far more than 125 participants with effective results if the programs have sufficient personnel and resources to accommodate larger numbers of individuals. In fact, studies have reported positive outcomes for well-resourced Drug Courts serving more than 400 participants (Carey et al., 2012a; Cissner et al., 2013; Marlowe et al., 2008; Shaffer, 2010).

Nevertheless, the above results raise a red flag that as the census increases, Drug Courts may have greater difficulty delivering the quantity and quality of services required to achieve effective results. Therefore, when the Drug Court census reaches 125 active participants, this milestone should trigger a careful reexamination of the program's adherence to best practices. For example, staff should monitor Drug Court operations to ensure the judge is spending at least three minutes interacting with each participant in court [see Standard III, Roles and Responsibilities of the Judge], drug and alcohol testing is being performed randomly at least twice per week [see Standard VII, Drug and Alcohol Testing], team members are attending pre-court staff meetings and status hearings on a consistent basis [see Standard III and Standard VIII, Multidisciplinary Team], and team members are receiving up-to-date training on best practices [see Standards III and VIII]. If the results of this reexamination suggest some operations are drifting away from best practices, the team should develop a remedial action plan and timetable to rectify the deficiencies and evaluate the success of the remedial actions. For example, the Drug Court might need to hire additional staff to ensure it has manageable participant-to-staff caseloads, schedule status hearings on more days of the week, purchase more drug and alcohol tests, or schedule more continuing-education workshops for staff.

Studies have not determined whether censuses greater than 125 participants should trigger additional reexaminations of adherence to best practices. Until research addresses this question, at a minimum Drug Courts are advised to reexamine adherence to best practices when the census increases by successive increments of 125 participants.

B. Supervision Caseloads

In most Drug Courts, probation officers or pretrial services officers are responsible for supervising participants in the community; however, some Drug Courts may rely on law enforcement or specially trained court case managers to provide community supervision. Duties of the supervision officer may include performing drug and alcohol testing, conducting home and employment visits, enforcing curfews and geographic restrictions, and delivering cognitive-behavioral interventions designed to improve participants' problem-solving skills or alter dysfunctional criminal-thinking patterns (Harberts, 2011).

No study has examined the influence of supervision caseloads in Drug Courts. However, many studies have examined supervision caseloads in the context of adult probation. Early studies found that small probation caseloads were paradoxically associated with *increased* rates of technical violations and arrests for new offenses (Gendreau et al., 2000a; Petersilia, 1999; Turner et al., 1992). This counterintuitive finding was attributable to increased surveillance of the probationers coupled with a failure to apply evidence-based practices. Smaller caseloads led to greater detection of infractions, but most infractions received excessively punitive responses, such as probation revocations, rather than evidence-based treatment or gradually escalating incentives and sanctions (Andrews et al., 1990; Gendreau et al., 2000b; Hollin, 1999).

Recent studies have reported improved outcomes when reduced probation caseloads were combined with evidence-based cognitive-behavioral counseling, motivational interviewing, or gradually escalating incentives and sanctions (Jalbert & Rhodes, 2012; Jalbert et al., 2010, 2011; Paparozzi & Gendreau, 2005; Pearson & Harper, 1990; Worrall et al., 2004). Results of these newer studies confirm that detecting infractions alone is insufficient to improve outcomes. To achieve positive results, probation officers must respond to infractions and achievements by delivering effective behavioral contingencies (incentives and sanctions) and ensuring probationers receive effective and adequate evidence-based treatment and social services (Center for Effective Public Policy, 2014; Paparozzi & Hinzman, 2005; Skeem & Manchak, 2008).

Identifying optimal probation caseloads has been a challenging task. In 1990, the American Probation and Parole Association (APPA, 1991) issued caseload guidelines derived from expert consensus. The 1990

guidelines recommended caseloads of 30:1 for high-risk probationers who have a substantial likelihood of failing on probation or committing a new offense (Table 2). In 2006, the APPA guidelines were amended, in part, to add a new category for intensive supervised probation (ISP). ISP was designed for probationers who are both high risk and high need, meaning they pose a substantial risk of failing on probation and also have serious treatment or social-service needs (Petersilia, 1999). Because ISP and Drug Courts are both intended for high-risk and high-need individuals, recommendations for ISP may be particularly instructive for Drug Court best practices. Based on expert consensus, the 2006 APPA amendments recommended caseloads of 20:1 for high-risk and high-need probationers on ISP, and increased the recommended caseloads to 50:1 for moderate- and high-risk probationers who do not have serious treatment or social-service needs (Byrne, 2012; DeMichele, 2007).

TABLE 2	APPA* RECOMMENDED CASELOADS	
Probationer Risk and Need Level	**1990 Guidelines**	**2006 Guidelines**
ISP:† high risk and high need	NR§	20:1
High risk	30:1	50:1
Moderate risk	60:1	50:1
Low risk	120:1	200:1

*American Probation and Parole Association

†Intensive supervised probation

§Not reported

Sources: APPA (1991); Byrne (2012); DeMichele (2007)

Recent studies examined the effects of adhering to the 2006 APPA guidelines. A randomized experiment compared the services received and outcomes achieved when probation officers had reduced caseloads of approximately 50:1 for moderate and high-risk probationers as compared to typical probation caseloads of approximately 100:1 (Jalbert & Rhodes, 2012). Results confirmed that probationers on 50:1 caseloads received significantly more probation office sessions, field visits, employer contacts, telephone check-ins, and substance abuse and mental health treatment (Jalbert & Rhodes, 2012). As a consequence of receiving more services, they also had significantly better probation outcomes, including fewer positive drug tests and other technical violations (Jalbert & Rhodes, 2012). Probation officers with caseloads substantially above 50:1 had considerable difficulty accomplishing their core missions of monitoring probationers closely and reducing technical violations.

Another quasi-experimental study examined the effects of reducing caseloads from 50:1 to 30:1 for high-risk and high-need probationers on ISP (Jalbert et al., 2010). A 30:1 caseload is greater than the APPA recommended guideline of 20:1 for ISP, but is considerably smaller than typical probation caseloads of 100:1 (Bonta et al., 2008; Paparozzi & Hinzman, 2005) and recommended caseloads of 50:1 for most high-risk probationers (Byrne, 2012). Results confirmed that probationers on 30:1 caseloads had more frequent and longer contacts with their probation officers, and received more specialized services designed to reduce their risk to public safety, including behavior therapy, domestic-violence counseling, spousal-batterer interventions, and sex-offender treatment (Jalbert et al., 2010). Most striking, probationers on 30:1 caseloads had significantly lower recidivism rates lasting for at least two and a half years, including fewer new arrests for drug, property, and violent crimes (Jalbert et al., 2010).

Taken together, the weight of scientific evidence (Jalbert & Rhodes, 2012; Jalbert et al., 2011) and expert consensus (APPA, 1991; Byrne, 2012; DeMichele, 2007) suggests supervision officers are unlikely to manage high-risk cases effectively and reduce technical violations when their caseloads exceed 50:1. Supervision officers in Drug Courts are unlikely to accomplish their core functions of monitoring participants accurately, applying effective behavioral consequences, and sharing important compliance information with Drug Court team members if their caseloads exceed this critical threshold.

Research in ISP programs suggests long-term reductions in criminal recidivism are most likely to be achieved for high-risk and high-need participants when caseloads stay at or below 30:1 (Jalbert et al., 2010). Whether 30:1 caseloads are required similarly for Drug Courts is an open question. Drug Courts

include several components not encompassed by ISP, which may enhance the influence of supervision officers. For example, Drug Court participants are supervised and treated by a multidisciplinary team of professionals and attend status hearings in court on a frequent basis. Larger caseloads may be manageable for supervision officers in light of these additional service elements. Until research resolves the issue, Drug Courts are advised to monitor their operations carefully when caseloads for supervision officers exceed 30:1; caseloads should never exceed a 50:1 ratio. Assurance is needed that supervision officers can monitor participant performance effectively, contribute critical observations and information during pre-court staff meetings and status hearings, and complete other assigned duties such as performing drug and alcohol testing, conducting field visits, and delivering cognitive-behavioral criminal-thinking interventions.

Bear in mind these caseload guidelines assume the supervision officer is assigned principally to Drug Court and is not burdened substantially with other professional obligations. Smaller caseloads may be required if supervision officers are also managing caseloads outside of Drug Court or if they have supplementary administrative or managerial duties in addition to supervising Drug Court participants.

C. Clinician Caseloads

In Drug Courts, addiction counselors, social workers, psychologists, or clinical case managers are typically responsible for assessing participant needs, delivering or overseeing the delivery of treatment services, charting treatment progress, and reporting progress information to the Drug Court team (Lutze & Van Wormer, 2007; Shaffer, 2010; Van Wormer, 2010). Outcomes are significantly better in Drug Courts when participants meet individually with one of these clinicians on a weekly basis for at least the first phase of the program [see Standard V, Substance Abuse Treatment and Standard VI, Complementary Treatment and Social Services].

National studies of outpatient individual substance abuse treatment consistently find that the size of clinician caseloads is inversely correlated with patient outcomes and clinician job performance (Hser et al., 2001; McCaughrin & Price, 1992; Stewart et al., 2004; Vocisano et al., 2004; Woodward et al., 2006). As caseloads increase, patients receive fewer services, patients are more likely to abuse illicit substances, clinicians are more likely to behave punitively toward patients, and clinicians are more likely to report significant job burnout and dissatisfaction (King et al., 2004; Stewart et al., 2004). Comparable studies are lacking for residential substance abuse treatment and for group clinicians who deliver services to several participants simultaneously.

Determining appropriate caseloads for clinicians in Drug Courts depends largely on their role and the scope of their responsibilities:

- Clinical Case Management Role—Some clinicians in Drug Courts serve principally as clinical case managers, assessing participant needs, brokering referrals for services, and reporting progress information to the Drug Court team (Monchick et al., 2006). They may also represent treatment concerns during pre-court staff meetings and status hearings.
- Treatment Provider Role—Some clinicians serve principally as treatment providers, administering individual therapy or counseling and perhaps facilitating or cofacilitating group interventions (Cissner et al., 2013; Zweig et al., 2012). They may also provide or refer participants for indicated complementary services, such as mental health treatment or vocational counseling.
- Combined Clinical Case Management and Treatment Provider Roles—Some clinicians serve both clinical case management and treatment provider functions. In addition to providing individual therapy or counseling, they are responsible for assessing participant needs, referring participants for complementary services, coordinating care between multiple service providers, reporting progress to the Drug Court team, and representing treatment concerns during pre-court staff meetings and status hearings (Braude, 2005; Monchick et al., 2006).

National practitioner organizations have published broad caseload guidelines based in part on these professional roles and responsibilities (Case Management Society of America & National Association of Social Workers, 2008; North Carolina Administrative Office of the Courts, 2010; Rodriguez, 2011). These guidelines have not been validated empirically in terms of their effects on outcomes. Rather, they are

derived from expert consensus about heavy caseloads that are likely too large to deliver adequate services or that contribute to staff burnout and job dissatisfaction. The guidelines focus exclusively on individual counseling and clinical case management. Comparable guidelines for group counselors have not been published. Table 3 summarizes the consensus conclusions.

TABLE 3	CASELOAD GUIDELINES DERIVED FROM EXPERT CONSENSUS	
Principal Role and Responsibilities	**Caseload**	**Reference**
Clinical case management	50:1 to 75:1	Rodriguez (2011)
Individual therapy or counseling	40:1 to 50:1	CMSA* & NASW† (2008) Hromco et al. (2003)
Combination of clinical case management and individual therapy or counseling	30:1	CMSA & NASW (2008) NCAOC§ (2010)

*Case Management Society of America
†National Association of Social Workers
§North Carolina Administrative Office of the Courts

To reiterate, these guidelines are derived from expert consensus and have not been validated against outcomes. Moreover, professional roles and responsibilities are rarely so clearly delineated in day-to-day Drug Court operations. Clinicians in Drug Courts may provide clinical case management for some participants and therapy or counseling for others, may have a mixture of individual and group treatment responsibilities, and may have other nonclinical duties, such as drug and alcohol testing, that reduce the time they have available for clinical assessment, treatment, or case management. Caseload expectations need to be adjusted in light of actual job responsibilities.

Nevertheless, these guidelines should serve as broad milestones to alert Drug Courts to the possibility of clinician overload and the need to audit their operations to ensure adequate services are being delivered. Because Drug Courts serve high-risk and high-need individuals, programs are advised to reexamine adherence to best practices when clinician caseloads reach the lowest ratios reported in Table 3. For example, when clinical case management caseloads exceed 50:1, individual counseling caseloads exceed 40:1, or combined caseloads exceed 30:1, staff should monitor Drug Court operations to ensure participants are being assessed appropriately for risk and need [see Standard I, Target Population], participants are meeting individually with a clinician on a weekly basis for at least the first phase of treatment [see Standard V, Substance Abuse Treatment and Standard VI, Complementary Treatment and Social Services], participants are receiving at least 200 hours of cognitive-behavioral treatment [see Standard V], and clinicians are providing reliable and timely progress information to the Drug Court team [see Standard VIII, Multidisciplinary Team]. Drug Courts are unlikely to achieve the goals of rehabilitating participants and reducing crime if clinicians are spread too thin to assess and meet participants' service needs.

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X. Monitoring and Evaluation

The Drug Court routinely monitors its adherence to best practice standards and employs scientifically valid and reliable procedures to evaluate its effectiveness.[8]

A. Adherence to Best Practices
B. In-Program Outcomes
C. Criminal Recidivism
D. Independent Evaluations
E. Historically Disadvantaged Groups
F. Electronic Database
G. Timely and Reliable Data Entry
H. Intent-to-Treat Analyses
I. Comparison Groups
J. Time at Risk

A. Adherence to Best Practices

The Drug Court monitors its adherence to best practice standards on at least an annual basis, develops a remedial action plan and timetable to rectify deficiencies, and examines the success of the remedial actions. Outcome evaluations describe the effectiveness of the Drug Court in the context of its adherence to best practices.

B. In-Program Outcomes

The Drug Court continually monitors participant outcomes during enrollment in the program, including attendance at scheduled appointments, drug and alcohol test results, graduation rates, lengths of stay, and in-program technical violations[9] and new arrests.

C. Criminal Recidivism

Where such information is available, new arrests, new convictions, and new incarcerations are monitored for at least three years following each participant's entry into the Drug Court. Offenses are categorized according to the level (felony, misdemeanor, or summary offense) and nature (e.g., person, property, drug, or traffic offense) of the crime involved.

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[8] Herein, monitoring refers to periodic descriptions of the services delivered and outcomes achieved in a Drug Court without inferring a causal relationship between the services and outcomes. An evaluation includes a comparison condition and other scientific procedures designed to attribute outcomes to the effects of the Drug Court. Most Drug Courts are capable of monitoring their services and outcomes but may require expert consultation to evaluate the causal effects of their program.

[9] A *technical violation* refers to a violation of a court order that does not constitute a crime per se. For example, drinking alcohol is legal for most adults but is usually a technical violation in a Drug Court.

D. Independent Evaluations

A skilled and independent evaluator examines the Drug Court's adherence to best practices and participant outcomes no less frequently than every five years. The Drug Court develops a remedial action plan and timetable to implement recommendations from the evaluator to improve the program's adherence to best practices.

E. Historically Disadvantaged Groups

The Drug Court continually monitors admission rates, services delivered, and outcomes achieved for members of historically disadvantaged groups who are represented in the Drug Court population. The Drug Court develops a remedial action plan and timetable to correct disparities and examines the success of the remedial actions [see also Standard II, Historically Disadvantaged Groups].

F. Electronic Database

Information relating to the services provided and participants' in-program performance is entered into an electronic database. Statistical summaries from the database provide staff with real-time information concerning the Drug Court's adherence to best practices and in-program outcomes.

G. Timely and Reliable Data Entry

Staff members are required to record information concerning the provision of services and in-program outcomes within forty-eight hours of the respective events. Timely and reliable data entry is required of each staff member and is a basis for evaluating staff job performance.

H. Intent-to-Treat Analyses

Outcomes are examined for all eligible participants who entered the Drug Court regardless of whether they graduated, withdrew, or were terminated from the program.

I. Comparison Groups

Outcomes for Drug Court participants are compared to those of an unbiased and equivalent comparison group. Individuals in the comparison group satisfy legal and clinical eligibility criteria for participation in the Drug Court, but did not enter the Drug Court for reasons having no relationship to their outcomes. Comparison groups do not include individuals who refused to enter the Drug Court, withdrew or were terminated from the Drug Court, or were denied entry to the Drug Court because of their legal charges, criminal history, or clinical assessment results.

J. Time at Risk

Participants in the Drug Court and comparison groups have an equivalent opportunity to engage in conduct of interest to the evaluation, such as substance use and criminal recidivism. Outcomes for both groups are examined over an equivalent time period beginning from a comparable start date. If participants in either group were incarcerated or detained in a residential facility for a significantly longer period of time than

participants in the other group, the length of time participants were detained or incarcerated is accounted for statistically in outcome comparisons.

COMMENTARY

A. Adherence to Best Practices

Adherence to best practices is generally poor in most sectors of the criminal justice and substance abuse treatment systems (Friedmann et al., 2007; Henderson et al., 2007; McLellan et al., 2003; Taxman et al., 2007). Programs infrequently deliver services that are proven to be effective and commonly deliver services which have not been subjected to careful scientific scrutiny. Over time, the quality and quantity of the services provided may decline precipitously (Etheridge et al., 1995; Van Wormer, 2010). The best way for a Drug Court to guard against these prevailing destructive pressures is to monitor its operations routinely, compare its performance to established benchmarks, and seek to align itself continually with best practices. Not knowing whether one's Drug Court is in compliance with best practices makes it highly unlikely that needed improvements will be recognized and implemented; therefore, evaluating a Drug Court's adherence to best practice standards is, itself, a best practice.

Studies reveal that Drug Courts are significantly more likely to deliver effective services and produce positive outcomes when they hold themselves accountable for meeting empirically validated benchmarks for success. A multisite study involving approximately seventy Drug Courts found that programs had more than twice the impact on crime and were more than twice as cost-effective when they monitored their operations on a consistent basis, reviewed the findings as a team, and modified their policies and procedures accordingly (Carey et al., 2008, 2012).

Like many complex service organizations, Drug Courts are highly susceptible to *drift*, in which the quality of their services may decline appreciably over time (Van Wormer, 2010). Management strategies such as continuous performance improvement (CPI), continuous quality improvement (CQI), and managing for results (MFR) are designed to avoid drift and enhance a program's adoption of best practices. Each of these management strategies emphasizes continual self-monitoring and rapid-cycle testing. This process involves collecting real-time information about a program's operations and outcomes, feeding that information back to key staff members and decision makers on a routine basis, and implementing and evaluating remedial action plans where indicated. Research consistently shows that continual self-monitoring and rapid-cycle testing are critical elements for improving outcomes and increasing adoption of best practices in the health care and criminal justice systems (Damschroder et al., 2009; Rudes et al., 2013; Taxman & Belenko, 2013). These strategies are essential for programs that require cross collaboration and interdisciplinary communication among multiple service agencies, including Drug Courts (Bryson et al., 2006; Wexler et al., 2012).

Studies have not determined how frequently programs should review performance information and implement and evaluate self-corrective measures. Common practice among successful organizations is to collect performance data continually and meet at least annually as a team to review the information and take self-corrective measures (Carey et al., 2012; Rudes et al., 2013; Taxman & Belenko, 2013).

Reporting outcomes from Drug Courts without placing those findings into context by describing the quality of the programs is no longer enough. Meta-analyses (Aos et al., 2006; Latimer et al., 2006; Lowenkamp et al., 2005; Mitchell et al., 2012; Shaffer, 2010; Wilson et al., 2006) and large-scale multisite studies (Rossman et al., 2011) have already clearly established that Drug Courts reduce crime by approximately 8% to 14% on average. These averages, derived from evaluations of more than 100 Drug Courts, mask a great deal of variability between programs. Some Drug Courts reduce crime by more than 50%, others have no impact on crime, and still others increase crime rates in their communities (Carey et al., 2012; Carey & Waller, 2011; Cissner et al., 2013; Downey & Roman, 2010; Government Accountability Office, 2011; Mitchell et al., 2012; Shaffer, 2010). The important question is no longer whether Drug Courts can work,

but rather how they work and what services contribute to better outcomes (Marlowe et al., 2006). Understanding what distinguishes effective Drug Courts from ineffective and harmful Drug Courts is now an essential goal for the field. Unless evaluators describe each Drug Court's adherence to best practices, there is no way to place that program's outcomes in context or interpret the significance of the findings.

B. In-Program Outcomes

One of the primary aims of a Drug Court is to rehabilitate seriously addicted individuals, which means that retaining participants in treatment, reducing drug and alcohol use, and helping participants to complete treatment successfully are important indicators of short-term progress. However, policymakers, the public, and other stakeholders are likely to judge the merits of a Drug Court by how well it reduces crime, incarceration rates, and taxpayer expenditures. Therefore, Drug Courts need to measure in-program outcomes that not only reflect clinical progress, but are also significant predictors of postprogram criminal recidivism and other long-term outcomes.

At minimal cost and effort, Drug Courts can evaluate short-term outcomes while participants are enrolled in the program. These short-term outcomes provide significant information about participants' clinical progress and the likely long-term impacts of the Drug Court on public health and public safety. Studies have consistently determined that postprogram recidivism is reduced significantly when participants attend more frequent treatment and probation sessions, provide fewer drug-positive urine tests, remain in the program for longer periods of time, have fewer in-program technical violations and arrests for new crimes, and satisfy other conditions for graduation (Gifford et al., 2014; Gottfredson et al., 2007, 2008; Huebner & Cobbina, 2007; Jones & Kemp, 2011; Peters et al., 2002). Drug Courts should, therefore, monitor and report on these in-program outcomes routinely during the course of their operations.

Several resources are available to help Drug Courts define and calculate performance measures of in-program outcomes (Berman et al., 2007; Heck, 2006; Marlowe, in press; Peters, 1996; Rubio et al., 2008a). In 2006, NADCP convened leading Drug Court researchers and evaluators to form the National Research Advisory Committee (NRAC). One goal of this committee was to define a core data set of in-program performance measures for adult Drug Courts (Heck, 2006). NRAC selected measures that are simple and inexpensive to track and evaluate and proven to predict long-term outcomes. These performance measures include the following:

- *Retention*—the number of participants who completed the Drug Court divided by the number who entered the program
- *Sobriety*—the number of negative drug and alcohol tests divided by the total number of tests performed
- *Recidivism*—the number of participants arrested for a new crime divided by the number who entered the program, and the number of participants adjudicated officially for a technical violation divided by the number who entered the program
- *Units of Service*—the numbers of treatment sessions, probation sessions, and court hearings attended
- *Length of Stay*—the number of days from entry to discharge or the participant's last in-person contact with staff

Longer lists of performance measures addressing a wide range of outcomes in Drug Courts and other problem-solving courts have been published by expert organizations including the National Center for State Courts (Rubio et al., 2008a; Waters et al., 2010), the Center for Court Innovation (Rempel, 2006, 2007), American University (Peters, 1996), the Organization of American States (Marlowe, in press), the National Center for DWI Courts (Marlowe, 2010), and the National Institute of Justice (NIJ, 2010). Drug Courts are advised to consult these and other resources for further information on how to calculate and interpret additional performance measures for their evaluations.

C. Criminal Recidivism

For many policymakers and members of the public, reducing criminal recidivism is one of the primary aims of a Drug Court. Recidivism is defined as any return to criminal activity after the participant entered the Drug Court. Recidivism does not include crimes that occurred before the participant entered Drug Court even if those crimes are charged or prosecuted after entry.

Recidivism is measured most commonly by new arrests, new convictions, or new incarcerations occurring over a two- or three-year period (Carey et al., 2012; King & Elderbroom, 2014; Rempel, 2006). For example, the Bureau of Justice Statistics (BJS) tracks new arrests, convictions, and incarcerations occurring within three years of the date that state and federal inmates are released from jail or prison (Durose et al., 2014).

Based on scientific considerations, evaluators should follow participants for at least three years, and ideally up to five years, from the date of entry into the Drug Court or from the date of the arrest or technical violation that made the individual eligible for Drug Court. The date of entry should be the *latest* start date for the evaluation because that is when the Drug Court becomes capable of influencing participant behavior directly.

Starting from the date of arrest or technical violation takes into account the potential impact of delays in admitting participants to Drug Court. The sooner participants enter Drug Court after an arrest or probation violation, the better the results (Carey et al., 2008, 2012); therefore, evaluators may wish to examine how delayed entry affects outcomes. However, because Drug Courts cannot always control what transpires before participants enter the Drug Court program, attributing to the Drug Court any recidivism occurring before entry may not fairly represent the Drug Courts' effects on recidivism. Starting from the date of entry ensures recidivism may be attributed fairly to the effects of the Drug Court. No one answer fully addresses the issues surrounding selection of a start date for evaluation; therefore; evaluators should state clearly what start date was selected and the rationale for choosing that start date.

Rates of criminal recidivism among drug-involved offenders become relatively stable after approximately three to five years (King & Elderbroom, 2014). After three years, statistically significant between-group differences in recidivism are likely to remain significant going forward (e.g., Knight et al., 1999; Martin et al., 1999; Wexler et al., 1999). For example, if Drug Court participants have significantly lower rearrest rates than comparison group subjects after three years, this difference is likely (although not guaranteed) to remain significant after an additional two years (DeVall et al., 2015). After five years, recidivism rates tend to reach a plateau, meaning that most (but not all) participants who will recidivate have likely done so by then (e.g., Gossop et al., 2005; Inciardi et al., 2004; Olson & Lurigio, 2014).

Importantly, these findings do not suggest Drug Courts must wait three to five years before reporting recidivism outcomes. Recidivism occurring during enrollment and shortly after discharge from Drug Court may be of considerable interest to practitioners, policymakers, and other stakeholders. However, implying that recidivism rates occurring within the first two years are likely to reflect the long-term effects of a Drug Court is inappropriate. Evaluators should state clearly that such recidivism rates are preliminary and likely to increase over time.

No one basis exists for deciding whether new arrests, new convictions, or new incarcerations are likely to be the most valid or informative indicator of recidivism. As discussed below, each measure has advantages and disadvantages that the evaluator must take into account. Because no one measure is clearly superior to another, whenever possible evaluators are advised to report all three measures of recidivism, discuss the implications and limitations of each, or indicate why a particular measure is not being reported.

Analyzing new arrests as a measure of criminal recidivism provides at least two advantages. First, arrests are often substantially closer in time to the alleged offense than convictions. Resolving a criminal case and determining guilt or innocence may take months or years. Evaluators can usually report arrest outcomes in much less time than waiting for lengthy legal proceedings to resolve. Second, criminal cases are often dismissed or pled down to a lesser charge for reasons having little to do with factual guilt, such as

insufficient evidence or plea bargains. As a result, the absence of a conviction or conviction on a lesser charge may not reflect the offense that occurred.

However, some individuals are arrested for crimes they did not commit. This fact may lead to an overestimation of the true level of criminal recidivism. Relying on conviction data rather than arrest data may provide greater assurances that the crimes did, in fact, occur.

Incarceration has substantial cost impacts that may far exceed those of arrests and convictions. A day in jail or prison can cost between five and twenty times more than a day on probation or in community-based treatment (Belenko et al., 2005; Zarkin et al., 2012). Evaluators typically distinguish between incarceration that occurred while participants were enrolled in the Drug Court and incarceration that occurred after discharge. In-program incarceration often reflects brief jail sanctions that may be imposed for misconduct in the program, whereas postprogram incarceration typically reflects pretrial detention for new charges, sentences for new charges, or (for terminated participants) sentencing on the original charge that led to participation in Drug Court. In cost evaluations, in-program jail sanctions are typically counted as an investment cost for the Drug Court whereas postprogram detention is typically counted as an outcome cost (Carey et al., 2012).

Evaluators must also consider the timeliness and accuracy of information contained in criminal justice databases. In some jurisdictions, arrest data may be recorded in a more timely and faithful manner than conviction or incarceration data. Evaluators must familiarize themselves with how and when information is entered into national, state, and local criminal justice records and should describe clearly in their evaluation reports any limitations that may relate to the accuracy or timeliness of the data.

Self-report information could potentially provide the most accurate assessment of criminal recidivism because it does not require detection or prosecution by law enforcement. Because many crimes are unreported by victims and undetected by the authorities (Truman & Langton, 2014), arrest and conviction data may underestimate true levels of criminal activity. For obvious reasons, however, individuals cannot be relied upon to acknowledge their crimes unless they receive strict assurances that the information will be kept confidential and will not be used against them in a criminal proceeding. Drug Courts will typically be required to hire an independent evaluator who has no connection to the court or criminal justice system to confidentially survey participants. This method is likely to be prohibitively costly for many Drug Courts, which explains why it has rarely been employed with the notable exception of one highly funded national study (Rossman et al., 2011).

Whether measured by arrests, convictions, or incarcerations, categorizing recidivism according to the level (i.e., felony, misdemeanor, or summary offense) and nature (e.g., drug offenses, property and theft offenses, violent offenses, technical violations, prostitution, and traffic offenses) of the crimes involved is highly informative and necessary. Different categories of crime can have very different implications for public safety and cost. For example, violent offenses may have serious victimization costs and may result in substantial jail or prison sentences, whereas drug possession may not involve an identifiable victim and is more likely to receive a less costly probation sentence (Zarkin et al., 2012).

As a final note, not all Drug Courts have reasonable access to data on new arrests, convictions, or incarcerations occurring after participants have been discharged from the program. In some jurisdictions, these records may be in the possession of other executive agencies, such as the police department or department of corrections, and the Drug Court may not be entitled to the information. Under such circumstances, Drug Courts should make every effort to negotiate access to the data, but of course, Drug Courts cannot be held accountable for reporting information beyond their reach.

D. Independent Evaluations

In addition to monitoring their own performance, Drug Courts benefit greatly from having an independent evaluator examine their program and issue recommendations to improve their adherence to best practices. Drug Courts that engaged an independent evaluator and implemented at least some of the evaluator's recommendations were determined in one multisite study to be twice as cost-effective and nearly twice as

effective at reducing crime as Drug Courts that did not engage an independent evaluator (Carey et al., 2008, 2012).

Drug Courts benefit from an independent evaluation for several reasons. Every program has blind spots that prevent staff from recognizing their own shortcomings. Some team members, such as the judge, may have more social influence or power than others, making it difficult for some team members to call attention to problems in court or during team meetings. Drug Courts also operate in a political environment and staff may be hesitant to criticize local practices for fear of reprisal. An independent evaluator from another jurisdiction can usually offer frank criticisms of current practices with less fear of repercussions (Heck & Thanner, 2006).

Although most Drug Courts are capable of keeping descriptive statistics about their program, considerably more expertise is required to perform *inferential analyses*, which compare Drug Court outcomes to those of a comparison group. Controlling statistically for preexisting group differences that could bias one's results is often necessary. For example, if Drug Court participants had fewer previous convictions than comparison subjects before entering the study, better outcomes for the Drug Court might simply reflect the fact that it treated a less severe population. Evaluators must take numerous scientific matters into consideration and may need to apply several levels of statistical corrections to produce valid and reliable results.

Studies also reveal that participant perceptions are often highly predictive of outcomes in Drug Courts. For example, perceptions concerning the procedural fairness of the program (Burke, 2010; McIvor, 2009), the manner in which incentives and sanctions are delivered (Goldkamp et al., 2002; Harrell & Roman, 2001; Marlowe et al., 2005), and the quality of the treatment services provided (Turner et al., 1999) are often predictive of recidivism and correlate significantly with adherence to best practices. Needless to say, participants are more likely to be forthright with an independent evaluator about their perceptions of the Drug Court than with staff members who control their fate in the criminal justice system.

Studies have not determined how frequently Drug Courts should be evaluated by an independent investigator. Generally speaking, a new evaluation should be performed whenever a program or the environment within which it operates changes substantially. Staff turnover and evidence of drift from the intended model are critical events that call for a new evaluation (Yeaton & Camberg, 1997). Evidence suggests that staff turnover and model drift occur within five-year intervals in Drug Courts. Within five years, between roughly 30% and 60% of Drug Courts experience substantial turnover in key staff positions (Van Wormer, 2010). The highest turnover rates, commonly exceeding 50%, are among substance abuse and mental health treatment providers (Lutze & Van Wormer, 2007; McLellan et al., 2003; Taxman & Bouffard, 2003; Van Wormer, 2010). Evidence further reveals that staff turnover correlates significantly with drift in the quality of the services provided (Van Wormer, 2010). Therefore, five years is a reasonable outside estimate of how frequently Drug Courts should be evaluated independently. If resources allow, Drug Courts should engage independent evaluators at more frequent intervals to detect drift readily and prevent services from worsening with time.

Drug Courts need to select competent evaluators. The first step in selecting a competent evaluator is to request recommendations from other Drug Courts and national organizations that are familiar with Drug Court operations and research. Senior staff at NADCP and NDCI are familiar with the evaluation literature and the skill sets of dozens of evaluators nationally. When selecting an evaluator, review prior evaluation reports, especially those involving Drug Courts or other problem-solving courts. If prior evaluations failed to follow the practices described herein, consider selecting another evaluator who has demonstrated expertise in applying best practices related to Drug Court program evaluations. One of the most important questions to consider when reviewing prior evaluations is whether the report recommended concrete actions the Drug Court could take to enhance its adherence to best practices and improve its outcomes. The most effective evaluators are aware of the literature on best practices, measure Drug Court practices against established performance benchmarks, and promote useful strategies to improve each program's operations and results.

Many Drug Courts do not have sufficient resources to hire independent evaluators. One way to address this problem is to contact local colleges or universities to determine whether graduate or undergraduate students may be interested in evaluating the Drug Court as part of a thesis, dissertation, or capstone project. Because

such projects require close supervision from senior academic faculty, the Drug Court can receive high-level research expertise at minimal or no cost. Moreover, students are likely to be highly motivated to complete the evaluation successfully because their academic degree and standing depends on it.

E. Historically Disadvantaged Groups

The term *historically disadvantaged groups* refers to socio-demographic groups that have historically experienced sustained discrimination or reduced social opportunities due to their race, ethnicity, gender, sexual orientation, sexual identity, physical or mental disability, religion, or socioeconomic status. Best practices for ensuring equivalent treatment of historically disadvantaged groups in Drug Courts are described in Standard II, Historically Disadvantaged Groups.

Evidence suggests racial and ethnic minority individuals are underrepresented in some Drug Courts and may have lower graduation rates than other participants [see Commentary in Standard II, Historically Disadvantaged Groups]. Drug Courts have an affirmative obligation to determine whether racial and ethnic minority individuals and members of other historically disadvantaged groups are being disproportionately burdened or excluded from their programs; and if so, to take reasonable corrective measures to rectify the problem and evaluate the success of the corrective actions [see Standard II]. Not knowing whether one's Drug Court is disproportionately burdening disadvantaged groups is itself a violation of best practice standards (Marlowe, 2013).

Studies have not determined how frequently Drug Courts should review performance information for members of historically disadvantaged groups. Consistent with the general literature on CPI, CQI and MFR, the Drug Court team should review performance information at least annually and implement and evaluate self-corrective measures on a rapid-cycle basis (Rudes et al., 2013; Wexler et al., 2012).

A number of resources are available to help Drug Courts identify and rectify disparate impacts for historically disadvantaged groups (e.g., Casey et al., 2012; Rubio et al., 2008b; Yu et al., 2009). Seasoned evaluators and university faculty are likely to be familiar with this literature and to know how to perform these types of analyses. Many analyses, such as comparing graduation rates between different racial groups, are relatively simple and straightforward to perform. Other analyses, such as determining whether disadvantaged groups have equivalent access to Drug Court, are considerably more difficult. Many Drug Courts may not have adequate information about the relevant arrestee population to determine whether disadvantaged groups are gaining access to the Drug Court at equivalent rates. For example, information might not be available to determine what proportion of racial-minority arrestees have serious drug problems and are therefore eligible for participation in Drug Court. The primary challenge for such Drug Courts may be to gain better access to a wider range of information on the arrestee population, and as a practical matter, such analyses may be beyond the ability and expertise of some programs to accomplish.

F. Electronic Database

Paper files have minimal value for conducting program evaluations. Evaluators are typically required to extract information from handwritten notes and progress reports that are difficult to read, contain contradictory information, and have numerous missing entries. As a consequence, many evaluations are completed months or years after the fact when the results may no longer reflect what is occurring in the program. Such evaluations often contain so many gaps or caveats in the data that the conclusions which may be drawn are tentative at best.

Drug Courts are approximately 65% more cost-effective when they enter standardized information concerning their services and outcomes into an electronic management information system (MIS), which is capable of generating automated summary reports (Carey et al., 2008, 2012). The cost of purchasing an MIS is offset many times over by providing greater efficiencies in operations and yielding the type of performance feedback that is necessary to continually improve and fine-tune one's Drug Court program.

Appendix E provides examples of MISs that have been developed for use in Drug Court evaluations. Some of the older and less sophisticated systems can be obtained free of charge. For example, the Buffalo System (so named because it was developed in a Drug Court in Buffalo, New York) is a Microsoft Access database

that can be obtained at no cost by contacting NADCP. Newer systems must be purchased or licensed, but are more likely to be web-based and can be accessed simultaneously by multiple users and agencies. Allowing multiple agencies to use the same MIS, each with its own secured and encrypted access, can spread the cost of the system across several budgets. Newer systems are also more likely to have preprogrammed analytic reports that provide important summary information for staff at the push of a button. Finally, newer systems are more likely to include a data-extraction tool. A data-extraction tool allows information to be imported readily into a statistical program, such as SAS or SPSS, which skilled evaluators then can use to conduct sophisticated statistical analyses.

G. Timely and Reliable Data Entry

The biggest threat to a valid program evaluation is poor data entry by staff. The adage “garbage in/garbage out” is particularly apt in this regard. If staff members do not accurately record what occurred, no amount of scientific expertise or sophisticated statistical adjustments can produce valid findings.

The best time to record information about services and events is when they occur. For example, staff members should enter attendance information into an MIS or written log during court hearings and treatment sessions. This is referred to as *real-time recording*. The typical staff person in a Drug Court is responsible for dozens of participants and each participant has multiple obligations in the program, such as appearing at court hearings, attending treatment sessions, and delivering urine specimens. Only the rare staff person can recall accurately what events transpired or should have transpired days or weeks in the past. Attempting to reconstruct events from memory is likely to introduce unacceptable error into a program evaluation.

Data should ordinarily be recorded within no more than forty-eight hours of the respective events. Medicare, for instance, requires physicians to document services within a “reasonable time frame,” defined as twenty-four to forty-eight hours (Pelaia, n.d.). After forty-eight hours, errors in data entry have been shown to increase significantly. After one week, information is so likely to be inaccurate that it may be better to leave the data as missing than attempt to fill in gaps from faulty memory (Marlowe, 2010).

Staff members who are persistently tardy when entering data pose a serious threat to the integrity of a Drug Court. Not only are evaluation results unlikely to be accurate, but those same staff persons are unlikely to be delivering appropriate services. Good-quality treatment and supervision require staff to monitor participant behavior vigilantly, record performance information in a timely and actionable fashion, and adjust services and consequences accordingly. Failing to record performance information in a timely and reliable manner undermines the quality and effectiveness of a Drug Court and seriously jeopardizes participant care.

H. Intent-to-Treat Analyses

A serious error in some Drug Court evaluations is to examine outcomes only for participants who graduated successfully from the program. The logic for performing such an analysis is understandable. Evaluators are often interested in learning what happens to individuals who received all of the services the program has to offer. If individuals who dropped out or were terminated prematurely from the Drug Court are included in the analyses, the results will be influenced by persons who did not receive all of the intended services.

Although this reasoning might seem logical, it is scientifically flawed (Heck, 2006; Heck & Roussell, 2007; Marlowe, 2010, in press; Peters, 1996; Rempel, 2006, 2007). Outcomes must be examined for all eligible individuals who participated in the Drug Court regardless of whether they graduated, were terminated, or withdrew from the program. This is referred to as an *intent-to-treat analysis* because it examines outcomes for all individuals whom the program initially set out to treat. Reporting outcomes for graduates alone is not appropriate because such an analysis unfairly and falsely inflates the apparent success of the program. For example, individuals who graduated from the Drug Court are more likely than terminated participants to have entered the program with less severe drug or alcohol problems, less severe criminal propensities, higher motivation for change, or better social supports. As a result, they might have been less likely to commit future offenses or relapse to substance abuse regardless of the services they received in Drug Court.

This issue is particularly important when outcomes are contrasted against those of a comparison sample, such as probationers. Selecting the most successful Drug Court cases and comparing their outcomes to all of the probationers unfairly skews the results in favor of the Drug Court. It is akin to selecting the A+ students from one classroom, comparing their scores on a test to those of all of the students in a second classroom, and then concluding the first class had a better teacher. Such a comparison would clearly be slanted unfairly in favor of the first teacher.

This is not to suggest that outcomes for graduates are of no interest. Drug Courts may, indeed, want to know what happens to individuals who receive all of the services in the program. This, however, should be a *secondary analysis* that is performed after the intent-to-treat analysis has shown positive results. If it is first determined that the Drug Court achieved significantly improved outcomes on an intent-to-treat basis, it may then be appropriate to proceed further and determine whether outcomes were even better for the graduates. If the intent-to-treat analysis is not significant, then it is not acceptable to move on to evaluate outcomes for graduates alone.

Importantly, if secondary analyses are performed on Drug Court graduates, then the comparison sample should also comprise successful completers. For example, outcomes for Drug Court graduates should be compared to those of probationers who satisfied the conditions of probation. Comparing outcomes for Drug Court graduates to all probationers, including probation failures, would unfairly favor the Drug Court.

The only exception to an intent-to-treat analysis is for what are sometimes referred to as *neutral discharges*. Some Drug Courts assign a neutral discharge to participants who are withdrawn from the program for reasons beyond the control of the participant and the program. A neutral discharge is assigned most commonly when the Drug Court discovers a participant was admitted to the program erroneously. For example, a participant might need to be withdrawn from Drug Court if he or she had a prior conviction that precluded eligibility for the Drug Court or resided in a judicial district that was not within the jurisdictional boundaries of the Drug Court. A neutral discharge may also be assigned to participants who are withdrawn from the program because they enlisted in the military or moved out of the jurisdiction with the court's permission. A neutral discharge should never be assigned to cases in which termination was related to a participant's performance in Drug Court.

I. Comparison Groups

The mere fact that individuals perform well after participating in Drug Court does not prove the Drug Court was responsible for their favorable outcomes. Those same individuals might have functioned just as well if they had never entered Drug Court. To examine the important question of causality, the performance of Drug Court participants must be compared against that of an equivalent and unbiased comparison group. Comparing what happened in the Drug Court to what would most likely have happened if the Drug Court did not exist is referred to as testing the *counterfactual hypothesis,* or the possibility that the Drug Court was ineffective (Popper, 1959).

Some comparison groups are reasonably unbiased and can yield a fair and accurate assessment of what would most likely have occurred without the Drug Court. Others, however, may be systematically biased in such a manner as to make the Drug Court look better or worse than it deserves. This may lead to the unwarranted conclusion that the Drug Court was effective or ineffective when, in fact, the reverse could be true.

Random Assignment—The strongest inference of causality may be reached when eligible individuals are randomly assigned either to the Drug Court or to a comparison group. Random assignment provides the greatest assurance that the groups started out with an equal chance of success; therefore, better outcomes for one group can be confidently attributed to the effects of the program (Campbell & Stanley, 1963; Farrington, 2003; Farrington & Welsh, 2005; National Research Council, 2001; Telep et al., 2015). Even when an evaluator employs random assignment, there is still the possibility (albeit a greatly diminished possibility) that the groups differed on important dimensions from the outset. This possibility requires the evaluator to perform a confirmation of the randomization procedure. The evaluator will need to check for preexisting differences between the groups that could have affected the results. If the groups differed significantly on variables that are correlated with outcomes (such as the severity of participants' criminal

histories or drug problems), the evaluator might employ statistical procedures to adjust for those differences and obtain defensible results.

As a practical matter, conducting random assignment is often very difficult in Drug Courts. Some staff members may have ethical objections against denying potentially effective services to eligible individuals. Moreover, some Drug Courts may have difficulty filling their slots and may not wish to turn away eligible individuals. The evaluator will also need to gain approval and buy-in for random assignment from numerous professionals and agencies, including the court, prosecution, and defense counsel. Finally, random assignment usually requires implementation of ethical safeguards (National Research Council, 2001). For example, participants may need to provide informed consent to random assignment, and an independent ethics review board may need to oversee the safety and fairness of the study. Local colleges and universities often have institutional review boards (IRBs) or data and safety monitoring boards (DSMBs) which have the authority and expertise to provide ethical oversight for randomized studies.

Random assignment poses far fewer challenges if a Drug Court has insufficient capacity to treat many individuals who would otherwise be eligible for its services. If many eligible people must be turned away, then it would arguably be fairest to select participants randomly rather than allow staff members to pick and choose who gets into the program. Under such circumstances, random assignment may provide the best protection against unfair discrimination and unconscious bias (National Research Council, 2001). In fact, a number of Drug Court studies have used random assignment successfully in light of insufficient program capacity (e.g., Gottfredson et al., 2003; Jones, 2011; Turner et al., 1999).

Quasi-Experimental Comparison Group—In many Drug Courts, engaging in random assignment is simply impractical. The next best approach is to use a quasi-experimental comparison group (Campbell & Stanley, 1963). This refers to individuals who were eligible for the Drug Court but did not enter for reasons that are unlikely to have influenced their outcomes. Perhaps the best example is individuals who were eligible for and willing to enter the Drug Court, but were denied access because there were no empty slots available. This is referred to as a *wait-list comparison group*. The mere happenstance that the Drug Court was full is unlikely to have led to the systematic exclusion of individuals who had more severe problems or poorer prognoses to begin with, and therefore is unlikely to bias the results.

Less optimal, but still potentially acceptable, quasi-experimental comparison groups include individuals who would have been eligible for the Drug Court but were arrested in the year or so before the Drug Court was established, or were arrested in an immediately adjacent county that does not have a Drug Court (Heck, 2006; Heck & Roussell, 2007; Marlowe, 2010, in press; Peters, 1996). Because these individuals were arrested at an earlier point in time or in a different geographic region than the Drug Court participants, such comparison groups might still be different enough from the Drug Court group to bias the results. For example, socioeconomic conditions might differ significantly between neighboring communities, or law enforcement practices might change from year to year. The likelihood of this occurring, however, is usually not substantial and these may be the only practical comparison conditions that can be used for many Drug Court evaluations.

When using a quasi-experimental comparison group, the evaluator must check for preexisting differences between the groups that could have affected the results (Campbell & Stanley, 1963). For example, the comparison individuals may have had more serious criminal histories than the Drug Court participants to begin with. This, in turn, might have put them at greater risk for criminal recidivism. If so, then superior outcomes for the Drug Court participants might not have been due to the effects of the Drug Court, but rather to the fact that it treated a less severe population. A skilled evaluator can use a number of statistical procedures to adjust for such differences and potentially obtain scientifically defensible results.

Matched Comparison Group—Evaluators do not always have a quasi-experimental comparison group at their disposal. Under such circumstances, they may be required to construct a comparison group out of a large and heterogeneous pool of offenders. For example, an evaluator might need to select comparison subjects from a statewide probation database. Many of those probationers would not have been eligible for Drug Court, or are dissimilar to Drug Court participants on characteristics that are likely to have influenced their outcomes. For example, some of the probationers might not have had serious drug problems, or might have been charged with offenses that would have excluded them from participation in Drug Court. The

evaluator must, therefore, select a subset of individuals from the entire probation pool that are similar to the Drug Court participants on characteristics that are known to affect outcomes. For example, the evaluator might pair each Drug Court participant with a probationer who has the same or similar criminal history, demographic characteristics, and substance use diagnosis (Heck, 2006; Marlowe, 2010, in press). Because the evaluator will choose only those probationers who are similar to the Drug Court participants on multiple characteristics, it is necessary to start out with a large sample of potential candidates from which to select comparable individuals.

The success of any matching strategy will depend largely on whether the evaluator has adequate information about the comparison candidates to make valid matches (Campbell & Stanley, 1963). If data are not available on such important variables as the probationers' criminal histories or substance abuse problems, evaluators and Drug Courts will not be able to place confidence in the validity of the matches. Simply matching the groups on variables that are easy to measure and readily available, such as gender or race, is not sufficient because the groups might differ on other important dimensions that were not taken into account.

Propensity Score Analysis—An evaluator may also use an advanced statistical procedure called a propensity score analysis to mathematically adjust for differences between the Drug Court and comparison groups. This procedure calculates the statistical probability that an individual with a given set of characteristics would be in the Drug Court group as opposed to the comparison group—in other words, the relative similarity of that individual to one group as opposed to the other (Dehejia & Wahba, 2002). The analysis then mathematically adjusts for this relative similarity when comparing outcomes. Advanced statistical expertise is required to implement and interpret this complicated procedure.

As with any statistical adjustment, the success of a propensity score analysis will depend on whether the evaluator has adequate information about the comparison subjects to make valid adjustments. If data are not available on such important variables as the comparison subjects' criminal histories or substance abuse problems, evaluators and Drug Courts will not be able to place confidence in the adjustments (Peikes et al., 2008). Again, merely adjusting the scores based on easily measured variables, such as gender or race, is not sufficient because the groups might differ on other important dimensions that were never taken into account.

Invalid Comparison Groups—Several comparison groups have been used in Drug Court evaluations that quite likely produced seriously biased results. Comparing outcomes from a Drug Court to those of individuals who refused to enter the Drug Court, were denied access to the Drug Court because of their clinical or criminal histories, dropped out of the Drug Court, or were terminated prematurely from the Drug Court is rarely, if ever, justified (Heck, 2006; Heck & Thanner, 2006; Marlowe, 2010, in press; Peters, 1996). The probability is unacceptably high that such persons had poorer prognoses or more severe problems to begin with. For example, they very likely had more serious criminal or substance abuse histories, lower motivation for change, or lesser social supports. Given the high likelihood that these individuals were seriously disadvantaged from the outset, statistical adjustments cannot be relied upon to overcome the differences (Campbell & Stanley, 1963).

J. Time at Risk

For an evaluation to be valid, Drug Court and comparison participants must have the same time at risk, meaning the same opportunity to engage in substance abuse, crime, and other behaviors of interest to the evaluation. If, for example, an evaluator measured criminal recidivism over a period of twelve months for Drug Court participants, but over a period of twenty-four months for the comparison group, this would give an unfair advantage to the Drug Court participants. The comparison group participants would have twelve additional months in which to commit new crimes or other infractions.

Ensuring an equivalent time at risk requires the evaluator to begin the analyses from a comparable start date for both groups. As was mentioned earlier, Drug Court evaluations typically use the date of entry into Drug Court or the date of the arrest or technical violation that made the individual eligible for Drug Court as the start date for analyses. If the comparison group is comprised of probationers, comparable start dates might be the date the individual was placed on probation or the date of the arrest that led to a probation sentence.

If the time at risk differs significantly between groups, the evaluator might be able to compensate for this problem by adjusting statistically for time at risk in outcome comparisons. For example, the evaluator might enter time at risk as a covariate in the statistical analyses. A *covariate* is a variable that is entered first into a statistical model. The independent effect of the variable of interest (in this case, being treated in a Drug Court) is then examined after first taking the effect of the covariate into account. This procedure would indicate whether Drug Court participants had better outcomes after first taking into account the influence of their shorter time at risk. The use of covariates is not always successful, however, and the best course of action is to ensure the groups have equivalent follow-up windows.

A related issue is referred to as *time at liberty.* Time at liberty and time at risk are similar in that both affect a participant's opportunity to reoffend or engage in other behaviors of interest to the evaluation. The difference is that time at liberty relates to whether restrictive conditions were placed on the participant. The most obvious restrictive conditions involve physical barriers to freedom, such as incarceration or placement in a residential treatment facility. These physical barriers severely restrict a participant's ability to use drugs, commit new offenses, obtain a job, or engage in other behaviors of interest to evaluators.

A potential error in Drug Court evaluations is to neglect time at liberty when performing outcome comparisons. In some jurisdictions, for example, individuals who do not enter Drug Court may be more likely to receive a jail sentence. If they are jailed for a portion of the follow-up period, they might have fewer opportunities to reoffend or use drugs than Drug Court participants who are treated in the community. The evaluator might conclude, erroneously, that Drug Court caused participants to reoffend or use drugs more often, when in fact they simply had more time at liberty to do so. Under such circumstances, the evaluator would need to adjust statistically for participants' time at liberty in the outcome analyses. For example, the evaluator might need to enter time at liberty as a covariate in the statistical models. This would indicate whether Drug Court participants had better outcomes after first taking into account their longer time at liberty. As was noted earlier, such adjustments are not always successful and Drug Courts will require expert consultation to ensure the analyses are carried out appropriately.

Note that evaluators are not always advised to adjust for time at liberty. In cost analyses, for example, the time participants spend in jail or a residential treatment facility is an important outcome in its own right and should be valued accordingly from a fiscal standpoint. Deciding whether to adjust for time at liberty, like many evaluation-related decisions, requires scientific expertise and careful consideration of the aims of the study. For such analyses, Drug Courts are strongly advised to obtain expert statistical and scientific consultation.

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APPENDIX C

COMPLEMENTARY NEEDS ASSESSMENTS

This list provides examples of instruments used to assess complementary needs among substance-involved individuals in the criminal justice system. Additional information about needs assessment instruments may be obtained from the following Web sites:

Alcohol and Drug Abuse Institute Library at the University of Washington

http://lib.adai.washington.edu/instruments/

The National GAINS Center

http://gainscenter.samhsa.gov/pdfs/disorders/ScreeningAndAssessment.pdf

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MULTIDIMENSIONAL CLINICAL NEEDS ASSESSMENTS

Addiction Severity Index (ASI)

http://www.tresearch.org/wp-content/uploads/2012/09/ASI_5th_Ed.pdf

Global Appraisal of Individual Needs (GAIN)

http://www.gaincc.org/products-services/instruments-reports/

MULTIDIMENSIONAL CRIMINOGENIC NEEDS ASSESSMENTS

Correctional Offender Management Profiling for Alternative Sanctions (COMPAS)

http://www.northpointeinc.com/products/northpointe-software-suite

Inventory of Offender Risk, Needs, and Strengths (IORNS)

http://www4.parinc.com/Products/Product.aspx?ProductID=IORNS

Offender Profile Index (OPI)

https://www.ncjrs.gov/pdffiles1/Digitization/148829NCJRS.pdf

Offender Screening Tool (OST)

http://www.azcourts.gov/apsd/EvidenceBasedPractice/RiskNeedsAssessment/OffenderScreeningTool%28OST%29.aspx

Ohio Risk Assessment System (ORAS)

http://www.ocjs.ohio.gov/ORAS_FinalReport.pdf

Level of Service/Case Management Inventory (LS/CMI)

https://ecom.mhs.com/(S(0aqkan55ovozwq55w2oxt445))/saf_om.aspx?id=Training

Static Risk and Offender Needs Guide (STRONG)

https://www.assessments.com/purchase/detail.asp?SKU=5205

MENTAL HEALTH SCREENS

Beck Depression Inventory-II (BDI-II)

http://www.pearsonclinical.com/psychology/products/100000159/beck-depression-inventoryii-bdi-ii.html?Pid=015-8018-370&Mode=summary

Beck Anxiety Inventory (BAI)

http://www.pearsonclinical.com/psychology/products/100000251/beck-anxiety-inventory-bai.html?Pid=015-8018-400&Mode=summary

Brief Jail Mental Health Screen (BJMHS)

http://gainscenter.samhsa.gov/pdfs/disorders/bjmhsform.pdf

CJ-DATS Co-Occurring Disorder Screening Instrument (CJ-CODSI)

https://www.drugabuse.gov/sites/default/files/files/CJ-CODSI.pdf

Generalized Anxiety Disorder 7-Item Scale (GAD-7)

http://www.integration.samhsa.gov/clinical-practice/GAD708.19.08Cartwright.pdf

Global Appraisal of Individual Needs-Short Screener (GAIN-SS)

http://www.gaincc.org/products-services/instruments-reports/

Mental Health Screening Form-III (MHSF-III)

https://www.idph.state.ia.us/bh/common/pdf/substance_abuse/integrated_services/jackson_mentalhealth_screeningtool.pdf

Modified Mini-Screen (MMS)

http://www.nyc.gov/html/doh/downloads/pdf/qi/qi-mms-scoringsht.pdf

Mood Disorder Questionnaire (MDQ)—Bipolar Disorder

http://www.integration.samhsa.gov/images/res/MDQ.pdf

Symptom Checklist-90-Revised (SCL-90-R)

http://www.pearsonclinical.com/psychology/products/100000645/symptom-checklist-90-revised-scl90r.html

TRAUMA AND PTSD SCALES

Acute Stress Disorder Structured Interview (ASDI)

http://www.istss.org/assessing-trauma/acute-stress-disorder-structured-interview-(asdi).aspx

Clinician-Administered PTSD Scale for DSM-5 (CAPS-5)

http://www.ptsd.va.gov/professional/assessment/adult-int/caps.asp

Life Events Checklist

http://www.integration.samhsa.gov/clinical-practice/life-event-checklist-lec.pdf

Posttraumatic Symptom Scale Interview (PSS-I)

http://www.ptsd.va.gov/professional/assessment/adult-int/pss-i.asp

PTSD Checklist (PCL)

https://www.facs.org/~/media/files/quality%20programs/trauma/vrc%20resources/10_ptsd_checklist_and_scoring.ashx

PTSD Checklist—Civilian Version

http://www.integration.samhsa.gov/clinical-practice/Abbreviated_PCL.pdf

Trauma History Screen

http://www.ptsd.va.gov/professional/assessment/te-measures/ths.asp

HEALTH-RISK BEHAVIOR SCALES

HIV Risk Assessment

http://hivaidsresource.org/hiv-testing/hiv-risk-assessment/

Texas Christian University (TCU) HIV/AIDS Risk Assessment

http://ibr.tcu.edu/wp-content/uploads/2014/07/HIV-AIDS-intake-ara.pdf

University of Pennsylvania Risk Assessment Battery (RAB)

http://www.med.upenn.edu/hiv/rab_download.html

Wisconsin AIDS/HIV Program: Client Assessment Survey

https://wi-ew.lutherconsulting.com/Wisconsin/commonFiles/downloads/BehavioralRiskSurvey.pdf

CRIMINAL THINKING SCALES

Criminal Sentiments Scale

https://www.dpscs.state.md.us/publicservs/procurement/QA_5_ATTACHMENT_2_CRIMINAL_SENTIMENT_SCALE.pdf

Texas Christian University Criminal Thinking Scales (TCU-CTS)

http://ibr.tcu.edu/forms/tcu-criminal-thinking-scales/

Psychological Inventory of Criminal Thinking Styles (PICTS)

http://asm.sagepub.com/content/9/3/278.short

APPENDIX D

EVIDENCE-BASED COMPLEMENTARY TREATMENT AND SOCIAL SERVICES

The following Web sites provide information about evidence-based treatments and social services to address the complementary needs of individuals with substance abuse problems in the criminal justice system.

CLINICAL CASE MANAGEMENT

Case Management Society of America

http://www.cmsa.org/Home/CMSA/WhoWeAre/tabid/222/Default.aspx

Commission for Case Management Certification

http://ccmcertification.org/

National Treatment Accountability for Safer Communities

http://nationaltasc.org/resources/

Treatment Accountability for Safer Communities
Crime and Justice Institute, Illinois

http://www2.tasc.org/

EVIDENCE-BASED PREVENTION EDUCATION

Bureau of Justice Assistance
Naloxone Overdose Reversal Toolkit

https://www.bjatraining.org/tools/naloxone/Naloxone%2BBackground

Centers for Disease Control and Prevention (CDCP), HIV/AIDS Prevention Programs

http://www.cdc.gov/hiv/prevention/programs/index.html

SAMHSA
Opioid Overdose Prevention Toolkit

http://store.samhsa.gov/product/Opioid-Overdose-Prevention-Toolkit-Updated-2014/SMA14-4742

EVIDENCE-BASED TREATMENT AND SOCIAL SERVICES

The Campbell Collaboration
Library of Systematic Reviews

http://www.campbellcollaboration.org/lib/

The Cochrane Collaboration

http://www.thecochranelibrary.com/view/0/index.html

CrimeSolutions.gov

National Institute of Justice (NIJ)

http://www.crimesolutions.gov/Programs.aspx

International Society for Traumatic Stress Studies

https://www.istss.org/

National Registry of Evidence-Based Programs and Practices (NREPP)

Substance Abuse and Mental Health Services Administration (SAMHSA)

http://www.nrepp.samhsa.gov/

APPENDIX E

MANAGEMENT INFORMATION SYSTEMS FOR DRUG COURT EVALUATIONS

This list provides examples of management information systems (MISs) developed to assist in evaluating Drug Courts or other problem-solving courts. Information about additional MISs may be obtained by contacting NDCI faculty or other organizations that perform Drug Court program evaluations.

Buffalo, NY, Drug Court Case Management System (contact the NDCI for more information)

http://www.ndci.org/contact

Advanced Computer Technologies
Drug Court Case Management (DCCM) System

http://www.actinnovations.com/solutions/cms.aspx

Treatment Research Institute Court Evaluation Program (TRI-CEP)

http://www.tresearch.org/tools/for-courts/tri-cep/demo/

Criminal Justice—Drug Abuse Treatment Studies (CJ-DATS)
eCourt System

http://www.gmuace.org/documents/prod-pub/cjdats/cjdats-summary-ecourt.pdf

Social Solutions
Adult Drug Court Performance Model, Efforts to Outcomes (ETO) Software

http://www.socialsolutions.com/adc/

Strength Based Digital Connections, LLC
The Virtual File Case Management System for Tribal Courts

www.thevirtualfile.com

DRUG COURT REVIEW

Volume VIII, Issue 1

Special Issue

BEST PRACTICES IN DRUG COURTS

NATIONAL DRUG COURT INSTITUTE
ALEXANDRIA, VIRGINIA

SPECIAL ISSUE

DRUG COURT REVIEW **VOLUME VIII, ISSUE 1**

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The National Drug Court Institute (NDCI) is the Professional Services Branch of the National Association of Drug Court Professionals (NADCP). NDCI is grateful to the Office of National Drug Control Policy of the Executive Office of the President and the Bureau of Justice Assistance within the Office of Justice Programs at the U.S. Department of Justice for the support that made this publication possible.

This project was supported by Grant No. 2010-DC-BX-K081 awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the SMART Office, and the Office for Victims of Crime. Points of view or opinions in this document are those of the author and do not represent the official position or policies of the U.S. Department of Justice.

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THE DRUG COURT REVIEW

Published annually, the *Drug Court Review's* goal is to keep the Drug Court practitioner abreast of important new developments in the Drug Court field. Drug Courts demand a great deal of time and energy of the practitioner, allowing little opportunity to read lengthy evaluations or keep up with important research in the field. Yet, the ability to marshal scientific and research information and "argue the facts" can be critical to a program's success and ultimate survival.

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The *Drug Court Review* is a project of the National Drug Court Institute (NDCI). NDCI was established under the auspices of the National Association of Drug Court Professionals with support from the Office of National Drug Control Policy, Executive Office of the President, and the Bureau of Justice Assistance, U.S. Department of Justice.

NDCI's mission is to promote education, research, and scholarship to the Drug Court field and other court-based intervention programs.

Since its inception in December 1997, NDCI has emerged as the preeminent source of cutting-edge training and technical assistance to the Drug Court field, providing research-driven solutions to address the changing needs of treating substance-abusing offenders. NDCI launched five separate team-oriented Drug Court training programs, eight comprehensive, discipline-specific training programs, and five separate subject matter training programs.

NDCI developed a research division responsible for creating a scientific agenda and publication dissemination strategy for the field. NDCI has published a monograph series, fact sheets, and legal issues publications on relevant issues to Drug Court to help maintain fidelity to the Drug Court model and expansion.

For additional information about NDCI and its training programs, visit http://www.ndci.org.

ACKNOWLEDGMENTS

I wish to thank all those who have contributed to this issue of the *Drug Court Review*: the Office of National Drug Control Policy, Executive Office of the President, and the Bureau of Justice Assistance, U.S. Department of Justice, for the leadership, support, and collaboration that these agencies have offered to the National Drug Court Institute.

For their contributions as authors, I would like to thank Dr. Shannon Carey, Mr. Mitchell Downey, Dr. Karen Dugosh, Dr. David Festinger, Dr. Michael Finigan, Dr. Christine Lindquist, Dr. Juliette Mackin, Dr. Douglas Marlowe, Dr. Gerald Melnick, Dr. David Metzger, Dr. John Roman, Ms. Shelli Rossman, Mr. Michael Tobin, Dr. Harry Wexler, Mr. Mark Zehner, and Dr. Janine Zweig.

Finally, I would like to thank the peer reviewers, Fred Cheesman, Jim Egar, David Festinger, Kirstin Frescoln, Scott Henggeler, Norma Jaeger, Kevin Knight, Elizabeth Letourneau, Michael McCart, Roger Peters, Josiah Rich, Hon. Robert Russell, Rick Schwermer, Jennifer Shackelford, and Jeff Thoma.

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INTRODUCTION

SPECIAL ISSUE ON BEST PRACTICES IN DRUG COURTS

Douglas B. Marlowe, JD, PhD

THE FIRST GENERATION of research on most programs addresses the basic question of whether the program can be effective under typical conditions. Studies compare the effects of the program to no treatment or to alternative programs addressing the same condition and determine whether, on average, it significantly outperforms the alternatives. These so-called horse races are necessary to decide whether continuing to invest time and effort in the intervention is justifiable, but they do not grapple with the more important questions of who the program is most effective for (i.e., its target population), how to make it most efficient and cost-effective, and how to avoid any negative side effects it might produce.

The second generation of research delves beyond the average effects of an intervention to identify the factors that distinguish effective programs from those that are ineffective or even harmful. This is referred to as research on *best practices*. The most common approach is for evaluators to compare the characteristics of programs that have significant positive outcomes with those that have poor or insignificant outcomes. Presumably, services that are provided by effective programs and not provided by ineffective programs are likely to be important ingredients of an effective intervention. Of course, one cannot place full confidence in the reliability of such findings because the services were not under experimental control. Programs may have differed, simply by chance, on dimensions that were not in fact responsible for the differences in outcomes. Nevertheless, in the absence of definitive evidence from controlled research studies, it makes logical sense to emulate the practices of effective programs and avoid the practices of ineffective or harmful programs.

Drug Courts have decidedly entered into the second generation of research on best practices. No longer preoccupied with the answered question of whether they work, Drug Courts are now focusing their attention on characterizing the attributes of exemplary programs. In the process, they are also identifying the attributes that are lacking in a small subgroup of poorly performing Drug Courts. These so-called outlier programs have the potential to give the Drug Court field a black eye, and provide fodder for critics who may be opposed to the Drug Court model on purely philosophical or attitudinal grounds.

This special issue of the *Drug Court Review* fills critical gaps in the literature on best practices in Drug Courts, and offers concrete guidance for Drug Court practitioners to enhance their operations and improve their outcomes. In the first invited article, Drs. Shannon Carey, Juliette Mackin, and Michael Finigan compare the programmatic policies and procedures, services offered, and outcomes produced from a large sample of sixty-nine Drug Courts in several states. Each of their studies employed a parallel methodology that permitted the researchers to examine common factors influencing effectiveness and cost-effectiveness across all or most of the jurisdictions. The results lent substantial support to many of the key components of the Drug Court model. For example, substantially greater reductions in crime and lower societal costs were produced by Drug Courts that had multidisciplinary team involvement in their court hearings and team meetings, held more frequent judicial status reviews, performed intensive urine drug testing, and administered gradually escalating incentives and sanctions. The best Drug Courts ensured their teams attended timely training events and engaged in ongoing performance monitoring of their operations and outcomes.

In the second article, Drs. Janine Zweig, Christine Lindquist, P. Mitchell Downey, John Roman and Ms. Shelli Rossman review findings from the Multisite Adult Drug Court Evaluation (MADCE). Funded by the National Institute of Justice (NIJ), this groundbreaking study compared outcomes for more than 1,000 participants in twenty-three adult Drug Courts located in seven geographic regions around the country to those of a carefully matched comparison sample. Not only did the findings confirm that the Drug Courts reduced crime and

drug abuse and improved the participants' psychosocial functioning, but, more importantly, they also revealed a number of practices that were associated with better results. Again, the findings confirmed many of the core tenets of the Drug Court model. Better outcomes were produced, for example, by Drug Courts that had moderately predictable sanctioning schedules, exercised greater leverage over their participants, and had judges with more positive interactional styles.

In the third article, Dr. Harry Wexler, Mr. Mark Zehner, and Dr. Gerald Melnick report on their application of the NIATx (Network for the Improvement of Addiction Treatment) process improvement model in ten Drug Courts. Funded by the Center for Substance Abuse Treatment (CSAT), NIATx has been proven to improve client access to and retention in substance abuse treatment, but had not heretofore been applied in the justice system. The results revealed that relatively simple and modest adjustments to the Drug Courts' organizational and administrative processes substantially reduced wait times and no-shows for appointments and increased admission rates and participant engagement in treatment. If Drug Courts intend to "go to scale" and make meaningful contributions to the justice system, they must learn new ways to improve their recruitment rates and streamline their operations to serve more people more efficiently. The NIATx model shows considerable promise for helping Drug Courts in this critical challenge.

In the fourth article, Mr. Michael Tobin, a highly experienced public defender, offers suggestions to help defense attorneys recognize and resolve ethical challenges in Drug Courts. Among many issues, Mr. Tobin offers practical suggestions for advising clients about the anticipated benefits and burdens of participating in Drug Court, advocating for fair and effective procedures in the program, educating the defense bar about the Drug Court option, and protecting client confidentiality and due process. Most importantly, he addresses the important issue of avoiding role conflicts when exercising the functions of adversarial counsel as opposed to membership on a multidisciplinary Drug Court team. Although the recommendations do not necessarily represent the unanimous opinion of the defense bar or

NADCP policy, they reflect the considered wisdom of an experienced defense expert who has carefully thought through these issues for decades.

Finally, in the fifth article, Drs. David Festinger, Karen Dugosh, David Metzger, and Douglas Marlowe report outcomes from a study examining HIV risk behaviors among participants in a felony Drug Court in Philadelphia. Funded by the National Institute on Drug Abuse (NIDA), the study revealed that sexual risk behaviors, including unprotected sex with multiple partners, were prevalent. Many of the Drug Court participants lived in geographic zones of the city characterized by high HIV seroconversion rates and a high prevalence of persons living with HIV/AIDS, thus heightening the probability of exposure to the virus. The criminal justice system, especially jails and prisons, has long been recognized as a major vector for the spread of HIV and a critical juncture for launching prevention and early detection efforts. The results of this study suggest Drug Courts should be playing a much more active role in administering HIV prevention and detection protocols.

In summary, the articles in this special issue address critical issues pertaining to best practices in Drug Courts that can optimize outcomes and make the most efficient use of scarce resources. Defining best practices is especially critical as Drug Courts go to scale and address the full scope of our nation's drug problem. The appalling figures are well known: 1 out of every 100 American citizens is behind bars with the burden borne disproportionately by minorities and the poor (Pew Center on the States, 2008). Our prisons are overcrowded with nonviolent offenders charged with drug-related offenses and our budgets are buckling under the weight of enormous correctional expenditures, yet, crime rates and drug-use initiation rates are barely budging or are merely shifting in character. Drug Courts have been credited with helping to "bend the curve" of incarceration downward, especially for racial minority citizens (Mauer, 2009). But Drug Courts still serve only a small fraction of the roughly 1.5 million adults arrested each year in the U.S. who are at risk for substance abuse or dependence (Bhati, Roman, & Chalfin, 2008). Drug Courts need to treat every American in need, and that requires them to optimize their ser-

vices, take advantage of economies of scale, and instill greater efficiencies in their operations. Best practice standards reflect the hard-won knowledge of the Drug Court field garnered from more than two decades of earnest labor and honest self-appraisal. As more and more Drug Courts come on line, it is essential they benefit from this institutional memory and avoid relearning the painful lessons of the past.

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INVITED SUBMISSION

WHAT WORKS? THE TEN KEY COMPONENTS OF DRUG COURT: RESEARCH-BASED BEST PRACTICES

Shannon M. Carey — Juliette R. Mackin
Michael W. Finigan

> ***[1] Best Practices in Drug Courts***—*Studies of 69 Drug Courts revealed significantly better outcomes for programs that followed the Ten Key Components.*
>
> ***[2] Characteristics of Effective Drug Courts***—*The most effective and cost-effective Drug Courts worked collaboratively as a team, provided structure and accountability, offered wraparound services, trained team members, and monitored performance and outcomes.*
>
> ***[3] Characteristics of Cost-Effective Drug Courts***—*Investments in treatment and supervision services, staff training, program evaluation, and management information systems were recouped by greater improvements in outcome costs to the taxpayer.*

DRUG COURT PROGRAMS VARY tremendously in how they operationalize the Ten Key Components (NADCP, 1997). Although research clearly shows that adult Drug Courts can significantly improve treatment outcomes and reduce recidivism, outcomes vary considerably across participants and programs (e.g., Lowencamp, Holsinger, & Latessa, 2005; Mackin et al, 2009; Carey & Waller, 2011). Thus, we must not only examine the effectiveness of the nation's Drug Courts, but get inside the "black box" to determine which practices lead to better participant and program outcomes such as reduced criminal recidivism and lower costs (i.e., greater savings).

For this study, we determined Drug Court practices related to lower recidivism and lower costs in sixty-nine Drug Courts nationally. The

analysis builds on a previous study of eighteen Drug Courts in four states and one U.S. territory (Carey, Finigan, & Pukstas, 2008).

RESEARCH ON DRUG COURT EFFECTIVENESS

Drug Courts use the coercive authority of the criminal justice system to provide treatment to addicts in lieu of incarceration. This model of linking the resources of the criminal justice system and substance treatment programs has proven effective for increasing treatment participation, decreasing criminal recidivism, and reducing use of the health care system (Carey & Finigan, 2004; Gottfredson, Najaka, & Kearley, 2003; Finigan, 1998).

In a 2001 review for the National Drug Court Institute, Belenko summarized Drug Court research, both published and unpublished, conducted between 1999 and 2001. Conclusions from his review indicated that Drug Courts were relatively successful in reducing drug use and criminal activity while participants were in the program. Program completion rates nationally were (and remain) around 47 percent. Belenko (1998, 2001) noted that the research on long-term outcomes was less definitive. In his report, he called for more research into the services that Drug Court participants receive while in the program as well as the long-term impact of Drug Courts. A myriad of research on Drug Courts has answered his call since this important review.

A 2005 review by the Government Accountability Office (GAO), looking at six New York State Drug Court programs found a significant reduction in crime in five of those programs. New arrests leading to a conviction one year postprogram decreased by 6–13 percentage points.

Adding to this evidence, a 2006 meta-analysis of sixty Drug Court outcome evaluations showed that postadjudication Drug Courts reduced recidivism by an average of 10%, and preadjudication courts averaged a 13% reduction (Shaffer, 2006).

Another study found twenty-four Oregon Drug Court programs reduced recidivism (measured as number of rearrests) on average by 44% (Carey & Waller, 2011). Finally, the National Institute of Jus-

tice's (NIJ's) Multisite Adult Drug Court Evaluation (MADCE) of twenty-three Drug Courts found an average reduction in recidivism of 16% (Rempel & Zweig, 2011).

Research has also shown that Drug Court programs are cost beneficial in local criminal justice systems with cost-benefit ratios ranging $3–$27 for every one dollar invested in the program (Carey & Finigan, 2004; Carey, Finigan, et al., 2006; Carey & Waller, 2011; Crumpton et al., 2004; Fomby & Rangaprasad, 2002; Marchand, Waller, & Carey, 2006a and 2006b). More limited research has shown that Drug Courts also fiscally benefit other publicly supported services, such as child welfare, physical health care, mental health care, and employment security (Finigan, 1998; Crumpton, Worcel, & Finigan, 2003; Carey, Sanders, et al., 2010a and 2010b). Studies show some Drug Courts cost less to operate than standard court processing of offenders (Carey & Finigan, 2004; Carey, Finigan, et al., 2006). The overall findings continue to show that Drug Courts are effective in many areas. The question as to *why* has fueled another body of research on Drug Courts.

Since Belenko's report, more Drug Court research has focused on identifying the characteristics of an effective Drug Court program and profiling the ideal participant. To this end, Marlowe and colleagues found that high-risk participants graduated at higher rates, provided more drug-negative urine specimens at six months after program admission, and reported significantly less drug use and alcohol intoxication at six months when they were matched to hearings held every other week as compared with the usual less frequent schedule (Marlowe et al., 2007). Many Drug Courts are working toward identifying and enrolling high-risk/high-need offenders into their programs as their target population.

In research on characteristics of an effective program (defined as a program that significantly reduced recidivism), Shaffer (2006) found that a program length between eight and sixteen months provided the best recidivism outcomes. Programs that lasted less than eight or more than sixteen months were significantly less effective. Also, program requirements such as restitution and education were associated with program effectiveness. Finally, Drug Courts that had

internal treatment providers were more effective than Drug Courts that had external treatment providers. Shaffer suggests this may be because of the direct control a Drug Court would enjoy with an internal provider. NIJ's MADCE study indicated drug testing, judicial supervision, and the threat of jail or prison upon termination were important contributing factors as to why Drug Courts work (Rempel & Zweig, 2011). Many of Shaffer's and the MADCE findings are supported by the promising practices research described below (Carey, Finigan, & Pukstas, 2008) and by the research presented in this paper.

PROMISING PRACTICES RELATED TO POSITIVE OUTCOMES IN DRUG COURTS

Results from previous Drug Court research in eighteen Drug Courts in four states and one U.S. territory (Carey, Finigan, & Pukstas, 2008) as well as other research in California (Carey, Pukstas, et al., 2008; Carey, Waller, & Weller, 2010; Carey, Finigan, et al., 2006) and Oregon (Carey & Waller, 2011; Finigan, Carey, and Cox, 2007) have shown several promising practices within the framework of the Ten Key Components. Carey and colleagues collected data on over 200 practices engaged in by twenty-five California Drug Courts and twenty-four Oregon Drug Courts. In all three of these studies, analyses were run to determine which practices related to higher graduation rates, lower recidivism, and greater cost savings. The studies found the following themes related to the best outcomes:

- *Team Engagement*—All team members (judge, attorneys, coordinator, probation, treatment, law enforcement) should attend case staffings and court sessions.
- *Wraparound Services*—Participants need additional support services such as anger management, educational assistance, and relapse prevention.
- *Drug Testing*—Programs should drug test two to three times per week, obtain test results back within forty-eight hours, and require participants to have no positive drug tests for at least ninety days before graduation.

- *Responses to Participant Behavior (Incentives and Sanctions)*—Team members should receive written rules or guidelines regarding sanctions and incentives and require participants to pay program fees and complete community service in order to graduate.
- *Drug Court Hearings and the Judge's Role*—Participants should be required to attend Drug Court hearings once every two weeks and the judge should spend at least three minutes per participants on average at court hearings.
- *Data Collection and Monitoring*—Data should be maintained electronically and programs should participate in evaluation and use program statistics to make program improvements.
- *Training*—Staff should participate in training prior to program implementation, judges should receive formal training, and all team members should be trained as soon as possible.

Volumes of research has been conducted on Drug Courts during the over twenty years of their existence. One can find journal articles written on almost any aspect of Drug Courts, from racial differences in Drug Court graduation rates (McKean & Warren-Gordon, 2011) to the effect of faith on program success (Duvall et al., 2008). Moreover, Drug Court best practices continue to be identified and taught at national Drug Court training conferences. Using a larger sample, this article further supports this previous research by confirming, updating, and adding to the research findings about specific Drug Court practices that relate to significantly better outcomes.

METHODS

Between 2000 and 2010, NPC Research conducted over 125 evaluations of adult Drug Court program operations. For this study, we selected sixty-nine of these evaluations because they used consistent methods for collecting detailed process information, included recidivism and cost analyses using the same methodology, and had sufficient sample sizes (total $n \geq 100$) for valid analysis. All process evaluations were designed to assess how and to what extent the Drug Court programs had implemented the Ten Key Components. The Drug Courts represented diverse geographic areas in Oregon, California, Indiana, Maryland, Michigan, Vermont, and Guam. In total, this

study included 32,719 individuals (16,317 Drug Court participants and 16,402 comparison group members).[1]

Participation by the Drug Court programs in these evaluations was voluntary. These courts either directly contracted with NPC Research for evaluation services as part of their own quality improvement initiatives or collaborated with NPC Research as part of larger state or federal grant initiatives.

Data Collection

The data used in these analyses were collected as a part of process, outcome, and cost evaluations performed by NPC Research between 2000 and 2010. A brief description of the process, outcome, and cost data collection methodology is summarized below.[2]

Process Data Collection

For the process evaluations, the team relied on a multi-method approach. This strategy included a combination of site visit observations, key informant interviews, focus groups, and document reviews. This broad approach allowed the team greater access to descriptive program data than would have been available using any single method. A standard methodology was applied at each site to provide comparable data.

Key informant interviews were conducted with the Drug Court coordinator, judge, prosecutor, defense attorney, treatment providers, and probation and law enforcement representatives. Frequently, representatives from other involved agencies were also interviewed. NPC Research developed a standardized Drug Court typology interview guide and online survey to provide a consistent method for collecting structure and process information. The topics for the survey and typology interview guide were based on the Ten Key Components

[1] See http://www.npcresearch.com/Files/Appendix_A_Adult_drug_courts_participating_in_this_research.pdf for the programs included in this analysis.

[2] Detailed descriptions of the methodology and data collection performed for each Drug Court's full evaluation can be found in the program site-specific reports at www.npcresearch.com.

(NADCP, 1997) and were chosen from three main sources: the evaluation team's extensive Drug Court experience, the American University Drug Court Survey, and a published paper by Longshore and colleagues (2001) describing a conceptual framework for Drug Courts. The survey and typology interview guide covered many areas including specific Drug Court characteristics, structure, processes, and organization.

Outcome Data Collection

For the Drug Court participant sample, NPC Research identified individuals at each Drug Court who enrolled in the programs over a specified time period (at least a 2-year period). These individuals were selected using a Drug Court database or paper files listing Drug Court participants. To create a comparison group, NPC Research identified similarly situated individuals who were eligible for Drug Court but did not participate and received traditional court processing. Both groups were examined through existing administrative databases for a period of at least two years following entry. When databases were not available, data were gathered from paper files maintained by the program and other agencies involved with the offender population. The evaluation team utilized county and statewide data sources on criminal activity and treatment utilization to determine how Drug Court participants and the individuals from comparison groups differed in court processing and subsequent recidivism-related events (e.g., rearrests, new court cases, new probation, and incarceration).

Cost Data Collection

NPC Research performed the cost studies in these Drug Court programs using an approach called transaction and institutional cost analysis (TICA) (Crumpton, Carey, & Finigan, 2004). The TICA approach views an individual's interaction with publicly funded agencies as a set of transactions in which the individual utilizes resources contributed from multiple agencies. Transactions are those points within a system where resources are consumed or change hands. In the case of Drug Courts, when a Drug Court participant appears in court or has a drug test, resources such as judge time, public defender

time, court facilities, and urine cups are used. Court appearances and drug tests are transactions. In addition, the TICA approach recognizes that these transactions take place within multiple organizations and institutions that work together to create the program. These organizations and institutions contribute to the cost of each transaction with program participants. TICA is a practical approach to conducting cost assessment in an environment such as a Drug Court, which involves complex interactions among multiple taxpayer-funded organizations.

In order to maximize the study's benefit to policymakers, a cost-to-taxpayer approach was used in these evaluations. This focus helps define which cost data should be collected (costs and avoided costs involving public funds) and which cost data are omitted from the analyses (e.g., costs to the individual participating in the program). In this approach, any criminal-justice-related cost incurred by the Drug Court or comparison group participant that directly impacts a citizen (either through tax-related expenditures or the results of being a victim of a crime perpetrated by a substance abuser) is used in the calculations.

Process Data Analysis

Analysis of Drug Court Practices

Statistical frequencies were performed across all sixty-nine Drug Court programs on each of over 200 adult Drug Court practices to determine the number of programs that implemented each practice. The frequencies provided us with the amount of variation that existed across programs in implementing any particular practice. The practices were categorized by component for each of the Ten Key Components (based on earlier work by Carey, Finigan, & Pukstas, 2008).

Some Drug Court practices did not vary greatly across these sixty-nine Drug Courts. If all Drug Courts performed the same practice, it was not possible to determine whether courts that performed a given practice had better outcomes than courts that did not. If a practice was not included in the results as a practice related to positive outcomes, this does not necessarily mean that the practice is not important; alternatively, it might not have been measurable with these

data. Practices that were common in over 90% of the programs are reported on the NPC Research Web site.[3]

Analysis of Practice in Relation to Recidivism and Costs

The analyses presented in this paper include only evaluations that had recidivism and cost outcomes (a total of sixty-nine programs). The quantitative analysis assessed court-level characteristics (practices performed or services provided by the program) and court-level outcomes, specifically, average reduction in number of rearrests and average increase in cost savings for each Drug Court. Costs, in particular, can vary across jurisdictions based on many factors that are not related to the Drug Court program, including cost of living in the area and the availability of different resources. For this reason, the *percent difference* (effect size) between the Drug Court participant sample and the comparison sample was used as a method for equilibrating the results across sites.

This study defines *recidivism* as the average number of rearrests over two years from program entry. *Reduction in recidivism* is defined as the percent decrease in average number of rearrests for the Drug Court participants when compared with the comparison group.

Outcome costs are defined as costs incurred because of criminal recidivism for both the Drug Court participants and comparison group members in the two years after Drug Court entry (or an equivalent date for the comparison group). Recidivism-related costs include rearrests, new court cases, probation and parole time served, and incarceration in jail and prison. For this study, reductions in outcome costs (or increases in cost savings) were calculated as the percent difference in outcome costs between the Drug Court group and the comparison group. The higher the percentage, the bigger the cost savings for Drug Court participants over the comparison group.

For the analyses of Drug Court practices in relation to outcomes, we coded the vast majority of the data on program practices as *yes* or *no* questions, either *yes,* the program performed that practice, or *no,*

[3] See Appendix B at http://www.npcresearch.com/Files/Appendix_B_Practices_performed_in_90_percent_or_more_of_the_programs_in_this_analysis.pdf.

the program did not perform that practice. For example, the practice "a representative from treatment regularly attends Drug Court sessions" was coded as *yes* if the treatment representative regularly attended court or *no* if the treatment representative did not. In a few cases, we used continuous data (such as the number of days between arrest and program entry). We analyzed program recidivism and cost outcomes for those practices where the data revealed sufficient variation across sites.

To be considered a *best practice* for this article, data on a Drug Court practice had to be available in at least forty programs ($n \geq 40$), with at least ten programs in each yes or no category. That is, at least ten programs engaged in that practice *and* at least ten programs did not engage in that practice. However, in three cases where differences were substantial and significant, we included a practice where we had data for only thirty-five programs. In addition to best practices, we also included *promising practices*, where $n \geq 20$ and at least five programs represented each *yes/no* category.

We considered analyzing the practice and outcome data using a mixed model approach that used a nested design with *Drug Court program* as a grouping variable and outcome data at the client level (number of rearrests and two-year outcome costs per individual); however, we determined this would not best support the purpose of this analysis of best practices, which was to determine what program practices are related to program-level outcomes rather than individual outcomes (e.g., average reductions in recidivism, not whether or not a particular individual was rearrested or experienced a specific program practice). Therefore, these data could best be applied to program level analyses such as t-tests. The use of control variables was also considered (such as program population characteristics—ethnicity, gender, or drug of choice; rural vs. urban; program capacity; number of case managers or treatment providers; etc.). However, the sample size (n = 69) was not large enough to control for the numerous potential variables. Further, determining which variables to include as controls for each separate program practice on a theoretical basis when analyzing over 200 program practices was too complicated to be feasible and would not provide helpful or meaningful results.

We ran t-tests to compare the reduction in recidivism and the improvement in cost savings between courts that answered *yes* and courts that answered *no* for each practice. In cases where the data for a practice were continuous variables (such as number of treatment agencies that worked with the program), we used regression analyses to determine overall significance and examined the data for clear cut points. We then ran t-tests using these cut points. Results were considered statistically significant at $p < .05$ and considered "trends" up to $p < 0.15$.

Drug Court Population and Program Characteristics

Of the sixty-nine programs with recidivism data, 69% were post-plea only, 96% took offenders with felony charges, and 51% took offenders with either misdemeanor or felony charges.

The Drug Court programs included in this analysis ranged from a capacity of 20 active participants to over 400. The participant population for these programs varied in racial/ethnic composition within each Drug Court from 100% Latino to 99% White to 96% African–American. Participant gender ranged from 13% female in some Drug Courts to 55% female in others. Drugs of choice also varied widely, with some courts being made up entirely of methamphetamine users (100%), some consisting of mostly heroin users (80%), while others had a majority of marijuana users (78%). The average length of stay in these Drug Courts ranged from five months to twenty-nine months. The average graduation rate was 46%. A table that provides a description of the range in program and participant characteristics across the study sites can be found on the NPC Research Web site.[4]

Recidivism rates and costs also varied widely between sites based on factors that had little to do with the program itself, such as the availability of the police to make arrests (e.g., fewer police may result in fewer arrests) and the cost of living in the area. For this reason, we equilibrated the recidivism and cost outcomes across programs by

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[4] See http://www.npcresearch.com/Files/Characteristics_of_program_and_participant_population_in_69_drug_courts.pdf.

creating a percent difference between the Drug Court group and its comparison group for each outcome to establish the effect size. The effect size for the recidivism rate consisted of the difference in the number of rearrests between the Drug Court participants and comparison group divided by the number of rearrests for the comparison group. The percent increase in cost savings was calculated by subtracting the recidivism-related costs for the Drug Court from the recidivism costs for the comparison group, then dividing by the comparison group recidivism costs.

The average reduction in recidivism across these sixty-nine programs was 32%, and the average increase in cost savings was 27%. Just over 9% of the sixty-nine Drug Court programs had significantly greater participant recidivism than their comparison group, and 3% had outcomes that cost significantly more money than the comparison group. An additional 10% showed no significant difference in recidivism between the Drug Court and comparison group, and 23% showed no significant difference in costs. Just over 81% of the programs had significant reductions in recidivism of 10% or greater (up to 100% reductions), and 74% had significant cost savings of 16% or higher (up to 95% savings in costs).

Limitations of the Analyses

One limitation of these analyses is that some Drug Courts may have comparatively high-risk populations, for example, populations that have higher rates of mental illness, more severe addictions, low educational levels, and few economic opportunities. Drug Courts with proportionately more participants in this situation are more likely to have fewer positive outcomes, despite the fact that such Drug Courts might be implementing best practices. The data on risk level of the participants in these Drug Courts were not available to determine how this factor might have impacted outcomes.

Secondly, and related to the first limitation, is that the analyses performed were univariate correlations and there was no experimental control over what services or policies were provided by the programs in this study. Therefore, we cannot confidently attribute causality. That is, we cannot say with certainty that a particular practice caused

a particular reduction in recidivism or increase in cost savings. The more effective programs might have differed on variables that had nothing to do with their outcomes.

These analyses of best practices did not control for program population characteristics or some context characteristics (such as rural vs. urban programs). However, because of the vast flexibility and variation in the Drug Court model, many types of programs and populations were represented in this sample and, therefore, these findings should hold for many Drug Court programs.

RESULTS

The findings from these analyses are extensive. We found over fifty practices with significant correlations with recidivism or cost or both and some practices which were of interest because they were not significantly related to outcomes. The presentation of the results is therefore broken down into sections. The first section provides the full list of practices that met the criteria for best practices. This section also includes lists of the top ten practices by effect size for reduced recidivism and the top ten practices related to cost savings. The second section describes the promising practices that were significantly related to reductions in recidivism or to cost savings. The third section describes practices that are interesting because they were not significantly related to either outcome. Finally, the last section provides a discussion of the overarching themes among these practices.

Best Practices

Table 1 lists the best practices along with the overall effect sizes and level of significance for reductions in recidivism and for cost savings. These effect sizes show how large the reductions in recidivism and the increases in cost savings are for Drug Courts that perform a specific practice compared with the Drug Courts that do not. For example, courts where law enforcement is a member of the Drug Court team had 87% greater reductions in recidivism than courts that did not have law enforcement on the team. The figure 87% is the effect size. Although the Drug Courts that do not include law enforcement on the

team still reduced recidivism, the Drug Courts that do include law enforcement reduced recidivism 87% more. Table 1 also has the practices organized within each of the Ten Key Components (NADCP, 1997) following the convention established by these authors in an earlier study (Carey, Finigan, & Pukstas, 2008).[5]

TABLE 1	DRUG COURT BEST PRACTICES RELATED TO REDUCED RECIDIVISM AND HIGHER COST SAVINGS (BY KEY COMPONENT)		
KC[1]	Practice	Reduction in Recidivism	Increase in Cost Savings
1	Law enforcement is a member of the Drug Court team	0.87*	0.44†
1	Judge, both attorneys, treatment, program coordinator, and probation attend staffings	0.50*	0.20
1	The defense attorney attends Drug Court team meetings (staffings)	0.21	0.93*
1	A representative from treatment attends Drug Court team meetings (staffings)	1.05†	0.00
1	Coordinator attends Drug Court team meetings (staffings)	0.58†	0.41
1	Law enforcement attends Drug Court team meetings (staffings)	0.67*	0.42˜
1	Judge, attorneys, treatment, probation, and coordinator attend court sessions (status review hearings)	0.35†	0.36˜
1	A representative from treatment attends court sessions (status review hearings)	1.00†	0.81†

[5] NPC Research provides a table of these best practices with greater detail including the specific recidivism reductions and relative cost savings in programs that did and did not perform each practice as well the sample size for each category. See Appendix C at http://www.npcresearch.com/Files/Appendix_C_Best_practices_comparing_yes_to_no_with_N_sizes.pdf.

TABLE 1	DRUG COURT BEST PRACTICES RELATED TO REDUCED RECIDIVISM AND HIGHER COST SAVINGS (BY KEY COMPONENT)		
KC[1]	**Practice**	**Reduction in Recidivism**	**Increase in Cost Savings**
1	Law enforcement attends court sessions (status review hearings)	0.83*	0.64*
1	Treatment communicates with court via e-mail	1.19*	0.39
2	Drug Court allows nondrug charges	0.95*	0.30
3	The Drug Court excludes offenders with serious mental health issues	0.16	–0.43*
3	The time between arrest and program entry is 50 days or less	0.63*	–0.19
3	Program caseload (number of individuals actually participating at any one time) is less than 125	5.67*	0.35
4	The Drug Court works with two or fewer treatment agencies	0.74*	0.19
4	The Drug Court has guidelines on the frequency of individual treatment sessions that a participant must receive	0.52*	–0.19
4	The Drug Court offers gender-specific services	0.20†	–0.10
4	The Drug Court offers mental health treatment	0.80†	0.12
4	The Drug Court offers parenting classes	0.65*	0.52~
4	The Drug Court offers family/ domestic relations counseling	0.65†	–0.12
4	The Drug Court offers anger management classes	0.48	0.43~

Table 1	Drug Court Best Practices Related to Reduced Recidivism and Higher Cost Savings (by Key Component)		
KC[1]	Practice	Reduction in Recidivism	Increase in Cost Savings
4	The minimum length of the Drug Court program is 12 months or more	0.57*	0.39
5	Drug test results are back in two days or less	0.73*	0.68*
5	In the first phase of Drug Court, drug tests are collected at least two times per week	0.38	0.61˜
5	Participants are expected to have greater than 90 days clean (negative drug tests) before graduation	1.64˜	0.50†
6	Only the judge can give sanctions to participants	0.31˜	0.04
6	Sanctions are imposed immediately after noncompliant behavior (e.g., Drug Court will impose sanctions in advance of a participant's regularly scheduled court hearing)	0.32	1.00*
6	Team members are given a copy of the guidelines for sanctions	0.55†	0.72˜
6	In order to graduate participants must have a job or be in school	0.24	0.83*
6	In order to graduate participants must have a sober housing environment	0.14	0.48˜
6	To graduate participants must have paid all court-ordered fines and fees (e.g., fines, restitution)	0.48˜	0.30
7	Participants have status review sessions every two weeks in first phase	0.48†	–0.23

TABLE 1	DRUG COURT BEST PRACTICES RELATED TO REDUCED RECIDIVISM AND HIGHER COST SAVINGS (BY KEY COMPONENT)		
KC[1]	Practice	Reduction in Recidivism	Increase in Cost Savings
7	Judge spends an average of 3 minutes or greater per participant during status review hearings	1.53*	0.36
7	The judge was assigned to Drug Court on a voluntary basis	0.84˜	0.04
7	The judge's term is indefinite	0.35*	0.17
8	The results of program evaluations have led to modifications in Drug Court operations	0.85†	1.00*
8	Review of the data and/or regular reporting of program statistics has led to modifications in Drug Court operations	1.05*	1.31*
9	All new hires to the Drug Court complete a formal training or orientation	0.54†	0.07

NOTE: Practices that are significantly related to reductions in recidivism are not always significantly related to cost savings and vice versa. This finding is most likely because the two outcomes are indicators of different factors. The recidivism outcome essentially reflects the number of times participants engaged the criminal justice system (i.e., the number of rearrests). The cost outcome often reflects the seriousness of the crimes associated with those rearrests. More serious charges often result in more extensive sentences—more time incarcerated and on probation or parole—and a greater number of new court cases, all of which are related to higher costs.

[1]Key Component; ˜Trend (p<.15); †p < 0.1; *p < .05

Top Ten Practices for Reducing Recidivism

Following are the top ten practices related to reducing recidivism from Table 1 ranked by effect size, starting with the largest.

1. Drug Courts with a program caseload (number of active participants) of less than 125 had more than five times greater reductions in recidivism than programs with more participants.

Figure 1 demonstrates how the reductions in recidivism decrease as programs get larger. Likely, as the Drug Court gets larger, the caseloads per case manager and treatment provider also get larger. The larger programs may be tempted to decrease the level of supervision or otherwise "water down" the Drug Court intervention. In addition, the role of the judge has been demonstrated to be a key factor in participant success. All of the Drug Courts in this study were single-judge programs and therefore the larger programs had a single judge seeing up to 400 active participants. Judges report difficulty in getting to know participants to the extent that they need to when they see over 100 participants. Although the reason for this result is not clear from the available data, this finding had the largest effect size by far of any finding in this study. Part of the reason for this extremely large effect size is that programs with populations of greater than 125 participants had a very small reduction in recidivism (an average of 6%) compared with programs with 125 or fewer, which had an average of 40% reduction in recidivism. Clearly the smaller programs did substantially better. We do not believe that, based on this result, larger

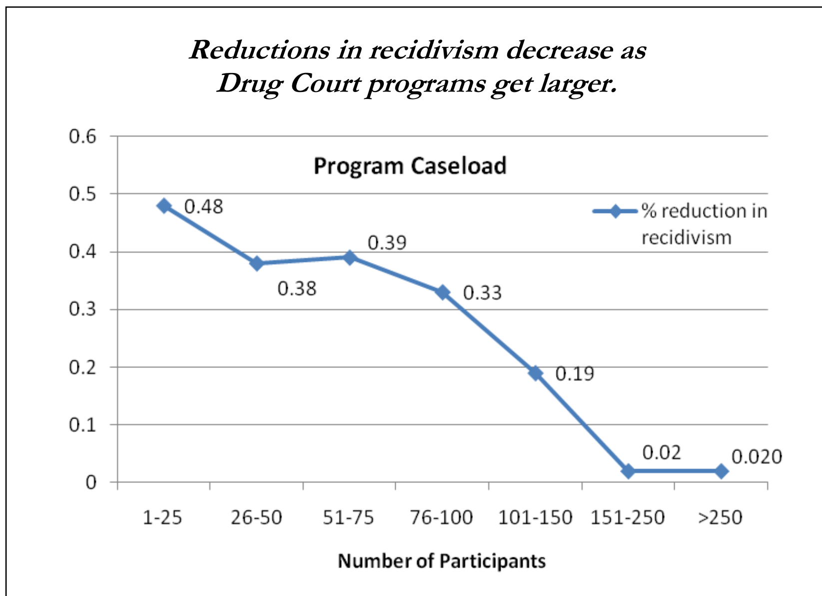

Figure 1. Participant Caseload Compared with Reductions in Recidivism

programs must become smaller. More research is needed to fully understand what is driving this result. In the meantime, larger programs should be examining their practices to ensure that they are maintaining fidelity to the Drug Court model and to best practices.

2. Drug Courts where participants were expected to have greater than 90 days clean (negative drug tests) before graduation had 164% greater reductions in recidivism compared with programs that expected less clean time.

Graduation requirements have been an important issue, and a contentious one, for some Drug Courts. This finding is consistent with the literature, which shows that the longer individuals remain abstinent from drugs and alcohol, the more likely they will continue to remain abstinent in the future (e.g., Kelly & White, 2011).

3. Drug Courts where the judge spent an average of three minutes or greater per participant during court hearings had 153% greater reductions in recidivism compared with programs where the judge spent less time.

Three minutes does not seem like much time. Yet one of the crucial aspects of the Drug Court model is the influence of the judge, which requires significant and meaningful interaction with the participant. Our data show a linear effect on positive outcomes when more judge time is spent with the participant (see Figure 2). Moving from under three minutes to just over three minutes effectively doubles the reduction in recidivism, while spending seven minutes or more effectively triples the positive outcome.

4. Drug Courts where treatment providers communicated with the court or team via e-mail had 119% greater reductions in recidivism.

Good communication is important for any successful team effort, and this is particularly true of Drug Court. For a Drug Court to provide immediate sanctions and rewards, communication about participant activities must be quick and accurate. Using e-mail as a primary communication method allows swift communication simultaneously with all team members, making this an effective format.

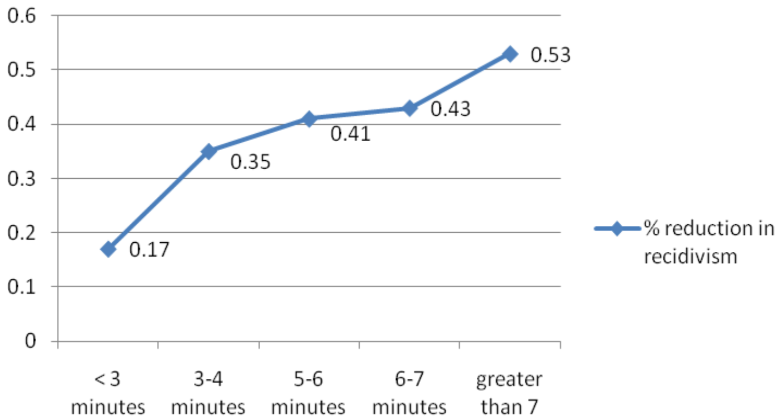

Figure 2. Number of Minutes before the Judge Compared with Reductions in Recidivism

5. Drug Courts where a representative from treatment attended Drug Court team meetings (staffings) had 105% greater reductions in recidivism.

Most of our sites (*n* = 50) required treatment providers to attend the case staffing because this is highly relevant to their role and is a crucial place for their feedback, but a large minority (11) did not. While they may have had feedback about participants delivered to the staffing, they did not send a representative to be part of the team. These data suggest that this is not as good a practice.

6. Drug Courts where internal review of the data and program statistics led to modifications in program operations had 105% greater reductions in recidivism.

Parallel to the practice of having independent evaluation of the Drug Court program (point ten on this top ten list) is the internal collecting, tracking, and use of data to improve program practice. The key elements to this best practice are twofold:

- The program uses an electronic data collection and management system that allows staff to provide the Drug Court with relevant statistics on program performance and operations, which the team can use to garner insights into its performance, guide improvements, and reveal areas where training is needed.
- The Drug Court *uses* the data as a basis for practical program change and continues to use it to monitor progress.

7. Drug Courts where a treatment representative attended court hearings had 100% greater reductions in recidivism than programs where treatment did not attend.

Most of the programs in this study required treatment providers to attend the case staffing because this is highly relevant to their role and is a crucial place for their feedback. However, the role of treatment seems less obvious when it comes to status hearings. Status hearings for Drug Court generally involve sanctions and rewards for activities related to treatment. Having treatment providers attend status hearings demonstrates to participants that the team works together to make decisions about their care and demonstrates in court that the program is intended to be therapeutic. This also makes it more difficult for participants to tell different stories to treatment and the Drug Court, thus "playing off" treatment providers and the rest of the team against each other.

8. Drug Courts that allowed nondrug charges (e.g., theft or forgery) had 95% greater reductions in recidivism than Drug Courts that accepted only drug charges.

This practice has been a source of controversy among Drug Courts. Early in the Drug Court movement, common belief held that the Drug Court was primarily geared to offenders with drug possession charges. This idea ignored the important role of drug addiction and abuse in many other crimes such as burglary or robbery. Increasingly, prosecutors and other referral sources to Drug Court began to feel that offenders with nondrug charges would also benefit from Drug Court. These data support that conclusion. This finding illustrates the greater impact Drug Court can have on public safety when participants with more serious offenses (including higher-risk participants) are given the benefit of intense supervision and treatment.

9. Drug Courts that had a law enforcement representative on the Drug Court team had 88% greater reductions in recidivism than programs that did not.

Programs that include a law enforcement representative on the team describe that role as crucial for two main reasons:

- Law enforcement often has more frequent contact than Drug Court personnel with Drug Court participants on the street and in home settings and therefore provides good insight into what is happening to participants in their lives outside of court and treatment.
- Including law enforcement creates a two-way process where law enforcement representatives not only contribute an important perspective to the Drug Court, but also return information to law enforcement organizations, which promotes a better understanding of the value of Drug Court.

10. Drug Courts that had evaluations conducted by independent evaluators and used them to make modifications in Drug Court operations had 85% greater reductions in recidivism than programs that did not use these results.

Evaluations by independent research teams are sometimes viewed by sites as an inconvenience required by a funder. Partly this perception may result from using evaluators who do not understand Drug Courts and do not address questions that might lead to program improvement. However, part of this perception may also reflect the discomfort or lack of familiarity of some Drug Court staff with the use of numbers or statistics. Whatever the reason, using evaluation feedback to modify program practices appears to be worth the effort.

The key elements to this best practice are twofold:

- The program has an evaluation by an independent research team that provides insights into its program performance, guidance on potential improvements, and training in ongoing data collection to monitor improvements.
- The Drug Court *uses* the independent evaluation as a basis for practical program change.

Top Ten Practices for Cost Savings

Many of the top ten practices for reducing recidivism are the same ones that also contribute to saving costs. Following are the top ten practices related to increased cost savings from Table 1 ranked by effect sizes, starting with the largest.

1. Drug Courts where internal review of the data and program statistics led to modifications in program operations had 131% higher cost savings.

Using data from program management information systems (MIS) to track progress and make program modifications correlates strongly with cost savings. Regularly monitoring data further provides feedback that the team can use to make necessary adjustments to meet goals in a timely and regular manner. This finding appears in both of the top ten practices lists.

2. Drug Courts that had evaluations conducted by independent evaluators and used them to make modifications in Drug Court operations had 100% greater cost savings.

Having a good, useful independent evaluation is important to this best practice. As with the preceding practice, this practice depends on the program's willingness to make changes based on data and to continue to use data to monitor progress. This finding appears in both of the top ten practices lists.

3. Drug Courts where sanctions were imposed immediately after noncompliant behavior had 100% greater cost savings.

The value of having sanctions imposed immediately after noncompliant behavior is a central tenet of behavior modification. It also appears to increase positive outcomes and cost savings in Drug Courts. *Immediately* is defined as bringing a participant in to the next available court hearing if they are not already scheduled for it, or administering the sanction before the next court hearing. Study results also showed that when programs wait until the scheduled court appearance for noncompliant participants instead of bringing them in earlier, participant outcomes do not improve. If teams wait too long (two weeks or more) before applying a sanction, the participants may

have other issues that are more relevant by then, or they may even have worked to improve their behavior by then, in which case they are receiving a sanction at the same time as they are doing well, providing them with a message that is unclear and may even be defeating.

4. Drug Courts where the defense attorney attended Drug Court team meetings (staffings) had 93% greater cost savings.

The value of having a defense attorney present at staffing is twofold: first, it helps protect the rights of the Drug Court participant, and second, it appears to increase positive outcomes and cost savings. The goal of problem-solving courts is to change behavior by leveraging compliance with treatment while protecting both participant rights and public safety. Drug Court participants are seen more frequently, supervised more closely, and monitored more stringently than other offenders. Thus, they often have violations of program rules and probation. Counsel must be there to rapidly address the legal issues, settle the violations, and move the case back into treatment and program case plans.

5. Drug Courts where participants must have a job or be in school in order to graduate had 83% greater cost savings.

Both having a job and being in school have a clear and logical connection to costs after the participant leaves the program. If the participant is engaged in positive activities that lead to higher (and legal) income, they are less likely to engage in drug use or other criminal activities.

6. Drug Courts where a treatment representative attended court sessions had 81% greater cost savings.

Having a treatment representative at Drug Court sessions related to significant cost savings, illustrating the importance of treatment providers as team members. This finding appears in both of the top ten practices lists.

7. Drug Courts where team members are given a copy of the guidelines for sanctions had 72% greater cost savings.

Interestingly, the results also showed that providing *participants* with written guidelines was not related to recidivism or cost outcomes. Therefore, it appears that guidelines may be more crucial for the *team* in determining its responses to participant behavior. Written guidelines can provide a range of potential team responses to participants' behaviors, including treatment responses, sanctions, and incentives rather than a one-to-one response for each behavior. This range of potential responses serves to remind team members of the variety of incentives and sanctions available while also providing some consistency across participants. Programs without written guidelines have a tendency to use a smaller number of sanctions and limit themselves to the incentives that they are most familiar with.

8. Drug Courts where drug test results were available in 48 hours or less had 68% greater cost savings.

Receiving drug test results quickly allows the team to respond more quickly with swift and certain sanctions and incentives. One method that works well for many programs is to use instant-results tests for the majority of drug tests, only sending to a lab for confirmation if the participant continues to deny use after a positive instant result. If the confirmation test comes back positive, the participant pays for that test as a sanction for providing false information in addition to any sanction or treatment response for the drug use itself. If the confirmation is negative, then the program pays the testing fee.

9. Drug Courts where drug tests were collected at least two times per week in the first phase had 68% greater cost savings.

Drug testing is the one truly objective means Drug Courts have of assessing whether their services are successfully changing participant behavior. It plays a crucial role in participant success. In focus groups, participants regularly reported that the only thing that kept them from using at the beginning of the program (before they were truly engaged in recovery) was knowing they would be tested and caught. Drug testing at least twice per week makes it more difficult for participants to use between tests, particularly if the tests occur on a random schedule. Testing less frequently makes prediction easier so that participants can find times to use without detection.

10. Drug Courts where a law enforcement representative attended court sessions had 64% greater cost savings than courts where law enforcement did not.

A law enforcement team member provides a unique perspective on participants and can contribute information that is invaluable to the team and the participants.

Promising Practices

Promising practices are those that significantly related to recidivism and costs, but did not meet the more stringent criteria outlined for best practices. The practices listed in Table 2 show promise for providing adult Drug Court programs with a strong infrastructure that contributes to program and participant success.[6]

Offer Services to Address Participant Needs

Drug Court programs that provide participant supports appear to have better outcomes. Many program services that address participant needs, including gender-specific services, mental health treatment, parenting classes, family counseling, and anger management classes, help participants avoid rearrest and save the program money in the long run (see Table 1). Three practices related to program services were encouraging enough to include under promising practices: residential treatment, health care, and dental care.

Residential Treatment—Offering residential treatment often completes a continuum of treatment services for those participants with the most severe substance abuse issues and may translate into a 106% improvement in recidivism outcomes.

Health and Dental Care—Most Drug Court participants had lifestyles that negatively impacted their physical health and many did not have consistent access to health or dental care. For example, use of

[6] The NPC Research Web site provides a table of promising practices with greater detail including the specific number of Drug Courts in each category and the specific recidivism reductions and relative cost savings. See Appendix D at http://www.npcresearch.com/Files/Appendix_D_Promising_practices_comparing_yes_to_no_with_N_sizes.pdf.

TABLE 2	DRUG COURT PROMISING PRACTICES		
KC[1]	Practice	Reduction in Recidivism	Increase in Cost Savings
4	The Drug Court offers residential treatment	1.06†	0.26
4	The Drug Court offers health care	0.50˜	0.46
4	The Drug Court offers dental care	0.59†	0.38
6	Participants are required to pay court fees	0.18	2.08*
6	The Drug Court reports that the typical length of jail sanction is longer than two weeks	–0.59*	–0.45˜

NOTE: For promising practices, $n \geq 20$ with at least 5 in each category.
[1]Key Component; ˜Trend (p<.15); †$p < 0.1$; *$p < .05$

some substances (e.g., methamphetamines) creates serious physical health and dental problems. Programs that offered dental care had 59% greater reductions in recidivism than programs that did not and programs that offered health care had 50% greater reductions in recidivism.

Although not statistically significant, offering any one of these three services also produced improvements in cost of 23–26 percent.

Require Participants to Pay Court Fees

Court fees are one way that Drug Court programs create an institutionalized, sustainable source of program funding. These fees must be proportional to a participant's ability to pay and should not create a barrier to success or a disincentive to participate in the program. This fee strategy enhances participant engagement, promotes the belief that the program is valuable, and allows participants to invest in their own change process. Programs that required court fees had 208% higher cost savings than programs that did not. Note that these cost savings do not reflect the costs of running the program, but specifically refer only to outcome costs, costs that occurred outside of the program and are related to recidivism events such as rearrests and time in jail.

Therefore, the cost savings are not achieved because the program had collected larger participant fees.

Consider Participant Sanctions Carefully

Two of the promising practices involve the use of sanctions in Drug Court programs, specifically the use of jail as a sanction and terminating program participation owing to rearrest for drug possession. Some view these sanctions as tougher on crime, yet the results of this study indicate that programs have better outcomes when they address noncompliance issues through other strategies.

Use Jail As a Sanction Sparingly—This study assessed the impact of using briefer compared with longer jail sanctions. Drug Courts that levied longer-term jail sanctions had worse outcomes than those using shorter-term jail sanctions (see Figure 3).

Programs that used sanctions of less than six days had average reductions in recidivism of 46% compared with 19% for programs that used longer-term jail sanctions. In addition, jail is an extremely expensive resource. Programs relying on jail sanctions longer than two weeks saw 45% less cost savings after program participation.

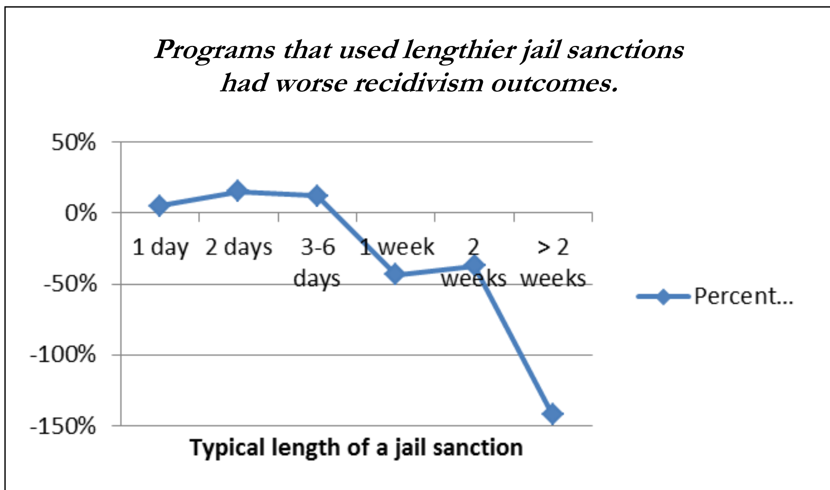

Figure 3. Duration of Jail Sanction Time Compared with Reduction in Recidivism

Retain Participants with New Possession Charges Rather Than Terminate Them—Although all programs must consider and establish policies and procedures for maintaining public safety and determining when participants are no longer appropriate for community-based interventions, a new arrest should not necessarily be grounds for automatic program termination. This study found that programs that terminated participants upon a new arrest for drug possession had lower recidivism reductions and lower cost savings than programs that did not terminate participants for a new drug charge. Programs that terminated participants for drug-possession arrests had 50% worse recidivism outcomes and 48% worse cost savings than programs that retained these participants in the program. These findings illustrate the importance of providing more services to this population of offenders, and that the continuity and persistence of Drug Court supervision and treatment pays off in the long run.

Train Staff in Preparation for Drug Court Program Implementation

Good management practices consistently demonstrate that employees need to understand their roles and tasks if they are to do their jobs effectively, and Drug Courts are no exception. As this article supports, Drug Court programs are collaborations with key elements that are important to implement to achieve desired outcomes. In this study, those programs that trained team members in preparation for program implementation averaged a 55% greater reduction in recidivism. Even more striking was the cost savings that resulted from training. Programs that invested in this practice had an average of 238% greater cost savings than programs that did not invest in training.

In sum, many of the promising practices described in this section involve activities or services that have resource implications programs might consider too expensive or time consuming, such as offering residential treatment or dental care or paying for staff training. However, this study provides evidence that these investments likely pay off in better long-term outcomes for both participants and the program as a whole. Smart use of system resources, such as limited

use of jail as a sanction and implementation of affordable participant fees, can also help make program investments feasible while at the same time improving outcomes.

Interesting Practices Not Significantly Related to Outcomes

Some practices are important by virtue of the fact that they were *not* significantly related to better or worse outcomes. Three main findings are particularly relevant to programs in determining their target population and their overall model. These findings relate to violence charges, mixing certain participant populations, and frequency of court appearances.

Drug Courts that allow participants with current violence charges or prior violence convictions had no difference in recidivism or cost outcomes.

This has been a highly political and controversial topic. Many prosecutors will not allow violent offenders in Drug Court because of public safety concerns. However, the data show that programs that allow violent offenders do equally well as programs that allow only nonviolent offenders. Other research also supports this finding (see Saum, Scarpitti, & Robbins, 2001; Saum & Hiller, 2008). In fact, research suggests allowing violent offenders into Drug Court programs can have a bigger positive effect on recidivism and cost outcomes than allowing only nonviolent offenders because greater savings are achieved when violent crimes are prevented rather than less serious (less costly) crimes.

In general, most violent offenders are not incarcerated for long and are subsequently back in the community under supervision that is much less intensive than the supervision provided by Drug Court. Because of proven reductions in recidivism for Drug Court programs compared with the traditional court system, Drug Courts actually do a better job of protecting public safety. However, choosing what kind of violence charges are allowed is important because the safety of the staff and other participants is paramount.

Drug Courts that mix pre- and postadjudication participants or allow participants with misdemeanors or felonies into the program had no difference in recidivism or cost outcomes.

The Drug Court model appears to work for offenders who have a substance use problem and are involved with the criminal justice system. Whether the program operated with a mix of pre- and postadjudication participants or operated either preadjudication or postadjudication exclusively had no relation to recidivism or cost in the current study. This finding is contrary to the findings by Shaffer (2006) and for the MADCE study (Rempel & Zweig, 2011) that mixing pre- and postadjudication offenders had worse outcomes compared with programs that served each of those populations exclusively. Further research needs to be performed to resolve this discrepancy.

Similarly, whether the charge that led to Drug Court participation was a misdemeanor or felony also had no relation to subsequent outcomes.

Drug Courts that see participants at court sessions weekly during the first phase had no better outcomes than courts that saw them every two weeks.

Although our best practice results show that seeing participants every two weeks in the first phase is related to significantly better outcomes (see Table 1) compared with programs that see participants monthly or less often, weekly court appearances do not appear to have significant additional benefit. Overall, what is important is assessing the risk and need level of participants and determining the appropriate level of court supervision needed at the time of entry (Marlowe et al., 2006). Perhaps for very high-risk and high-need participants, weekly court appearances might be appropriate, while participants that are more in the middle of the risk/need range might perform adequately with less frequent supervision.

Reiteration of Study Limitations

With over 200 practices being examined, determining a theoretical reason for using a particular covariate in the analysis for each in-

dividual practice was not feasible. Therefore, the analyses performed for the above results did not adjust for covariates (e.g., services available in the community or numbers of available case managers) or for the risk or need level of the participant populations.

SUMMARY AND CONCLUSIONS

Themes in Best Practices

Interestingly, when the best and promising practice results were examined for emerging themes among practices (see Tables 2 and 3), those themes led us back to the Ten Key Components. Following is a discussion of the main themes that emerged from a review of practices that significantly related to program outcomes.

Teams Sink or Swim Together—A holistic approach works. Having more people at the table collaborating pays off. Everyone brings value and the investment is worth the effort and cost. This result may be a function of communication. These data strongly make a case that all key players (e.g., judge, coordinator, treatment representative, prosecutor, defense attorney, law enforcement representative) should be members of the Drug Court team and be present both at status hearings and at staffing meetings.

Relationships Matter—Having teams that get together and work together, having fewer providers (which promotes more individual relationships and communication) and fewer participants (so that the team and judge know everyone), and ensuring participants get at least three minutes on average of the judge's attention at each review session all help create an effective program.

Wraparound and Habilitation Services Are Key—Drug Court programs that focus on providing participant supports have better outcomes. Programs with such wraparound services avert rearrests and save taxpayer money in the long run when they address participant needs such as relapse prevention, gender-specific services, mental health treatment, parenting classes, family counseling, anger management classes, health and dental services, and residential care.

Structure and Consistency Are Crucial—Practices that demonstrate this theme include having written guidelines for sanctions, guidelines on the number of individual treatment sessions, drug test results within forty-eight hours, drug testing at least twice per week, status reviews every other week, immediate sanctions (including those that occur outside of court and thus happen more swiftly), and a program designed to take at least twelve months. These factors ensure that participants are learning about structure, accountability, safety, and dependability.

Participants Must Be Set Up for Success—Participants should be stable before leaving the program. Best practices within this theme include requiring that participants have a job or be in school, have at least ninety days clean, have participated in the program at least twelve months, have sober housing, and have paid all fees before they can graduate. If these practices are in place, participants should be ready to set their own goals and succeed in their lives.

Continuous Program Improvement Leads to Positive Outcomes—Programs that collect and use data, seek out training, acquire the support and insights of experts (including evaluators), and use the data and expert feedback to make ongoing adjustments to enhance practices see improvements in outcomes. These results demonstrate that Drug Courts that develop practices that focus on understanding and improving program performance have better outcomes than those that do not.

The Drug Court Model Is Effective with Difficult Populations—Drug Courts work for a wide range of populations and for participants who are seen as difficult to change and serve. These findings show that an offender's criminal justice status (or mental health status) should not be a barrier. It does not matter whether a program's population is only preadjudication, only postadjudication, or a mix of both. Nor does it matter whether participants have violent histories or not, or whether they have misdemeanors or felonies. The focus is on treatment and consistent supervision. These results suggest that Drug Courts can successfully include a wide variety of offender populations.

Perhaps the most overarching theme is a picture of Drug Courts that are well organized. These programs have teams that are engaged in program activities and are collaborating, think through their program and clearly communicate expectations to staff and participants, and are dedicated to program improvement. These Drug Courts are the most effective in helping participants recover their futures, reducing participant recidivism, decreasing crime, and saving taxpayer money.

This manuscript is an original work by the three authors, Shannon Carey, Juliette Mackin, and Mike Finigan.

Funding for this project was provided by the National Drug Court Institute through Grant No. 2009-DC-BX-K006 awarded by the Bureau of Justice Assistance. The Bureau of Justice Assistance is a component of the Office of Justice Programs, which also includes the Bureau of Justice Statistics, the National Institute of Justice, the Office of Juvenile Justice and Delinquency Prevention, the SMART Office, and the Office for Victims for Crime. Points of view or opinions in this document are those of the authors and do not represent the official position or policies of the United States Department of Justice or the National Association of Drug Court Professionals, the National Drug Court Institute, or its sponsors, staff members, or officers.

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Drug Court Policies and Practices: How Program Implementation Affects Offender Substance Use and Criminal Behavior Outcomes

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*[4] **Adult Drug Court Rankings—**A sample of 23 adult Drug Courts were ranked by their ability to reduce substance use and criminal behavior.*

*[5] **Drug Court Practices and Criminal Behavior—**Drug Courts that prevented more criminal acts had high leverage over their participants, medium predictability of sanctions, positive judicial attributes, and admitted participants at the same point in the criminal justice process (i.e., all pre-plea or post-plea).*

*[6] **Drug Court Practices and Substance Use Outcomes—**Drug Courts that prevented more drug use had medium predictability of sanctions, participant populations that entered post-plea, and positive judicial attributes.*

*[7] **High-Performance Drug Courts—**The most effective Drug Courts created synergistic effects by implementing multiple best practices.*

THE JUSTICE POLICY CENTER at the Urban Institute, RTI International (RTI), and the Center for Court Innovation (CCI) conducted the Multisite Adult Drug Court Evaluation (MADCE)—a five-year study of adult Drug Courts funded by the National Institute of Justice. In addition to examining whether Drug Courts work to reduce drug use and crime, another goal of the MADCE was to explain *how* Drug Courts work by studying key program policies and practices that lead to more successful outcomes for participants. In this report, we identify variations in policies and practices across Drug Courts and determine whether these variations influenced program effectiveness.

In 1997, the Bureau of Justice Assistance (BJA) promulgated ten key components of Drug Courts. In part, these components recommend that Drug Courts monitor abstinence through frequent alcohol and drug testing, use coordinated strategies to respond to participants' compliance with sanctions and incentives, and provide ongoing judicial interaction with each Drug Court participant. Although the ten key components are consistently recommended as central to the Drug Court model, many have not been subjected to empirical investigation. When Drug Court programs have been evaluated, much of the previous literature focused on participant-level experiences rather than on court-level practices. However, the receipt and amount of Drug Court services correlates highly with individual outcomes. That is, Drug Courts routinely increase the amount of services they provide to participants in direct response to participants' infractions or other behaviors.

For this reason, this article focuses on the effectiveness of court-level practices. Few previous studies focused on court-level policies and many of those examined the effectiveness of specific Drug Court practices, primarily court appearances, treatment, and sanctions. In brief, although most Drug Courts require regular status hearings for program participants, requirements pertaining to the frequency of status hearings vary across courts. In a series of related studies, researchers were able to compare the impact of twice-monthly versus as-needed status hearings (Festinger et al., 2002; Marlowe et al., 2003; Marlowe, Festinger, & Lee, 2004; Marlowe et al., 2005). Overall, little support was found for the relationship between frequency of judicial status hearings and drug use or recidivism with the exception of two subgroups—those with a history of substance abuse treatment and those with antisocial personality disorder (ASPD)—who benefited from twice-monthly status hearings. Beyond the frequency of judicial status hearings, Finigan, Carey, and Cox (2007) examined whether judges differed in their success in reducing recidivism among Drug Court participants and whether they improved with experience. They found that all judges exhibited fewer rearrests for Drug Court participants than for comparison cases, and judges who had more than

one rotation on the bench achieved better outcomes during their second rotation.

The provision of substance abuse treatment is a major component of most Drug Courts and key to the program model (BJA, 1997). Harrell, Cavanagh, and Roman (2000) explored treatment as a court-level practice in an experimental study in which drug felony defendants were randomly assigned to one of three court dockets (sanctions, treatment, and standard[1]). After random assignment, defendants in the sanctions and treatment dockets who failed two drug tests while on pretrial release—and were therefore considered program eligible—were offered the intervention services available within their respective dockets. Outcomes were compared for program-eligible defendants in all three dockets, with some analyses restricted to the subset of defendants who agreed to participate in the intervention services available within the sanctions and treatment dockets.

Results indicated that program-eligible defendants within the treatment docket were more likely to test drug-free in the month prior to sentencing and had a smaller percentage of positive drug tests than program-eligible defendants in the standard docket. Reductions in drug use were even more significant among program participants in the treatment docket (i.e., those who agreed to receive the comprehensive treatment available). Being eligible for the treatment program had no impact on self-reported drug use or the likelihood of arrest in the year after sentencing, although program participants in the treatment docket did have fewer arrests for drug offenses.

Another key component of Drug Courts is using a coordinated strategy for governing participant compliance and noncompliance (BJA, 1997). Typically, Drug Courts respond to participant behavior with sanctions for noncompliance and incentives for compliance. Re-

[1] For the purposes of this study, the dockets were defined as follows: The sanctions docket had clearly defined penalties that were applied swiftly to participants for failing drug tests and encouraged entering treatment. The treatment docket offered comprehensive treatment programs designed to provide participants with skills, self-esteem, and community resources to help them leave the criminal life. While the sanctions and treatment dockets offered new intervention services, the standard docket handled drug cases in a routine manner (Harrell, Cavanagh, & Roman, 2000).

lated to this, results for the sanctions docket in the Harrell, Cavanagh, and Roman (1998) study included the following: program-eligible defendants in the sanctions docket who agreed to receive the intervention services were more likely to test drug-free in the month before sentencing (and had a lower percentage of positive drug tests) and were less likely to be arrested in the year after sentencing than program-eligible defendants in the standard docket.

Current Study

Although Drug Courts share several common elements, substantial variation has been documented in how policies and practices are implemented across Drug Courts (Carey, Finigan, & Pukstas, 2008; Rempel et al., 2003). The purpose of the current study is to identify how implementation of Drug Court policies and practices varies and which strategies are most effective in reducing and preventing criminal behavior and drug use. The study included a number of Drug Courts ($n = 23$) selected to reflect variations in key policies and practices. We chose ten specific policies and practices to explore that might relate to the ability to prevent future crime and substance use. Specifically, we examined the influence of leverage, predictability of sanctions, adherence to treatment best practices, drug testing, case management, judicial status hearings, point of entry into the program, multidisciplinary decision making among the Drug Court team, positive judicial attributes, and judicial interaction.

METHODS

Design

The MADCE was a longitudinal, quasi-experimental design consisting of twenty-three Drug Courts and six comparison sites. The study was designed to compare Drug Court participants to offenders with similar drug use, criminal histories, and psychosocial profiles in jurisdictions that do not offer Drug Courts. We conducted an extensive site-selection process to identify Drug Courts and comparison sites that reflected substantial variation in the implementation of various Drug Court polices, such as differences in sanction and supervi-

sion policies. To identify sites, we first administered the adult Drug Court survey as a Web-based instrument between February and June 2004 (see Zweig, Rossman, & Roman, 2011). A total of 380 Drug Courts completed the survey, representing a 64% response rate of the 593 Drug Courts identified across the U.S. that met the eligibility requirements of primarily serving adults and being in operation for at least one year at that time. Although national in scope, the sample was not nationally representative. Nonetheless, it provided an important foundation for understanding Drug Court programs throughout the country.

Using data from the survey, we chose twenty-three Drug Courts located in seven geographic clusters and then identified six comparison jurisdictions in similar locations.[2] The comparison sites included several alternative models for handling drug-involved offenders, representing the diverse activities employed in jurisdictions that had not implemented Drug Courts.[3] Notably, some comparison sites mandated offenders to community-based treatment, but without other components of the Drug Court model; other comparison sites involved standard probation.

Procedure

The data for the current analyses came from three sources. The first source of data was the Web-based adult Drug Court survey identified above. Drug Court staff completed the survey, answering general information questions about the Drug Court, program structure and operations, treatment and drug testing, and courtroom practices.

The second source of data was a process evaluation that included multiple contacts with Drug Courts ultimately included in the study.

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[2] More detail about recruiting sites and selection criteria can be found in Rossman et al. (2011). Altogether, MADCE includes 29 sites in eight states (Florida, Georgia, Illinois, New York, North Carolina, Pennsylvania, South Carolina, and Washington).

[3] Comparison sites included: Pierce County, WA Breaking the Cycle program; Human Services Associates TASC in Florida; Stewart-Marchman-ACT Behavioral Health Care, Florida; Illinois TASC; and North Carolina probation (NC is divided into two judicial districts and, therefore, we divided the comparison participants similarly, representing two comparison sites).

In 2004, phone interviews about court operations were conducted with potential Drug Courts during site selection. The process evaluation assessed each Drug Court's adherence to best practices related to leverage, sanctioning, and treatment in order to secure a varied sample of Drug Courts. In 2006 after the impact study began, evaluation team members visited the twenty-three Drug Courts to interview stakeholders and conduct observations of staffing meetings and court hearings. Program structure and management, operations, treatment, drug testing, and courtroom practices were assessed through open-ended questions and observations.

The third source of data was in-person interviews with offenders across the twenty-nine Drug Court and comparison sites conducted at three intervals: (1) when participants enrolled in the Drug Courts or comparison sites to provide a baseline, (2) six months after the baseline interview, and (3) eighteen months after baseline. Baseline enrollment took place during a 16-month period from March 2005 through June 2006. During that time, Drug Courts and comparison sites identified people enrolling in or entering their systems. These individuals were recruited by trained field interviewers who conducted informed consent procedures. The interviews with study participants lasted 1.5–2 hours and covered topics such as background characteristics, attitudes and perceptions (e.g., perceived legal pressure, motivations, perceptions of court, and judicial fairness), in-program behavior (e.g., receipt of treatment and other services), and outcomes (criminal behavior, drug use, and other measures of personal functioning).

Offender Sample

We enrolled 72% of eligible study participants at baseline, for a total initial sample of 1,781 offenders. Subsequently, 86% of those individuals completed 6-month interviews, and 83% completed 18-month interviews. The majority of the sample was male (70%), and the average age of study participants was 33.7 years with the Drug Court group being significantly younger than the comparison group. More than half the sample was white (55%), one-third was black/African–American (33%), 6% was Hispanic/Latino, and 6% fell

into other categories including multiracial. Just over one-third (35%) of the sample reported having a high school diploma or GED equivalency diploma; one-quarter (25%) reported having some college-level education; and 41% of the sample had less than a high school education. Slightly more than one-third of sample members (36%) were working at the time of baseline. Sixty-two percent of the sample had never been married; 11% were married; and 27% were divorced, separated, or widowed at the time of the baseline interview. Half reported having children younger than 18 years of age.

Study members, on average, reported that they began using drugs at the age of 13.6 years and had been using drugs for an average of 20 years. In the six months before they entered the program, 81% of the sample used some form of illicit drug or alcohol, and 57% used drugs other than alcohol or marijuana (including amphetamines, cocaine, heroin, hallucinogens, and nonprescribed medications). The study grouped participants by their primary substance of abuse, because many were polysubstance users. The subgroups were alcohol; marijuana; amphetamines (including methamphetamine); cocaine (powder and crack cocaine); and a subgroup hereafter referred to as *other drugs* (heroin, hallucinogens, and nonprescribed medications).

More participants in the Drug Court group reported using drugs than in the comparison group. They also reported significantly more days of use. On average, participants in both groups used drugs or alcohol 12.9 days per month, or 7.4 days per month when alcohol and marijuana were excluded.

Significantly more individuals in the comparison group had prior arrests before the one that brought them into the study (92% of the comparison group versus 86% of the Drug Court group). Of those arrested, comparison participants reported having more prior arrests (about eleven) than the Drug Court group (about eight).[4]

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[4] Although we employed strategies to recruit comparable offenders for both the treatment and comparison samples, some differences existed, and although we retained in the study the majority of offenders at 6 and 18 months, some differences existed between those who remained in the study and those who did not. We employed two statistical corrections to correct for baseline differences between the Drug Court

Analytic Strategy

We employed complementary approaches using quantitative and qualitative methodologies to evaluate the effectiveness of Drug Court policies and practices. First, we tested the effectiveness of particular practices using a traditional quantitative approach, hierarchical modeling. Generally, Drug Court participants are repeatedly exposed to the same judge; thus, it is easy to confuse the effect of the judge on outcomes with the effect of the court. Hierarchical models parse out individual effects on outcomes from court effects. This article presents findings for each policy and practice using hierarchical analysis of variance with follow-up Tukey tests of group comparisons.[5]

Second, we employed an innovative approach that ranked Drug Courts' levels of effectiveness at preventing drug use and crime. We created a score for each individual that was the difference between the person's expected outcome and his or her observed outcome in Drug Court. Thus, we predicted what participants' drug use and criminal activities would have been without Drug Court and subtracted the observed outcomes from the predicted outcomes.[6] For example, a Drug Court participant's actual observed outcome may have been two days of drug use per month. But, the same person's predicted outcome had they not been in Drug Court might have been ten days of drug use per month. Thus, this person's score on number of days of drug use prevented per month would be eight days.[7]

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and comparison samples and between retained and attrited cases in the two follow-up interviews. More details can be found in Rempel and Farole (2011).

[5] Further details on why we chose this statistical analysis can be found in Zweig and colleagues (2011).

[6] We estimated drug use and criminal activity outcomes for the comparison group based on variables that predict such activities (e.g., criminal history at baseline, substance use history at baseline, etc.). Then, estimated coefficients from the comparison group were applied to Drug Court participants' characteristics (i.e., their values on variables that predict substance use and criminal activity) to determine the expected behaviors for each individual had they not been in the Drug Court program.

[7] Further details on how the study scored outcomes can be found in Zweig and colleagues (2011).

We then ranked Drug Courts based on the average performance of their participants. Overall, Drug Courts as a whole prevented 1.7 crimes per month on average, but this ranged widely ($SD = 16$, $r = -264$–32). Also, Drug Courts as a whole prevented 1.6 days of drug use per month on average, but this, too, ranged widely ($SD = 7$, $r = -33$–37). Positive average values for the Drug Courts indicated that participants did better as a result of being in Drug Court, whereas negative values indicated participants did worse than expected. Drug Courts were ranked based on two outcomes: days of drug use prevented and number of criminal activities prevented. Courts were ranked in general and then by particular subgroups of participants. [8]

Once the court rankings were created for the two outcomes, we assigned codes to each Drug Court that characterized the way they implemented particular policies and practices. From this, we identified patterns within effective Drug Courts and top–performing Drug Courts in how they implemented policies and practices and compared these with lower-performing Drug Courts.

RESULTS

Court Rankings

To determine whether the effect of Drug Court practices varied across participants, we created thirty-one subgroups based on participant attributes as self-described in the baseline interview. We chose these thirty-one measures for two reasons. First, the effectiveness of Drug Courts has been shown to vary based on some individual characteristics, such as participants' substance use and criminal histories. Second, we identified individual characteristics that seemed related to substance use and criminal behavior even if they had not been studied as part of a previous Drug Court evaluation. The thirty-one subgroups for which rankings were created reflect three broad categories:

- *Background Characteristics*—Age 30 and older or under age 30; male or female; in an intimate relationship or not; having features

[8] Further details on how rankings were developed can be found in Zweig and colleagues (2011).

of depression or not; and having antisocial personality disorder (ASPD) or not

- *Criminal History*—No prior arrests, one to four prior arrests, or more than four prior arrests; previous incarceration or no previous incarceration; and any relatives or friends with a conviction or no such relatives or friends
- *Substance Use Factors*—Age of first drug use 15 years or younger or over 15 years; any substance abuse treatment during the six months before baseline or no such treatment; any relatives or friends with drug problems or no such relatives or friends. Primary drug of choice: alcohol, marijuana, amphetamines, cocaine, or other drugs; drug use of any kind other than marijuana. Used aggression-inducing drugs (i.e., amphetamines, cocaine) at some point or never used aggression-inducing drugs

Court Rankings for Crimes Prevented

Table 1 describes the Drug Court rankings for crimes prevented. Throughout the rankings, each Drug Court is represented by a letter rather than court name to provide anonymity. Letters above the bold line in each column represent Drug Courts achieving participant outcomes better than the expected outcomes—that is, effective courts. Drug Courts below the bold line are those where participant outcomes were worse than the expected outcomes. In columns without a bold line, all courts achieved positive results.

In each column, bold letters represent the top three Drug Courts with the most participants meeting that subgroup criterion. To be eligible for such, a Drug Court had to have at least 50% of its population meeting that criterion. Columns with no bold letters indicate that no court in that subgroup met this criterion. In addition, a Drug Court had to provide five participants in the given subgroup to be included in that ranking. Therefore, some subgroups contain fewer courts because some courts did not meet this criterion. The general ranking indicates that eighteen of the twenty-three Drug Courts in our study effectively prevented crime for their participant populations. However, rankings varied substantially among the subgroups. On average, more Drug Courts performed positively for the following groups:

TABLE 1	COURT RANKINGS: SUBSTANCE USE PREVENTED AT 18 MONTHS									
	General Ranking	Age 30 and Over	Under Age 30	Male	Female	In Intimate Relationship	Not in Intimate Relationship	Features of Depression	No Features of Depression	Features of ASPD[1]	No Features of ASPD
1	W	**W**	Q	Q	W	**Q**	D	E	T	Q	W
2	Q	**S**	M	W	S	W	S	R	E	W	L
3	S	**G**	G	G	Q	G	W	A	//	G	S
4	G	Q	L	**L**	**I**	T	**I**	//	//	D	**G**
5	L	L	D	D	V	V	M	//	//	S	Q
6	D	V	V	B	M	M	**L**	//	//	M	V
7	M	D	T	M	T	S	V	//	//	V	D
8	V	B	S	S	U	N	K	//	//	L	M
9	T	R	U	V	G	L	G	//	//	T	N
10	N	N	K	K	O	D	B	//	//	R	**I**
11	I	I	I	R	R	O	**R**	//	//	I	B
12	R	M	N	N	C	R	N	//	//	N	K
13	B	T	O	T	K	**I**	T	//	//	O	T
14	K	K	R	E	E	B	E	//	//	B	E
15	O	O	E	I	B	E	J	//	//	K	U
16	E	J	B	O	**P**	K	O	//	//	J	O
17	F	E	J	**J**	A	A	C	//	//	E	R
18	J	A	**P**	F	//	J	P	//	//	C	P
19	C	C	C	C	//	**U**	U	//	//	A	**F**
20	U	U	**H**	A	//	H	F	//	//	P	J
21	P	F	A	U	//	C	A	//	//	U	C
22	A	H	//	**H**	//	P	**H**	//	//	H	A
23	H	//	//	//	//	//	//	//	//	//	H

Table 1		Court Rankings: Substance Use Prevented at 18 Months										
	General Ranking	No Prior Arrests	1–4 Prior Arrests	More Than 4 Prior Arrests	Previous Incarceration	No Previous Incarceration	Relatives/Friends with a Conviction	No Relatives/Friends with a Conviction	First Drug Use Age 15 or Younger	First Drug Use Over Age 15	Substance Abuse Treatment Before Baseline	No Treatment Before Baseline
1	W	R	L	W	I	Q	W	T	G	W	I	**Q**
2	Q	S	D	G	W	S	**Q**	V	S	**Q**	**W**	G
3	S	Q	**M**	S	O	D	**S**	K	W	**D**	S	T
4	G	P	N	**L**	S	M	G	M	Q	L	**L**	S
5	L	D	V	M	Q	V	D	O	V	S	M	**D**
6	D	O	Q	V	T	G	**L**	P	L	M	G	V
7	M	A	T	T	K	W	V	**I**	I	T	K	L
8	V	H	K	**J**	R	F	**M**	B	M	G	N	U
9	T	J	C	B	V	**L**	R	H	N	V	O	M
10	N	K	U	**I**	M	**N**	I	C	R	K	E	B
11	**I**	T	S	K	E	U	E	A	T	B	**R**	N
12	R	//	G	R	C	T	T	E	O	C	H	R
13	B	//	**I**	E	A	B	**N**	J	B	N	A	K
14	K	//	B	O	U	K	B	R	E	R	P	O
15	O	//	E	**F**	//	R	J	//	K	I	B	E
16	E	//	O	U	//	**I**	K	//	**F**	O	C	J
17	F	//	R	C	//	E	O	//	A	E	J	**F**
18	J	//	A	A	//	O	C	//	**P**	**J**	T	**C**
19	C	//	P	P	//	**J**	F	//	U	U	U	**I**
20	U	//	J	H	//	A	A	//	C	A	//	A
21	P	//	H	//	//	C	P	//	**H**	P	//	P
22	A	//	//	//	//	P	U	//	J	H	//	H
23	H	//	//	//	//	H	H	//	//	//	//	//

TABLE 1	COURT RANKINGS: SUBSTANCE USE PREVENTED AT 18 MONTHS									
				Primary Drug of Choice						
	General Ranking	Relatives/ Friends with Drug Problems	No Relatives/Friends with Drug Problems	Alcohol	Marijuana	Amphetamines	Cocaine	Other Drugs[2]	Other Than Marijuana	Tried Aggression Drugs[3]	Never Tried Aggression Drugs
1	W	Q	T	M	S	**V**	Q	M	Q	Q	A
2	Q	W	F	**I**	T	U	S	K	**M**	W	I
3	S	S	O	G	Q	W	M	T	G	S	O
4	G	D	P	L	G	S	W	E	W	G	K
5	L	G	C	**N**	B	T	K	R	V	**D**	**P**
6	D	**L**	I	C	K	D	R	O	**D**	L	E
7	M	**M**	K	J	V	R	L	S	S	M	C
8	V	V	H	A	O	//	E	P	I	**V**	J
9	T	E	R	T	M	//	J	//	L	N	//
10	N	I	A	K	R	//	**I**	//	**N**	T	//
11	I	**N**	E	//	I	//	V	//	E	E	//
12	R	T	J	//	**P**	//	B	//	R	I	//
13	B	R	//	//	E	//	T	//	T	K	//
14	K	K	//	//	C	//	O	//	K	B	//
15	O	B	//	//	A	//	A	//	J	**R**	//
16	E	J	//	//	J	//	C	//	B	O	//
17	F	O	//	//	U	//	H	//	O	J	//
18	J	C	//	//	//	//	U	//	P	P	//
19	C	A	//	//	//	//	//	//	C	C	//
20	U	U	//	//	//	//	//	//	U	F	//
21	P	P	//	//	//	//	//	//	A	U	//
22	A	H	//	//	//	//	//	//	F	A	//
23	H	//	//	//	//	//	//	//	H	H	//

NOTES: (A) Courts below the black lines were ones where we predicted that participants' expected outcomes would be better than their actual outcomes. (B) Courts were not included in the ranking if they had fewer than five people meeting the category criterion (indicated by //). (C) Bold letters represent the top three Drug Courts for percentage of population meeting that criterion. No bold letter indicates that no Drug Court had over 50% of their population meeting that criterion.

[1]Antisocial personality disorder; [2]Heroin, hallucinogenics, & prescription drugs; [3]Amphetaines, cocaine

- People age 30 years and older compared with younger than 30 years
- Males compared with females
- People with one to four prior arrests compared with those with no prior arrests or with more than four prior arrests
- People with no previous incarceration compared with those who had been incarcerated before
- People with relatives or friends with a conviction compared with those with no such relatives or friends
- People whose age of first drug use was older than 15 years compared with those age 15 or younger
- People with relatives or friends with drug problems compared with those with no such relatives or friends

We also examined court success for participant subgroups characterized by primary drug of choice. Drug Courts were more effective at preventing crime for participants whose primary drugs of choice included alcohol, amphetamines, cocaine, and other drugs.

All Drug Courts were effective at preventing crime within the other drug subgroup. All Drug Courts but one had positive outcomes within the alcohol and amphetamine subgroups. Drug Courts were less effective at preventing crime within the marijuana subgroup. Of the seventeen Drug Courts serving participants whose primary drug of choice was marijuana, only nine were effective.

When looking across the columns of Table 1, the top performing Drug Courts appear effective across a range of participant types, although the exact placement of the courts in the rankings varies somewhat across subgroups. For example, Court S ranked third in the general ranking, second for participants age 30 years and older, and eighth for participants under age 30. In addition, although rankings varied by subgroup, a set of high-performing Drug Courts emerged—with the top courts largely remaining the same across subgroups—as did a set of low-performing courts. The top five Drug Courts in the general ranking were G, L, Q, S, and W. Four of these Drug Courts appeared routinely in the top five courts across subgroups (G was in the top five courts 15 times; Q and S, 19 times; and W, 18 times). The other court that appeared in the top five courts across subgroups was

Court D, ranked sixth in the general ranking and ranked in the top five in twelve subgroups.

Court Rankings for Substance Use Prevented

Table 2 shows the Drug Court rankings for days of substance use prevented. According to the general ranking, twenty-two of the twenty-three Drug Courts in our study effectively prevented future substance use for their participant populations overall. Thus, more Drug Courts in the MADCE were effective at preventing substance use than criminal behavior.

Again, subgroups varied substantially. On average, more courts performed positively in preventing substance use for the following groups:

- People age 30 years and older compared with younger than 30 years
- Males compared with females
- People who had not been incarcerated before compared with those who had
- People with relatives or friends with a conviction compared with those with no such relatives or friends
- People whose age of first drug use was 15 years or younger rather than older
- People who had no substance abuse treatment within six months before baseline compared with those who had some
- People with relatives or friends with drug problems compared with those with no such relatives or friends

The pattern of Drug Court effectiveness for substance use prevented was similar to that found for crimes prevented. Court performance varied based on the participants' primary drug of choice. Drug Courts effectively prevented crime when the participants' primary drugs of choice included alcohol, amphetamines, cocaine, and other drugs but were less effective at preventing crime among participants whose primary drug of choice was marijuana. Therefore, although not all Drug Courts were effective for their participants in the marijuana subgroup, more of these Drug Courts prevented substance use more effectively than they prevented crime.

Table 2 Court Rankings: Substance Use Prevented at 18 Months

	General Ranking	Age 30 and Over	Under Age 30	Male	Female	In Intimate Relationship	Not in Intimate Relationship	Features of Depression	No Features of Depression	Features of ASPD[1]	No Features of ASPD
1	G	M	G	G	M	G	D	E	E	G	L
2	M	B	U	Q	W	**U**	I	R	T	D	U
3	Q	I	Q	U	S	M	M	A	//	Q	M
4	U	Q	D	M	U	**Q**	U	//	//	M	Q
5	I	L	M	V	I	**I**	S	//	//	U	**I**
6	D	N	S	I	Q	T	V	//	//	S	N
7	S	U	V	K	T	W	**L**	//	//	I	**G**
8	L	C	I	T	**P**	S	N	//	//	V	V
9	F	**G**	K	**L**	G	V	C	//	//	C	**F**
10	V	**S**	L	F	V	B	O	//	//	T	T
11	C	**W**	T	C	O	K	G	//	//	K	C
12	T	T	**P**	S	R	D	K	//	//	W	W
13	W	V	C	B	C	P	W	//	//	L	B
14	K	O	**H**	D	E	L	T	//	//	O	S
15	N	R	O	E	B	C	J	//	//	P	E
16	B	J	A	W	A	E	B	//	//	R	K
17	P	E	N	O	K	N	**R**	//	//	H	P
18	O	D	E	N	//	R	P	//	//	B	O
19	E	K	R	R	//	A	E	//	//	A	D
20	R	A	J	**J**	//	H	F	//	//	N	R
21	J	F	B	A	//	O	A	//	//	J	J
22	A	H	//	**H**	//	J	**H**	//	//	E	A
23	H	//	//	//	//	//	//	//	//	//	H

Table 2	Court Rankings: Substance Use Prevented at 18 Months											
	General Ranking	No Prior Arrests	1–4 Prior Arrests	More Than 4 Prior Arrests	Previous Incarceration	No Previous Incarceration	Relatives/Friends with a Conviction	No Relatives/Friends with a Conviction	First Drug Use Age 15 or Younger	First Drug Use Over Age 15	Substance Abuse Treatment Before Baseline	No Treatment Before Baseline
1	G	S	Q	G	I	U	G	T	U	G	I	U
2	M	D	U	U	O	Q	**Q**	V	M	L	C	G
3	Q	P	**M**	M	W	M	I	O	Q	**Q**	**L**	M
4	U	R	V	I	Q	F	**M**	I	G	M	S	**Q**
5	I	Q	C	**L**	M	G	U	B	I	I	M	T
6	D	J	K	P	T	S	**S**	C	S	W	G	**D**
7	S	H	L	T	K	D	D	P	V	S	**W**	V
8	L	A	T	S	C	V	C	K	**F**	T	E	B
9	F	O	D	K	S	I	**L**	A	C	**D**	N	S
10	V	T	S	V	R	**L**	V	E	T	U	P	**F**
11	C	K	N	W	E	C	T	R	W	C	K	**C**
12	T	//	G	A	V	T	W	J	L	K	O	I
13	W	//	B	**J**	U	**N**	K	H	K	V	U	K
14	K	//	I	C	A	K	F	//	**P**	B	**R**	R
15	N	//	O	B	//	P	E	//	A	N	T	L
16	B	//	E	E	//	B	B	//	O	R	H	J
17	P	//	P	**F**	//	O	J	//	E	O	A	O
18	O	//	R	O	//	E	R	//	B	P	J	P
19	E	//	A	R	//	W	**N**	//	R	E	B	E
20	R	//	J	H	//	R	P	//	**H**	**J**	//	A
21	J	//	H	//	//	A	O	//	//	A	//	H
22	A	//	//	//	//	**J**	A	//	//	H	//	//
23	H	//	//	//	//	H	H	//	//	//	//	//

Table 2	Court Rankings: Substance Use Prevented at 18 Months										
	General Ranking	Relatives/ Friends with Drug Problems	No Relatives/Friends with Drug Problems	Primary Drug of Choice: Alcohol	Primary Drug of Choice: Marijuana	Primary Drug of Choice: Amphetamines	Primary Drug of Choice: Cocaine	Primary Drug of Choice: Other Drugs[2]	Other Than Marijuana	Tried Aggression Drugs[3]	Never Tried Aggression Drugs
1	G	I	F	I	Q	**V**	U	M	G	G	I
2	M	Q	C	M	V	U	S	K	U	M	A
3	Q	G	T	C	S	S	Q	T	M	U	K
4	U	**M**	P	G	I	T	M	S	Q	Q	O
5	I	U	O	**N**	M	D	J	E	I	D	P
6	D	D	I	L	K	W	R	P	D	I	C
7	S	S	R	T	B	R	T	O	S	S	E
8	L	V	E	J	G	//	W	R	C	L	J
9	F	**L**	K	A	C	//	E	//	T	C	//
10	V	K	A	K	**P**	//	I	//	V	V	//
11	C	T	H	//	U	//	C	//	J	T	//
12	T	E	J	//	T	//	L	//	L	W	//
13	W	W	//	//	A	//	O	//	O	F	//
14	K	C	//	//	O	//	V	//	E	E	//
15	N	J	//	//	E	//	B	//	B	K	//
16	B	N	//	//	J	//	K	//	R	B	//
17	P	B	//	//	R	//	A	//	F	P	//
18	O	O	//	//	//	//	H	//	N	N	//
19	E	R	//	//	//	//	//	//	K	O	//
20	R	P	//	//	//	//	//	//	W	R	//
21	J	A	//	//	//	//	//	//	P	J	//
22	A	H	//	//	//	//	//	//	A	A	//
23	H	//	//	//	//	//	//	//	H	H	//

NOTES: (A) Courts below the black lines were ones where we predicted that participants' expected outcomes would be better than their actual outcomes. (B) Courts were not included in the ranking if they had fewer than five people meeting the category criterion (indicated by //). (C) Bold letters represent the top three Drug Courts for percentage of population meeting that criterion. No bold letter indicates that no Drug Court had over 50% of their population meeting that criterion.

[1]Antisocial personality disorder; [2]Heroin, hallucinogenics, & prescription drugs; [3]Amphetaines, cocaine

Although rankings shift somewhat for the substance abuse outcome as they did with the criminal behavior outcome, a set of high-performing Drug Courts emerged—with the top courts largely remaining the same across subgroups—as did a set of low-performing courts. The top five Drug Courts in the general ranking were G, I, M, Q, and U. These five appeared in the top five performing Drug Courts across subgroups the most (G was in the top five courts 14 times; I, 17 times; M, 24 times; Q, 19 times; and U, 18 times). Thus, we concluded that the top-performing Drug Courts at preventing substance use were the same for both their overall population served and specific participant types. In addition, note that two Drug Courts (G and Q) appeared in the top five for both the crime and substance abuse outcomes.

Drug Court Policies and Practices

Below are the results of the analyses for each of the ten policies and practices examined. First, we present how the policy or practice was measured and operationalized in this study. Then, we present findings from both the qualitative and quantitative analyses. For each item, we describe the results for the criminal behavior outcome followed by the substance use outcome.

Leverage

Leverage measures the coercive power of the Drug Court (Longshore et al., 2001). The commonly held consensus is that the more leverage the court has over an individual, the more likely that individual will comply with the Drug Court requirements and therefore succeed in the program. Data for the leverage measure were collected from telephone interviews conducted before the impact study. We operationalized leverage based on five factors that we scored and summed for an overall leverage score:

- An employee of the Drug Court conducted case management (2 points).
- Drug Court participants regularly participated in court hearings (2 points).

- The Drug Court had explicit consequences for dropping out or failing out (2 points).
- The Drug Court told the participant about the explicit consequences (1 point).
- The participant signed a contract which specified the explicit consequences (1 point).

Each Drug Court's leverage was classified as high (7–8 points; 11 courts total), medium (5–6 points; 6 courts total), or low (0–4 points; 6 courts total). We overlaid these classifications on the rankings, coding each Drug Court based on its implementation, and examined resulting patterns.[9]

The qualitative analysis for leverage showed that nearly all of the high-leverage Drug Courts effectively prevented crime. Additionally, many high-leverage Drug Courts clustered toward the top of the ranks, indicating that the highest-performing courts had high leverage and lower-performing courts had either low or medium leverage, though no medium-leverage court was ineffective.

The quantitative analysis revealed that high-leverage Drug Courts prevented significantly more crimes than low-leverage courts ($F = 4.15$, $p < .05$). No statistically significant differences were found between medium- and high-leverage Drug Courts or between low- and medium-leverage Drug Courts for preventing crime. High-leverage courts prevented an average of 4.1 crimes per month compared with 1.4 crimes prevented by low-leverage courts. Medium-leverage courts prevented 2.0 crimes per month.

For substance use, again, most of the high-leverage Drug Courts were effective. However, the clustering of high-leverage Drug Courts toward the top of the ranks for the crime outcome was less pronounced than for the substance use outcome. Low- and medium-leverage courts were distributed throughout the ranks of effective courts, but no medium-leverage courts were ineffective.

In terms of preventing substance use, we found marginally significant differences among Drug Courts with varying leverage ($F = 2.38$,

[9] The full documentation of the qualitative analysis and tables for this finding and all later findings can be found in Zweig and colleagues (2011).

$p < .10$). High-leverage courts prevented an average of 2.6 days of substance use per month, medium-leverage courts prevented 3.1 days, and low-leverage courts prevented 1.8 days.

Predictability of Sanctions

Predictability of sanctions measures the extent to which the Drug Court communicated to participants how and when they would be sanctioned. A coordinated sanction policy (BJA, 1997; Goldkamp, White, & Robinson, 2001) and the extent to which participants are aware of the policy, aware of consequences for noncompliance, able to predict when a sanction will occur, and able to predict what the sanction will be (Longshore et al., 2001) are believed to influence a participant's compliance with program requirements and, thereby, program success. We measured this concept during process evaluation telephone interviews and operationalized predictability of sanctions based on three factors:

- The Drug Court maintained an official schedule of sanctions (2 points).
- The Drug Court provided the official schedule of sanctions to the participant (2 points).
- The Drug Court always or almost always adhered to the official schedule of sanctions (2 points).

We scored and summed responses to quantify the predictability of the sanction policies. Each Drug Court was classified as high predictability (6 points; 9 courts total), medium predictability (3–5 points; 4 courts total), or low predictability (0–2 points; 10 courts total).

The qualitative analysis showed all but one of the medium-predictability courts effective, and many of the low-predictability courts were more successful than anticipated. The high-predictability courts were dispersed throughout the ranks of effective Drug Courts and clustered below the bold line in Tables 1 and 2.

The quantitative analysis revealed that, for the overall model, statistically significant differences existed among Drug Courts with varied predictability of sanctions ($F = 3.31$, $p < .05$). However, the follow-up Tukey tests of differences among groups failed to identify

which groups were significantly different from one another. This was likely because Tukey tests of comparisons between groups are a conservative method for identifying group differences. However, the means for each group indicated that the medium-predictability Drug Courts were the most effective at preventing future crimes (4.3 per month), followed by the low-predictability courts (3.9 per month), whereas the high-predictability courts prevented 1.8 crimes per month. Nearly all medium-predictability courts were effective, while courts with a high predictability of sanctions were generally ineffective.

For the substance use outcome, our qualitative analysis showed a similar pattern to the crime outcome. However, all of the medium-predictability Drug Courts were effective and clustered toward the top of the rankings, and low-predictability Drug Courts were dispersed throughout the rankings. Medium-predictability courts prevented significantly more days of substance use than high-predictability courts ($F = 4.32$, $p < .05$), an average of 4.1 days as compared with 2.0 days per month. Low-predictability courts prevented 2.7 days of substance use per month.

Point of Entry into Drug Court Program

Goldkamp and colleagues and Longshore and colleagues (2001) both identify the point in the criminal justice process at which participants enter the Drug Court program—either pre- or post-plea—as important to the Drug Court model. The point in the criminal justice process at which participants enter the Drug Court program may influence how well they perform and their ability to succeed. We asked program representatives where in the criminal justice process participants entered into the Drug Court program, and operationalized the concept as pre-plea entry (diversion strategies) and post-plea entry (in which convictions stood or were lessened after completion of the program). Drug Courts were classified as pre-plea (all participants entered as part of a diversion strategy; 7 courts), combination (courts where some participants entered the program pre-plea and some, post-plea; 6 courts), or post-plea (10 courts).

The qualitative analysis for preventing criminal acts showed that pre-plea Drug Courts and post-plea Drug Courts clustered toward the upper rankings across subgroups. Combination Drug Courts dispersed throughout the rankings, and most of the ineffective Drug Courts were combination courts. Thus, Drug Courts with one point of entry into their program performed more effectively and prevented more crime than those that allowed multiple points.

The quantitative analysis supports this claim. Statistically significant differences ($F = 7.42$, $p < .05$) existed between Drug Courts in which all the participants entered the program through pre-plea courts versus through combination courts. Also, significant differences existed between post-plea courts and combined courts. The average number of crimes prevented per month for pre-plea courts was 4.6, for post-plea courts was 3.6, and for combined courts was 0.8.

In the qualitative analysis for the substance use outcome, a similar pattern holds as for the crime outcome. Drug Courts that had one point of entry into their program prevented more substance use. Drug Courts with participants who came in post-plea prevented significantly more days of drug use per month (3.0 days) than combined courts (1.7 days; $F = 3.88$, $p < .05$). Pre-plea courts prevented an average of 2.9 days of drug use per month.

Positive Judicial Attributes

Goldkamp and colleagues and Longshore and colleagues (2001) include courtroom dynamics and interactions with judges as important factors of the Drug Court experience for program participants. The idea was that participants developed a relationship with the judge, and the extent to which participants saw this relationship as constructive contributed to their program compliance and success. MADCE quantified this by measuring positive judicial attributes. The site-visit team observed, measured, and scored the judge's actions and demeanor toward the participants during Drug Court proceedings.

The team assigned the Drug Court judge a value of 1 to 5 for respectfulness, fairness, attentiveness, enthusiasm, consistency/predictability, caring, and knowledge. After summing the ratings for

each judge, the team created three approximately equal performance categories for the Drug Courts: high (30 points or more; 8 courts), medium (27–29 points; 7 courts), and low (0–26 points; 7 courts).

This qualitative coding showed that, across several subgroups, Drug Courts with high and medium scores for positive judicial attributes clustered in the upper rankings. Those with low scores clustered toward the bottom with a few exceptions. Drug Courts with high and medium scores on positive judicial attributes were more likely to be among top-performing courts than among ineffective courts.

The results of the quantitative analysis revealed statistically significant differences among Drug Courts depending on how they were coded for positive judicial attributes ($F = 5.81$, $p < .05$). Significant differences existed between Drug Courts with high scores on positive judicial attributes and courts with low scores. Also, significant differences existed between courts with medium scores and courts with low scores. Drug Courts with high scores for positive judicial attributes prevented 3.6 crimes per month, courts with medium scores prevented 4.2, and courts with low scores, 0.7 crimes per month.

A similar pattern holds for preventing substance use based on judicial attributes. In terms of the quantitative analysis, Drug Courts with high scores on positive judicial attributes prevented significantly more days of drug use per month (3.2 days) than courts with low scores (1.9 days; $F = 3.16$, $p < .05$). Courts with medium scores prevented 2.6 days of drug use.

Case Management

All Drug Courts in the MADCE sample had case managers to oversee participant progress and assist in accessing necessary services. We wanted to determine if the frequency of contact with case managers related to program success. A question on the Adult Drug Court Survey (Zweig, Rossman, & Roman, 2011) inquired about the frequency at which participants saw case managers during phase 1 (the first two months) of the program. Each Drug Court was classified as high frequency (more than one contact per week; 6 courts total),

medium frequency (one contact per week; 13 courts total), or low frequency (less than one contact per week or not at all; 4 courts total).

Drug Court rankings for preventing criminal acts based on frequency of case management during the first two months of the program showed no strong pattern, but some patterns emerged. Most of the high-frequency Drug Courts in which participants met with their case managers more than once per week were effective. Medium-frequency Drug Courts were dispersed throughout the ranks, both above and below the bold line in Tables 1 and 2, and ranked in the top two courts in several subgroups. All but a couple of courts classified as low frequency were ineffective or lower-performing.

Although no clear patterns were identified based on the qualitative coding, the results of the quantitative analyses showed evidence of some relationships between frequency of case management and court effectiveness. In terms of preventing criminal acts, the model was marginally significant ($F = 2.84$, $p < .10$). Drug Courts with case managers who met with participants more than once per week prevented more criminal acts per month (4.3 acts) than did low-frequency courts (1.2 acts). Medium-frequency courts prevented 3.0 criminal acts per month.

As with the crime outcome, no clear pattern emerged for the Drug Court rankings regarding preventing substance use. Many of the Drug Courts where case managers met with participants more than once per week proved effective, as did all of the courts where participants met with case managers less than once per week or not at all. Drug Courts that had case managers meet with participants once per week were dispersed throughout the rankings.

The quantitative analysis testing prevention of substance use showed marginally significant differences among Drug Courts based upon the frequency of case management meetings ($F = 2.50$, $p < .10$). Drug Courts where case management meetings occurred more than once per week prevented an average of 3.0 days of substance use per month; courts with case management meetings one time per week prevented an average of 2.1 days of substance use; and courts with less than one meeting per week or no meetings prevented 3.2 days of

use. Notably, Drug Courts that had infrequent case management meetings tended to rely on treatment providers to do this work. When treatment providers were the case managers, they were more likely than other providers to see participants more than once weekly (Zweig et al., 2011). This might explain why the Drug Courts with both high and low frequency of case management meetings prevented about the same numbers of days of drug use.

Other Court Policies and Practices

The remaining five Drug Court policies and practices did not relate to offender outcomes. However, because most of the Drug Courts included in MADCE followed a high standard with respect to these policies and practices, insufficient variation made empirically establishing their effectiveness difficult. Below are results summaries for these practices.

Adherence to Treatment Best Practices—The provision of treatment is considered a core aspect of the Drug Court model (BJA, 1997). To be included in the MADCE, the Drug Court had to provide some type of substance abuse treatment to their program participants. To understand the quality of the treatment, we asked a series of questions during the initial telephone interviews with potential sites. These questions did not cover a full set of best practices for treatment provision but did capture a picture of the treatment being provided. Thus, we operationalized adherence to treatment best practices based on the following five factors:

- The treatment provided by the Drug Court was structured, that is, the Drug Court followed a treatment program manual (2 points).
- A clinical assessment was conducted for treatment needs (1 point).
- Individualized treatment plans were developed for each participant (1 point).
- Individualized treatment plans were used to make referrals (1 point).
- Individualized treatment plans were updated periodically (1 point).

The responses were scored and summed for an overall score of adherence to best practices and each Drug Court was classified as high (6 points; 15 courts total), medium (4–5 points; 6 courts total), or low (0–3 points; 2 courts total).

After scoring Drug Courts for the above ratings, no clear patterns emerged for the crime or drug outcomes during the qualitative analysis. Similarly, we found no statistically significant differences between low-, medium-, and high-adherence courts for crimes prevented and substance use prevented during the quantitative analysis. Not enough variation existed among Drug Courts to fully examine this practice because most courts adhered to treatment best practices at either medium or high levels, based on very limited information rating the quality of the treatment provided.

Drug Testing—Routine drug testing to examine compliance with drug-use requirements is important to Drug Courts (BJA, 1997). During the Adult Drug Court Survey (Zweig, Rossman, & Roman, 2011), Drug Courts were asked about the frequency of drug testing during phase 1 (or first two months) of the program and classified as high frequency (more than once per week; 19 courts total), medium (once per week; 4 courts total), or low (less than once per week or not at all; 0 courts).

The results for frequency of drug testing during the first two months of the program mirror the results for adherence to treatment best practices. After coding court rankings for frequency of drug testing, most of which ranked as high frequency, neither qualitative nor quantitative analyses revealed any clear or statistically significant patterns for the crime or drug-use outcomes. Not enough variation exists between Drug Courts to fully examine this practice.

Judicial Status Hearings—Regular contact between Drug Court participants and the Drug Court judge is considered an essential aspect of the Drug Court model (BJA, 1997; Longshore et al., 2001), and the contact between participant and judge is thought to be an essential catalyst to program compliance and success. The practice was measured through questions asked during process evaluation site visits and operationalized as average frequency of judicial status hear-

ings each month. Each Drug Court was classified as high (four times per month; 16 courts total), medium (twice per month; 4 courts total), or low (once per month; 1 court). Two Drug Courts were missing data on this variable.

The results for frequency of judicial status hearings mirror the results for the two previous low-variability practices. Most Drug Courts had high frequency of status hearings; thus, neither the qualitative nor quantitative analyses show differences in outcomes among Drug Courts based on frequency of such hearings.

Multidisciplinary Team Decision Making—The foundation of the Drug Court model includes an interdisciplinary team of interested parties comprising court staff, treatment staff, prosecutors, defense attorneys, etc. (BJA, 1997). The MADCE hypothesized that the extent to which team members participated in a collaborative manner—that is, the extent to which members attend and interact in court staffings and decisions about specific participants—may affect program outcomes. Thus, during site visits, we observed team member interactions during court staffing meetings.

We operationalized multidisciplinary team decision making by scoring the attendance and level of participation of the following stakeholders at Drug Court staffings: judges, prosecutors, defense attorneys, program coordinators, case managers, probation officers, treatment liaison staff, and other stakeholders. Scores of 1 to 5 were assigned to each stakeholder (with zero points assigned if the stakeholder did not attend), and the scores were summed to reflect overall participation from the stakeholders. Each Drug Court was classified as high (23–25 points; 8 courts), medium (18–22 points; 6 courts), or low (15–17 points; 6 courts). Three Drug Courts were not scored because of missing data.

The results of the qualitative analysis showed no clear patterns for high-, medium-, and low-rated Drug Courts, and the quantitative analyses indicated no statistically significant differences among courts for either preventing crime or substance use. Thus, multidisciplinary team decision making was not directly related to outcomes for participants in this study.

Judicial Interaction—In addition to positive judicial attributes, the MADCE team created a second measure to capture interaction between Drug Court participants and judges. During process evaluation site visits, the team observed Drug Court hearings and noted the frequency with which the judge engaged in interactive behaviors during the court session. For each case reviewed by the judge during the session, the site visit team documented whether the judge made regular eye contact with the defendant for most of the appearance, talked directly to the defendant as opposed to through the defendant's attorney, asked nonprobing questions (e.g., questions eliciting only yes, no, or one-word answers), asked probing questions, imparted instructions or advice, explained the consequences of future compliance (e.g., phase advancements, graduation), explained consequences of future noncompliance (e.g., jail or other legal consequences), allowed the defendant to ask questions or make statements.

For each of these eight actions, we created a variable reflecting whether the judge engaged in that action for more than 50% of his or her cases. Then, we counted the total number of actions that the judge regularly displayed (i.e., actions displayed for more than 50% of observed cases). Based upon these scores, the Drug Courts were assigned a value of low, medium, or high with the cut points selected to create a relatively even spread of courts across categories. Six courts were classified as having high judicial interaction (6 or more actions); seven courts were classified as having medium judicial interaction (4–5 actions); and seven courts were classified as low (0–3 actions).

The results of the qualitative analysis showed no clear patterns for high-, medium-, and low-rated Drug Courts, and the quantitative analyses indicated no statistically significant differences among courts for either preventing crime or substance use. Thus, judicial interaction did not directly relate to participant outcomes in this study.

DISCUSSION

This analysis examined how the relationship between variation in implementation of ten Drug Court policies and practices affects participant outcomes. Among the Drug Court policies and practices ex-

amined, four predicted court effectiveness: leverage, predictability of sanctions, the point in the criminal justice process at which participants enter the program, and positive judicial attributes. We found all four of these policies and practices effective at preventing crime, and all but leverage to be effective in preventing substance use (although this finding was marginally significant). More specifically, Drug Courts that prevented higher numbers of criminal acts per month had high leverage, medium predictability of sanctions, participant populations that enter at the same time point in the criminal justice process, and medium or high scores on positive judicial attributes. Drug Courts that prevented more days of drug use per month had medium predictability of sanctions, participant populations that enter at post-plea, and high scores on positive judicial attributes.

In addition, when Drug Courts implemented the combined practices in the ways found to be effective, a synergistic effect may have occurred such that they were among the top-performing Drug Courts (that is, courts able to prevent the most crimes and the most days of drug use for many participant subgroups). Table 3 identifies the court policies and practices of the top-performing Drug Courts with respect to the four components that emerged in our analyses. Recall that

TABLE 3 **COURT POLICIES AND PRACTICES FOR TOP-PERFORMING COURTS**

Court Policy/ Practice	Top Performers: Crime & Drug Use Prevention		Remaining 3 Top Performers: Crime Prevention			Remaining 3 Top Performers: Drug Use Prevention		
	G	Q	L	S	W	I	M	U
Leverage	High	High	Med	High	High	Low	High	Med
Sanctions predictability	High	Med	High	Low	High	Low	Low	Med
Program Point of Entry	post-plea	post-plea	post-plea	pre-plea	pre-plea	post-plea	post-plea	pre-plea
Positive Judicial Attributes	High	High	Med	Med	Med	High	High	Low

two courts were in the top-five-ranked courts for both crime and drug use prevention—Courts G and Q. As shown in Table 3, Court Q implemented all four policies in the ways we found to be effective, and Court G implemented three of the four policies in those ways. The remaining three courts in the top five for crime prevention (L, S, and W) and the remaining three courts in the top five for substance use prevention (I, M, and U) all implemented at least two or three of the four policies in the ways that appeared to produce positive outcomes.

These top-performing Drug Courts seemed purposeful in the ways they implemented policies and practices described here as most effective. The combination of these practices implied that these Drug Courts did not simply implement such components randomly; they fit the practices together. They apparently differentiated participants according to risk, need, or circumstance, rather than trying to fit one model of the Drug Court program to all participants. Additionally, these Drug Courts appeared to have judges who understood the value of building relationships with participants in which the individuals felt respected and supported, perhaps inclining them toward more success.

Several of the policies and practices we examined here have not been previously examined in the literature. Specifically, no previous studies of which we were aware examined the differential effectiveness of programs based on their participants' stage of criminal justice system processing when they enter the program. In addition, although leverage has been hypothesized to be a critical factor for Drug Court success (Longshore et al., 2001), ours was the first study to empirically document that Drug Courts classified as having high levels of leverage were the most effective at reducing criminal behavior among their participants.

Other findings generated from these analyses build on previous court-level research. For example, Harrell and colleagues (2000) demonstrated that graduated sanctions (as a court-level characteristic) were more effective than standard dockets in reducing arrest and the number of offenses committed among program participants. We built on these findings by examining the predictability of sanctions as a court-level characteristic. Interestingly, although highly predictable

sanctioning practices are considered a cornerstone for developing a coordinated strategy governing Drug Court responses to participants' compliance (and are listed as one of the Drug Court key components), we did not find empirical support for this practice. Drug Courts classified as having medium predictability of sanctions were the most effective, which suggests that flexibility in responding to participants' performances may be desirable.

In addition, we found strong evidence that positive judicial attributes positively influenced participant performance. Previous studies have identified substantial variation in participant success among various Drug Court judges (Finigan, Carey, & Cox 2007). We found that Drug Courts with a judge with more positive attributes were better able to prevent criminal behavior and substance use.

Conclusions and Implications

This study[10] contributes to our understanding of how Drug Courts should implement practices to increase their effectiveness in preventing crime and drug use. First, the results suggest that Drug Courts with high leverage, medium predictability of sanctions, single points of entry into the program, and high positive judicial attributes are better at preventing criminal activities and substance use. More specifically, Drug Courts with high leverage regularly monitor participants through Drug Court case managers and judicial hearings. They also have explicit known consequences for failure in the program that participants acknowledge in signed contracts. These practices might focus a participant's attention on the fact that the alternative to Drug Court is not desirable and that he or she is being monitored closely, making the consequence of noncompliance and the alternative for failure very real. These findings also imply that Drug Courts with low leverage (those courts which participants perceive as not having obvious consequences for failure or as not closely monitoring program compliance) are unable to succeed in preventing crime.

[10] Limitations to this analysis and how we addressed them can be found in Zweig et al., (2011).

Second, Drug Courts with medium predictability of sanctions have sanction schedules that participants may or may not know about and that may or may not always be followed. These courts have a coordinated sanctioning strategy, yet exercise some flexibility in its implementation in a way that apparently matters to participants. Perhaps participants perceive flexibility in implementation of sanctions as more fair than those Drug Courts that strictly follow a schedule that does not take into account particular individuals or circumstances. While it seems clear that participants need to know that sanctions are a consequence of noncompliance in the program, sanctions that are rigidly set or perceived as unfair may actually frustrate participants or weaken their resolve to comply with program requirements. In addition, if programs with rigid, highly predictable sanctioning practices had been shown to be the most effective in this analysis, that finding would run counter to our other finding on positive judicial attributes. Programs with judges who treated participants fairly and respectfully achieved better success than programs without such judges. Perhaps rigid sanctioning practices and some features of positive judicial attributes do not easily coexist in a single Drug Court.

Third, Drug Courts with single points of entry into their program have participant populations that either all entered the program before they entered a plea (a diversion program) or all entered the program after their plea. These courts do not have a mix of participants who represent different stages of the criminal justice system process. Perhaps Drug Courts that have a singular focus of participant population might be better at tailoring their practices to meet the needs of a preadjudication or a postadjudication population. When a mixed population is in the program, Drug Courts may be less organized in their approach or may be uniformly implementing practices when such practices might not be appropriate for their clientele.

Fourth, Drug Courts that have high scores on positive judicial attributes are those courts in which judges demonstrate to defendants respect, fairness, attentiveness, enthusiasm, consistency and predictability, caring, and knowledge about the person's case and situation. Our courtroom observations of judicial attributes indicate that how the judge builds a relationship with participants, treats participants,

and behaves in the courtroom matters for participant outcomes. This finding once again underlines the role of therapeutic jurisprudence in problem-solving courts.

Fifth, although the study results focused on the practices that were most effective for the most subgroups, policy makers and practitioners can see the results by subgroups in Tables 1 and 2 and use the information to determine which policies and practices are effective for the subgroups they serve. We find that while the top-performing Drug Courts tend to be effective across subgroups, the specific practices that are most effective vary for different groups. This analysis builds on the limited previous research indicating that not all practices are equally effective across the population subgroups served by Drug Courts.[11] Clearly, more detailed analyses of what works for specific subgroups could be conducted based on the findings presented in this paper.

Finally, findings from this study lend themselves to other future research endeavors. Specifically, we examined each Drug Court policy and practice by itself. Future analysis and research might include looking more closely at different combinations of policies and practices in order to identify critical combinations that appear to account for most of the variability in program effectiveness.

This project and report were supported through Grant Number 2003-DC-BX-1001 from the National Institute of Justice, Office of Justice Programs, U.S. Department of Justice. Points of view in this document are those of the authors and do not necessarily represent the official position or policies of the U.S. Department of Justice, Urban Institute, or its trustees.

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[11] For examples see Marlowe et al., 2003; Marlowe et al., 2005; Marlowe, Festinger, & Lee, 2004; and Festinger et al., 2002.

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IMPROVING DRUG COURT OPERATIONS: NIATX ORGANIZATIONAL IMPROVEMENT MODEL

Harry K. Wexler — Mark Zehner — Gerald Melnick

> ***[8] Applying NIATx to Drug Courts****—The NIATx (Network for the Improvement of Addiction Treatment) performance improvement model was used to increase client access to and engagement in Drug Court services.*
>
> ***[9] Improving Participant Flow in Drug Courts****—The NIATx performance improvement model reduced wait times, increased admissions rates, and reduced no-show rates in nine Drug Courts.*
>
> ***[10] Achieving Best Practices in Drug Courts****—The NIATx performance improvement model shows promise for helping Drug Courts implement organizational changes to adopt best practices.*

BY UNITING JUSTICE with rehabilitation for substance-abusing offenders, Drug Courts introduced an important innovation to the court system. The expansion of the adjudication role and allowing judges to divert offenders from prison created a new paradigm. The use of criminal justice and social services in tandem (i.e., a carrot and stick approach) is widely accepted, and the Drug Court movement has achieved considerable recognition; however, to succeed, Drug Courts have had to respond to the challenge of integrating disparate criminal justice and treatment system components, each with individual concerns and philosophies regarding public safety missions, individual rights, and personal growth. While the Drug Court movement has consistently reported positive outcomes (Marlowe, 2010), offering substance abuse treatment as an alternative to incarceration requires substantial integration and management of organizational processes for each Drug Court—administrative practices that create barriers to treatment, duplication of efforts, and long wait times for treatment.

Each Drug Court's success corresponds with how well it addresses these operational challenges.

This article reports on a program in which NIATx (Network for the Improvement of Addiction Treatment) with assistance from the National Development & Research Institutes (NDRI) provided technical assistance for adult treatment Drug Courts that received grant awards from the Center for Substance Abuse Treatment (CSAT) in 2009. The program goal was to improve Drug Court operations that increase client access to and engagement in Drug Court services, thereby increasing recovery and reducing recidivism. The organizational improvement model that NIATx developed has been highly successful in improving the functioning of substance abuse treatment programs (McCarty et al., 2007; Hoffman et al., 2008). The present program applied these same techniques to improve access and engagement in Drug Courts.

ABOUT NIATX

Founded in 2003, NIATx works with behavioral health organizations to help them get more people into treatment and *keep* them in treatment long enough to experience the benefits of recovery. The NIATx model was developed in response to two national initiatives: Paths to Recovery, funded by the Robert Wood Johnson Foundation (RWJF), and Strengthening Treatment Access and Retention (STAR), funded by CSAT. The thirty-nine substance abuse treatment organizations that participated in the first initiatives used a simple process-improvement model to change the business practices and reduce administrative barriers to treatment that impeded their ability to deliver quality care (Cappocia et al., 2007).

NIATx Areas Of Application

The original NIATx projects generated a strong body of knowledge about how substance abuse treatment organizations could improve the quality of addiction treatment. NIATx has worked with nearly 3,000 behavioral health organizations around the country, most of whom are health care providers treating persons suffering from

substance use, mental health disorders, or both (McCarty et al., 2007; Hoffman et al., 2008). Within substance abuse treatment, the NIATx model has demonstrated success in all aspects of care, from screening and brief intervention to medically managed intensive residential treatment and therapeutic communities. NIATx has organized learning collaboratives (Kilo, 1998) for provider agencies working to improve outcomes for pregnant and postpartum women, adolescent substance abusers, those at risk for or suffering from HIV/AIDS, opioid abusers, cultural minorities (such as African–Americans and Latinos), and many other targeted treatment programs.

Calls for organizational and systems improvement to increase treatment access and quality within criminal justice settings have been growing (Heck & Thanner, 2006; McCarty & Chandler, 2009). Applications of the NIATx model have helped organizations to reduce their paperwork burden, increase recovery services for persons who have completed treatment, or adopt evidence-based practices such as medication-assisted treatment. Adopting a NIATx approach within Drug Courts offers an excellent opportunity to identify and remove process barriers in both the treatment and justice systems that impede the ability of substance abusers to achieve and maintain recovery.

The NIATx Model

As a starting place, the NIATx model of process improvement leads organizations or programs to focus upon four aims that address client access to and continuation in substance abuse treatment:

- Reduce wait time to treatment
- Reduce no-shows
- Increase admissions
- Increase continuation in treatment

To create improvement in these four aims, the NIATx model stresses five principles for successful organizational change (Gustafson & Hundt, 1995):

- Understand and involve the customer (the offender, or participant, in the case of Drug Courts)
- Fix key problems

- Pick a powerful change leader
- Get ideas from outside the organization or field
- Use rapid-cycle testing

In addition to these five principles, bringing management and staff together to work in an integrated manner is central to the NIATx model (McCarty et al., 2007). Support from a senior leader (the *executive sponsor*) is essential for a quality improvement project to succeed. The executive sponsor is usually the director or CEO of an organization or, in the case of Drug Courts, a judge. This person becomes responsible for authorizing the time and resources needed to complete the project successfully. The executive sponsor also designates a staff member as the *change leader* to manage the organizational improvement process that addresses one of the four aims. Together, the executive sponsor and the change leader agree to establish a *change project*—a process improvement initiative that sequentially targets *one* NIATx aim at *one* location with *one* population. The change leader, who is responsible for organizing and conducting the project, together with the executive sponsor, assembles a *change team*, which includes a short list of staff members from their Drug Court system. The change team measures baseline data, selects change ideas to test, implements and monitors the change, determines its impact, and reports the results.

The change team uses process improvement tools to identify and address organizational structural or system issues that interfere with or inhibit clients from accessing and continuing in treatment. Two fundamental tools are the walk-through and rapid-cycle testing using the plan-do-study-act (PDSA) cycle.

Walk-Through—This is the primary method of identifying potential targets for change. Staff members take on the role of a client needing treatment to experience the process as a participant would. Taking this view of Drug Court and treatment services—from arrest or first contact, through intake, screening, assessment, and admission, to final discharge or graduation—helps staff members to understand problems from the participant's perspective. Simultaneously, staff members involved with the process are asked to provide a candid description of their observations and experience. Input from participants

and from those who serve them helps the change team to prioritize areas that need work to achieve their change project goal.

Rapid Cycle Testing—After using the walk-through observations and feedback to identify areas for change, the change team (which should have an appointed data coordinator) relies on the PDSA cycle to turn a change idea into action. The PDSA cycle represents the sequential flow of information gathering, decision making, action, and assessment. Critical to change team success is doing a series of short rapid cycles, with each cycle—from planning through implementation—taking only two weeks. This allows the change team to assess quickly whether the new idea is leading them toward the intended improvement and to make decisions about what next steps should be. The team adopts the change as a new standard of operation only when it has been demonstrated to be an improvement through comparison of baseline and follow-up observations (for example, reducing time from first contact to assessment from eight days to two days).

The process of measuring change is very important and should speed the improvement process rather than delay it. By collecting just enough consistent data before, during, and after each change, teams measure progress with respect to the goals they set and provide information for evaluating a change's impact. Often in the PDSA change process, it is easier to rely on manual data collection for quick and rapid feedback on the success of the change. This means relying on small samples collected over short time periods to measure change progress.

Using this method of testing changes, the NIATx model (1) minimizes risks and expenditures of time and money because changes are not implemented systemwide until effectiveness is demonstrated; (2) reduces disruption to participants and staff in making changes; (3) lessens resistance to change by starting on a small scale; and (4) learns from the ideas that work as well as from those that do not. By starting with small changes to test ideas quickly and easily and by using simple, pragmatic measurements to monitor the effect of changes over time, the PDSA model can lead to larger improvements through successive quick cycles of change.

The NIATx Learning Collaborative

To foster the adoption and implementation of the process improvement model and expedite the sharing of innovations, NIATx organizes learning collaboratives that involve a variety of activities and services intended to facilitate the formation of a learning community for adult learning and provide practice in using the NIATx model, including the following:

- *Learning Sessions*—Change teams convene at single- or multiday workshops to learn from each other and outside experts.
- *Conference Calls*—Teleconference calls and webinars are held, generally monthly, during which change leaders discuss issues and share progress on their change projects.
- *Coaching*—An expert in process improvement works with a change team to help it make, sustain, and spread process improvement.
- *NIATx Web Site*—A storehouse of process improvement tools, promising practices, and success stories, this Web site (www.niatx.net) provides complete instructions on how to conduct a NIATx change project.

IMPLEMENTATION

CSAT funded grants to forty-four Drug Court treatment projects in 2009 (Substance Abuse & Mental Health Services Administration (SAMHSA), 2009). These grantees were invited to participate in the program to focus on access and engagement improvement efforts during 2010. Ten Drug Courts were chosen to participate in the NIATx Learning Collaborative for Adult Treatment Drug Courts to improve client access to and retention in Drug Courts. The ten courts represented diverse geography (East Coast, West Coast, Midwest, South,) urban and rural settings, ranges in size, different types of Drug Courts (tribal, family, prison diversion, etc.), and varying stages of maturation (less than two years of court existence to more than twenty years).

NIATx Technical Assistance

The approach with the ten Drug Courts followed the NIATx learning collaborative model described above. The first step toward participation in the NIATx learning collaborative for each Drug Court was to conduct a walk-through prior to any coaching or in-person training. Based on their walk-through findings and exploratory baseline measures, each Drug Court considered an aim, formed change teams, and delegated executive sponsor and change leader roles prior to attending the first of three learning sessions.

Two to three members of each Drug Court's change team attended the first learning session, a kickoff meeting that included training in the NIATx process improvement model and tools for change team success, establishing goals for their change project from the four NIATx aims, and creating a project charter. Subsequent learning sessions, held six months and one year after the kickoff, focused on peer networking and sharing lessons learned and success stories so that Drug Courts could learn from each other and from expert NIATx coaches in person.

Each site received additional assistance in the form of coaching via monthly technical-assistance telephone calls and a one-day site visit. Coaching support helped Drug Courts select personnel for change teams, utilize process improvement tools to identify change barriers (flow charts, fish-bone diagrams, etc.), select improvements to test (nominal group technique, etc.), monitor change data (spreadsheets, graphs, etc.), and communicate the results (storytelling, etc.). Each month, NIATx conducted a conference call or webinar for members of the ten change teams, which offered continued training and provided a forum for the teams to share their experiences in applying process improvement in Drug Court settings.

Over the course of one year, change teams implemented test changes through PDSA cycles progressively until they had achieved their target improvement, lost momentum on an aim, or identified a higher priority aim to address. At the third and final learning session,

nine of the ten original Drug Courts[1] came together to report their progress and exchange ideas on the success of their process improvement projects.

IMPROVEMENTS IN COURT OPERATIONS

Over the course of the 12-month collaborative, eight Drug Courts worked on reducing the wait time to treatment, two Drug Courts targeted reducing no-shows to appointments, and four Drug Courts targeted increasing admissions.

Each Drug Court self-reported its change project results to its collaborative peers at the final learning session in short presentations consisting of essential information that summarized the data they used to monitor and measure the effectiveness of their NIATx change efforts, what process they changed, and how.

Wait Time Reductions

The eight Drug Courts that focused on wait times conducted eleven change projects targeting the steps in the client flow. These courts achieved a median reduction of 57% in client wait time. The time it takes participants to traverse the steps from arrest to receiving addiction counseling is often influenced by inefficient business, bureaucratic, or administrative practices and policies. Wait time reduction improvements adopted by these Drug Courts fell into three general categories: scheduling modifications, paperwork revisions, and inclusive communications.

Scheduling Changes

Some Drug Courts improved wait times by modifying their scheduling practices. One court's change team concentrated on the treatment agency's process of scheduling admissions appointments. Traditionally participants had to contact the counselor, who would then offer an appointment slot according to his or her availability. Al-

[1] One of the original ten courts dropped out because of internal administrative issues but expressed interest in continuing with the NIATx process after the issues were resolved.

ternatively, the agency adopted an open-clinic scheduling method where participants needed only to contact the agency front-office staff for the next available appointment slot; counselors were assigned when the participants arrived for their appointment. This scheduling method produced an 84% reduction in wait time for participants between the orientation session and an admissions appointment, decreasing from an average of over twelve days to around two days.

A second Drug Court's change team addressed the elapsed time between screening for Drug Court and admission thereto. Their change team initially found that an unsatisfactory number of clients were being held over each week for a decision on admission. They PDSA-tested a different scheduling process wherein the daily docket for the court team began one-half hour before other Drug Court activity, thereby reducing distractions. This practice created a better environment for Drug Court staff to communicate about clients that resulted in thirty-seven and fifteen fewer days between screening and admission for preadjudication and postadjudication participants, respectively.

A third Drug Court reduced wait times by implementing a centralized electronic scheduling program coupled with the reassignment of participant scheduling responsibility away from counselors and onto the treatment facility administrative support staff. The Drug Court also changed the practice of having participants return for treatment the following Monday to having participants report for the next available session, sometimes resulting in same-day treatment, thereby considerably reducing wait times.

Paperwork Revisions

Drug Courts also improved wait times through paperwork reduction. One Drug Court's efforts reduced the time required for a Drug Court referral to be assessed for treatment from twenty-eight days to twelve days by developing an improved flow of referral paperwork between other criminal court divisions and the Drug Court team. They did this through the addition of an inbox in the courthouse specifically for Drug Court orders and by sharing new participant information among all Drug Court team members using a tracking spreadsheet.

However, while the improved wait times increased efficiency between referral and assessment, doing so created a new problem: it increased time between a participant's completed assessment and admission to treatment by 140%. The wait times between assessment and treatment grew from twenty-five days to as many as sixty, providing a lesson regarding the interdependence of many of the processes involved in getting participants into treatment. As part of the continuous improvement process, the change team then turned its attention to overcoming this new bottleneck.

Another Drug Court that implemented a paperwork change project improved wait times by changing the paperwork requirements, including the revision of a standard screening form to a simplified checklist that reduced the narrative obligation and included the date of referral. By including the date, the staffing team became more aware of the elapse of time to sentencing and allowed them to prioritize cases accordingly.

Inclusive Communication

Drug Courts also pursued reducing wait times by setting up more inclusive communication practices. One Drug Court did this by including a partner agency staff person in case management efforts. The court implemented a monthly clinical case staffing between treatment staff, Drug Court coordinators, and court staff to coordinate discharges, new admissions, and directly monitor capacity.

Another Drug Court, where participants waited on average sixty-two days for treatment assessment and placement, addressed this by increasing informal communications between the court staff and the health center. The Drug Court instituted a standard 30-day maximum wait. Communication between the court coordinator and treatment counselors increased, and they concentrated on efficiently assigning appointments, resulting in an average wait time of only ten days.

Admissions Increases

Four Drug Courts tested ways to improve their admission or referral totals. For three of these courts, monthly average admissions to

Drug Court treatment increased sharply to almost double (92%–100%) and the fourth court showed a fourfold increase in referrals owing to their very low baseline. Change team interventions that were effective for increasing admissions included staff placement and outreach.

Staff Placement

To boost their enrollment totals, the change teams of three courts placed a Drug Court coordinator on-site at the courthouse on the day of hearings to meet with new clients and their families to increase the rate of new admissions.

Outreach

Another court conducted substantial outreach and education about Drug Court with social workers at a partner referral agency to increase admissions to the court. The Drug Court ran successive change cycles that included developing a newsletter, conducting in-person meetings between court and referral agency personnel to build understanding and strengthen relationships, and rerouting referrals from the public defender's office to the jail social workers so that Drug Court staff received earlier notice.

Reductions in No-Show Rates

Reductions in no-show rates and related increases in program participation were accomplished by change team interventions including reminder calls, escorting participants, and reporting attendance to the Drug Court.

Reminder Calls

One Drug Court with a failure rate of 41% for participant appearances at scheduled orientation appointments was able to reduce that to 18% by making reminder phone calls to the participant the day prior to their appointment.

Escorting Participants and Reporting Attendance

Another Drug Court focused on participants' attendance at a 2-day pretreatment group with baseline attendance rates of 62 percent. After several PDSA cycles, they adopted changes that included escorting participants to the classroom and reporting attendance directly to the Drug Court. The rate of participant attendance improved to 76 percent.

Synergistic Improvement Effects

Drug Courts that achieved improvements on one aim realized improvements on other measures. For example, a Drug Court that produced a seven-day reduction in wait time by making intakes available on the same day the participant called for an appointment found a concomitant 35% increase in their intake completion.

DISCUSSION

The project described in this article represents a first step in applying the NIATx model to achieve organizational improvement best practices in the Drug Court environment. NIATx offers a method to pair systematic experimentation with innovation until it can be fully adopted in the court. Through participation in the learning collaborative and applying the NIATx process improvement model, the adult treatment Drug Courts improved organizational and administrative processes in their programs that reduced wait times and no-shows and increased admissions and participant engagement with treatment. These improvement projects provided courts of different models, sizes, populations, and geographies substantial gains in performance, experience, and training in the application of process improvement tools and organizational change for continued growth. At the final learning session, each of the Drug Courts reported that changes they had developed during this project had become standard procedure.

The Drug Court community appears especially interested in exploring and adopting best practices to improve their operations and outcomes. In a system focused on rehabilitation and accountability, strengthening offender adherence at each step, from monitoring ap-

pearances through treatment participation, imparts considerable value. During walk-through and change team discussions, a number of courts reported that delaying treatment hindered operations and interfered with the offender's recovery. The participating Drug Courts demonstrated the capacity of the NIATx model to facilitate organizational improvements such as timeliness of services in complex Drug Court environments. The NIATx approach has proved an effective practice in the participating Drug Courts and is a promising best practice for Drug Courts that face similar challenges.

Next Steps

Increasingly, Drug Courts and treatment programs serving criminal justice populations are requesting training and tools to implement process improvement. In addition to a wide array of free guides, tools, and other resources, NIATx regularly offers free webinars on current topics of interest as well as continuing education in NIATx implementation (available online at www.niatx.net). Several state and national Drug Court professional associations have hosted NIATx training workshops at annual meetings. NIATx continues to develop a pool of expert coaches, to maintain a roster of NIATx-experienced peer mentors within Drug Courts to support process improvement efforts in criminal justice, and to serve future collaborative efforts for the field.

New Directions

Research is needed to evaluate the longer-term impact of NIATx-facilitated changes and enhanced communication among Drug Court participants. The improved client flow within participating Drug Courts demonstrates the positive organizational effects of the NIATx-related changes, which may in turn improve participant recovery and recidivism. Considerable evidence supports the effectiveness of Drug Courts. A next step is to explore how organizational functioning influences outcomes. Proving the value of improved organizational effectiveness for participants would be especially beneficial.

The experiences of the Drug Courts that participated in the *NIATx* Learning Collaborative for Adult Treatment Drug Courts program of-

fer information and guidance to other court systems seeking operational changes to improve service coordination and delivery. Applying NIATx process improvement practices can help overcome resistance to organizational change and resolve operational issues that hinder the delivery of effective services. The lessons learned from this project confirm that the NIATx organizational change model offers a highly promising practice for improving the efficiency and success of Drug Court systems.

> *Points of view, opinions, and conclusions in this paper do not necessarily reflect those of the U.S. Department of Health & Human Services (DHHS), Substance Abuse and Mental Health Administration (SAMHSA), Center for Substance Abuse Services (CSAT), NIATx, or NDRI.*
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> *This report was supported in part by a purchase order (HHSP233200900406P) from the Substance Abuse and Mental Health Administration (SAMHSA), Center for Substance Abuse Services (CSAT), which was awarded to the Center for the Integration of Research & Practice (CIRP), National Development and Research Institutes, Inc. (NDRI) and by contract (HHSS283200700003I) from JBS, funded by the Substance Abuse and Mental Health Administration (SAMHSA), which was awarded to the University of Wisconsin–Madison.*

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PARTICIPATION OF DEFENSE ATTORNEYS IN DRUG COURTS

Michael Tobin

> ***[11] Responsibilities of Defense Attorneys in Drug Court—*** *A defense attorney's responsibilities to an individual client may differ from those of a member of a collaborative treatment court team.*
>
> ***[12] Decision to Enter Drug Court—****In representing a client potentially eligible for treatment court, a defense attorney should be knowledgeable about the court's procedures and explain the potential advantages and disadvantages of treatment court compared to traditional litigation.*
>
> ***[13] Defense Representation on a Drug Court Team—*** *Defense representatives must advocate for fair procedures in the Drug Court and educate the defense bar generally regarding Drug Court operations.*
>
> ***[14] Defense Attorneys Serving in Dual Roles—****Where the same defense attorney acts as adversary counsel for individual clients and a Drug Court team member, the attorney must take precautions to balance potential role conflicts.*

THE ROLE OF A DEFENSE ATTORNEY in a Drug Court is a complex one. General guidelines for defender programs (including assigned-counsel systems) and for individual defense attorneys can be useful, contributing to the effectiveness of Drug Courts. The recommended best practice for a defender organization is to recognize and implement the collaborative and nontraditional role of a defense representative on a Drug Court team. This representative does not serve as adversary counsel for individual Drug Court participants, but rather as an advocate for evidence-based practices that advance the court's

therapeutic goals.[1] Because Drug Courts' primary goals are to help participants overcome addiction and thereby to reduce recidivism, the defense representative helps the Drug Court's participants by advocating for effective court policies and practices.

General Purposes and Attributes of Treatment Courts

Drug Courts and other treatment courts "were created in response to the perception that the traditional, adversarial criminal justice system does not adequately address"[2] issues such as alcohol or drug abuse, which in turn are risk factors for future criminal involvement. These courts blend attributes of traditional court procedures with therapeutic procedures not generally associated with court hearings. The traditional attributes include mandatory court appearances and the potential for sanctions. The therapeutic procedures include the delivery of support services to participants and the use of incentives to encourage and recognize progress in treatment.

Drug Courts typically conduct frequent review hearings to oversee treatment for drug abuse, which may include abuse of alcohol as well as abuse of controlled substances. The Drug Courts offer participants the opportunity to obtain a lesser sentence or dismissal of charges upon successful completion of the treatment program. The Drug Court model "calls for collaboration among various components

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[1] *EDITOR'S NOTE—The author's recommendation that "adversary counsel" and "defense representative" functions should ordinarily be performed by different attorneys is not universally agreed upon by defense experts and does not reflect an official position of NADCP or NDCI. Nevertheless, this article presents the considered wisdom of a highly experienced defense expert in addressing thorny ethical dilemmas commonly confronted in Drug Courts. Moreover, research does suggest outcomes may be improved by including separately designated defense representatives on the Drug Court team who have substantial training and experience with the Drug Court model, practices, and procedures.*

[2] *Critical Issues for Defense Attorneys in Drug Court,* p. 3 (National Drug Court Institute 2003). Although this article specifically references Drug Courts, many jurisdictions have implemented treatment courts to focus on other issues, such as alcohol abuse, mental illness, or issues unique to veterans. *See* W. Huddleston & D. Marlowe, *Painting the Current Picture: A National Report on Drug Courts and Other Problem-Solving Court Programs in the United States*, p. 1 and nn. 1–2 (Bureau of Justice Assistance 2011) (reporting a total of 3,648 problem-solving courts, including 2,459 Drug Courts).

of the criminal justice and substance abuse treatment systems to combine the coercive power of the court with effective and scientifically based treatment practices."[3] Studies of Drug Courts have confirmed that treatment is more successful than incarceration in preventing recidivism.[4]

The collaborative aspects of Drug Courts often include the participation of a public defender or other defense attorney on a Drug Court team.[5] As a team member, the defense attorney may have the opportunity to improve justice policy by expanding opportunities for defendants to have their social service needs addressed effectively and to have their cases dismissed or reduced. However, the nontraditional role of team member also raises ethical and practical questions regarding the boundaries of this collaborative role and the traditional adversarial role of defense counsel.[6]

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[3] *Drug Courts: The Second Decade*, p. 17 (National Institute of Justice 2006).

[4] *See* W. Huddleston & D. Marlowe, *Painting the Current Picture: A National Report on Drug Courts and Other Problem-Solving Court Programs in the United States*, p. 9 (Bureau of Justice Assistance 2011) (citing numerous studies showing that Drug Courts reduce crime in comparison to other justice-system dispositions).

[5] *See, e.g.*, Defining Drug Courts: The Key Components, p. 8 (National Association of Drug Court Professionals (NADCP) 1997) (listing defender among important participants in the planning process for a Drug Court); *id.*, p. 11 (prosecutor and defense counsel, as members of drug-court team, must shed adversarial roles and focus on participant's "recovery and law-abiding behavior").

[6] See *America's Problem-Solving Courts: The Criminal Costs of Treatment and the Case for Reform,* pp. 30–41 (National Association of Criminal Defense Lawyers 2009). The defense attorney is not the only member of the typical Drug Court team who needs to adapt to a nontraditional role. The judge, although still the ultimate decision maker, receives input from all other team members and often seeks consensus from the team. The judge also talks directly to participants about many facets of their lives at the regular review hearings. The prosecutor and law enforcement (including the probation department) refrain from investigating or prosecuting violations of law that come to light as part of Drug Court.

The ability of team members to adapt to the nontraditional role of team member is critical to the success of the court; conversely, an inability to accept a collaborative role is counterproductive. The nontraditional role does not mean that the defense representative should always agree with other team members. The defense representative will generally best understand the barriers that make it difficult for participants to overcome addiction and to manage other life issues while engaged in an intensive treatment program. The defense representative may have the most compassion for and patience with Drug Court participants. Therefore, the defense representative may

Although research conclusively shows the effectiveness of Drug Courts, studies also show that effectiveness depends upon fidelity to specific components of such courts.[7] When key components are dropped or when the treatment programs are "watered down," lower graduation rates and higher recidivism have occurred.[8] Therefore, attorneys working in treatment courts need to be aware of (and to advocate for) the research-based approaches that lead to successful results for participants.

SUMMARY OF RECOMMENDATIONS

Defense attorneys should participate in all aspects of Drug Courts to ensure that these courts treat defendants fairly, following effective and therapeutic procedures. Each treatment court should include a defense representative on a team that oversees the court's policies and operations. Defendants participating in a Drug Court should also have access to adversary counsel, although as a practical matter, the therapeutic model of a Drug Court is inconsistent with traditional litigation procedures.[9]

Managers or staff attorneys of indigent-defense providers often serve on a Drug Court team to represent the interests of participants. This role is referred to as the "defense representative" in the balance of this article, and depending on the features of the jurisdiction, the

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often need to remind and persuade other team members to refrain from unduly punitive actions and policies.

[7] W. Huddleston & D. Marlowe, *Painting the Current Picture: A National Report on Drug Courts and Other Problem-Solving Court Programs in the United States*, p. 14 (Bureau of Justice Assistance 2011).

[8] *Id.*, pp. 14–15.

[9] *See generally infra* nn. 56–60 and associated section. If the court is operating fairly and effectively, the participants view the Drug Court as collaborative, rather than as adversarial. Conversely, if participants frequently perceive unfairness in the court's procedures, the court is probably not fulfilling its therapeutic goals (because court participants are not necessarily defendants in pending cases while in Drug Court and are not necessarily formally represented by an attorney during Drug Court proceedings, the term "participants" is used in this article to refer generally to the individuals supervised in the treatment court program; the terms "clients" or "defendants" are used to emphasize either the attorney-client relationship or the pendency of criminal proceedings).

role may also be fulfilled by a private attorney or a representative of a bar association.[10] The defense representative should know the local justice system sufficiently to assess the benefits and risks of a proposed or existing Drug Court. The defense representative should also communicate regularly with the defense bar regarding the Drug Court's policies and practices.

The differences between the roles of defense representative and adversary counsel are discussed in detail below. Practical and ethical challenges often arise if the same person serves both as the defense representative on a Drug Court team and as adversary counsel for individual participants in the court. Thus, when possible, the defense representative should refrain from serving in these two roles simultaneously. The dual roles create at least the appearance of a conflict between the duty to assist the Drug Court (in fulfilling its broad, therapeutic mission) and the duty to advocate at each court session for individual clients.[11]

If the circumstances of a jurisdiction require an attorney to serve in these roles simultaneously,[12] he or she should clearly communicate

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[10] Although indigent defendants and other defendants have common interests in a fair process, indigent defendants have the additional concern that Drug Courts do not impose financial requirements that render their participation impossible or impractical. Thus, the indigent-defense perspective is critical to ensure that any fees imposed on participants are waived or substantially reduced for indigent participants.

[11] For example, research suggests that direct interaction between the judge and participants furthers the court's therapeutic mission. *See, e.g.*, J. Miller and D. Johnson, *Problem Solving Courts: New Approaches to Criminal Justice,* p. 158 (Rowman & Littlefield 2009) (discussing how a judge in a reentry court promotes success of participants through "unique dialogues that address their individual strengths, needs, and challenges"). However, as adversary counsel, an attorney generally discourages a client from speaking in open court, especially if the judge is asking the client about possible rules violations.

[12] In a rural area, for example, there may be only one public defender in the county. The same attorney often serves both as a member of the Drug Court team and as the adversary attorney for individual participants. Serving in the dual roles may be the only practical way in such a county to operate a Drug Court with a defense attorney participating as a team member. If so, the defense attorney should educate other team members regarding the areas in which duties to individual clients take precedence over the role of a team member. However, when resources allow for separation of the team-member and adversary roles, this separation is the best practice both to avoid

with clients regarding the attorney's responsibilities as a member of the Drug Court team. The attorney should also advise other members of the team that when serving an individual client, the attorney may challenge the Drug Court's procedures and the specific actions of other team members.[13]

IMPORTANCE OF DEFENSE PARTICIPATION

Principle Eight of the American Bar Association (ABA) Ten Principles of a Public Defense Delivery System recommends that "[p]ublic defense should participate as an equal partner in improving the justice system." Although the attributes and policies of treatment courts vary widely, national studies show that when operated effectively, treatment courts can benefit individual defendants and the broader community by helping individuals overcome issues often linked to criminal behavior.[14]

A large percentage of defendants in the criminal justice system have a history of irresponsible use of drugs or alcohol.[15] Many others

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ethical conflicts for the attorney and to promote fidelity to effective practices in the Drug Court.

[13] The attorney might, on behalf of a client, challenge a drug-testing procedure or the accuracy of a specific test result, even without any specific evidence that the test result was inaccurate. Depending on their frequency and the litigation methods used, these types of challenges may cause other team members to view the attorney as an adversary instead of a partner on the treatment court team.

In the role of team member, the defense representative should be interested in the accuracy of testing procedures and of specific test results (an interest that all team members should share). Thus, the defense representative should advocate for fair procedures to correct or confirm the results of less-reliable screening tests. The defense representative could also properly suggest ways to eliminate or reduce the ability of participants to use someone else's urine for testing. An adversary attorney, however, would arguably be unable to take steps that the attorney knew or suspected would lead to adverse legal consequences for a client.

[14] *See* R. Warren, *Evidence-Based Practices to Reduce Recidivism: Implications for State Judiciaries*, p. 15 & n. 86 (Crime and Justice Institute, National Institute of Corrections and National Center for State Courts 2007) (citing numerous "[r]igorous scientific studies and meta-analyses" showing "that Drug Courts significantly reduce recidivism among Drug Court participants in comparison to similar but nonparticipating offenders").

[15] *See, e.g., Drug Use and Dependence, State and Federal Prisoners,* 2004, p. 1 (U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics Spe-

suffer from mental disorders,[16] and some have multiple treatment needs.[17] Drug Courts and other treatment courts have shown the potential to reduce recidivism by combining regular court reviews with evidence-based treatment and case management.[18] These courts are also able to keep defendants in the community instead of serving substantial terms of incarceration.

Generally, these courts are operated by a team comprising representatives of several agencies. For example, a Drug Court team often includes a judge, prosecutor, probation agent, social worker, public defender, and law enforcement officer. "Active defender participation in all phases of the Drug Court, from design to operation, makes it more likely that the program will be client-oriented."[19]

A resolution of the National Association of Drug Court Professionals (NADCP) also supports the participation of a defense representative in the development and operation of Drug Courts. This resolution identifies eligibility criteria, selection of treatment provid-

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cial Report, October 2006) (citing 2004 statistics that showed 53% of state inmates and 45% of federal inmates met the psychiatric community's criteria for drug dependence or abuse); *Alcohol and Crime*, p. 1 (U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics, April 1998) (citing 1996 statistics that showed 36% of the estimated 5.3 million persons supervised by corrections officials in the U.S. had been drinking when they committed the offense for which they were convicted).

[16] *See, e.g., Mental Health Problems of Prison and Jail Inmates*, p. 1 (U.S. Department of Justice, Office of Justice Programs, Bureau of Justice Statistics Special Report, September 2006) (citing 2005 statistics showing that slightly more than half of the inmates surveyed reported either a recent mental-health diagnosis or recent symptoms of a mental disorder).

[17] *See, e.g.*, *id.* (citing 2005 statistics showing that of state prison inmates reporting a recent mental-health diagnosis or recent symptoms of a mental disorder, 74% reported a history of substance abuse).

[18] *See, e.g.*, W. Huddleston & D. Marlowe, *Painting the Current Picture: A National Report on Drug Courts and Other Problem-Solving Court Programs in the United States*, p. 14 (Bureau of Justice Assistance 2011).

[19] Michael Judge, *Critical Issues for Defenders in the Design and Operation of a Drug Court*, p. 2 (NLADA Indigent Defense, November 1997). *See also* K. Weibrecht, *Evidence-Based Practices and Criminal Defense: Opportunities, Challenges, and Practical Considerations*, pp. 26–27 (National Institute of Corrections 2008) (discussing how when involved as a policy maker, defense attorney can educate others regarding the needs of defendants).

ers, confidentiality, and other court policies as proper topics for defender input.[20]

DEFENSE PARTICIPATION IN DEVELOPING A DRUG COURT

Defense representatives often participate in the planning for and development of a Drug Court.[21] This participation may result from membership in a criminal justice coordinating council or from formation of a local ad hoc work group interested in a treatment court. Some grant applications require that planning groups include a defense representative. Defense participation helps to ensure that the Drug Court has a therapeutic focus rather than a punitive focus.[22] To help ensure that the Drug Court provides effective services to participants, the defense representative should address such issues as eligibility criteria, application and admission process, access to treatment and other services, court expectations and procedures, incentives and sanctions, and confidentiality of information that court officials learn about participants in the Drug Court context.

The defense representative must work with representatives of other agencies in the planning and development of a Drug Court (the

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[20] NADCP, Resolution regarding Indigent Defense in Drug Courts (April 19, 2002), *reprinted at* nlada.org/Defender/Defender_Library. *See also* K. Weibrecht, *Evidence-Based Practices and Criminal Defense: Opportunities, Challenges, and Practical Considerations*, pp. 26–28 (National Institute of Corrections 2008) (defense attorney should advocate for matching treatment to the needs of program participants, for use of treatment modalities that have a track record of effectiveness, and for evaluation procedures to ensure that practices remain evidence based).

[21] *See* G.F. Roper and J.E. Lessenger, Drug Court Organization and Operations, *reprinted in Drug Courts: A New Approach to Treatment and Rehabilitation,* p. 287 (Springer Science and Business Media 2007). *But see America's Problem-Solving Courts: The Criminal Costs of Treatment and the Case for Reform*, p. 8 (National Association of Criminal Defense Lawyers 2009) (noting that the criminal defense bar has not consistently had input in development of problem-solving courts throughout the country).

[22] *See* C.L. Asmus and D.E. Columbini, Juvenile Drug Courts, *reprinted in Drug Courts: A New Approach to Treatment and Rehabilitation,* p. 271 (Springer Science and Business Media 2007) (recognizing that the public defender advocates for rights of participants and "monitors sanctions imposed by the court to ensure that they are within the legal and philosophical parameters of the program").

court, prosecution, law enforcement, probation and parole, and social services are ordinarily represented on a Drug Court team). Thus, although the defense representative can influence the standards and procedures adopted for the Drug Court, the team must reach a consensus.

Ultimately, for the defense representative to recommend the Drug Court for consideration by the defense bar in individual cases, the court must present potential benefits to defendants when compared to other available means of resolving their cases (litigation or negotiation under preexisting procedures and penalty structures). If the Drug Court has this beneficial potential (for example, it provides both treatment services and the potential to earn dismissal or substantial reduction of charges), defense attorneys and their clients can assess the potential benefits on a case-by-case basis to determine whether to seek admission to the Drug Court. Conversely, if efforts to work in a collaborative manner are ultimately unsuccessful in developing a therapeutic court program with significant benefits for participants, the defense representative should consider withdrawing from further participation as a member of the Drug Court team.[23]

Written policies and other documents are important to provide consistency and fairness in the Drug Court's operations.[24] Written informational materials can assist the defense representative in educating other defense attorneys about the Drug Court. Standard forms

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[23] Because the ability to influence court policies is generally greater for a member of the court team, a defense representative should not take this action lightly or without making every reasonable effort to improve the court's procedures. However, at some point, if the court is not providing effective services to participants, the continued participation of the defense representative sends the wrong message to the defense bar and to defendants. The label "treatment court" is misleading if the court does not follow effective practices.

[24] *See* G.F. Roper and J.E. Lessenger, Drug Court Organization and Operations, *reprinted in Drug Courts: A New Approach to Treatment and Rehabilitation,* p. 286 (Springer Science and Business Media 2007) (stating that benefits of a written manual include notice to participants of court's requirements and permanent record of the respective duties of court personnel).

should address waivers and authorizations that defendants are required to sign as a condition of participation.[25]

The success of Drug Courts depends on adherence to research-based practices. If either the court procedures or the treatment protocols are deficient, the Drug Court is unlikely to reduce recidivism. Therefore, the defense representative needs to learn the underlying principles behind a successful Drug Court and apply that knowledge to the specific criteria adopted or proposed in his or her jurisdiction.[26]

DEFENSE PARTICIPATION IN DRUG COURT OPERATIONS

Defense representatives often serve as members of a Drug Court team that oversees ongoing court operations.[27] If the planning phase

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[25] *See id.*, p. 292 (recognizing need for waiver if defense attorneys do not appear at regular status hearings; need for waiver of confidentiality of medical information). If a Drug Court is complying with best practices, including participation of an effective defense representative on the court team, participants will rarely request the assistance or presence of an adversary attorney at the status hearings. Nonetheless, it is helpful for all defense attorneys to be familiar with the operations of a local Drug Court, and the court should welcome their attendance.

[26] Without a thorough knowledge of the type of treatment and supervision that is effective for the court's participants, the defense representative is unable to advocate for practices that will maximize the opportunities for participants to succeed. For example, the prevalent model for a Drug Court (including frequent judicial reviews) is most effective for high-risk participants. Michigan Supreme Court Administrative Office, *Best Practices for Standardized Risk Assessment*, p. 9 (2010); *see also* K. Weibrecht, *Evidence-Based Practices and Criminal Defense: Opportunities, Challenges, and Practical Considerations*, pp. 4, 8 (National Institute of Corrections 2008) (a higher level of treatment is appropriate for individuals who present a high risk of recidivism).

If the court's participants include persons properly classified as low risk, it may be counterproductive to require the same frequency of in-person court appearances. Michigan Supreme Court Administrative Office, *Best Practices for Standardized Risk Assessment*, p. 9 (2010). By keeping current with research findings regarding treatment courts, the defense representative is best able to advocate for effective practices and advise other defense attorneys about the strengths and weaknesses of the local Drug Court.

[27] *See* G.F. Roper and J.E. Lessenger, Drug Court Organization and Operations, *reprinted in Drug Courts: A New Approach to Treatment and Rehabilitation,* p. 288 (Springer Science and Business Media 2007).

has resulted in standards and procedures that benefit clients, the defense representative's main goal on the team may be to ensure that the Drug Court adheres to these standards and procedures (while continuously evaluating the court's benefits to clients and looking for areas for improvement). If the Drug Court's framework does not provide significant benefits to clients, however, the defense representative may need to insist upon substantial changes in the court's operations before he or she agrees to serve on the team.

If the same defense representative serves on the planning team and the operations team, the transition from one role to the other may be relatively seamless. The representative will generally understand the perspectives of the other team members and the reasons behind the written standards and procedures. Conversely, a defense representative without experience on the planning team may lack this base of knowledge and may need to learn enough information to evaluate the beneficial potential for clients.

Changes in Drug Court personnel, such as a new judge or prosecutor, can result in significant changes in court operations. Thus, the defense representative may have an opportunity to promote improvements in court procedures, but may also need to advocate against proposals that dilute the court's effectiveness.

The responsibilities of the Drug Court team may include the selection of treatment providers, admission of participants into the court, review of participants' progress, and regular staffing meetings before each court session. At the staffing meetings, the team generally reviews how each participant has done since his or her last court date and recommends to the Drug Court what action to take or what topics to address with each participant.[28]

For participants who are doing well, the Drug Court action will generally consist of a positive progress report, a brief conversation between the judge and the participant, and scheduling of the next

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[28] *See id.*, pp. 294–96 regarding a typical day of Drug Court review hearings, including the team meeting before court.

court date.[29] The participant may be eligible for modest rewards for his or her positive report, such as a longer interval between court hearings (many Drug Courts have three specified phases for participants, each characterized by its own frequency of hearings and drug or alcohol tests[30]). A participant who has violated the Drug Court's rules may face a sanction, which could be community service work, a written assignment, extra drug or alcohol testing, ineligibility for an incentive, or brief confinement in jail.[31]

The defense representative, although not serving in the role of adversary counsel for each participant, can and should advocate generally for Drug Court practices that benefit participants. For example, the defense representative should advocate for a broad array of supportive services, including help with transportation, housing, and education, to assist indigent participants. Similarly, the defense representative should advocate for adherence to policies that protect participants and can seek to amend the Drug Court's policies and operations to serve participants better.[32]

The defense representative should advocate for policies of graduated sanctions and rewards that recognize the high incidence of relapse during treatment programs.[33] In the team meetings that often

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[29] *See generally id.*, pp. 296–98, regarding the typical interaction between the Drug Court judge and participants at the court's review hearings.

[30] *See, e.g., id.*, p. 293 & Table 19.1.

[31] *See generally* D. Marlowe, Strategies for Administering Rewards and Sanctions, *reprinted in Drug Courts: A New Approach to Treatment and Rehabilitation,* pp. 317–333 (Springer Science and Business Media 2007) (describing strategies for use of rewards and sanctions in treatment courts in light of research regarding behavior modification).

[32] *See id.*, p. 325 (discussing "ratio burden" that can result from "multiple demands on clients that can be difficult to fulfill simultaneously"). The defense representative should assist participants in voicing practical considerations, such as work or school schedules, child-care duties, and transportation issues, that may limit their ability to attend all the recommended or required programming.

[33] *See, e.g.*, *id*., pp. 325–26 (distinguishing between "behaviors that clients are readily capable of engaging in," such as attending court and treatment sessions, and goals that may take longer to accomplish, such as prolonged abstinence from drugs). During the early phases of a client's treatment, rewards and sanctions of a relatively higher magnitude should be reserved for behaviors that the client can readily control. *Id.*, p. 326.

precede the court's review hearings, the defense representative should point out mitigating factors and may suggest potential sanctions other than incarceration.[34]

The defense representative should educate the local defense bar regarding treatment courts.[35] This education should include the Drug Court's potential advantages and disadvantages for clients represented by the local defense bar. Specific topics should include eligibility criteria and processes, legal consequences of successfully completing treatment (and of failure to complete treatment), and general policies and procedures of the Drug Court. The defense representative should encourage defense attorneys to contact him or her for specific information as needed. The defense representative should also encourage attorneys to observe at least one session of the Drug Court to understand the review sessions that their clients will attend if admitted to the program.

Drug Court participants are often not represented by adversary counsel at the court's review hearings. Participants frequently have questions and concerns that they may prefer to share with the defense representative rather than with the judge or with treatment providers. The defense representative should support participants by providing them with information about Drug Court procedures and by encouraging them in their efforts to complete the treatment court program. Where applicable, the defense representative must make clear that he or she is not serving as adversary counsel for program participants.[36]

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[34] *See infra* nn. 71–74 and associated section regarding principles for effective sanctions in drug court.

[35] *See* NADCP, Resolution regarding Indigent Defense in Drug Courts (April 19, 2002), *reprinted at* nlada.org/Defender/Defender_Library ("Inclusion and training of private counsel appointed to represent indigent defendants in Drug Court is necessary, particularly in jurisdictions which do not have an institutional public defense entity"). *See also America's Problem-Solving Courts: The Criminal Costs of Treatment and the Case for Reform*, p. 40 (National Association of Criminal Defense Lawyers 2009).

[36] Although the defense representative protects the general interests of participants in fair and compassionate court procedures, his or her proper role is to work as a collaborative team member to promote the successful rehabilitation of participants. *See, e.g.*, J. Miller and D. Johnson, Problem Solving Courts: New Approaches to Criminal Justice, p. 166 (Rowman & Littlefield 2009) (acknowledging team approach as best

ADVERSARY COUNSEL: ADVICE TO CLIENTS REGARDING DRUG COURTS

All defense attorneys should be reasonably knowledgeable about Drug Courts operating in the jurisdiction where they practice.[37] This knowledge should include a general understanding of the criteria for eligibility, the requirements for successful completion of the treatment program, and the likely consequences for failure to complete the program.

Defense counsel should be familiar with a wide range of potential dispositions that may benefit his or her clients. Thus, knowledge about a local Drug Court is a specific example of an attorney's obligation to investigate potential ways of resolving cases to his or her clients' benefit.[38] The attorney need not have an encyclopedic knowledge of the specific details of the potential treatment programs offered or available through the court, but should have general knowledge and should be able to respond to reasonable questions from clients about the Drug Court. The attorney may wish to communicate with the defense representative on the Drug Court team regarding specific questions.

In advising a client about potential participation in a Drug Court, defense counsel should provide competent and zealous representation, which should include reasonable factual investigation, consideration of potential legal and factual defenses, consideration of other dispositional alternatives, and communication with the client about the potential advantages and disadvantages of the Drug Court.[39]

Participation in a treatment court often occurs as a result of a negotiated agreement to settle a pending case. The client must ultimate-

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practice in a problem-solving court); J.L. Nolan, Jr., Reinventing Justice: The American Drug Court Movement, pp. 75–76 (Princeton, N.J. 2001) (successful Drug Courts rely upon a collaborative team approach).

[37] *See* ABA Model Rules of Professional Conduct 1.1 (lawyer shall provide competent representation, which includes necessary knowledge and preparation).

[38] *See id.*

[39] *See* ABA Model Rules of Professional Conduct 1.1 (competence), 1.4 (communication).

ly decide whether to seek admission to the Drug Court, to proceed to trial, or to pursue another disposition. Counsel's obligation is to prepare the client to make an informed choice. Counsel meets this obligation by preparing the case thoroughly, by negotiating effectively, and by communicating with the client regarding the range of possible ways to proceed.[40] In addition to describing the Drug Court, counsel may help the client make an informed choice by arranging for the client to attend a Drug Court session[41] and to meet with current or former participants of the Drug Court program.

As part of the adversary representation, counsel should advise the client about any waiver of rights in the Drug Court. In large part, the waiver of rights may be similar to any waiver of rights that accompanies a plea of guilty or no contest. However, there may be specific rights waived in connection with the Drug Court procedures, including the right to counsel at court hearings and the right to confidentiality of treatment records.[42]

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[40] The timeline for applying to enter a Drug Court can be a concern for adversary counsel in advising a client (and for the defense representative, in the broader context of promoting fair procedures). A legitimate therapeutic purpose is served by encouraging a prompt commitment to treatment. *See, e.g.*, La Crosse County Drug Treatment Court Program, *Policies and Procedures Manual*, p. 5 (May 2009) ("Addicts are most vulnerable to successful intervention when they are in the crisis of initial arrest and incarceration, so intervention must be immediate and up-front"). Further, for a defendant with a serious addiction or a pattern of abusing drugs or alcohol, a delay in starting a treatment program may be detrimental. The defendant will be either in jail unable to post bail or at risk of arrest for additional offenses because of his or her drug or alcohol use.

However, an arbitrary deadline can interfere with counsel's ability to investigate the facts of the case, to investigate other possible dispositions, and to consult adequately with the client. *See generally America's Problem-Solving Courts: The Criminal Costs of Treatment and the Case for Reform*, p. 38 (National Association of Criminal Defense Lawyers 2009) (recommending that Drug Court should allow adequate time for case preparation, including litigation of motions). One possible approach is an opt-out period during which a client may enter Drug Court while adversary counsel continues to investigate the case, obtain and review discovery, and discuss with the client potential legal and factual defenses.

[41] *See id.*

[42] *See infra* n. 46 for sample language regarding a waiver of the right to counsel at review hearings in Drug Court. Regarding treatment records, the Drug Court will ordinarily require participants to sign an agreement that information may be released to specific individuals and agencies. Although the judge often will discuss aspects of a

Adversary counsel does not generally attend all Drug Court sessions.[43] Counsel should clearly communicate to his or her client, before the client seeks admission in the Drug Court, the extent to which counsel will be available to attend court hearings or to answer questions while the client is a participant.[44] If the client is required to request a new appointment of an adversary attorney for any issue that arises in the Drug Court, counsel should advise the client regarding the process for such a request.

Adversary counsel should also advise the client regarding the consequences of an unsuccessful termination from the Drug Court. The client needs to know the sentence or the range of potential sentences that he or she could face in a future sentencing hearing. Similarly the client needs to know the potential sentence that could follow future revocation of probation or parole. Counsel should also discuss with the client that if the client is unsuccessful in Drug Court, the client will have spent a period of time in a challenging and structured treatment program, after which the client may still face the applicable sentence. In sum, although the benefits of success may be substantial, the client also needs to understand that if he or she is unsuccessful, the overall consequences for the underlying charge may be more onerous than if the client has received a traditional sentence.

ADVERSARY REPRESENTATION IN DRUG COURT

The best practice for an indigent-defense program is to offer adversary representation whenever a Drug Court participant faces incarceration as a sanction.[45] If adversary representation is limited or

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participant's treatment at the review hearings, in the presence of team members and the other participants, the records are not made available to the general public.

[43] *See infra* nn. 52–53 and accompanying text.

[44] *See* ABA Model Rules of Professional Conduct 1.4(b) (a lawyer shall explain an issue sufficiently that the client may make an informed decision). Access to the assistance of counsel could be a pertinent factor for a client to consider when deciding whether to participate in a Drug Court.

[45] *See* State of New Jersey Drug Court Program, Participation Agreement, ¶ 17 (participant has "right to an attorney during court proceedings"). *See generally* Rothgery

unavailable in Drug Court proceedings, prospective participants should be notified before entering the Drug Court. Participants may knowingly and voluntarily waive the right to counsel as part of an agreement to follow the rules of the Drug Court.[46] Despite this type of waiver, the attorney who served as adversary counsel on the underlying case should remain available to answer his or her client's questions during the time that the client is participating in the Drug Court.[47]

Ideally, Drug Court participants should have access to adversary counsel throughout the process. Regardless of the court's therapeutic purpose, the availability of adversary counsel is important, especially when a sanction will impact the client's liberty (for example, jail or an inpatient program). Participants may not need to consult frequently with counsel, especially when they are progressing well in their treatment programs or when they are satisfied with the court's measured response to infractions. However, their conduct in treatment and in the court hearings can affect the ultimate disposition of their under-

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v. Gillespie County, 554 U.S. 191, 128 S. Ct. 2578, 2591 n.16 (2008) (constitutional right to counsel applies to critical stages of a criminal proceeding that amount to "trial-like confrontations") (citations omitted). When the court confronts a treatment court participant with information regarding a failed drug test or other alleged rules violations, the proceeding arguably meets the criteria for a "critical stage," thus implicating the constitutional right to counsel. As a practical matter, however, the court may have authority to modify bail (or the probation department may have authority to hold the participant in jail) pending an adversary hearing. Thus, if the participant is facing a sanction of one or two days in jail, he or she may agree to the sanction instead of requesting a formal hearing.

[46] Several Wisconsin counties include the following standard language in their participant contracts: "For purposes of regular drug court review hearings, I agree to waive my right to have my attorney of record present. I understand that my case may be discussed without my attorney or the prosecutor present." *See, e.g.*, *Dunn County Diversion Court Participant Contract*, ¶ 21; *Eau Claire County Drug Court Program Participant Contract*, ¶ 21; *Jackson County Drug Court Participant Contract*, ¶ 20; *Polk County Drug Court Participant Contract*, ¶ 20; *Trempeleau County Drug/OWI Court Participant Contract*, ¶ 20.

[47] *See generally supra* nn. 37–44 and associated section. The defense representative should be available to answer the questions of participants regarding the Drug Court. However, adversary counsel can best answer questions regarding the underlying case and the likely effect on its ultimate resolution if the client does or does not successfully complete the court program.

lying criminal cases and can affect their status in the Drug Court from week to week. Therefore, the ability to confer confidentially with adversary counsel can benefit participants while they participate in a Drug Court.

Because of differences among both the structures of defender programs and the procedures of treatment courts, local practices vary regarding the availability of appointed counsel throughout an individual defendant's participation in a Drug Court.[48] The defense representative should provide interested parties (including the local defense bar, prospective participants in the Drug Court, and other justice agencies) information regarding the scope of adversary representation that attorneys appointed for the indigent will provide in the Drug Court.[49] This communication should include providing access to materials such as policy manuals, participant contracts, and authorization forms for release of treatment information to specified parties.

In many Drug Courts, a defendant's participation in the court follows a negotiated agreement, such as a plea agreement or a diversion agreement.[50] If the defendant successfully completes the treatment

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[48] Drug Courts follow one of three different models regarding the phase of the criminal proceeding at which the defendant is admitted to the court: pre-plea, between plea and adjudication, or postadjudication. *See* G.F. Roper, Roadblocks to Success, *reprinted in Drug Courts: A New Approach to Treatment and Rehabilitation,* p. 342 (Springer Science and Business Media 2007). The model of a particular court may affect whether the appointment of the attorney on the original charge continues throughout the time that the client is in the treatment court. For example, an appointment might continue for a case in which no adjudication of guilt has yet occurred, but not for a case in which the client has already been convicted and placed on probation.

[49] For staff public defenders, office policies may define the scope of representation that they are required or expected to provide. The high volume of cases assigned to public defenders make it difficult for them to appear regularly at review hearings for each client whom they represented before admission to treatment court. For appointed private attorneys, local rules regarding reimbursement and the attorneys' duties to other clients may influence whether or not attorneys ordinarily attend review hearings. However, the main reason for the rare attendance of adversary counsel may be the fairness of the procedures followed in many Drug Courts. *See infra* n. 53.

[50] *See* W. Huddleston & D. Marlowe, *Painting the Current Picture: A National Report on Drug Courts and Other Problem-Solving Court Programs in the United States*, pp. 24-25 (Bureau of Justice Assistance 2011) (noting that the participants in most adult Drug Courts have entered a plea of guilty as a condition of entering the court program). The agreement may call for dismissal of charges, reduction of charg-

program, the charge is often reduced or dismissed.[51] An indigent defendant is eligible for appointment of an attorney on the underlying charge. The attorney may negotiate on the client's behalf regarding participation in Drug Court. (Although the appointment is not for the specific purpose of seeking admission to Drug Court, the attorney advises the client of this option as part of representation on the pending charge.) However, in most Drug Courts, the attorney does not attend the court's regular review hearings, even when the defendant faces a sanction for noncompliance.[52] Nonetheless, Drug Courts should permit attendance and participation of adversary counsel.[53]

Defendants should be advised when a defense representative attends the Drug Court as a member of the court team, rather than as adversary counsel, for each individual defendant.[54] Although an attor-

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es, and/or a lesser sentence upon successful completion of the treatment court program. Some Drug Courts accept individuals who are on supervision (parole or probation) and who seek to participate in Drug Court as an alternative to revocation of supervision.

[51] *See, e.g.*, Michael O'Hear, Rethinking Drug Courts: Restorative Justice as a Response to Racial Injustice, 20 *Stan. L. & Policy Rev*. 463, 479 (2009).

[52] *See, e.g., America's Problem-Solving Courts: The Criminal Costs of Treatment and the Case for Reform*, p. 34 (National Association of Criminal Defense Lawyers 2009) (describing some jurisdictions in which the custom for defense attorneys is not to appear in Drug Court). The absence of adversary counsel at these hearings is consistent with the collaborative approach characteristic of Drug Courts. *See Defining Drug Courts: The Key Components*, p. 11 (NADCP, Drug Court Standards Committee 1997) (recommending that the defense counsel and prosecutor "shed their traditional adversarial courtroom relationship and work together as a team").

[53] *See* G.F. Roper, Roadblocks to Success, *reprinted in Drug Courts: A New Approach to Treatment and Rehabilitation,* pp. 348–49 (Springer Science and Business Media 2007) (recommending that judge offer to adjourn hearing on imposition of sanctions until adversary counsel is available, but sharing experience that defendants and defense bar rarely contest sanctions when "satisfied that the judge will not impose sanctions heavy-handedly or without abundant, clear evidence of a violation"). Conversely, if participants are frequently contesting alleged violations or the severity of the sanctions, the court may lack that shared confidence in a fair process.

[54] *Cf. Defining Drug Courts: The Key Components*, p. 12 (NADCP, Drug Court Standards Committee 1997) (defense counsel should explain to the defendant the rules of the Drug Court and all rights that he or she is relinquishing as part of an agreement to enter the court program). Although *The Key Components* does not explicitly differentiate between a defense attorney serving in a representative capacity and serving as adversary counsel, many of the actions recommended for defense

ney who has served for a long time on a Drug Court team may understand his or her nontraditional role at the review hearings, the attorney should ensure that Drug Court participants also understand that the attorney's role is not to provide individual representation in Drug Court. If the Drug Court is not treating defendants fairly at the review hearings, the defense representative should seek improvements in the court process and should advise the defense bar of the concerns about the court's actions.[55]

A major distinction exists between an ordinary review hearing and an expulsion hearing, the latter generally occurring only after a participant has failed repeatedly to comply with treatment expectations or has been imprisoned for a new violation (and thus is unavailable for community-based treatment). Depending upon the original charges, a participant may face months or years of incarceration following expulsion rather than the day or two in jail he or she might receive as a Drug Court sanction. Thus, prompt access to adversary counsel is especially critical when a participant faces either an expulsion hearing or a sentencing hearing following expulsion.

ATTORNEY FULFILLING DUAL ROLES IN DRUG COURT

In some jurisdictions, the same attorney may simultaneously serve as adversary counsel and as the defense representative on the Drug Court team. For many Drug Court hearings (particularly for clients in compliance with the court's requirements), the client's wishes and the team's treatment goals for the client are identical. In this common situation, the dual roles do not present a challenge for the attorney. However, because many clients relapse or commit other infractions during the difficult treatment process, the potential exists for conflict between the two roles.

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counsel are consistent with the role of defense representative described in this report. *See id.*, pp. 11–12.

[55] In addition to the efforts of the defense representative to improve court processes or to discourage further referrals to the court, adversary counsel may pursue litigation on behalf of clients aggrieved by actions of the Drug Court.

The attorney's adversarial role, ethically required for direct client representation, may be counterproductive for the therapeutic goals of the Drug Court.[56] Therefore, when the attorney is required as an advocate to argue against sanctions, he or she may be jeopardizing the collaborative approach that is widely accepted as integral to the effectiveness of Drug Courts.[57]

The different roles impact how the defense attorney perceives the direct conversations that regularly occur between the Drug Court judge and the individual participants. The success of Drug Courts stems in part from this interaction, which increases participants' belief that they are being treated fairly.[58] However, an attorney providing adversary representation does not ordinarily encourage a client to

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[56] *See Defining Drug Courts: The Key Components*, p. 6 (NADCP 1997) (observing that the traditional role of defense counsel may contribute to alcohol or drug abuse by reinforcing the client's denial of the underlying problem). *See also Critical Issues for Defense Attorneys in Drug Court*, p. 3 (National Drug Court Institute 2003) ("desires of the treatment team are, at times, conflicting and seemingly put the defense attorney in a box"). For example, despite believing that a client needs long-term or intensive treatment to achieve and maintain sobriety, adversary counsel will ordinarily advocate for a lesser treatment dosage if consistent with the client's wishes. *See* K. Weibrecht, *Evidence-Based Practices and Criminal Defense: Opportunities, Challenges, and Practical Considerations*, p. 31 (National Institute of Corrections 2008) (interpreting ethical standards for defense counsel to presume that counsel should advocate for the dispositional result preferred by the client)

[57] *See, e.g.*, *Defining Drug Courts: The Key Components*, p. 3 (NADCP 1997) (after the participant is accepted into the Drug Court, the team's focus is "on the participant's recovery and law-abiding behavior"); J. Miller and D. Johnson, *Problem Solving Courts: New Approaches to Criminal Justice,* p. 158 (Rowman & Littlefield 2009) (stating that Drug Court team members must step outside their ordinary professional roles to work collaboratively).

[58] *See, e.g.*, D.C. Gottfredson, B.W. Kearley, S.S. Najaka, and C.M. Rocha, *How Drug Treatment Courts Work: An Analysis of Mediators*, p. 26, 44:1 Journal of Research in Crime and Delinquency (2007) (number of judicial hearings increases participants' perceptions of procedural fairness, which in turn reduces drug usage and criminal activity); *Defining Drug Courts: The Key Components*, p. 15 (NADCP 1997) (Key Component # 7 addresses ongoing judicial interaction with each participant to demonstrate that the judge cares about the participant and is keeping track of his or her progress).

communicate directly with the judge, particularly if the attorney does not know in advance the substance of the client's statements.[59]

Another challenge for a dual-role attorney is the simultaneous representation of all or most of the Drug Court participants. For example, if multiple participants face sanctions during the same review session, it may be difficult for the attorney to present a credible argument that each one has a unique mitigating circumstance.[60]

If a Drug Court consistently follows fair procedures and relies more heavily on incentives than on sanctions, many participants will become comfortable with direct and candid conversations with the presiding judge. Thus, the conflicts between the adversary role and the defense representative role may be relatively infrequent during the court's staffing meetings and review hearings. Nonetheless, when possible, an individual attorney should refrain from serving simultaneously in both roles.

MAJOR ISSUES FOR THE DEFENSE ATTORNEY IN DRUG COURT

Eligibility for Participation

A critical and difficult issue for a Drug Court is the eligibility criteria. A Drug Court that limits eligibility to defendants charged with minor offenses may not provide sufficient incentives for many defendants to complete a long period of intense treatment and supervi-

[59] *Cf.* ABA Standards for Criminal Justice, Defense Function, § 4–6.2 (Commentary) (3rd ed. 1993) (because statements made by the defendant during plea negotiations may be used against the defendant in future proceedings, "the accused should be cautioned by counsel against making any statements that have not been carefully explored in advance with counsel").

[60] ABA Model Rules of Professional Conduct 1.7(a)(2) prohibits representation of a client when a substantial risk exists that the representation will be materially limited by obligations to another client. For example, in the context of arguing against sanctions that the Drug Court generally imposes, an attorney might have to argue on behalf of one client that her brief time in the court is a mitigating factor (she is still under the powerful effects of addiction) and then to have to argue that another client's substantial time in the court without a violation is a mitigating factor. Arguably, both clients would be better served by separate attorneys who would not have to argue seemingly inconsistent positions before the same judge.

sion.[61] Conversely, a Drug Court that accepts defendants charged with serious offenses (and defendants with prior records) may achieve a higher rate of program completion because defendants are motivated to complete the program instead of serving a substantial term of imprisonment.[62] A defense representative, through familiarity with research regarding this risk–reward principle, may influence other members of the Drug Court team regarding eligibility criteria.

A defense representative is expected, as a member of the Drug Court team, to support agreed-upon eligibility criteria (particularly if he or she participated in establishing them). Therefore, a conflict of interest may arise if the defense representative (or a colleague in the same defender organization) acts as adversary counsel for clients seeking admission to the Drug Court.[63] The defense representative has an institutional interest in supporting the agreed-upon admission criteria, which support successful treatment outcomes and favorable dis-

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[61] *See, e.g.*, Michael O'Hear, Rethinking Drug Courts: Restorative Justice as a Response to Racial Injustice, 20 *Stan. L. & Policy Rev.* 463, 480 (2009) (a Drug Court is "less a diversion from prison than a diversion from other alternatives" if it focuses on possession offenses and on defendants without serious prior records); G.F. Roper, Roadblocks to Success, *reprinted in Drug Courts: A New Approach to Treatment and Rehabilitation,* p. 348 (Springer Science and Business Media 2007) (some defense attorneys recommend a straight sentence of "weeks or months" to their clients instead of a longer period of participation in Drug Court).

Furthermore, the Drug Court should take into account the risk level and risk factors (needs) of participants to determine the appropriate level and type of treatment. *See* L. Gutierrez and G. Bourgon, *Drug Treatment Courts: A Quantitative Review of Study and Treatment Quality 2009-04*, p. 3 (Public Safety Canada 2009). Low-risk individuals do not need (and should not receive) the same treatment programming as high-risk individuals. *Id.*

[62] *See Drug Courts: The Second Decade*, p. 2 (National Institute of Justice 2006) (Drug Courts have moved from "low-level first-time offenders to focusing on those whose substance abuse and criminal activity may be more serious"). *See also* R. Warren, *Evidence-Based Practices to Reduce Recidivism: Implications for State Judiciaries*, pp. 21–22 (Crime and Justice Institute, National Institute of Corrections and National Center for State Courts 2007) ("Effective recidivism-reduction programs target moderate- and high-risk offenders"; participation of low-risk offenders in intensive treatment can actually increase their risk of reoffending).

[63] ABA Model Rules of Professional Conduct 1.7(a)(2) prohibits representation of a client when a substantial likelihood exists that the attorney's ability to represent the client will be materially limited by the attorney's other responsibilities. *See supra* n. 11 and accompanying text.

positions for participants. However, adversary counsel for an individual client has an obligation to advocate for admission to the Drug Court, if the client wishes to participate, even if the circumstances of the client's case do not appear to meet the admission criteria.[64]

Regardless of the specific eligibility criteria and screening procedures, the defense representative should communicate to other Drug Court personnel that defense attorneys are ethically required to seek admission for clients on a case-by-case basis. By learning about practices and outcomes in other jurisdictions, the defense representative may persuade the team to expand the eligibility criteria or to apply them more flexibly. If other members of the Drug Court team respect the defense representative's duty to individual clients, he or she may be effective in advocating for their admission to the Drug Court.

The defense representative may also seek to persuade policy makers to allocate additional resources to the Drug Court, which may expand its capacity to accept new applicants. The court's track record in reducing recidivism can be used to show whether that jurisdiction should support the Drug Court as a viable option to traditional prosecution and punishment.

Cultural Competency in Drug Court

Drug Courts should provide services that effectively meet the needs of all participants, regardless of race, gender, age, or ethnicity. By collecting demographic information of participants and by track-

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[64] *See generally* ABA Model Rules of Professional Conduct 1.2(a) (lawyer shall generally abide by decisions of the client regarding the objectives of the representation, including whether to settle a case or proceed to trial). As an adversary attorney, an attorney may be ethically required to seek admission to Drug Court for a low-risk client, if the client prefers that disposition. Thus, if the same attorney also serves as the court's defense representative, he or she may be precluded from advocating for the best practice regarding the population served by the treatment court. *See supra* nn. 61–62 and accompanying text regarding the reasons for accepting moderate-risk and high-risk defendants as participants in Drug Court.

A jurisdiction with a Drug Court may also provide other diversion options for low-risk defendants. If so, adversary counsel may seek a favorable disposition that does not require the intensive treatment and the frequent court appearances characteristic of Drug Courts.

ing outcomes, a Drug Court team can assess whether it is providing services that lead to success for participants from all cultural backgrounds.

NADCP has recognized that Drug Court teams should continually review their programs for evidence of racial or ethnic disparity and, if necessary, take corrective action to address such disparity.[65] In recommending that Drug Courts focus on this issue, NADCP noted the disproportionate incarceration of racial and ethnic minorities nationwide.[66] NADCP also noted lower success rates reported for minority participants in some Drug Courts[67] and the importance of training Drug Court personnel "on how to identify and administer evidence-based, culturally sensitive and culturally competent interventions and assessment tools."[68]

Incentives and Sanctions for Drug Court Participants

Drug Courts generally use incentives and sanctions to shape participants' behavior, rewarding compliance and imposing negative consequences for noncompliance. The defense representative can help temper the tendency that other team members may have to recommend or impose unnecessarily harsh sanctions. Familiarity with research regarding incentives and sanctions can help in ensuring that the Drug Court does not overreact to the inevitable instances of noncompliance. This knowledge of the research can also help other team members to understand the importance of incentives to provide positive reinforcement.

Defense attorneys, whether serving as a defense representative on a Drug Court team or as adversary counsel, should be aware of the likely consequences for participants for conduct occurring after they enter the Drug Court. Negative consequences can occur either as sanctions (within the framework of the Drug Court) or as a sentence

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[65] NADCP, *Resolution of Board of Directors on the Equivalent Treatment of Racial and Ethnic Minority Participants in Drug Courts*, p. 2 (June 2010).

[66] *Id.*, p. 1.

[67] *Id.*, p. 2.

[68] *Id.*, p. 3.

following expulsion from the Drug Court. Both types of consequences need to be considered in light of the dispositional alternatives other than Drug Court (for example, a participant might face short periods of incarceration as a sanction in Drug Court, but might face a prison sentence for the underlying offense if expelled).

Incentives

Not all justice professionals instinctively embrace the idea of a court providing tangible incentives such as gift cards or movie passes to a participant for having a clean urine test and appearing in court as scheduled. After all, millions of people obey the law every day without receiving these rewards. However, to counteract the power of chemical addiction and dependency, immediate and tangible rewards are important ways for a Drug Court to show some benefits of abstinence.[69]

Sanctions

Four general principles for effective sanctions within a treatment program are certainty, promptness, magnitude, and fairness.[70] Certainty and promptness of sanctions are the most important principles.[71] Therefore, the Drug Court's ability to identify and to respond

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[69] M. Stitzer, Motivational Incentives in Drug Courts, *reprinted in Quality Improvement for Drug Court: Evidence-Based Practices,* p. 99 (National Drug Court Institute 2008). *See also* Strategies for Administering Rewards and Sanctions, *reprinted in Drug Courts: A New Approach to Treatment and Rehabilitation,* pp. 326–328 (Springer Science and Business Media 2007) (discussing the value of tangible rewards for Drug Court participants, particularly to help new participants before they begin to experience intrinsic rewards of sobriety and other prosocial behaviors).

[70] D. Marlowe, Strategies for Administering Rewards and Sanctions, *reprinted in Drug Courts: A New Approach to Treatment and Rehabilitation,* pp. 319–324 (Springer Science and Business Media 2007).

[71] *Id.*, pp. 319–322. Frequent and random drug tests for participants create a high degree of certainty that the Drug Court will discover a participant's drug usage. Conversely, if testing is conducted infrequently or on a predictable schedule, the certainty of a sanction for drug usage is greatly reduced. The promptness principle reflects that the more quickly a sanction occurs, the greater likelihood that the participant recognizes that connection between the sanction and the underlying conduct. Conversely, when a criminal defendant is sentenced months or years after an offense, "the effects of sanctions should be expected to be minimal." *Id.*, p. 321.

quickly to misconduct is more critical than the severity of the sanctions imposed.

The magnitude of the response, in a Drug Court environment, should take into account the strength of the participant's drug or alcohol dependency and the expectation that relapse is a common occurrence during treatment. During the early phase of treatment, "clients might receive verbal reprimands or writing assignments for providing drug-positive urine samples but might receive community service or brief jail detention for failing to show up for counseling sessions or failing to provide urine samples."[72] The fourth principle, fairness, calls for fair procedures and professional, respectful communication with participants when imposing sanctions.[73]

Indiscriminate use of incarceration as a sanction can result in substantial incarceration for participants in a Drug Court, even for those who successfully complete the treatment program.[74] In advising a client regarding potential participation in a Drug Court, defense counsel should be aware not only of the range of sanctions generally used, but also the likelihood that most participants will experience some setbacks during their time in the court-sponsored program.

Conversely, counsel should consider and discuss with the client the likely outcome if he or she receives a traditional sentence. This

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[72] *Id.*, p. 326; *see also* T.J. Kelly, J.M. Gaither, and L.J. King, Relapse, *reprinted in Drug Courts: A New Approach to Treatment and Rehabilitation,* p. 386 (Springer Science and Business Media 2007) ("it is not necessary or desirable that a participant be incarcerated for every drug use episode"). The harsher sanctions during the early phase of treatment should be reserved for intentional violations of court procedures, such as skipping an appointment, rather than for succumbing to a powerful addiction of dependency.

[73] D. Marlowe, Strategies for Administering Rewards and Sanctions, *reprinted in Drug Courts: A New Approach to Treatment and Rehabilitation,* p. 324 (Springer Science and Business Media 2007). A Drug Court's failure to follow fair procedures, including the opportunity to respond to alleged violations, may adversely affect the commitment of participants to their treatment programs. *Id.* If participants perceive that they have been treated fairly and respectfully, they are likely to accept sanctions for misconduct. *Id.*

[74] *See, e.g.*, M. O'Hear, Rethinking Drug Courts: Restorative Justice as a Response to Racial Injustice, 20 *Stan. L. & Policy Rev.* 463, 481 (2009) (citing studies from Santa Clara and Baltimore that showed an average time in excess of 50 days' incarceration for sanctions).

consideration should encompass not only the length of the initial period of incarceration, but also whether the client is likely to comply with probation or parole requirements. Most clients eligible for a Drug Court have a history of court involvement that suggests, absent an intensive and successful course of treatment, the potential for future legal difficulties.

Confidentiality of Information Disclosed in Drug Court

Participants may have concerns not only about use of information within the justice system (e.g., in a future sentencing or revocation proceeding), but also about public access to information stemming from their participation in a Drug Court. Local law and procedures may differ regarding specific practices such as whether review hearings are transcribed, whether members of the public may attend the review hearings, whether records are accessible under local law on public records, and whether the judge orders attendees not to disclose information communicated in these hearings.

Although members of the Drug Court team need to receive information about participants, such as treatment records and results of drug tests, the defense representative should seek to protect confidentiality through adoption of procedures limiting access to information, disclosure of information, and use of information.

When a defendant agrees to participate in a Drug Court, he or she is required to sign release forms to allow members of the court team to review treatment records. Despite the legitimate purpose for requiring this consent to disclosure of records, the defense representative should ensure that disclosure is no broader than is necessary. A policy manual, written contract, or memorandum of understanding can be a valuable resource to document the limits on disclosure of treatment records.[75]

The frequency of treatment sessions, tests for alcohol and drug use, and review hearings results in members of the treatment court

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[75] *See, e.g.*, *La Crosse County (Wisconsin) Drug Court Manual*, p. 10 (2009) ("Drug Court files are separate and distinct from Circuit Court files…All Drug Court files are confidential and are not open to the general public").

team learning when participants relapse. Members of the team thus commonly encounter evidence of positive drug tests and incriminating statements during the participant's gradual and uneven path to recovery. "Defenders will want to ensure that such evidence is used for the limited purpose of treatment and cannot be used against the client" in other contexts.[76]

Criteria and Procedures for Expulsion from Drug Court

The criteria for expulsion from Drug Court contribute to the completion rate for participants. The therapeutic model anticipates relapse and uses a range of sanctions and incentives to enhance the chances for successful completion of treatment. If a Drug Court is impatient with the uneven progress of participants and expels them after a specified number of violations, the court will likely have a lower completion rate. Because the length of time that a person participates in treatment is directly related to the likelihood of future success,[77] Drug Courts should use the motivational tools of incentives and sanctions to retain participants and to optimize their chances for success.

The success of an individual participant depends in large part upon his or her conduct while in the Drug Court. A participant who regularly adheres to the court's expectations will ordinarily complete the program; a participant who regularly skips court sessions, who is imprisoned for a new crime, or who is unable to benefit from treatment is much less likely to succeed. Nonetheless, the court's overall completion rate and its general policies regarding expulsion are pertinent information for defense attorneys in advising their clients regarding participation in a Drug Court.

Expulsion from Drug Court may result in substantial incarceration. Depending upon the stage of the criminal proceeding at which the participant entered Drug Court, he or she may face sentencing in an adjourned felony case or may face revocation of parole. Further-

[76] M. Judge, Critical Issues for Defenders in the Design and Operation of a Drug Court, *Indigent Defense,* p. 4 (National Legal Aid and Defender Association 1997).

[77] *See, e.g.,* W. Meyer, *Developing and Delivering Incentives and Sanctions*, p. 1 (National Drug Court Institute, April 2007).

more, the postexpulsion decision of the sentencing court or parole board may be influenced by the participant's failure to complete the treatment court program successfully. Therefore, the Drug Court should provide the participant with the right to appointment of adversary counsel in an expulsion hearing.[78]

Sentence Following Expulsion from Drug Court

Although Drug Courts have shown success at reducing recidivism,[79] not all participants successfully complete the court program. The unsuccessful participant typically faces a sentencing hearing on the original charge (or faces imprisonment in the revocation proceeding) that precipitated the referral to the treatment court. In some jurisdictions, an unsuccessful participant may face a greater penalty than if he or she had never participated in the Drug Court.[80] However, absent a new conviction, a participant's failure to complete the program should not be a basis for an increased sentence.[81] The defense repre-

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[78] Some Drug Courts have adopted specific policies to notify participants of the right to counsel in this type of hearing. *See, e.g.*, *Brown County (Wisconsin) Drug Court Program Manual*, p. 13 (2009) (expulsion hearing, if requested, occurs on the record, "and the participant is entitled to legal representation"); *La Crosse County (Wisconsin) Drug Court Participant Handbook,* p. 10 (2009) (attorney may appear both for initial hearing before Drug Court team and, if the matter proceeds further, for judicial hearing on expulsion).

[79] *See supra* nn. 4, 14, and accompanying text.

[80] *See, e.g.*, M. O'Hear, Rethinking Drug Courts: Restorative Justice as a Response to Racial Injustice, 20 *Stan. L. & Policy Rev.* 463, 481& n. 100 (2009) (citing studies from New York that showed failing participants receiving longer sentences than nonparticipants receive).

[81] The defense representative may wish to consider whether unsuccessful participants should have the option of having their cases transferred from the Drug Court judge to another judge for sentencing. In some jurisdictions, cases may routinely be returned to another judge when the defendant (whether successful or unsuccessful) has ended his or her participation in Drug Court. If the defendant has the option of remaining before the Drug Court judge or having the case transferred, the decision is a tactical one to make in consultation with adversary counsel.

Another potential safeguard is to let the defendant know, before he or she enters Drug Court, what the sentence will be if the defendant does not complete the court program. This alternative depends on local sentencing law and practices, as well as the phase of the proceedings at which the participant enters the Drug Court (for example, if the participant enters Drug Court in lieu of revocation of parole, the potential in-

sentative (and the defense bar in general) should advise judges and prosecutors that increased sentences for noncompletion may deter many defendants from participation in Drug Court.

Defense Representative's Role in Decisions about Individual Participants

The defense representative on a Drug Court team should ordinarily refrain from voting to admit to the court clients represented by attorneys working in his or her office. Similarly, the defense representative should not vote on sanctions or expulsion of these clients. If the defense representative intends to vote (or otherwise advocate) regarding these decisions, the clients should be notified that the defense representative is acting as a representative of the Drug Court and will vote according to the court's applicable standards and policies. Present or former clients of the public defender agency should be given the same access and consideration as clients of the private bar.

In general, the interests of indigent defendants are better served if a defense representative participates in admission decisions. The defense representative may be more receptive than other team members to accepting defendants with serious charges or significant criminal records. Also, the defense representative may advocate for criteria and policies that provide access regardless of financial status (for example, procedures to waive or defer fees that might otherwise preclude participation by indigent persons). However, when the defense representative's colleagues are serving as adversary counsel for defendants seeking admission to the Drug Court, ethical and practical concerns make the defense representative's recusal preferable to voting on the admission decision.

If the defense representative opposes admission into the Drug Court of a colleague's client, ethical issues arise regarding conflict of interest and confidentiality. A conflict of interest arguably exists between the defense representative's responsibility as part of the Drug Court team (which may include adherence to specified admission cri-

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carceration time may be predetermined by the sentence originally imposed and the local parole law.

teria) and his or her responsibility to take no action adverse to a colleague's client (this responsibility exists whenever attorneys work together in the same office).[82] The confidentiality issue arises because attorneys in the same office generally have access to information regarding all clients of the office,[83] and the defense representative may not ethically use client-related information adversely in the decision regarding admission to the Drug Court.[84]

The ethical issues are magnified if the defense representative supervises the attorney providing the adversary representation. The defense representative must not discourage adversary counsel from seeking admission to the Drug Court on behalf of his or her clients (even for clients who may appear not to meet the stated admission).

Practical considerations also support the recommendation that the defense representative has a policy of not voting on the admission of a colleague's client. If the representative invariably votes in favor of admission, he or she will lose credibility with other members of the Drug Court team. However, if the representative votes against admission (or abstains) only in some cases when the prospective participant is a client of a colleague, others on the Drug Court team may believe that the representative has confidential and negative information about the client derived from working in the same office with adver-

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[82] ABA Model Rules of Professional Conduct 1.10(a) provides that for attorneys "associated in a firm," a conflict of interest precluding representation by one attorney is generally imputed to his or her colleagues. An exception exists, however, that allows other attorneys in the firm to represent the client if the conflict "is based on a personal interest of the prohibited lawyer and does not present a significant risk of materially limiting the representation of the client by the remaining members of the firm. *Id.* 1.10(a)(1). Thus, whether other public defenders may represent a client in Drug Court (or seeking admission to the court) despite a conflict affecting their colleague depends on the interpretation of this rule on imputed disqualification (some states have adopted the ABA Model Rules with changes, so attorneys should review local rules and opinions).

In analyzing this ethical issue and others, attorneys must be familiar with the specific rules and ethics opinions applicable in their respective jurisdictions.

[83] *Id.*, 1.6, Comment ("Lawyers in a firm may, in the course of the firm's practice, disclose to each other information relating to a client of the firm," unless the client has given contrary instructions).

[84] *Id.*, 1.6(a) (general rule of confidentiality, which broadly prohibits a lawyer from revealing "information relating to the representation of a client").

sary counsel. Furthermore, multiple clients of the office may be applying for a single place in the Drug Court.[85]

Participation in decisions on expulsion or sanctions can be similarly problematic. The defense representative can support the therapeutic goals of the Drug Court by reminding other team members that overcoming addiction or dependence is generally an uneven journey, interrupted by relapse.[86] However, voting on potential expulsion or sanction for each individual creates the same dilemma as with admission decisions. The defense representative may lose credibility by opposing all negative consequences for violations.[87] Conversely, if the

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[85] Because of limited resources (e.g., staff, treatment providers, or funding), Drug Courts may have a maximum number of participants at a given time. Therefore, if the number of applicants exceeds the court's capacity, the team may need to make admission decisions from among a pool of applicants all of whom meet the eligibility requirements. Ethical issues related to admission decisions may be minimized if the court uses criteria such as a diagnosis of addiction and a risk determination (from a standardized assessment instrument) to select participants. Another possible approach to address these ethical issues is to screen the defense representative from confidential information about treatment court applicants represented by colleagues (other members of the Drug Court team should then be informed of this screening procedure, so that they do not draw any inferences from the statements or votes of the defense representative).

The defense representative may also work with other team members to seek additional resources to expand the Drug Court's capacity. If the court can document its success in reducing recidivism, policymakers may increase funding to allow the court to serve additional participants.

[86] *See* T.J. Kelly, J.M. Gaither, and L.J. King, Relapse, *reprinted in Drug Courts: A New Approach to Treatment and Rehabilitation,* p. 386 (Springer Science and Business Media 2007) (stating that Drug Court judge "should carefully consider the consequences of incarceration and not allow traditional notions of 'tough on crime' to interfere with the effective use of treatment."); *see also* K.R. Lay and L.J. King, Counseling Strategies, *reprinted in Drug Courts: A New Approach to Treatment and Rehabilitation,* p. 170 (Springer Science and Business Media 2007) ("Relapse is an expected part of recovery in Drug Courts and might or might not occur at any stage and require return to an earlier stage").

[87] For example, the defense representative might be called upon to vote on potential sanctions for misconduct that occurred during a treatment session or for failure to show up to provide a urine sample. Members of the Drug Court team may reasonably conclude that the failure to impose some sanctions for violations potentially undermines not only the court's ability to promote participant compliance, but also the court's relationship with the service provider (for example, an agency providing treatment or drug testing). *See* D.A. Reilly, Building Supportive Services in Drug

defense representative votes for such consequences in selected cases, other team members may infer that the representative has confidential and negative information about the client.

In a jurisdiction in which the local public defender staff represent a large percentage of defendants, this issue can be difficult. The defense representative should consider reasonable alternatives to preserve a defense voice in these decisions without creating the ethical and practical issues discussed above. The participation of a private defense attorney in admission decisions may be an option in some Drug Courts. Another option may be that the applicant's adversary counsel, after having reviewed the eligibility criteria, presents the application to other members of the team, with the defense representative refraining from any formal vote.

In sum, the defense representative can advocate generally for fair criteria in all aspects of Drug Court's operations without formally advocating for specific actions requested by a client (or colleague's client). If participants have been fully informed of and agreed to the Drug Court's procedures, the defense representative can ethically, collaboratively, and effectively support the court's evidence-based practices.

CONCLUSION

Drug Courts provide a potentially beneficial option to persons who would otherwise be at high risk of substantial incarceration and recidivism. By addressing underlying risk factors such as addiction or a mental disorder, Drug Courts can benefit both the individual participants and the public safety of the broader community. Public defenders (and other representatives of the defense bar) can and should play an important role in ensuring the fairness and effectiveness of Drug Courts.

> *Points of view, opinions, and conclusions in this paper do not necessarily reflect those of the NADCP, National Legal Aid and Defender Association (NLADA,) or the Office of the Wisconsin State Public Defender.*

Courts, *reprinted in Drug Courts: A New Approach to Treatment and Rehabilitation,* p. 212 (Springer Science and Business Media 2007).

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THE PREVALENCE OF HIV RISK BEHAVIORS AMONG FELONY DRUG COURT PARTICIPANTS

David S. Festinger — Karen L. Dugosh
David S. Metzger — Douglas B. Marlowe

> ***[15] HIV Risk Behaviors in Drug Court****—A small percentage of participants in a large metropolitan felony Drug Court engaged in high-risk injection drug use, but a large percentage engaged in high-risk sexual behaviors.*
>
> ***[16] HIV Risk Factors in Drug Court****—HIV risk behaviors were associated with being male, African–American, and younger.*
>
> ***[17] Geographic Risk for HIV****—A large proportion of Drug Court participants resided in areas of the city with a high prevalence of persons living with HIV/AIDS, thus heightening the probability of exposure to the virus.*

ACCORDING TO RECENT ESTIMATES from the Centers for Disease Control and Prevention (CDC; Hall et al., 2008), approximately 1.2 million adults and adolescents in the United States are HIV positive, representing approximately 0.4% of the total population. An estimated 56,300 adolescents and adults were newly infected with the HIV virus in 2006. Seventy-three percent of these new infections occurred among males, 45% among African–Americans, and 17% among Hispanics. Over half of the new infections occurred among males who have sex with males (MSM).

The relationship between drug use and HIV risk is well documented. According to CDC estimates, injection drug use (22%) was the third most common high-risk behavior among individuals living with HIV [after male-to-male sexual contact (45%) and high-risk heterosexual contact (27%)]. In addition to risks of direct and indirect transmission associated with injection drug use, noninjection substance users are also disproportionately at risk for contracting HIV through sexual transmission. Substance use has been frequently linked to sexual risk behaviors and viral

transmission among both heterosexuals and MSM. Clearly, drug and alcohol use can affect economic status, social network membership, and decision making with respect to partner selection and condom use. These factors often lead to unsafe sexual practices (e.g., Brewer et al., 2007; Celentano, Latimore, & Mehta, 2008; Cheng et al., 2010; Kwiatkowski & Booth, 2000; Molitor, Bautista, & Choi; Royce et al., 1997). Finally, research has demonstrated that the biological effects of drug abuse can affect a person's susceptibility to HIV infection and the progression of AIDS (e.g., Bagby et al., 2006; Samet et al., 2003, 2004).

The high rates of drug use put substance-abusing offenders at a high risk for contracting HIV infection and for transmitting the virus to others. It is estimated that approximately 80% of prison and jail inmates were under the influence of drugs or alcohol at the time of their arrest (Belenko & Peugh, 2005; James, 1988; Teplin, 1994). Of those in jail who are HIV positive, intravenous drug use is among the most predominant methods of transmission (Dean, Lansky, & Fleming, 2002; Hammett et al., 1994, as cited in Swartz, Lurigio, & Weiner, 2004). In fact, early estimates (Vlahov et al., 1989) indicated that 85% of these infections were linked to intravenous drug use. More recent estimates identify this rate to be closer to one-half (Dean et al., 2002). In addition, other factors are likely to contribute to the elevated HIV risk in incarcerated individuals including poverty, unemployment, lack of health care access (Hammet, Harmon, & Maruschak, 1999), and social networks that include high-risk associates (Friedman et al., 1999).

Individuals in the criminal justice system have been found to be at a particularly high risk for HIV/AIDS infection and transmission. The relatively high prevalence rate for HIV infection has been well established in incarcerated populations. Nationwide, an estimated 22,144 HIV positive inmates were in state and federal prisons at the end of December 2008, accounting for 1.5% of the total prison population (Maruschak, 2009), almost four times higher than in the total U.S. population. Among them were 5,113 confirmed AIDS cases accounting for 0.4% of the total prison population. Furthermore, it has been estimated that 17%–25% of HIV-infected individuals pass through the prison system annually (Braithwaite & Arriola, 2003; Spalding et al., 2009).

Although the primary focus of HIV prevention efforts for the criminal justice system has been on incarcerated populations (e.g., Braithwaite & Arriola, 2003; Hammet et al., 1999), the majority of offenders are actually not incarcerated but rather are under community supervision, with over five million offenders on probation or parole (Glaze & Bonczar, 2009). Rates of drug involvement are particularly high in this population, putting them at higher risk for HIV infection. At the end of 2008, 30% of probationers had been charged with drug offenses and another 17% had been charged with driving while impaired (DWI). Approximately 37% of parolees had served a sentence for a drug offense. Belenko et al. (2004) examined the prevalence of HIV and risk behaviors in a sample of offenders who were under community supervision. They reported HIV/AIDS prevalence rates that mirrored those observed in inmates, rates of injection drug use that were slightly higher, and a high prevalence of risky sex behaviors.

Little research has focused on the rates of engagement in HIV risk behaviors in other types of community corrections settings. For instance, Drug Courts are one of the most empirically supported approaches for successfully diverting drug using offenders from incarceration to drug treatment and case management in the community (e.g., Aos et al., 2001; Latimer, Morton-Bourgon, & Chretien, 2006; Lowenkamp, Holsinger, & Latessa, 2005; Marlowe, DeMatteo, & Festinger, 2003; Marlowe, Festinger, & Lee, 2004; Wilson, Mitchell, & MacKenzie; Schaffer, 2006). Drug Courts are special criminal court dockets that provide a judicially supervised regimen of substance abuse treatment and other needed services for nonviolent, substance-abusing offenders in lieu of criminal prosecution or incarceration (Marlowe et al., 2008). The first Drug Court was established in 1989, and there are now more than 2,500 Drug Courts in the United States and its territories (National Association of Drug Court Professionals, 2011). Given the rapid expansion of Drug Courts to serve the needs of drug-involved offenders and the high prevalence of HIV risk behaviors that have been identified among other substance-abusing criminal justice populations, it is important to understand the prevalence of HIV risk behaviors among this growing population.

The purpose of this descriptive paper is to examine the prevalence of HIV drug and sex risk behaviors in a sample of participants from one felony Drug Court located in Philadelphia, Pennsylvania. Nearly two-thirds of all people living with HIV/AIDS in the city of Philadelphia are African–American, 75% are males, and almost two-thirds are under the age of 40 (Philadelphia Department of Public Health, 2009). Given these demographic disparities in HIV/AIDS rates in the city of Philadelphia, we also examined the relationship between race, gender, and age and engagement in high-risk behaviors. Findings from the study may provide an important first step in establishing the need for evidence-based HIV risk reduction interventions as a standard part of the Drug Court curriculum.

METHOD

Participants

A total of 269 participants were recruited from a felony preadjudication Drug Court located in the urban City of Philadelphia. To be eligible for the Drug Court program, participants are required to (1) be at least 18 years of age; (2) be charged with a nonviolent felony offense; (3) have no more than two prior nonviolent convictions, juvenile adjudications, or diversionary opportunities; (4) be in need of treatment for drug abuse or dependence as assessed by a clinical case manager employed by the court; and (5) be willing to participate in the Drug Court program for at least twelve months. Consecutive admissions over a 22-month period were approached at entry about their willingness to participate in the study, and the consent rate was 75% (269 of 360).

The study participants were primarily male (80%) and most self-identified as African–American (61%), Caucasian (18%), or Hispanic (24%). Their mean age was 24.31 years (*SD* = 7.55) and their mean educational attainment was 11.25 years (*SD* = 1.57). Less than one-half (44%) were regularly employed full or part time. Virtually all of the participants were unmarried (98%) and many lived in the homes of family or friends (61%) or in a controlled environment such as recovery housing (8%). They reported an average annual legal income of $7,040 (*SD* = $9,077) with a range of $0–$55,000. Approximately 73% reported

marijuana as their primary drug of abuse, and 13% had a history of prior substance abuse treatment.

Nearly all of the participants (97%) were currently charged with delivery of a controlled substance or possession with the intent to deliver a controlled substance. In addition, 28% were charged with conspiracy related to a drug offense, and small proportions were charged with forgery (1%), felony retail theft (1%), or prostitution (1%) (participants could have multiple charges). They had an average history of 1.15 (*SD* = 0.71) criminal arrests prior to their current charge. Most participants were represented by a public defender (84%).

To monitor potential selection bias, demographic data and criminal records were obtained for individuals who did not participate in the study. These data were received in aggregate batches from the Drug Court and were de-identified. Individuals who did not participate in the study were more likely to be male (91% vs. 80%), $X^2(1) = 7.76$, $p < .005$, African–American (75% vs. 61%), $X^2(1) = 6.78$, $p < .01$, and represented by private defense counsel (22% vs. 16%), $X^2(1) = 3.57$, $p = .06$.

Procedures

Study procedures were approved by the Institutional Review Boards of the Treatment Research Institute and the City of Philadelphia. After participants provided informed consent to participate in the study, a research assistant administered a battery of instruments to the participants in a private room. The battery included a health behavior survey that contained six items designed to evaluate the extent to which participants engaged in drug use and sexual behaviors in the past six months that increased their risk for HIV infection. Three items were related to intravenous drug use (i.e., number of times injected drugs, number of people shared needles with, frequency of needle cleaning rated on a five-point Likert-type scale), and three items were related to high-risk sexual behavior (i.e., number of sexual partners, number of same-gender partners, frequency of condom use rated on a five-point Likert-type scale). Importantly, these items were adapted from the well-validated Risk Assessment Battery (RAB) (Metzger, Navaline, & Woody, 2001) and were selected to measure rates of engagement in HIV risk behaviors that are

directly responsible for viral transmission. The 6-month time frame was selected to capture a representative sample of recent risk behavior and is standard for the RAB.

Data Analyses

Response frequencies were calculated for each item, and the results of these descriptive analyses are presented in the section that follows. In addition, chi-square analyses were used to examine differences in the rates of engagement in high-risk behaviors as a function of race (African–American vs. other) and gender. Correlation analyses were performed to examine the relationship between engagement in these behaviors and age among sexually active study participants. Finally, we used participant zip codes to map our study sample to the population-adjusted geographic concentration of HIV/AIDS in Philadelphia in order to identify their risk of coming into contact with the virus.

RESULTS

Drug-Use Risk Behaviors

Only two people in the sample (0.7%) reported injection drug use in the past six months. Both of these individuals indicated sharing needles with one person in the past six months and that they had cleaned their needles prior to use.

Sexual Risk Behaviors

Approximately 54% of participants reported having sex with multiple partners in the past six months, while 41% reported having only one partner and 6% reported not being sexually active during this time period. The average number of partners for those reporting multiple partners was 6.12 ($SD = 11.20$). Three percent of participants reported having sexual relations with same-gender partners.

Frequency of condom use among those who were sexually active ($N = 244$) is presented in Figure 1 following. Almost two-thirds (62%) reported engaging in unprotected sex at least once in the past six months, and 26% reported never using a condom during sexual activity. Among

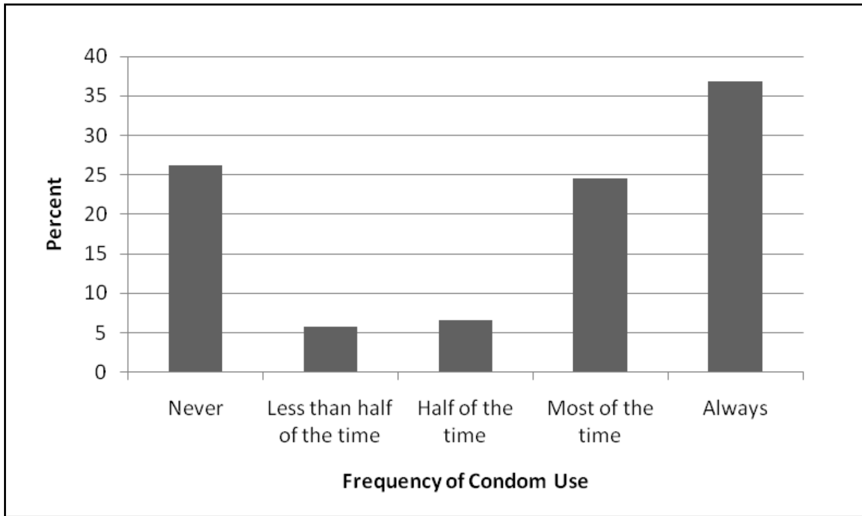

Figure 1. Frequency of Condom Use in Sexually Active Sample (*N* = 244)

those who had multiple partners (*N* = 139), 52% reported engaging in unprotected sex at least once in the past six months. Within the small sample of participants with same-gender partners (*N* = 9), 56% reported never using a condom and 44% reported always using a condom.

Gender Differences in Sexual Risk Behaviors

Within the sexually active sample, males were significantly more likely to report having multiple sexual partners in the past six months (63% vs. 30%, $X^2(1) = 16.28$, $p < .0001$). On average, men reported 4.51 (*SD* = 9.69) sexual partners and females reported 1.37 (*SD* = 0.61). There was a trend for males to be more likely to report having sex without a condom than females (74% vs. 61%, $p < .10$). While the overall rate was low, females were more likely than males to report having same-gender sexual partners (17% vs. 1%, $p < .0001$, Fisher's exact test).

Racial Differences in Sexual Risk Behaviors

Within the sexually active sample, African–Americans were significantly more likely to report having multiple sexual partners than members of other racial groups (63% vs. 47%, $X^2(1) = 5.92$, $p < .05$. There

were no significant differences in the reporting of sexual activity without a condom (60% vs. 67%, $p = .19$) or having same-gender sexual partners (4% vs. 3%, $p = 1.0$, Fisher's exact test).

Age Differences in Sexual Risk Behaviors

Within the sexually active sample, age was significantly related to reporting multiple sexual partners ($r = -.15$, $p < .05$). The likelihood of reporting multiple sexual partners decreased as a function of age. There was a nonsignificant trend for condom use to decrease as a function of age ($r = .11$, $p < .10$). Age was not related to having same-gender sexual partners ($p = .21$).

Zip Code Mapping

As displayed in Figure 2, over one-third of the Drug Court participants in this study resided in Philadelphia zip code areas with the highest prevalence (1%–4%) of the adult population currently living with AIDS.

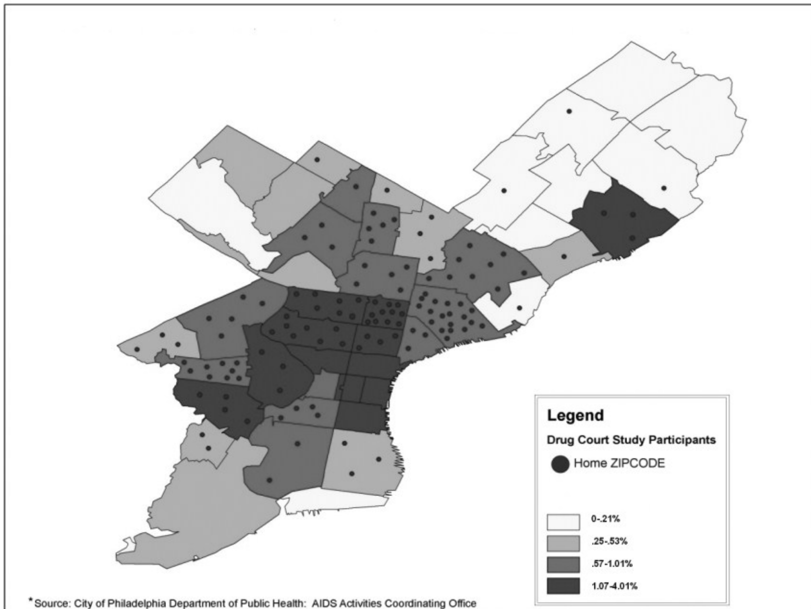

Figure 2. Prevalence of Persons Living with AIDS in Philadelphia by Participant Zip Code

Fully 80% were from zip code areas with over 0.5% prevalence of adults living with AIDS.

DISCUSSION

The current study is among the first to provide estimates of the prevalence of HIV risk behaviors in a Drug Court population. Understanding the extent to which Drug Court participants engage in behaviors that put them at risk for contracting HIV infection is important for a number of reasons. First, research has demonstrated that individuals who are involved in the criminal justice system are at high risk of contracting HIV. In addition, criminally involved offenders who are under supervision in the community have more opportunities to engage in risky behaviors than persons in prison, which may increase their risk of contracting HIV infection. Finally, Drug Courts are becoming an increasingly popular diversion strategy for criminally involved substance abusers. The size of this population is expected to increase exponentially as more and more Drug Courts are established. Understanding the prevalence of HIV risk behaviors among Drug Court participants will help us to determine the extent of the need for HIV risk reduction interventions in Drug Court programs.

Rates of HIV drug risk behaviors were low in the current sample. The rate of injection drug use was 0.7%, only slightly higher than the rate reported for probationers and parolees (0.15%) (Belenko et al., 2004) and in the general population (0.17% in the past year) (Substance Abuse and Mental Health Services Administration, 2009). Importantly, the rate of injection drug use in the Drug Court sample is significantly lower than the rates reported among prisoners (e.g., Abiona et al., 2009; Swartz, Lurigio, & Weiner, 2004; Fox et al., 2005). Of the two people who reported any injection drug use in the past six months, both indicated that they cleaned their needles prior to use. Of course, we cannot verify the effectiveness of their cleaning methods or needle sharing behaviors. While one may have expected higher rates of IV drug use in this felony Drug Court, this rate is not surprising given the fact that almost three-fourths of the sample reported marijuana as their primary drug of abuse.

Conversely, Drug Court participants engaged in a number of sexual behaviors that may increase their risk of contracting HIV. Over half of the sample indicated they had sex with multiple partners in the past six month, and two-thirds of the sexually active sample reported having sex without a condom at least once during the past six months. About half of participants who reported having multiple partners indicated that they had sex without a condom at least once during the past six months. These rates are slightly higher than those reported in a sample of probationers and parolees (Belenko et al., 2004). Among probationers and parolees, about half (48%) of individuals reported having vaginal sex with casual partners in the past six months. Of those with casual partners, a little more than a third (38%) reported having sex without a condom at least once in the past six months. Among the general population, estimates of the percentage of people who have had sex with multiple partners during the past year range from 9% to 13% (Holtzman, Bland, Lansky, & Mack, 2001; Leigh, Temple, & Trocki, 1993).

Consistent with the disparities in the rate of HIV transmission in the U.S. (CDC, 2008) and in line with data specific to the City of Philadelphia (Philadelphia Department of Public Health, 2009), significantly higher rates of engagement in risky behaviors were associated with being African–American and male. Results related to age were mixed. While younger people were significantly more likely to have multiple partners, there was a nonsignificant trend for them to be more likely to use condoms every time they had sex. The results related to age are consistent with those observed in other studies (e.g., Binson et al., 1993; Dolcini et al., 1993; Leigh, Temple, & Trocki, 1993; Reece et al.; Sanders et al., 2010).

Perhaps the most striking finding comes from the results of the zip code mapping analysis. Over a third of Drug Court participants resided in areas of Philadelphia with the highest density of persons living with AIDS (i.e., 1%–4%). According to the World Health Organization, an epidemic is considered generalized when greater than 1% of the population is infected. This designation not only provides a measure of prevalence but also indicates the increased potential for individuals to come in contact with the virus. In high-prevalence settings, most unprotected sex

can be considered high risk. In the current sample, the great majority of participants come from high prevalence neighborhoods, and all have a history of substance use, which is associated with sexual risk and infection among heterosexuals and MSM (Metzger, Woody, & O'Brien, 2010).

This study has several limitations. First, the study relies on self-reported data that were collected during a face-to-face interview. Participants may have felt embarrassed or uncomfortable answering questions of such a personal nature and, for this reason, may have under-reported their engagement in drug and sexual risk behaviors. Second, the risk instrument had a limited number of items and was intended to be a survey rather than a risk scale. For this reason, we could not calculate composite risk scores. Future studies should evaluate HIV risk using validated risk measures that provide composite scores and that can be self-administered to help reduce self-presentation concerns (e.g., Audio Computer Assisted Self Interview RAB) (Metzger et al., 2000). Third, 25% of those approached refused to participate in the study. Because participants who refused were more likely to be male and African–American, the prevalence rates of high-risk behaviors cited in the present study may be an underestimate of rates in the Drug Court population as a whole. Finally, the study examines the prevalence of HIV risk behaviors in a single felony Drug Court in Philadelphia. Future research should be conducted in other settings in order to evaluate the generalizability of the current findings.

Despite their proven efficacy in addressing substance abuse and criminal recidivism, Drug Courts have yet to be evaluated with respect to HIV and sexually transmitted infection (STI) risk reduction. Given the prevalence of high-risk behaviors (e.g., Belenko at al., 2004) and the alarming rates of HIV infection and STIs among criminal offenders (14%–26%) (Hammet, Harmon, & Rhodes, 2002; Spaulding et al., 2009) along with the rates of high-risk behaviors found in the current study, Drug Courts may represent an important yet unexplored opportunity to deliver risk reduction interventions, HIV testing, and referral to HIV care. Research should be expanded to further document the prevalence of high-risk behaviors among Drug Court participants and to identify useful strategies for reducing risk.

This research was supported by grant #R01-DA-14566 from the National Institute on Drug Abuse (NIDA). This research has been approved by the Institutional Review Boards of the Treatment Research Institute and the City of Philadelphia. The views expressed are those of the authors and do not necessarily reflect the views of NIDA.

The authors gratefully acknowledge the continuous collaboration of the staff and clients of the Philadelphia Treatment Court as well as the Office of the District Attorney of Philadelphia, Defender Association of Philadelphia, Philadelphia Coordinating Office of Drug and Alcohol Abuse Programs, and Philadelphia Health Management Corporation. We also thank Patricia Arabia, Jason Croft, Gloria Fox, Matthew Haines, and Jason Matejkowski for their assistance with this project.

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Best Practices by Drug Court Key Component

Key Component #1: Drug courts integrate alcohol and other drug treatment services with justice system case processing	
1.1	Program has a Memorandum of Understanding (MOU) in place between the drug court team members (and/or the associated agencies) a. MOU specifies team member roles b. MOU specifies what information will be shared
1.2	Program has a written policy and procedure manual
1.3	All key team members attend staffing (Judge, prosecutor, defense attorney, treatment, program coordinator, and probation)
1.4	All key team members attend court sessions/status review hearings (Judge, prosecutor, defense attorney, treatment, program coordinator, and probation)
1.5	Law enforcement (e.g., police, sheriff) is a member of the drug court team
1.6	Law enforcement attends drug court team meetings (staffings)
1.7	Law enforcement attends court sessions (status review hearings)
1.8	Treatment communicates with court via email
Key Component #2: Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights	
2.1	A prosecuting attorney attends drug court team meetings (staffings)
2.2	A prosecuting attorney attends court sessions (status review hearings)
2.3	The defense attorney attends drug court team meetings (staffings)
2.4	The defense attorney attends court sessions (status review hearings)
Key Component #3: Eligible participants are identified early and promptly placed in the drug court program.	
3.1	The time between arrest and program entry is 50 days or less
3.2	Current program caseload/census (number of individuals actively participating at any one time) is less than 125
3.3	The drug court allows other charges in addition to drug charges
3.4	The drug court accepts offenders with serious mental health issues, as long as appropriate treatment is available
3.5	The drug court accepts offenders who are using medications to treat their drug dependence
3.6	Program uses validated, standardized assessment to determine eligibility
3.7	Participants are given a participant handbook upon entering the program
Key Component #4: Drug courts provide access to a continuum of alcohol, drug and other treatment and rehabilitation services	
4.1	The drug court works with two or fewer treatment agencies or has a treatment representative that oversees and coordinates treatment from all agencies

4.2	The drug court requires participants to meet individually with a treatment provider or clinical case manager weekly in the first phase of the program
4.3	The drug court offers a continuum of care for substance abuse treatment (detoxification, outpatient, intensive outpatient, day treatment, residential)
4.4	Program uses validated, standardized assessment to determine level or type of services needed
4.5	Treatment providers administer evidence-based, manualized behavioral or cognitive-behavioral treatments
4.6	The drug court offers gender specific services
4.7	The drug court offers mental health treatment
4.8	The drug court offers parenting classes
4.9	The drug court offers family/domestic relations counseling
4.10	The drug court offers residential treatment
4.11	The drug court offers health care
4.12	The drug court offers dental care
4.13	The drug court offers anger management classes
4.14	The drug court offers housing assistance
4.15	The drug court offers trauma-related services
4.16	The drug court offers a criminal thinking intervention
4.17	The drug court provides relapse prevention services for all participants
4.18	The drug court provides services to participant's children
4.19	The drug court provides childcare while participants are in treatment or in court (or participating in other drug court requirements)
4.20	Program provides (or partners with service providers who provide) participants with legally prescribed psychotropic or addiction medication (MAT)
4.21	The minimum length of the drug court program is 12 months or more
4.22	Treatment providers are licensed or certified to deliver substance abuse treatment
4.23	Treatment providers have training and/or experience working with a criminal justice population
4.24	Caseloads for probation/supervision officers do not exceed 30 active participants (up to 50 if mix of low risk and no other caseloads/responsibilities)
4.25	Caseloads for clinicians providing case management and treatment do not exceed 30 active participants (up to 40 if only counseling OR 50 if only case management)
Key Component #5: Abstinence is monitored by frequent alcohol and other drug testing	
5.1	Drug testing is random/unpredictable
5.2	Drug testing occurs on weekends/holidays
5.3	Collection of test specimens is witnessed directly by staff
5.4	Staff that collect drug testing specimens are trained in appropriate collection protocols
5.5	Drug test results are back in 2 days or less
5.6	Drug tests are collected at least 2 times per week

5.7	Participants are expected to have greater than 90 days clean (negative drug tests) before graduation
Key Component #6: A coordinated strategy governs drug court responses to participants' compliance	
6.1	Program has incentives for graduation, including avoiding a criminal record, avoiding incarceration, or receiving a substantially reduced sentence
6.2	Sanctions are imposed immediately after non-compliant behavior (e.g., drug court will impose sanctions in advance of a client's regularly scheduled court hearing)
6.3	Team members are given a written copy of the incentive and sanction guidelines
6.4	Program has a range of sanction options (including less severe sanctions such as writing assignments and community services and more severe sanctions such as jail time)
6.5	In order to graduate participants must have a job or be in school
6.6	In order to graduate participants must have a sober housing environment
6.7	In order to graduate participants must have pay all court-ordered fines and fees (e.g., fines, restitution)
6.8	Participants are required to pay court fees
6.9	The drug court reports that the typical length of jail sanctions is 6 days or less
6.10	The drug court retains participants with new possession charges (new possession charges do not automatically prompt termination)
Key Component #7: Ongoing judicial interaction with each participant is essential	
7.1	Participants have status review sessions every 2 weeks, or once per week, in the first phase
7.2	Judge spends an average of 3 minutes or greater per participant during status review hearings
7.3	The judge's term is as least 2 years or indefinite
7.4	The judge was assigned to drug court on a voluntary basis
7.5	In the final phase of drug court, the clients appear before the judge in court at least once per month
Key Component #8: Monitoring and evaluation measure the achievement of program goals and gauge effectiveness	
8.1	The results of program evaluations have led to modifications in drug court operations
8.2	Review of program data and/or regular reporting of program statistics has led to modifications in drug court operations
8.3	The drug court maintains data that are critical to monitoring and evaluation in an electronic database (rather than paper files)
Key Component #9: Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations	
9.1	All new hires to the drug court complete a formal training or orientation
9.2	All members of the drug court team are provided with training in the drug court model
9.3	Drug court staff members receive ongoing cultural competency training

Key Component #10: Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court program effectiveness	
10.1	The drug court has an advisory committee that includes community members
10.2	The drug court has a steering committee or policy group that meets regularly to review policies and procedures