ADULT DRUG COURT
BEST PRACTICE STANDARDS

VOLUME I
TEXT REVISION

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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 use.

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 use 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 use 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
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Individuals 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 individuals to participate and succeed in the Drug Court.

III. ROLES AND RESPONSIBILITIES OF THE JUDGE 20

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IV. INCENTIVES, SANCTIONS, AND THERAPEUTIC ADJUSTMENTS 26

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 use disorder treatment based on a standardized assessment of their treatment needs. Substance use disorder 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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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. Equity and Inclusion
III. Roles and Responsibilities of the Judge
IV. Incentives, Sanctions, and Therapeutic Adjustments
V. Substance Use Disorder 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 equivalently

[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 *severe substance use disorder* 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.

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 severe substance use disorder 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 use disorder treatment, or both.

Otherwise, the programs risk wasting resources or making outcomes worse for some of their participants (Lowenkamp & Latessa, 2004). Providing substance use disorder treatment for nonaddicted substance users can lead to higher rates of reoffending or substance use 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 use screening tools are not sufficient for this purpose because they do not accurately differentiate more severe substance use disorder or addiction from lesser degrees of substance use or substance involvement (Greenfield & Hennessy, 2008; Stewart, 2009). A structured psychiatric interview is typically required to make a valid diagnosis of severe substance use disorder 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 use disorder 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 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

[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.

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 Use Disorder Treatment].

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II. EQUITY AND INCLUSION

Individuals 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 individuals 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 group that has historically experienced discrimination, 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 groups that have historically experienced discrimination who are represented in the respective arrestee population.

B. Equivalent Retention

The Drug Court regularly monitors whether members of groups that have historically experienced discrimination complete the program at equivalent rates to other participants. If completion rates are significantly lower for members of a group that has historically experienced discrimination, 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 groups that have historically experienced discrimination 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 groups that have historically experienced discrimination who are represented in the Drug Court population.

D. Equivalent Incentives and Sanctions

Except where necessary to protect a participant from harm, members of groups that have historically experienced discrimination 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 groups that have historically experienced discrimination 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 groups that have historically experienced discrimination.

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 individuals.

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 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.

[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.

A. Equivalent Access

Evidence suggests African-American and Hispanic or Latino individuals 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 groups that have historically experienced discrimination in Drug Courts.

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 groups that have historically experienced discrimination. 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 groups that have historically experienced discrimination 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 groups that have historically experienced discrimination 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 use disorder 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.

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

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 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 groups that have historically experienced discrimination 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 groups that have historically experienced discrimination (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 use, 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 groups that have historically experienced discrimination 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 other groups that have historically experienced discrimination.[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.

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

Substantial evidence shows that women, particularly those with histories of trauma, perform significantly better in gender-specific substance use disorder 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 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 groups that have historically experienced discrimination. 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 use disorder 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 use disorder 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.

[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.

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.

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.

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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.

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 are significantly better when the Drug Court judge attends annual training conferences on evidence-based practices in substance use disorder 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 use when the judges were rated by independent observers as being knowledgeable about substance use disorder 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 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

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

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 use disorder 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 a

[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.

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, Equity and Inclusion].

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

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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 use during the early phases of the program.

H. Incentivizing Productivity

The Drug Court places as much emphasis on incentivizing productive behaviors as it does on reducing crime, substance use, 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 (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 substance use disorder 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).

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

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 use 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 use 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 use 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 use 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 USE DISORDER TREATMENT

Participants receive substance use disorder treatment based on a standardized assessment of their treatment needs.[17] **Substance use disorder 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 use disorder 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 with severe substance use disorder or as 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 use disorder 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 use assessments, make referrals for substance use disorder treatment, or report on participant progress in treatment during court hearings or staff meetings, but does not provide substance use disorder 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 use disorder 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 use disorder 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 use disorder 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 use disorder 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 patients with substance use disorder 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

[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).

equivalent or 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 use disorder 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 groups that have historically experienced discrimination are receiving services equivalent to other participants in the program and to take remedial measures, where indicated, to correct any discrepancies [see Standard II, Equity and Inclusion].

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 use 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 use disorder 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 use disorder 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 use disorder 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 use, 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 use disorder 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 use disorder 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 substance use disorder 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 use (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 use, 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 use disorder. 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 use disorder 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 use, 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).

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

[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.

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

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

J. Continuing Care

Vulnerability to relapse remains high for at least three to six months after completion of substance use disorder treatment (Marlatt, 1985; McKay, 2005). One year after treatment, an average of 40% to 60% of treatment graduates will have relapsed to substance use (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 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 use disorder 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 use disorder 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 use disorder 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/