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A Technical Assistance Guide For Drug Court Judges on Drug Court Treatment Services

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I. INTRODUCTION

This *Guide* has been prepared for judges newly assigned to preside over a drug court program to serve as a quick primer to assist them in (a) becoming familiar with the key elements and evidence-based practices that should be reflected in the treatment services provided to drug court participants, and (b) working with local treatment provider(s) to ensure that these services are provided. The *Guide* is intended to serve as an introductory reference, addressing treatment related issues and practices that are critical to effective drug court program operations but too frequently not reflected in their design or services, as evidenced by numerous site visits to local drug courts conducted by the BJA Drug Court Technical Assistance Project at American University. Many of these visits have been to rural areas where treatment resources are often limited and we have therefore devoted a special chapter (See Chapter VII) to challenges rural drug courts are encountering and solutions that have been effective.[1] Some of the challenges rural drug courts encounter may also have relevance to large, sprawling urban areas where efficient public transportation is limited and judges must cover multiple court locations.

The *Guide* is designed to be used in conjunction with nationally recognized drug court treatment resources, including: NDCI's *Evidence-based Practices*[2]; NIDA's *Principles of Substance Abuse Treatment for Criminal Justice Populations*[3], the extensive additional resources available through NIDA[4] and SAMHSA[5], and the BJA/NIJ *Research to Practice*[6] resources.

Two of the troubling practices noted in drug courts where sound, evidence-based treatment practices are not being utilized are: (1) the use of automatic jail sanctions rather than enhanced treatment to respond to continued drug use (e.g., positive drug tests); and (2) an inclination to terminate participants during the early period of program participation – frequently when they are still suffering the acute effects of their addiction. This latter practice appears to be the result of: (1) front loading drug court programs with a myriad of requirements with which most addicts cannot possibly comply during their initial phase of participation; and (2) confusion between what can reasonably be expected of a drug court participant during the acute care phase of the drug court program when stabilization and other services are being provided, and the subsequent chronic care phases after stabilization when greater expectations can be had.[7]

Recognizing drug addiction as a chronic disease of which many drug court participants have been suffering for ten and more years, keeping drug court participants engaged in the program is crucial -- even when continued drug use – a prime symptom of the disease – is occurring. In this regard, the drug court judge is critical to promoting participant retention and ensuring that the court's response to continued drug use draws upon the growing body of knowledge of what constitutes effective treatment for this chronic, multifaceted disease. Hopefully, the complex interplay of factors that contribute to and underlie an individual's addiction addressed in this *Guide* will highlight the often circular route the recovery process may take and the foolhardiness of expecting an addict of many years to become sober and clearheaded overnight after entering the drug court.

WHAT DO DRUG COURT JUDGES NEED TO KNOW ABOUT DRUG COURT TREATMENT?

While judges are not treatment providers, they need to know enough about treatment services to be able to ask the right questions, be knowledgeable about the relevant diagnostic processes and approach that should be used for developing individual treatment plans, and require the necessary reporting and other information relevant to their decisions relating to the substance addiction treatment and related services participants in their respective drug courts need. Since drug courts are *court* programs, judges also need to ensure that the drug court programs they oversee are providing services that are supported by research findings and are comporting with accepted

[1] See also webinar: *Rural Drug Courts: Challenges and Solutions* conducted by the BJA Drug Court Technical Assistance Project and archived at: www.american.edu/justice.

[2] Hardin, Carolyn, and Jeffrey N. Kushner, eds. Publication. N.p.: n.p., n.d. Ser. 9. Quality Improvement for Drug Courts: Evidence-Based Practices. National Drug Court Institute, Apr. 2008. Web.

[3] Principles of Drug Abuse Treatment for Criminal Justice Populations - A Research-Based Guide. National Institute on Drug Abuse, Sept. 2006. Web.

[4] Http://www.drugabuse.gov/. National Institute on Drug Abuse, n.d. Web.

[5] Http://www.samhsa.gov/. The Substance Abuse and Mental Health Services Administration, n.d. Web.

[6] Http://www.nij.gov/nij/topics/courts/drugcourts/research2practice.htm. National Institute of Justice and Bureau of Justice Assistance, n.d. Web.

[7] See *Effective Use of Rewards & Sanctions*. Douglas B. Marlowe, J.D., Ph.D. Presentation. March 3, 2011, including discussion of "proximal" and "distal" behaviors. www.ndcrc.org/sites/default/files/sibehmodtalk4.pdf ·

national standards of practice. This function must occur outside of the courtroom, requiring the drug court judge to coordinate the services of numerous non-court agencies – often with little, if any, experience in working collaboratively together as a drug court program requires – and to develop and sustain the necessary partnerships among these agencies to assure that the various "moving parts" involved are aligned with the overall drug court mission. This coordination and oversight by the drug court judge is critical to sustaining the effectiveness of the drug court program model.

To carry out this role, we have found through our technical assistance services, that many judges, particularly those taking on the drug court assignment for the first time, welcome references that will assist them in increasing their knowledge of the information needed to become effective consumers of drug court treatment services. It is to this end that this *Guide* has been developed: to assist drug court judges in (a) ensuring that evidence-based treatment services and related practices are being provided for program participants; and (b) strengthening the critical partnership between the justice and public health and other support systems upon which the drug court model depends.

While this *Guide* has been developed for newly assigned drug court judges, hopefully it will also be useful to others, both judges and non-judges.

Section II of this *Guide* provides a synopsis of the key elements and evidence-based practices relevant to substance abuse treatment services generally and drug court treatment and related services, in particular.

Section III addresses three important topics relating to services drug courts may provide or require: Medication Assisted Treatment; Participation in Support Groups; and Acupuncture.

Section IV discusses special needs of six special populations served by most drug courts: (1) Persons with co-occurring mental health and substance use disorders; (2) Victims of Trauma; (3) Persons with Cognitive and Intellectual Disabilities; (4) Racial and Ethnic Minorities; (5) Gender; and (6) Young Adult Males.

Section V discusses other significant issues that bear on drug court treatment services: (1) the application of "Incentives" and "Sanctions"; (2) Confidentiality and Communication; (3) "Coerced Treatment" and the role of "Motivation"; (4) Drug Testing in a Drug Court Environment; and (5) Drug Court Program "Phases".

Section VI briefly addresses the complex area of payment for treatment services, the need for court oversight to ensure that publicly available services are accessed and, when private providers and other agencies are involved, what participants are being charged and who is charging them, and the opportunities offered by the Affordable Care Act (AC) which the court, and other justice agencies, need to promote.

Section VII addresses special challenges drug courts in rural areas have encountered, with examples of how these challenges are being addressed.

Section VIII, the Final Chapter, returns to the role of the drug court judge in ensuring that evidence-based treatment services are provided to participants – a precondition to the utility of any meaningful evaluation of the program that can be conducted.

The **Appendix** provides (a) a checklist drug court judges and others can use as a framework for visiting their local drug court treatment provider(s) and meeting with treatment staff to discuss services being provided; (b) a summary of key research findings, with citations, relating to addiction treatment effectiveness that can guide these discussions; (c) key components of aftercare/recovery support programs that should be part of the drug court treatment program; (d) a draft summary of "Over-arching Principles" developed by a committee of drug court judges who are working with the BJA Drug Court Technical Assistance Project to promote understanding of the judicial leadership needed to sustain drug court programs in the longer term; and (e) a list of organizations providing drug court training and/or technical assistance to support treatment program development.

II. Key Concepts Relevant To Drug Court Treatment And Related Services

A. Drug Court Treatment Services: How Do They Differ From Drug Treatment Services In A Non-drug Court Setting?

Treatment services for drug using offenders in a *non-drug court setting* are generally provided by treatment providers after the active involvement of the court has ended and the individual has been referred for treatment, generally through the probation officer, with the nature and extent of services determined by the treatment provider. Minimal, if any, summary reporting is provided to the court (e.g., "appeared", etc.). A non-drug court approach therefore generally entails placing an individual on probation with the condition that he/she be referred to treatment services (generally outpatient services of limited duration – e.g., 90 days), with the Court being further involved only if/when the individual does not comply with probation conditions and a Violation of Probation petition was filed.

Drug treatment services provided in a *drug court setting*, on the other hand, entail the integration of the justice system process(es) and the treatment process(es) under the oversight of the court rather the court's referral of defendants for services to be overseen by probation or another entity. The drug court approach therefore entails:

- The court exercising continuing active oversight over the individual, including provision of the addiction treatment and other support services needed, through regular reports from the treatment provider, associated case management services and drug testing;
- Provision of more intensive treatment services, generally of an outpatient, community-based nature, and for a longer period of time (ten- fifteen months) than would apply in a non-drug court setting. with the court working closely with the treatment provider to promote the individual's retention and progress in treatment;
- Frequent regular meetings of the court, the treatment provider, and other members of the "drug court team" – probation, prosecutor, defense, and others as may be appropriate (often weekly) -- to discuss the individual's progress in treatment and modifications and other support services that may be necessary;
- Frequent AND random drug testing, with reports provided promptly to the court and immediate action taken – either enhanced treatment or sanctions, as may be appropriate, for continued or resumed drug use;
- Intensive supervision and case management services; and
- Recovery support services that can provide the foundation for the individual's continuing care and continued sobriety after leaving the drug court program.

The drug court "model" therefore requires that treatment services be provided in close coordination with the court processes so that the court and the treatment components can work together to reinforce and support the mission of their respective entities. Through the leverage of the criminal justice system, the court can focus on keeping people in treatment long enough for the treatment services to be effective and to provide the supervision and ancillary support (e.g., clean and sober housing, medical care, etc.) to promote individuals remaining in treatment, thereby addressing the criminogenic risks to reduce the likelihood of their resuming drug use and criminal activity. Through frequent review hearings – and emergency hearings, if/as necessary -- the court can also ensure that participants are held accountable for complying with the program's requirements, encourage those who are making progress and determine the nature of response (e.g., more intense treatment? other services? etc.) for those who are not (e.g., "incentives and sanctions").

B. Key Elements Of The Drug Court Treatment Model

The following are key elements of the drug court treatment model that further distinguish it from non-drug court treatment services:

- Judicial leadership: drug courts are *court* programs that must be coordinated by the court/judge: the judge brings together agencies that frequently do not work collaboratively together to work seamlessly from their various disciplines to achieve the primary goals of drug courts: promote recovery[8] and reduce recidivism;

[8] SAMHSA definition of recovery: "A process of change through which individuals improve their health and wellness, live a self-directed life, and strive to reach their full potential" from "SAMHSA Announces a Working Definition of "recovery" from Mental Disorders and Substance Use Disorders."

- Immediacy of response[9] – in identifying participants; in ensuring their entry into the program; in providing access to treatment and other needed services; and in responding to participant progress or lack thereof, including various crises that participants may experience;
- A multidisciplinary, holistic, approach for addressing the participant's addiction, recognizing that addiction raises criminal justice and substance use issues as well as public health, socioeconomic, and other issues, all of which need to be addressed as part of the drug court's integrated response and require the services of multiple agencies;
- Ongoing communication among all team members regarding the participant's progress, or lack thereof, with emergency hearings scheduled, as necessary, to address urgent issues;
- Team input regarding participant progress (or lack thereof) and recommendations for appropriate program responses, with the judge as final decision-maker regarding program retention, sanctions, and/or delivery of services; and
- "Non-adversarial" review hearings designed to focus on the participant's progress (or lack thereof) in treatment, and address whatever modifications are needed and which the judge approves; the overall process, however, operates within the criminal justice system, which is an adversarial process and includes the potentially adversarial roles of the prosecutor and defense.

A variety of treatment modalities have been developed for treating addiction, as are further described in Section C. Drug courts rely primarily on treatment services provided in an intensive outpatient setting, with access to limited residential treatment and withdrawal management, as needed. A critical component of drug court addiction treatment should be relapse prevention and ongoing management of the disease through continuing care/recovery support, initiated during the early phases of program participation and available to the individual after completing the formal period of drug court program participation for at least 24 months.

Http://www.samhsa.gov/newsroom/advisories/1112223420.aspx. The Substance Abuse and Mental Health Services Administration, 22 Dec. 2011.

C. Substance Addiction Treatment: A Quick Overview

1. *Recognizing Addiction As A Chronic Disease Of The Brain And Implications For Drug Court Program Operations*

In the past two decades there have been impressive advances in our understanding of the neurobiology of addiction: how drug use affects the brain. This includes greater understanding of the biochemical changes that occur in the brain upon initial use, continued use, withdrawal from and cessation of use of drugs and how those neurobiological changes affect an individual's behavior – even after they have stopped using drugs. This enhanced understanding of the neurobiochemical changes that occur in the brain as a result of chronic drug use can also assist in our understanding of some of the behaviors that one commonly sees in drug court participants. While the disease nature of addiction does not absolve the user from responsibility for his/her behavior or for his/her recovery, it can at least promote understanding among drug court professionals of the reasons for the observed behaviors and provide a foundation for therapeutic, rather than punitive, responses.

The research into substance use disorders over the past two decades has confirmed that addiction is a chronic, relapsing – and treatable – disease of the brain. The American Society of Addiction Medicine (ASAM) has defined addiction as a "primary, chronic disease of brain reward, motivation, memory and related circuitry….characterized by inability to consistently abstain, impairment in behavioral control, craving, … and a dysfunctional emotional response… which… without treatment or engagement in recovery activities, … is progressive and can result in disability or premature death.[10]

Drug use, therefore, is not a matter of "just saying 'no'" and drug use brought on by the disease of addiction we now know requires *treatment* as a primary response; incarceration without treatment has minimal, if any, effect in terms of deterring drug use.

[10] Http://www.asam.org/research-treatment/definition-of-addiction. American Society of Addiction Medicine, 19 Apr. 2011.

RECOGNIZING ADDICTION AS A CHRONIC DISEASE
APPLICATION TO DRUG COURT PRACTICE

What are the implications of these research findings for drug court services and practices?

The research of the past two decades has yielded important lessons for drug court programs, both reinforcing and strengthening the original model. These lessons include the following:

- Drug use and substance use disorders present significant problems of public health and disease, family dysfunction, and major societal costs in addition to resulting in criminal conduct;
- Incarceration in and of itself – without treatment-- will not have a measurable impact on reducing substance use or crime;
- Recovery is a long term process, will likely entail relapses, and frequently requires multiple episodes of treatment;
- No single treatment modality is appropriate for everyone; developing individualized treatment plans, and modifying them as needed, is critical;
- Expectations for participants in terms of program compliance and progression should differ, depending upon their individual situation(s) and stage of program participation; all participants will not progress at the same pace and the drug court structure must therefore provide the flexibility to address the individual needs of each participant;
- Drug Court services need to provide a continuum that assures patients access to needed levels and intensities of services, as and when they need them; and
- Effective treatment must address the multiple needs of the individual, both substance addiction specifically and ancillary services, with particular focus on "criminogenic" factors that promote higher risks for reoffending.

2. *Making The Diagnosis Of Substance Addiction: Screening And Assessment*

All persons being considered for a drug court program should be screened for program eligibility. The screening generally entails: (a) criminal justice screening; and (b) clinical screening.

The *criminal justice screening* focuses on the individual's current charges, criminal history, and the degree to which he/she presents a threat to public safety. The *clinical screening* focuses on the nature and degree of the individual's substance use to determine whether he/she meets the diagnostic criteria for a "substance-related and/or addictive disorder" and, if so, the nature of his/her disorder and the level of care (e.g., treatment) needed.

A diagnosis of a substance use disorder can be made based on several reference tools, the most common of which is the *Diagnostic and Statistical Manual of Mental Disorders* (DSM-5)[11] which describes substance use disorder among a variety of diagnostic criteria as an individual's "persistent use of alcohol or other drugs despite problems related to use of the substance".

The diagnosis of substance use disorder and subsequent development of an appropriate treatment plan is made through the process of screening and assessment. While the terms *screening* and *assessment* are often used inter-changeably, they are actually distinct processes in drug courts.

Screening, when applied in a drug court setting, refers to the process of determining the appropriateness and eligibility of the person for admission to a drug court. In this process, brief screening tools are used and should be selected for their application to criminal justice populations, cost, ease of and time needed for administration.

Screening in the context of drug courts is a brief process conducted prior to program entry and designed to identify the following:

- That the individual has a substance use disorder;
- The severity of that disorder;
- Whether there is evidence of a co-occurring mental disorder;
- The criminogenic[12] needs and risks presented by the individual;
- Whether he/she meets the eligibility requirements of the drug court; and
- The level and intensity of treatment services the individual will need.

The determination of the "level and intensity of treatment services" needed is commonly performed through the application of the *ASAM Criteria - Treatment Criteria for Addictive, Substance-Related, and*

[11] American Psychiatric Association: *Diagnostic and Statistical Manual of Mental Disorders*, Fifth Edition, Arlington, VA, American Psychiatric Association, 2013

[12] *Criminogenic* refers to factors associated with the likelihood of the individual to relapse and recidivate.

Co-Occurring Conditions.[13] Although *risk assessment* is a common practice conducted in criminal justice settings that focuses on the *risk of reoffending, i*n a drug court setting risk assessment screening tools should be used that focus primarily on the risk of continuing drug use. Only tools that have been validated for application to drug using offenders should be used. Out of the over sixty risk assessment tools in existence, only twelve have been validated.[14] However, these tools do not predict the likelihood of reducing recidivism unless they are "…used in conjunction with a comprehensive case plan that addresses the areas of risk, needs, and builds on the offenders' strengths."[15]

Assessment refers to an intensive bio-psychosocial analysis of the individual's current situation and history by trained treatment team professionals who are most likely to be delivering the treatment services. The goals of the assessment process are to identify:

- The clinical and criminogenic needs of the client in sufficient detail that an individualized and comprehensive treatment plan can be developed; and
- Any special treatment modalities the client may need, such as trauma mitigation, criminal thinking curriculums, special case management services as well as any referrals necessary for further evaluation or treatment of co-occurring mental or other disorders.

Assessment is an ongoing process that should be conducted periodically to reflect the participant's progress or lack thereof in treatment as well as new issues that may emerge.

Current practice is to move away from "one-dimensional diagnosis-driven" approaches to treatment, to focus on special domains that reflect different areas of an individual's life to determine their treatment needs and necessary level of care placement.

[13] Mee-Lee D, Shulman GD, Fishman MJ, and Gastfriend DR, Miller MM eds. (2013). *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions.* Third Edition. Carson City, NV: The Change Companies.

[14] See *Understanding Risk Assessment and Its Applications* (PowerPoint Presentation http://csgjusticecenter.org/wp-content/uploads/2013/04/Plenary-2-.pdf) by Dr. Sarah Desmarais of North Carolina State University.

[15] Ibid.

The American Society of Addiction Medicine has identified the following six "dimensions'[16] that an assessment should address:

Dimension 1: Acute Intoxication And/or Withdrawal Potential: assessing the need for stabilization of acute intoxication, including the type and intensive of withdrawal management services that may be needed

Dimension 2: Biomedical Conditions and Complications: assessing the need for physical health services, including whether there are needs for acute stabilization and/or ongoing disease management for a chronic physical health condition.

Dimension 3: Emotional, Behavioral, Or Cognitive Conditions and Complications: assessing the need for mental health services. Depending on the results of the assessment, mental health needs may be treatable as part of the addiction treatment plan or, if related to a concurrent Bipolar Disorder, additional mental health services may be needed. The areas for assessment of mental health conditions include trauma-related issues and conditions such as posttraumatic stress; cognitive conditions and developmental disorders; and substance related mental health conditions. As part of the assessment within Dimension 3, various "risk" domains are assessed, including the individual's (a) potential risk to him/herself or others; (b) ability to focus on his/her addiction recovery; (c) social functioning; (d) ability to care for oneself; and (e) the history of the individual's illness and response to treatment.

Dimension 4: Readiness To Change: assessing the need for motivational enhancement services to engage the individual in the recovery process, building on the "stages of change models" of Prochaska, Di-Clemente, & Norcross.[17]

Dimension 5: Relapse, Continued Use, Or Continued Problem Potential: assessing the need for relapse prevention services if the individual has achieved a period of recovery from which he/she might relapse; or, if he/she has not achieved that period of recovery, the potential for continued use

[16] See Footnote 11.

[17] Prochaska, J.O., DiClemente, C.C., & Norcross, J. (1992). *In search of how people change: Applications to addictive behaviors*. AMERICAN PSYCHOLOGIST 47: 1102-1114.

Dimension 6: Recovery/Living Environment: assessing the need for specific individualized family, housing, vocational, transportation, childcare or other services.

As applied to drug courts the screening and assessment process should pay particular attention to the presence of mental disorders and history of trauma and Post-Traumatic Stress Disorder (PTSD), given the high rates of these disorders among offenders. Assessment of offender risk for recidivism should also be made to help drug courts target participants who are at higher levels of risk for continued drug use.

As noted earlier, the screening and assessment process should also utilize standardized instruments that have been validated for use with criminal justice populations. A variety of inexpensive evidence-based instruments are available, many of which are in the public domain. Not all screening and assessment instruments are equally effective with offenders, and drug courts should be aware of the advantages and disadvantages of using different instruments. The SAMSHA websites are an excellent source of information about screening and assessment tools.[18]

The following are examples of validated evidence-based instruments that can be used for conducting the screening and assessment drug court programs require:

- Screening Instruments

Mental Health Screening: Brief Jail Mental Health Screen, Global Appraisal of Individual Needs (Short Screener), Mental Health Screening Form III, MINI Screen;

Substance Use Disorders Screening: Addiction Severity Index (Alcohol/Drug Abuse sections), Global Appraisal of Individual Needs (Short Screener), Simple Screening Instrument, Texas Christian University-Drug Screen 2;

- Psychosocial And Addiction Severity Assessment Instruments

Addiction Severity Instrument, Global Appraisal of Individual Needs (Quick, or Initial), Texas Christian University-Institute for Behavioral Research (Brief Intake Interview, or Comprehensive Intake);

- Risk Assessment Instruments

Risk Assessment: Risk and Needs Triage (RANT), the Level of Service Inventor–Revised (LSI-R), and the Ohio Risk Assessment System (ORAS);

- Assessment Instruments For Trauma

Trauma/PTSD: Clinician Administered PTSD Scale, Posttraumatic Diagnostic Scale, Primary Care PTSD Screen, PTSD Checklist – Civilian Version, Stressful Life Events Screening Questionnaire – Revised

MAKING THE DIAGNOSIS OF SUBSTANCE ADDICTION
APPLICATION TO DRUG COURT PRACTICE

- *Participants should be screened at the earliest point possible for legal eligibility for the drug court program and, if legally eligible, for clinical eligibility to expedite engagement in drug court treatment and related services.*
- *Universal screening should be conducted for all individuals who meet the legal eligibility requirements of the drug court for substance use disorders, mental disorders, and history of trauma and PTSD. Standardized screening instruments that have been validated with criminal justice populations should be used.*
- *A risk assessment should be conducted to identify appropriate candidates for admission (i.e., those who are at moderate to high risk for continuing drug use, and those who present high levels of 'criminogenic needs, such as substance use disorders, lack of employment/employable skills, etc.), to determine the need for services in key areas associated with recidivism, and to guide placement of participants in different levels of treatment and supervision, as appropriate;*
- *A follow-up comprehensive assessment should then be conducted for all participants who are admitted to the drug court, with a diagnosis made regarding the substance use disorder and any associated conditions which should be addressed in the development of the individual's treatment plan. Results of the assessment should be reviewed by the drug court team and used to develop an individualized treatment plan (see below).*
- *Accuracy of drug court screening and assessment can be enhanced through review of collateral information (e.g., from persons residing with the drug court participant) and drug testing.*

[18] The Substance Abuse and Mental Health Services Administration, n.d. Retrieved from web: http://www.samhsa.gov/co-occurring/topics/screening-and-assessment/

3. Determining Level Of Care Needed

Once a diagnosis of drug and/or alcohol disorder is made using the diagnostic criteria established the Diagnostic and Statistical Manual of Mental Disorders[19], the ASAM criteria for determining level of care can be applied. The ASAM criteria encompass a continuum of five broad levels of care within which are additional discrete levels of recommended care and intensity of services[20]:

The ASAM Criteria also take note of special issues presented by "transitional age youth" – older adolescents and younger "20-somethings" who have a "foot in both worlds – adolescence and adulthood, roughly considered to be the 17 – 26 age groups who, from a national perspective, have presented challenges to many drug courts to initially engage and then retain.

An individualized approach is needed for these "transition age youth", who often present social vulnerabilities, needs as well as strengths. (See also **Section IV**.)

ASAM CRITERIA FOR DETERMINING LEVEL OF CARE		
ASAM CRITERIA LEVELS OF CARE	**LEVEL**	**DESCRIPTION OF ASSAM LEVELS OF CARE**
Early Intervention	0.5	Assessment and education for at-risk individuals who do not meet diagnostic criteria for a Substance-Related Disorder
Outpatient Services	1	Less than 9 hours of service/week (adults); less than 6 hours/week (adolescents) for the recovery or motivational enhancement therapies/strategies
Intensive Outpatient (IOP)	2.1	9 or more hours of services/week (adults); 6 or more hours/ week (adolescents) to treat multidimensional instability
Partial Hospitalization (PHP)	2.5	20 or more hours of service/week for multidimensional instability not requiring 24-hour care
Clinically Managed Low-Intensity Residential	3.1	24-hour structure with available trained personnel; at least 5 hours of clinical service/week (e.g., halfway house)
Clinically Managed Population-Specific High Intensity Residential	3.3 (Adult populations only) Not designated for adolescent populations	24–hour care with trained counselors to stabilize multi-dimensional imminent danger. Less intense milieu and group treatment for those with cognitive or other impairments unable to use full active milieu or therapeutic community
Clinically Managed High-Intensity Residential	3.5	24-hour care with trained counselors to stabilize multi-dimensional imminent danger and prepare for outpatient treatment. Able to tolerate and use full active milieu or therapeutic community
Medically Monitored Intensive Inpatient	3.7	24-hour nursing care with physician availability for significant problems in Dimensions 1, 2, or 3. 16 hours/day counselor availability
Medically Managed Intensive Inpatient	4	24-hour nursing care and daily physician care for severe, unstable problems in Dimensions 1, 2 or 3. Counseling available to engage patient in treatment
Opioid Treatment Program (OTP) (Level 1)	OTP	Daily or several times weekly opioid medication and counseling available to maintain multidimensional stability for those with severe opioid use disorder

[19] American Psychiatric Association. (2013). *Diagnostic and statistical manual of mental disorders (DSM-V)* (5th ed.). Arlington, VA: American Psychiatric Publishing.
[20] See Footnote 11.

4. *Identifying Criminogenic Risk*

Criminogenic Risk refers to the factors listed below that have been found to be associated with the increased likelihood that an individual will continue to be involved in the criminal justice system if these factors are not treated or otherwise addressed:

- Anti-social attitudes
- Antisocial friends and peers
- Antisocial personality patterns
- Substance abuse
- Family and/or marital problems
- Lack of education
- Poor employment history; and
- Lack of pro-social leisure activities

Individuals involved in the criminal justice system present a relatively high frequency of substance use, mental and other health disorders. Individuals for whom these disorders are undetected and not treated are likely to cycle back through the criminal justice system repeatedly. Adequate screening and assessment of each individual therefore promotes development of individualized treatment plans for each individual which target the criminogenic needs he/she presents and links them to appropriate treatment services.

Drug courts have been found to be most effective with persons who are determined to be "high risk"/"high need", exhibiting all or many of the eight criminogenic risk factors listed above. Addressing these needs is a prime focus of drug court programs through the holistic treatment and support services they need to provide. For those who can benefit from drug court services but who may present lower risk or lower need, appropriate tracks can be established tailoring the supervision, treatment and related services to the lower needs and/or risks the individual(s) present.

5. *Developing Individualized Treatment Plans*

The diagnostic and assessment process should result in a written individualized treatment plan for each individual, which the individual and the clinician jointly develop. The treatment plan should provide for a continuum of services to address the level of care determined needed for each dimension. The treatment plan should provide the framework for the treatment provider, the participant, and the Drug Court judge and team to work together to promote the participant's achievement of the goals and milestones specified in the plan. The treatment plan should be shared with the court and team members and updated regularly.

An initial treatment plan should include such information as:

- Reason for referral
- Client strengths
- Client barriers to progress
- Support
- Current symptoms and priorities
- Modality of treatment to be used
- Frequency of treatment services; and
- Specific goals and objectives the Client has agreed to work on, with timeframe(s) for their completion, and anticipated milestones

Updates of the plan should indicate any new developments that may affect the initial treatment plan, a narrative of the progress made to date, additional interventions that may be recommended, additional challenges that may need to be addressed, and updated goals, objectives, timeframes and milestones, as appropriate.

D. Ensuring Drug Court Treatment Services Use Evidence-Based Practices

1. *What Is Evidenced-Based Practice?*

Evidence-based practice is the use of research and scientific studies -- rather than anecdotal or personal experience -- as the basis for developing policies and practices. In the field of substance addiction generally and drug court treatment services particularly, research is being conducted continuously, resulting in new knowledge about what works and what doesn't work almost daily, making it imperative that drug court practitioners – treatment and others – stay continually abreast of new developments and modify their program design, services, and operations regularly to reflect these emerging developments. What might have been acceptable practice last year may need to be reconsidered in light of more recent research findings.

2. Evidence-Based Practices Applicable To Drug Courts

Evidence-based treatment practices in drug courts focus on interventions that blend "clinical expertise with the best available external clinical evidence from systematic research" (Sackett et al., 1996).[21] Although there are differing levels of scientific evidence supporting the effectiveness of interventions for substance-involved offenders, a general consensus has emerged that the best evidence that should be utilized entails the results of randomized clinical trials, meta-analytic studies, and expert panel reviews of research evidence (e.g., Cochrane Reviews; Center for Substance Abuse Treatment, 2007).[22] Drug court treatment services and their various components (screening, assessment, etc.) should be reviewed regularly to ensure that they reflect current evidence-based practices and continually emerging research applicable to (1) treatment processes (e.g., diagnosis, referral, program length, etc.); (2) treatment services (e.g., strategies used to address substance use after diagnosis); and (3) treatment models (e.g., the framework for providing treatment services.) Examples in each of these areas are listed below, along with recommendations for specific applications to drug court programs.

a. Treatment Processes

i. Early identification and engagement in drug court services is one of the key components of drug courts[23], and the length of time between arrest (and probation violation) and program entry significantly affects the rate of recidivism and program retention and dropout.[24] Capitalizing on the opportunity to engage participants in treatment at the time of arrest while they are in crisis is considered a major element of the drug court process. Delays in the drug court admission process often lead to reduced motivation and renewed substance abuse and criminal behavior.

ii. Duration in addiction treatment is an important predictor of offender treatment outcomes.[25] Treatment of less than 3 months generally does not affect recidivism or substance addiction; the largest positive effects of drug treatment come from involvement for 6-12 months in a drug treatment program. [26]

iii. Drug courts that provide greater intensity and comprehensiveness of treatment services have better outcomes.[27] These services include individual and group counseling, outpatient and residential services, case management, peer support/self-help groups, access to education, employment, and housing assistance, and specialized mental health treatment and other types of health care services.[28]

iv. Outpatient treatment is generally more effective than residential treatment for drug-involved offenders who are under criminal justice supervision in the community[29] and during reentry from incarceration.[30] Outpatient treatment for offenders is also more cost-effective than residential treatment.[31]

v. Use of criminal justice supervision and sanctions alone in the absence of intensive drug treatment are not sufficient to reduce recidivism

[21] Sackett, D.L., W.M. Rosenberg, J.A. Gray, R.B. Haynes, and W.S. Richardson. (1996). *Evidence-based Medicine: What It Is and What It Isn't*. British Medical Journal 312: 71-72. Web.

[22] Amato L, Minozzi S, Pani PP, Davoli M. (2007). *Antipsychotic medications for cocaine dependence*. Cochrane Database of Systematic Reviews 2007, Issue 3.

[23] National Association of Drug Court Professionals (NADCP, 1997). *Defining Drug Courts: The Key Components*. Washington, DC: Office of Justice Programs, U.S. Department of Justice.

[24] Carey, S.M., & Waller, M.S. (2011). *Oregon drug court cost study – statewide costs and promising practices: Final report*. Oregon Criminal Justice Commission. Portland, OR: NPC Research.; See also Carey, S.M., Mackin, J.R., Finigan, M.W. (2012). *What works? The ten key components of drug court: Research-based best practices*. National Drug Court Institute REVIEW, 8, 6-42.

[25] Grella, C.E., & Rodriguez, L. (2011). *Motivation for treatment among women offenders in prison-based treatment and longitudinal outcomes among those who participate in community aftercare.* Journal of Psychoactive Drugs, 43, 58-67.
See also Hubbard, R.L., Craddock, S.G., & Anderson, J. (2003). *Overview of 5-year follow-up outcomes in the drug abuse treatment outcome studies* (DATOS). Journal of Substance Abuse Treatment, 25, 125-134.

[26] Ibid. See also Marlowe, D. B. (2003). *Integrating substance abuse treatment and criminal justice supervision*. Science & Practice Perspectives, 2, 4-14.

[27] See Footnote 22.

[28] See Footnote 22. See also Zweig, J.M., Lindquist, C., Mitchell Downey, P., Roman, J.K., & Rossman, S.B. (2012). *Drug court policies and practices: How program implementation affects offender substance use and criminal behavior outcomes*. National Drug Court Institute Review, 8, 43-79.

[29] Krebs et al. (2009). *The impact of residential and nonresidential drug treatment on recidivism among drug-involved probationers: A survival analysis*. Crime and Delinquency, 55(3), 442-471.

[30] Burdon et al. (2004). *The California treatment expansion initiative: Aftercare participation, recidivism, and predictors of outcomes*. The Prison Journal, 84(1), 61-80.

[31] Aos, S., Miller, M., & Drake, E. (2006). *Evidence-based adult corrections programs: What works and what does not*. Olympia: Washington State Institute for Public Policy;
See also Ettner et al. (2006). *Benefit-cost in the California Treatment Outcome Project: Does substance abuse treatment "pay for itself?* Health Services Research, 41,192–213.

among offenders who have pronounced substance use disorders.[32]

vi. Improved outcomes are obtained for drug courts that provide immediate responses to the first positive drug test, and that provide a formal system of incentives and sanctions that are coupled with intensive treatment services.[33]

vii. Providing recovery support/continuing care services in the community for drug-involved offenders for a minimum of 24 months following program participation can significantly reduce recidivism and substance addiction[34], and outpatient continuing care services are particularly effective in reducing recidivism.[35] The provisions of recovery support/continuing care services should begin while the participant is actively engaged in the drug court program.

viii. Continuing care services for drug court participants can be expected to provide a $4-9 return for every dollar invested.[36] Several promising continuing care interventions for drug court participants with "high risk" and "high needs" for services include Recovery Management Checkups[37] and Critical Time Intervention case management services.[38] Enhanced outcomes are also reported for drug courts that involve participants in self-help groups to supplement core treatment services.[39] Involvement in self-help groups, such as AA/NA and others also help to engage drug court participants in treatment and recovery, and provide a critically important bridge to sustain ongoing recovery in the community following completion of the drug court program.

[32] Ibid. See also Prendergast, M. (2009). *Interventions to promote successful re-entry among drug-abusing parolees.* Addiction Science & Clinical Practice, 5, 4–13.
[33] Shaffer, D.K. (2011). *Looking inside the black box of drug courts: A meta-analytic review*. Justice Quarterly, 28, 493-521.
[34] Butzin, O'Connell, Martin & Inciardi. (2006). *Effect of drug treatment during work release on new arrests and incarcerations*. Journal of Criminal Justice, 34, 557-565.
[35] See Footnote 28.
[36] Roman & Chalfin. (2006). *Does it pay to invest in reentry programs for jail inmates? Jail Reentry Roundtable Initiative*, June 27-28, 2006. Wash. D.C: The Urban Institute.
[37] Rush et al. (2008). *The interaction of co-occurring mental disorders and recovery management checkups on substance abuse treatment participation and recovery.* Evaluation Review, 32(1), 7-38.
[38] Kasprow, W.J, & Rosenheck, R.A. (2007). *Outcomes of Critical Time Intervention case management of homeless veterans after psychiatric hospitalization*. Psychiatric Services, *58*(7), 929-935.
[39] See Footnote 22.

b. Treatment Services

i. Universal screening should be conducted for all participants, focusing on substance use disorders as well as mental disorders and history of trauma/PTSD, given the high rates of these disorders among offenders.[40] Screening for risk is also needed to identify higher risk individuals who tend to receive the greatest benefit from placement in drug courts.[41] Screening should be provided at the point of program admission to allow for triage to appropriate levels of treatment and supervision, and to rapidly engage participants in specialized services. Placement criteria (see Section C2 above and discussion of ASAM criteria) should be used to triage drug court participants to the most appropriate level of treatment services.

ii. Motivational Enhancement Therapy (MET) entails an interviewing and counseling technique to strengthen an individual's motivation to engage in treatment and to build a plan for change, including coping strategies for dealing with high-risk situations. MET has been used effectively to promote a participant's internal desire and motivation for change and engagement in treatment.[42] A recent meta-analysis[43] indicates that MET is effective with offenders in reducing recidivism, enhancing retention in treatment, and increasing motivation for behavior change. Other studies have shown that MET is linked with improvements in treatment attendance and long-term treatment outcomes.[44]

iii. Contingency management (CM) is a system offering incentives to encourage recovery-oriented outcomes such as attendance in treatment, sustained abstinence, and other behaviors.[45] Incentives that are

[40] Steadman et al. (2009). *Prevalence of serious mental illness among jail inmates.* Psychiatric Services, 60(6), 761-765.
[41] DeMatteo, D. (2010). *A proposed prevention intervention for nondrug-dependent drug court clients*. Journal of Cognitive Psychotherapy, 24, 104-115; See also Marlowe, D.B. (2012). *Targeting the right participants for adult drug courts. Drug Court Practitioner Fact Sheet.* Alexandria, VA: National Drug Court Institute.
[42] Miller & Rollnick. (2002). *Motivational interviewing: Preparing people for change* (2nd ed.). New York: Guilford Press.
[43] McMurran, M. (2009). *Motivational Interviewing with offenders: A systematic review.* Legal and Criminological Psychology, 14, 83-100.
[44] Lang & Belenko. (2000). *Predicting retention in a residential drug treatment alternative to prison program*. Journal of Substance Abuse Treatment, 19, 145-160.
[45] Higgens et al. (1994). *Applying behavioral concepts and principles to the treatment of cocaine dependence.* Drug and Alcohol Dependence, 34, 87–97; See also Stitzer, M. (2008). *Motivational incentives in drug court.* In Quality Improvement for Drug Courts: Evidence-Based Practices, Monograph Series 9. Alexandria, VA: National Drug Court Institute.

used include: non-cash store vouchers, prizes to be drawn from a 'fish-bowl', and graded reinforcement schedules, such as relaxation of curfew requirements, and are used to leverage adherence to drug court/recovery goals. A meta-analysis has shown that CM is effective in reducing substance abuse within community settings[46], and with offenders[47], particularly those who are at higher criminal 'risk'.[48]

iv. Medication-Assisted Treatment (MAT), further discussed in Chapter III, has demonstrated excellent outcomes among offenders, including drug court participants (Holloway et al., 2006, Johnson et al., 2001). MAT in a drug court setting entails the use of medications for alcohol and opioid use disorders in conjunction with psycho-social treatment and related services. These medications are helpful to reduce cravings, to block the reinforcing effects of alcohol and opioids, and to assist in the withdrawal management process. Key medications used for these purposes include buprenorphine, methadone, and naltrexone. A number of drug courts are also currently pilot testing Vivitrol (injectable, extended release naltrexone) which appears to offer potential advantages for drug court programs. Research reviews indicate that MAT is effective in reducing substance use, HIV transmission, and criminal activity among offenders and non-offenders.[49]

v. Relapse Prevention (RP) is widely used to identify past relapse events, manage high-risk situations for relapse, develop drug coping and other related cognitive and behavioral skills, and to build the individual's self-confidence in maintaining abstinence. Relapse prevention is particularly useful for persons who have had difficulty in sustaining abstinence and who are at high risk for recidivism. Use of RP with drug-involved offenders and non-offenders has been linked to longer periods of abstinence, improved psychosocial functioning, and reduced recidivism.[50] A meta-analysis examining the use of RP with offenders demonstrated an average 15% reduction in recidivism.[51]

vi. Treatment for Special Needs Populations, discussed in greater depth in Chapter IV, leads to improved engagement in drug court services for individuals requiring services to address multiple problems, such as co-occurring mental disorders, a history of trauma and PTSD, and/or poor literacy and education skills. Unless identified and addressed, these special needs often lead to poor outcomes in drug court programs, including early dropout and recidivism.[52]

vii. Addressing 'criminogenic needs' that independently contribute to the risk for continued drug use and recidivism is a critical factor in determining program and participant success. These 'criminogenic needs' (or risk factors) include: antisocial beliefs and behaviors, antisocial peers, substance abuse, family/marital problems, lack of education, poor employment history, and lack of prosocial leisure activities.[53], [54]

c. Treatment Models

Three common models of addiction treatment have been found to provide a useful organizing framework for delivering effective services in drug courts.

i. Key components of the Risk-Need-Responsivity (RNR) model include: (1) reserving inten-

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[46] Prendergast, M. (2009). *Interventions to promote successful re-entry among drug-abusing parolees*. ADDICTION SCIENCE & CLINICAL PRACTICE, 5, 4–13.

[47] Marlowe et al. (1997) *Impact of co-morbid personality disorders and personality disorder symptoms on outcomes of behavioral treatment for cocaine dependence.* JOURNAL OF NERVOUS & MENTAL DISEASE, 185, 483–490; See also Messina et al. (2003).

[48] Marlowe et al. (2008). *An effectiveness trial of contingency management in a felony preadjudication drug court.* JOURNAL OF APPLIED BEHAVIOR ANALYSIS, 41, 565-577.

[49] See Footnote 44. See also McKenzie, M., Nunn, A., Zaller, N. D., Bazazi, A. R., & Rich, J. D. (2009). *Overcoming obstacles to implementing methadone maintenance therapy for prisoners: implications for policy and practice*. JOURNAL OF OPIOID MANAGEMENT, 5(4), 219; See also Pecoraro, A., Ma, M., & Woody, G.E. (2012). *The science and practice of medicated-assisted treatments for opioid dependence*. SUBSTANCE USE & MISUSE*,* 48*,* 1026-1040.

[50] Dutra, L., Stathopoulou, G., Basden, S.L., Leyro, T.M., Powers, M.B., & Otto, M.W. (2008). *A meta-analytic review of psychosocial interventions for substance use disorders.* AMERICAN JOURNAL OF PSYCHIATRY, 165, 179-187; See also Poporino, F.J., Robinson, D., Millson, B., & Weekes, J.R. (2002). *An outcome evaluation of prison-based treatment programming for substance users.* SUBSTANCE USE & MISUSE*,* 37*,* 1047-1077; See also Rawson, R.A., Huber, A.M., McCann, M.S., Hoptaw, S.F., Farabee, D.R., Eiber, C., & Ling, W. (2002). *A comparison of contingency management and cognitive-behavioral approaches during methadone maintenance treatment for cocaine dependence.* ARCHIVES OF GENERAL PSYCHIATRY, 59, 817-824.

[51] Dowden, Antonowicz & Andrews (2003). *The effectiveness of relapse prevention with offenders: A meta-analysis.* INTERNATIONAL JOURNAL OF OFFENDER THERAPY AND COMPARATIVE CRIMINOLOGY, 47, 516-528

[52] Peters, R. & Osher, F. (2004). *Co-occurring Disorders and Specialty Courts* (2nd ed.) Delmar, NY: The National Gains Center.

[53] Andrews, Bonta & Wormith (2006). *The recent past and near future of risk and/or need assessment.* CRIME & DELINQUENCY, 52, 7-27; See also Marlowe, D.B. (2012). *Targeting the right participants for adult drug courts. Drug Court Practitioner Fact Sheet.* Alexandria, VA: National Drug Court Institute.

[54] Lowenkamp, C., Latessa, E., & Holsinger, A. (2006). *The risk principle in action: What have we learned from 13,676 offenders and 97 correctional programs?* CRIME & DELINQUENCY, 52, 77-93.

sive drug court treatment for persons who are at high risk for recidivism, (2) providing treatment services that target major 'criminogenic needs" (see previous section) related to recidivism, and (3) tailoring services to address special needs of offenders (e.g., mental disorders, history of trauma/PTSD, motivation, reading and language skills, etc.) to promote better engagement in addiction treatment. Programs that incorporate a greater degree of RNR principles have greater success in reducing recidivism among offenders.[55]

ii. The Cognitive-Behavioral Treatment (CBT) model is a type of psychotherapeutic treatment that helps individuals understands the thoughts and feelings that influence their behaviors. CBT is commonly used to treat a wide range of disorders including phobias, addiction, depression and anxiety. During the course of treatment, individuals learn how to identify and change destructive or disturbing thought patterns that have a negative influence on behavior. CBT therapies generally include role play, modeling, feedback, and skill rehearsal to promote individuals' learning and relevant skills. Several large meta-analyses and other large scale reviews[56] support the effectiveness of CBT in reducing recidivism and substance use among offenders.

iii. The Social Learning model of treatment emphasizes changes in negative peer associations and beliefs and attitudes, and builds on peer and staff modeling of prosocial behaviors, and use of incentives and sanctions to reinforce recovery-oriented behaviors.[57] Meta-analyses indicate that social learning models of treatment are among the strongest predictors in reducing criminal behavior among offenders.[58]

EVIDENCE-BASED PRACTICES
APPLICATION TO DRUG COURT PRACTICE

- *Drug courts should immediately place participants in drug court treatment and avoid delays of more than several days between admissions screening and engagement in treatment services;*
- *Universal and standardized screening instruments should be used to examine mental disorders, history of trauma and PTSD, and substance use disorders, recognizing the high rates of these disorders in drug courts. Screening for criminal risk should also be conducted to identify suitable drug court candidates and to triage participants to different levels of treatment and supervision;*
- *Drug courts should have access to both outpatient and residential treatment, but should provide a dominant focus on intensive outpatient treatment;*
- *Intensive drug court treatment services should be provided for 6-12 months;*
- *Treatment in drug courts should include evidence-based interventions such as Motivational Enhancement Therapy, Contingency Management, Medication-Assisted Treatment, and Relapse Prevention. Manualized curricula should be used to guide the implementation of these interventions;*
- *Drug court treatment should be based on principles of evidence-based offender treatment models such as Risk-Need-Responsivity (RNR), Cognitive-Behavioral Treatment (CBT), and Social Learning;*
- *Specialized services should be provided to meet the needs of persons with co-occurring mental disorders, history of trauma and PTSD, poor educational and vocational skills, and literacy problems;*
- *In addition to providing addiction treatment services, drug court treatment should focus on other major 'criminogenic needs' such as criminal thinking, antisocial behaviors, and antisocial peers; family/marital problems, education, employment, and prosocial leisure activities. Drug courts should avoid treatment interventions that address non-criminogenic needs (e.g., boot camp disciplinary programs, self-esteem, values clarification);*
- *Drug courts that engage participants in post-graduation treatment and other recovery and ancillary services can expect better outcomes;*

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[55] Lowenkamp, C. T., & Latessa, E. J. (2004). *Understanding the risk principle: How and why correctional interventions can harm low-risk offenders.* Topics in community corrections – 2004, 3-8; See also Lowenkamp, C.T., & Latessa, E.J. (2005). *Increasing the effectiveness of correctional programming through the risk principle: Identifying offenders for residential placement*. Criminology & Public Policy, 4, 263-290.

[56] See Footnote 29. See also Bahr, S.J., Masters, A.L., & Taylor, B.M. (2012). *What works in substance abuse treatment programs for offenders?* The Prison Journal, *92,* 155-174; See also Lipsey, M.W., Landenberger, N.A., & Wilson, S.J. (2007). *Effects of cognitive-behavioral programs for criminal offenders*. Campbell Systematic Reviews, 6, 1-27; See also Pearson, F.S., Lipton, D.S., Cleland, C.M., & Yee, D.S. (2002). *The effects of behavioral/cognitive-behavioral programs on recidivism*. Crime & Delinquency, 48, 476-496.

[57] Andrews, Bonta & Wormith, (2006). *The recent past and near future of risk and/or need assessment.* Crime & Delinquency, 52, 7-27; See also Kubrin, C. E., Stucky, T. D., & Krohn, M. D. (2009). *Researching theories of crime and deviance.* New York: Oxford University Press.

[58] Andrews, D. A., & Bonta, J. (2010). *The psychology of criminal conduct* (5th ed.). New Providence, N.J: Matthew Bender; See also Gendreau, P., Goggin, C., & Law, M. A. (1997). *Predicting prison misconducts*. Criminal Justice and Behavior, 24, 414-431.

- *Drug court programs should adopt procedures to routinely ensure that evidence-based treatment practices are used and that emerging research findings are regularly applied, with modifications in program services and operations instituted, as needed.*

E. Case Management Services

Drug court case management services are designed to coordinate, monitor, modify and/or enhance, as necessary, the treatment and related services being provided to participants and to ensure that the wide ranges of needs presented by each individual are being addressed. The case manager monitors the individual's progress in treatment regularly, identifies emerging issues that may affect their retention in treatment and recovery, such as a family crisis or housing problem, and works to ensure that the range of criminogenic needs the individual presents are effectively addressed, such as job training, mental health care and family services. Activities associated with case management also include linking individuals with community resources that can assist them, monitoring and supporting their involvement in services and advocating on their behalf during the course of recovery.[59]

Case Management Services
Application To Drug Court Practice

- *Case management services are an essential component of drug court programs, focusing on coordinating the range of treatment and related services needed to sustain the individual's recovery;*
- *The case manager should promptly address instances of non-compliance by the individual to determine whether they are symptomatic of the need for a modification in the individual's treatment plan and/or enhancement of services being provided;*
- *The case manager should coordinate with all of the individual's service providers and other community entities that can support the individual's retention in drug court and recovery and regularly report relevant information regarding services being provided to – or needed by – the individual to the drug court team;*
- *Case managers for drug courts require specialized training, particularly when the drug court caseload is particularly challenging (e.g., includes participants who have co-occurring disorders).*

[59] Center for Substance Abuse Treatment. (1998). *Comprehensive case management for substance abuse treatment.* Treatment Improvement Protocol (TIP) Series, No. 27; See also Vanderplasschen et al. (2007). *Effectiveness of different models of case management for substance-abusing populations.* JOURNAL OF PSYCHOACTIVE DRUGS, 39(1), 81-95.

F. Recovery Management/Continuing Care: When Should It Start? How Long Should It Last? What Strategies Can Be Used?

Given the substantial research demonstrating that alcohol and other drug addiction is a chronic disease characterized by relapse and the frequent need for multiple treatment admissions, drug courts should no longer utilize a model of acute care characterized by crisis-linked treatment, with a primary focus on abstinence and graduation but, rather carefully develop methods to provide participants with ongoing opportunities for involvement in recovery activities, facilitating their resumption of treatment services when necessary to prevent and cut short relapse and promote long-term recovery for individuals and families affected by severe substance use disorders.

Longitudinal studies have repeatedly demonstrated that addiction treatment (particularly for 90 days or more) is associated with major reductions in substance use, associated social and economic problems, and costs to society.[60] However, post-discharge relapse and eventual readmission are not uncommon. Although the drug court rates of graduation and re-offense are considerably better than traditional treatment completion rates and probation re-offense rates, drug courts must continue to look for ways to improve these rates and long-term cost effectiveness. One area that merits attention entails aftercare: the concept of Continuing Care and "Recovery Management."[61]

In addition to the positive effects of entering treatment when needed post-graduation, an emphasis on recovery and recovery management also enhances drug court outcomes. According to the "Working Definition of Recovery[62] and the Guiding Principles of Recovery:

> "There are many pathways to recovery. Individuals are unique with specific needs, strengths, goals, health attitudes, behaviors and expectations for recovery. Pathways to recovery are highly personal and generally involve a redefinition of identity in the face of crisis or a process of progressive change."

[60] Dennis M, Scott C. & Funk R. (2003)., *An experimental evaluation of recovery management check-ups (RMC) for people with chronic substance use disorders,* Evaluation and Program Planning 26, 339-352

[61] White, W.L., Evans, A.C. & Achara-Abrahams, I. (2012). *Recovery management matrices*. Posted at www.williamwhitepaers.com

[62] Center for Substance Abuse Treatment (2005). *National Summit on Recovery Conference Report*.

Drug courts should assist drug court participants to develop strategies for transitioning to long-term recovery maintenance while they are still actively enrolled in the program. Effectively managing this transition is critical for long term sobriety. Research indicates that only 1 in 5 of those who complete treatment actually attend continuing care.[63] Drug courts are in a unique position to considerably improve this 20% rate of participation in continuing care services, due to the length of stay required by most drug courts (12-18 months).

Recovery management services (including continuing care and relapse prevention) provide the opportunity to serve a variety of functions: (1) the benefits of an increased level of treatment contact with the participant after primary drug court treatment; (2) monitoring that provides an incentive for abstinence to be maintained especially if urinalysis is part of the monitoring; (3) reinforcement of attendance at self-help meetings, alumni groups, alcohol and other drug free social activities, conversing with a recovery coach, and a variety of other components in a recovery oriented system of care that facilitate long-term maintenance of sobriety; and (4) more efficient reentry to treatment when relapse occurs.

Continuing care in the form of post-treatment monitoring and support can also enhance long-term recovery outcomes in both adults[64] and adolescents.[65] Research has also validated the untapped potential of telephone-based continuing care following treatment.[66] This approach has many potential advantages (convenience, safety, accessibility, timing, and others) as well as being less costly.

Recent research also demonstrates that Recovery Management Checkups (assessments, motivational interviewing, and linkage to treatment re-entry) provide superior aftercare outcomes in comparison to other interventions.[67]

RECOVERY MANAGEMENT/CONTINUING CARE
APPLICATION TO DRUG COURT PRACTICE

- *The final drug court phase should focus on the participant taking control of their own recovery and carrying out their individualized Recovery Management plan. The Recovery Management plan should become a major focus for the final phase of drug court and monitored for early identification of problems. This plan should be the focus of the attention of the participant, the Judge from the bench, the case manager, the treatment provider and the entire drug court team as the participant becomes prepared for "after drug court".*
- *The Recovery Management Plan should be structured to cover most areas of the participant's life regarding remaining clean, sober and productive, including:*
  - ✓ *Strategies for avoiding alcohol and other drug use including identification of relapse triggers and how to avoid them*
  - ✓ *Identifying health disorders and wellness strategies;*
  - ✓ *Coping with thinking patterns that lead to relapse, criminal behavior, and other high risk situations;*
  - ✓ *Avoiding high risk places, peer pressure to use, and plans to cope with them;*
  - ✓ *Effectively managing relapse events and identifying persons to turn to for help;*
  - ✓ *Building a Recovery Support System, including linkage to recovery support groups, post-treatment recovery support institutions (e.g. re-*

[63] Godley MD, Godley SH, Dennis ML, Funk R, & Passetti LL, *Preliminary outcomes from the assertive continuing care experiment for adolescents discharged from residential treatment*, J Subst. Abuse Treatment, 2002, July 23 (1) 21-32; See also McKay, James R, *The role of continuing care in outpatient alcohol treatment programs*, Department of Psychiatry, University of Pennsylvania, Philadelphia, PA, Recent Dev. Alcohol, 2001; 15:357-72.

[64] Scott CK, Dennis ML, Foss MA. *Utilizing recovery management checkups to shorten the cycle of relapse, treatment reentry, and recovery.* Drug and Alcohol Dependence. 2005;78(3):325–338. [PubMed]; Scott CK, Foss MA, Dennis ML. *Pathways in the relapse–treatment–recovery cycle over 3 years*. Journal of Substance Abuse Treatment. 2005;28(Suppl 1):S63S72. [PubMed]. See also McKay JR & Hiller-Sturmhofel SH*, Treating Alcoholism As a Chronic Disease: Approaches to Long-Term Continuing Care*, Alcohol Research & Helath, Volume 33, Issue Number 4, 2010

[65] Godley MD, et al. *The effect of assertive continuing care (ACC) on continuing care linkage, adherence and abstinence following residential treatment for adolescents with substance use disorders*. Addiction. 2007;102(1):81–93. [PubMed]

[66] McKay, JR, (2009). Continuing Care Research*: What We've Learned and Where We're Going,* Journal of Substance Abuse Treatment,36(2): 131-145. See also McKay JR, et al. (2004). *The effectiveness of telephone-based continuing care in the clinical management of alcohol and cocaine use disorders*: 12-month outcomes. Journal of Consulting and Clinical Psychology,;72(6):967-979. (PubMed)

[67] Scott, C.K., & Dennis, M.L. (2003). *Recovery Management Checkups: An Early Re-Intervention Model.* Chicago: Chestnut Health Systems. Available online at http://www.chestnut.org/LI/downloads/Scott_&_Dennis2003 RMC Manual-2_25_03.pdf See also Scott, C.K., & Dennis, M.L. (2009). *Results from two randomized clinical trials evaluating the impact of quarterly recovery Management checkups with adult chronic substance users.* ADDICTION, 104:959-971. See also Scott, C.KI. Dennis, M.L. (2011). *Recovery Management Checkups with adult chronic substance users*. In Kelly, J.F., and White, W.L. (Eds) *Addiction Recovery Management: Theory, Research, and Practice*.; New York, NY: Springer, (Pp 87-102).

covery homes, recovery schools, and recovery ministries), abstinence-based social clubs, recovery support centers, recovery coaches, mentors and guides;*

- ✓ *Other life areas relevant to recovery, e.g. health problems, legal problems, overcoming educational and vocational skill deficits, etc.; and*
- ✓ *Use of "recovery checkups" telephone- and Internet-based systems of continuing care*
- ✓ *Assessment of family needs, services and supports*

III. Medication Assisted Treatment, Acupuncture, and Self-Help Groups

A. Medication-Assisted Treatment (MAT) In Drug Courts: How Should MAT Be Utilized?

The U.S. Food and Drug Administration (FDA) has approved a variety of medications as safe and effective for the treatment of alcohol and opioid use disorders. At this time there are no FDA-approved medications for the treatment of cocaine and methamphetamine use disorders.

The use of medications described in this *Guideline* has been shown to reduce opioid use and drinking and should be considered as an adjunct to treatment for drug court participants with alcohol and/or opioid use disorder in appropriate situations upon the recommendation of an attending physician. These medications, used in conjunction with other drug court treatment services and following protocols developed, may also reduce alcohol and drug-related criminal behavior. Benzodiazepines are particularly useful in withdrawal management for alcohol use disorder and opioid agonist medications such as methadone or buprenorphine are useful in withdrawal management for opioid use disorder.

While withdrawal management is often a necessary first step, it does not, however, constitute effective treatment in and of itself. Medications useful in reducing cravings for alcohol and opioids, and in blunting or blocking the pleasurable effects of these substances are helpful for drug court participants who are involved in both outpatient and residential programs, and their use is likely to improve outcomes for "high risk" and "high need" participants. In combination with other psychosocial treatment services, the use of medications may also provide a cost-effective alternative to residential treatment for some drug court participants.

The net effect of the use of medications is to allow drug court participants to curtail their use of alcohol or opioids and to more effectively engage in other evidence-based substance abuse treatments. The medications referenced can be administered to drug court participants by a physician through a health clinic, private physician's office, drug treatment clinic, or a specially regulated opioid treatment program (OTP).

The drug court program, with the intensive supervision and integrated treatment services provided to participants, provides an effective setting for the use of MAT. It is critical, however, that clear policies and protocols regarding its use, administration, and monitoring be developed.

1. Medications For Opioid Use Disorder

MAT is optimally suited for drug court participants who have opioid use disorder, and leads to enhanced accountability, retention in treatment, and positive treatment outcomes. There are three FDA-approved medications for the treatment of opioid use disorder. Two of them are opioid agonists (methadone and buprenorphine) and one is an opioid antagonist (naltrexone).

Opioid agonists bind to the opioid receptors in the brain. When taken on a regular basis as prescribed, methadone and buprenorphine satisfy opioid craving, while at the same time block the euphoric effects of other self-administered opioids, thus causing the person to sharply reduce or discontinue illicit opioid use. At the proper dose, these medications do not induce euphoria or impair the person's functioning.

Methadone, a full opioid agonist, is especially effective in drug courts for very high-level heroin users and pregnant women. Buprenorphine has a better safety profile than methadone because it is a partial rather than a full opioid agonist, and hence it is much more difficult to overdose on buprenorphine than methadone. An advantage of naltrexone is that it can be provided by any licensed physician. An advantage of injectable extended release naltrexone (Vivitrol®) is that it can be taken only once a month, and therefore is much easier to monitor in a drug court.

- <u>Methadone</u>

Methadone treatment for opioid use disorder is generally provided in the U.S. through Opioid Treatment Programs (OTPs) which require taking methadone

initially on a daily basis under direct observation. An individual can gradually earn the right to "take-home doses" on the basis of demonstrated progress in treatment. This treatment should be accompanied by counseling at the OTP as well as urine drug testing. In rural areas, where long distances might be required to travel for this treatment, it is possible for a physician to become licensed as a "medication unit" to administer medication from the physician's office through an application to the state substance abuse authority and the federal Drug Enforcement Agency.

The evidence for the effectiveness of methadone treatment in reducing opioid use comes from numerous randomized clinical trials, the gold standard for research methodology (Sibbald & Roland, 1998), conducted with thousands of persons in several different countries. Its effectiveness has also been confirmed in rigorous evidence-based meta-analyses which aggregate and analyze clinical trial results.[68] There is also evidence from large-scale, multi-site and single site longitudinal studies conducted in the U.S. that persons with opioid use disorders under criminal justice supervision in the community respond effectively to methadone treatment. (Simpson & Friend, 1988).

- Buprenorphine

Buprenorphine treatment can be provided through OTPs. However, more commonly and unlike methadone treatment, buprenorphine can also be dispensed through community pharmacies by prescriptions written by specially licensed physicians. To obtain this special license (called a waiver) licensed physicians must either hold a subspecialty board certification in addiction psychiatry or addiction medicine or complete specially approved eight hour training. The physician must also obtain this waiver from two federal agencies (SAMHSA and the DEA). It is the only medication in the United States that has its own special training requirement.

Approved physicians can provide buprenorphine prescriptions in whatever setting they practice, affording an advantage in rural areas. The medication comes in two forms: buprenorphine alone (generic) and buprenorphine combined with naloxone (Suboxone®). The combined form is the generally preferred choice because the presence of naloxone serves as a deterrent to ill-advised attempts to inject buprenorphine. Suboxone, a partial opioid agonist, is most effective for lower-level heroin abusers in drug courts. Naloxone is an opioid antagonist that induces opioid withdrawal when injected, but is minimally absorbed when taken as directed.

Buprenorphine has been shown in numerous randomized clinical trials to be effective in suppressing opioid use. As with methadone, it has also been shown to be effective through meta-analyses (Mattick et al., 2008). As buprenorphine has been only available in the last decade, there is relatively little research on its use for persons under criminal justice supervision.

- Naltrexone

Naltrexone is an opioid antagonist that is approved by the FDA for relapse prevention in opioid use disorder, and can be provided by any physician without a special license. It binds to the opioid receptor and blocks the euphoric effects of self-administered opioids. Unlike the opioid agonists, it provides no opioid effects of its own. If naltrexone is administered to a person with opioid use disorder within 7–10 days of the last use of opioids, it will induce an opioid withdrawal reaction. Thus, naltrexone must be used only after a period of opioid abstinence.

This medication comes in two forms: a tablet (Revia® and also generic) taken orally and an extended-release intramuscular injection (Vivitrol®) that lasts approximately one month. The tablets are rarely used due to potential non-compliance, although since it is possible to take the medication three times per week at double the daily dose, in some circumstances its administration can be monitored to increase compliance and success. The tablet's advantage over Vivitrol is that it has a generic formulation and therefore costs considerably less than Vivitrol. Oral naltrexone and Vivitrol, because they are non-opioid agonist medications, may meet with less resistance from those drug court staff who are philosophically opposed to the use of methadone or buprenorphine, despite the evidence of their effectiveness.

Extended release naltrexone has been shown to reduce the likelihood of relapse to opioid use in two randomized clinical trials (the largest one conducted in Russia; Krupitsky et al., 2011). Studies of its use in criminal justice populations are ongoing. The tablet form of naltrexone was shown to have positive outcomes in a study of federal probationers (Cornish et al., 1997), but these findings were not replicated among state probationers who received less intensive supervision.

[68] Mattick, R.P., Breen, C., Kimber, J., & Davoli, M. (2009). *Methadone maintenance therapy versus no opioid replacement therapy for opioid dependence.* Cochrane Database of Systematic Reviews, Issue 3, Art. # CD002209. DOI: 10.1002/14651858.CD002209.pub2.

2. Medications For Alcohol Use Disorder

There are three FDA-approved medications for the treatment of alcohol use disorders: naltrexone (both oral and extended-release forms), disulfiram (Antabuse), and acamprosate (Campral). These medications work in very different ways but all have been shown to reduce alcohol consumption. They can be prescribed by physicians in any practice setting without special licensing, and are often accompanied by counseling for the individual and their participation in self-help groups.

- Naltrexone

Naltrexone, described above, also appears to reduce alcohol use by blunting the euphoric effects of drinking. The extended-release form (see above) was developed to improve compliance with the oral form of the medication.

Naltrexone (both the oral form and the extended release form) has been shown to be more effective than a placebo in numerous randomized clinical trials.[69] Meta-analyses have found that oral naltrexone is more likely than a placebo to reduce drinking, reduce the likelihood of relapse to heavy drinking, and to reduce the rates of relapse.[70]

- Disulfiram

Disulfiram (Antabuse) inhibits the metabolism of alcohol in the liver, leading to the build-up of acetaldehyde, which can cause nausea, vomiting, facial flushing, dizziness, and shortness of breath. This unpleasant reaction will cause persons to stop drinking (or to stop taking Antabuse). Those taking disulfiram must be abstinent from alcohol for at least 24 hours prior to starting the medication and must be advised not to drink for several days even after they stop taking the medication.

Clinical research indicates that disulfiram can be effective in reducing drinking when taken under supervision. There have been a number of small longitudinal studies that indicate that persons taking disulfiram under community supervision are more likely to reduce drinking than those not taking the medication.[71]

- Acamprosate

Acamprosate (Campral) may exert its effects through reducing the hyperactivity of a neurotransmitter system (glutaminergic system) that occurs during protracted withdrawal from alcohol, thereby reducing withdrawal symptoms such as insomnia and anxiety. This medication is taken orally three times per day.

Most randomized trials have found that acamprosate increases the likelihood of maintaining abstinence compared to a placebo.[72]

3. Overcoming Barriers To The Use Of MAT In Drug Courts

Drug court participants should be allowed the opportunity to benefit from medications proved effective the same as any individual who is not supervised by the criminal justice system. Unfortunately, almost half of substance abuse treatment professionals don't "believe" in the use of medications (American Association for Treatment of Opioid Dependence, 2012) despite the evidence to the contrary, and for several decades, drug court judges have faced strong resistance from some treatment professionals, probation officers, and other team members in use of medications to augment traditional substance abuse treatment.

Because the "team concept" is important in a successful drug court, these philosophical differences pose an important challenge, but judges must address and overcome this resistance to make medications available to participants as part of a comprehensive approach to drug court treatment. In many cases resistance can be overcome by an educational program

[69] O'Malley, S. S., Jaffe, A. J., Chang, G., Schottenfeld, R. S., Meyer, R. E., & Rounsaville, B. (1992). *Naltrexone and coping skills therapy for alcohol dependence: a controlled study.* ARCHIVES OF GENERAL PSYCHIATRY, *49*(11), 881-887; See also Garbutt, J.C., Kranzler, H.R., O'Malley, S.S., Gastfriend, D.R., Pettinati, H.M., Silverman, B.L., Loewy, J.W., & Ehrich, E.W. (2005). *Efficacy and tolerability of long-acting injectable naltrexone for alcohol dependence: a randomized controlled trial.* Journal of The American Medical Association, *293*(13), 1617-1625.

[70] Srisurapanont, M., & Jarusuraisin, N. (2005). *Opioid antagonists for alcohol dependence.* Cochrane Database of Systematic Reviews, 25(1), CD001867; See also Rösner, S., Hackl-Herrwerth, A., Leucht, S., Vecchi, S., Srisurapanont, M., & Soyka, M. (2010). *Opioid antagonists for alcohol dependence*. Cochrane Database of Systematic Reviews, Issue 12. Art. #: CD001867. DOI: 10.1002/14651858.CD001867.pub3.

[71] Brewer & Smith. (1983). *Probation linked supervised disulfiram in the treatment of habitual drunken offenders: results of a pilot study.* British Medical Journal, 287, 1282-1283.

[72] Bouza, Magro, Muoz & Amate. (2004). *Efficacy and safety of naltrexone and acamprosate in the treatment of alcohol dependence: A systematic review.* Addiction, 99, 811-828.

that provides information about the use of medications, an informed discussion of their risks and benefits, and the evidence of their effectiveness. However, in some cases, judicial leadership must be exerted to engage medical professionals to advise and, if appropriate, implement evidence-based treatments such as MAT.

A common issue many programs that accept persons taking medications for alcohol or opioid use disorder upon entry encounter is whether their use should be discontinued prior to graduation. The issue usually arises in response to philosophical beliefs held by drug court staff (e.g., that participants shouldn't be taking any medications for substance abuse problems, e.g., that they should be drug free). However, the decision regarding use and/or termination of MAT should be made by medical professionals and not the drug court team.

4. Costs

Costs for MAT vary based on the type of medication, the setting in which treatment is provided, availability of insurance, and other factors. Publicly-funded substance abuse treatment programs often use sliding scales for payment based on income, which can make MAT more affordable. Medications that are available in generic form cost less than those available as name brand only, and pharmacies attached to large retail discount stores provide relatively cheap generic prescriptions. Drug courts should also be aware that some pharmaceutical companies provide free medications that are available upon an application from a physician. Drug courts should routinely assess whether participants have (or are eligible for) public or private insurance, or are eligible for treatment through the Veterans Administration (VA). Also, Federally Qualified Health Centers (FQHCs) provide treatment on a sliding scale which (like publically funded substance abuse treatment programs) may require minimal or no payments for indigent persons. The FQHCs and the VA also receive pricing discounts in purchasing medications.

Some medications like methadone are inexpensive (as little as 50 cents per day), but the treatment provided must be bundled with counseling and drug testing and can only be provided in certain licensed OTPs, which can increase the cost to as much as $70 - $100 or more per week. Medications for alcohol (except Vivitrol) are relatively inexpensive, but the individual has to pay for a physician visit. These visits may be provided at negligible cost if they occur at an FQHC or public substance abuse treatment program, or if they are covered by insurance. Otherwise, physician visits may cost more than the medications. One of the more expensive medications is Vivitrol, for which each monthly injection might cost several hundred dollars, in addition to the costs of a physician visit (these costs are significantly reduced if Vivitrol is accessed through the VA or an FQHC). Suboxone may cost $30-40 per week in addition to the cost of weekly or less frequent physician visits. Subutex (buprenorphine alone) is somewhat less expensive than Suboxone, but a physician visit is still required.

In summary, MAT treatments are relatively inexpensive in comparison to medications prescribed for other types of health disorders, but the costs may vary depending upon the type of entity that can be accessed to dispense it and the insurance status of the individual. The costs of these medications, however, are dwarfed by the costs related to rearrest and incarceration that may ensue if MAT is not available when deemed appropriate to augment other drug court treatment services.

MEDICATION-ASSISTED TREATMENT (MAT)
APPLICATION TO DRUG COURT PRACTICE

- *The use of medications should be guided by medical professionals working with the drug court team. The physician should determine whether to recommend medication for the treatment of alcohol or opioid use disorder based on: the severity of the person's alcohol or drug use, their history of relapse, any medical contraindications, the consequences of relapse, the availability and cost of the medication, and the person's preference, recognizing that an individual's use of MAT must be voluntary and not mandated;,*
- *Medications described in this section can increase the likelihood of reducing and discontinuing opioid and alcohol use among drug court participants. Drug courts are therefore likely to enhance their success rates if they routinely evaluate the need for medications for alcohol and opioid use disorder and make these medications available for participants who wish to take them, just as would be done with any other health-related disorder;*
- *An effective approach for implementing the use of medications might be for the drug court to appoint a liaison with one or more local physicians who are expert in addiction treatment and who can serve as a guide to use of medications. These arrangements can be made where possible through linkages with substance abuse treatment programs (both OTPs and non-*

OTPs) that involve physicians who are able to evaluate and treat persons with medications;

- *For drug courts in rural areas and other jurisdictions with few available substance abuse treatment services, it may be useful to connect with physicians who are certified by the American Society of Addiction Medicine and/or the American Academy of Addiction Psychiatry (see "Sources and Links" section in this guideline). Each state's substance use disorder authority/office and the above-mentioned professional societies can help to connect drug courts to these providers;*
- *In rural areas, it may also be possible for an ASAM certified physician in the state to collaborate with a local licensed physician through telemedicine;*
- *Consent should be obtained from drug court participants who agree to utilize these prescribed medications to allow for communication with medical providers to monitor progress with the medications;*
- *Drug Courts should be aware that methadone and the more easily diverted buprenorphine may be used without medical supervision to self-medicate opioid withdrawal, and thus are potentially subject to abuse. Protocols need to be established to address this potential situation;*
- *Caution also should be exerted when these medications are combined with benzodiazepines (e.g., Valium, Xanax), which are too easily obtained by prescription. For drug court participants who are receiving opioid agonist treatment and using other non-opioid drugs (e.g., cocaine or alcohol), these issues should be addressed in team meetings, court hearings, and counseling sessions as well as drug testing practices;*
- *Drug court participants who are administered buprenorphine or methadone can be drug tested specifically for these medications (results will not appear as a "morphine" positive). Positive results are expected for these tests, and clearly should not be considered a "violation" of program guidelines. In contrast, negative results may indicate medication diversion, a laboratory error, or that the person is taking a low dose of medication;*
- *Negative tests should be reviewed with both the drug court participant and the prescribing physician.*

B. THE ROLE OF ACUPUNCTURE

Acupuncture has been used for centuries in traditional Chinese medicine to treat a wide variety of ailments, and has been adopted for use in western society in the past 40 years. The most common use of acupuncture for substance abuse involves placement of needles in the ear (auricular acupuncture), and was introduced by Michael Smith, M.D. in the U.S. at the Lincoln Hospital in New York City in the 1970's.[73] A 5-point auricular protocol was developed by the National Acupuncture Detoxification Association[74] to guide placement of needles for use with substance-involved populations. Acupuncture has been used as an adjunction to treatment in over 400 substance abuse treatment programs in the U.S. and Europe.[75]

Although a literature review of seven studies of acupuncture for cocaine dependence with 1,433 participants did not find evidence that auricular acupuncture was effective for treatment of cocaine dependence (Gates et al., 2008), one study provided some evidence that acupuncture could reduce cocaine craving. The review recommended more research be done in this area because of limitations in the study designs. To the extent that acupuncture is used in drug courts, it should be provided as an adjunct to evidence-based treatments. Hopefully more rigorous methodological studies on the subject will be conducted in the future in the context of the Drug Court.[76]

THE ROLE OF ACUPUNCTURE
APPLICATION TO DRUG COURT PRACTICE

- *Acupuncture may potentially be an effective adjunct to addiction treatment services, decreasing cravings and promoting treatment program retention.*
- *If acupuncture is to be used for drug court participants, it must be combined with evidence-based substance abuse treatment and related services.*

C. ROLE OF SUPPORT GROUPS (E.G., AA/NA, 12-STEP, ETC.)

Support groups have long been considered a critical important component of recovery, providing a non-judgmental and safe forum for individuals to discuss a wide range of issues relating to their addiction, the underlying factors contributing to it and emotional issues that can be shared with others in similar situations. While support groups are not a substitute for professional treatment services, they can offer both

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[73] Gates, S., Smith, L.A., & Foxcroft, D. (2008). *Auricular acupuncture for cocaine dependence (Review)*. The Cochrane Collaboration Library, Issue 3. New York: John Wiley.
[74] American University (2013). *Effectiveness of acupuncture as an adjunct to substance abuse treatment: Summary of recent research findings.* Bureau of Justice Assistance, Drug Court Technical Assistance Project, Frequently Asked Questions Series. Washington, D.C.
[75] See Footnote 71.
[76] See Footnote 74.

reinforcement and fellowship that can supplement professional services.

Many support groups follow a 12-step treatment model with decades of proven success. The 12 steps function under a structure of anonymity and what is said during support group meetings is not repeated outside those walls. Other aspects of the 12-step program include personal accountability without self-pity or excessive guilt. The 12 steps teach members to recognize and understand past failings and correct them without dwelling on the past. 12-step programs also offer important help to their members beyond the meetings. Members typically exchange phone numbers and can call on each other during difficult times, like when an addict needs help with relapse prevention.

Alcoholics Anonymous (AA) is a self-help group, organized through an international organization of recovering alcoholics that offers emotional support and a model of abstinence for people recovering from alcohol dependence using a 12-step approach. There are also alternative interventions based on 12-step type programs, some self-help and some professionally-led. AA and other 12-step approaches are typically based on the assumption that substance dependence is a spiritual and a medical disease.

Drug courts that include involvement in recovery mutual aid groups (AA, NA, MA, CA, etc.) through assertive linkage and monitoring of attendance are likely to provide a strong foundation of social support for participants that may assist in achieving long-term recovery goals.

However, drug courts should be aware of the decision of the Ninth U.S. Circuit Court of Appeals in San Francisco and other court cases holding that Twelve Step programs, like NA and AA, are "based on monotheistic principles." Addressing this issue in the *Drug Court Judicial Benchbook* (February, 2011), the Honorable William G. Meyer (Ret.), in his chapter entitled, "Constitutional and Legal Issues in Drug Courts," states:

> "Although court-mandated participation in AA and NA may run afoul of the First Amendment, such referrals are not prohibited where there are alternatives available (emphasis added). The Establishment Clause is violated when the state coerces the participant to engage in a religious activity (Kerr v. Ferry, 95F.3d 472.479 [7th Cir. 1996]). Where there are other 12-step or secular self-help groups to which the drug court participant can readily be referred, use of AA or NA groups is constitutional for those individuals who do not object (O'Connor v. California, 855 F. Supp. 303, 308 [C.D. Cal. 1994] finding that the Establishment Clause was not violated because the DUI probationer has several choices of programs, including self-help programs that are not premised on monotheistic deity). For offenders who do object to the deity-based 12-step programs, placement in a secular program is appropriate (Bausch v. Sumiec, 139 F. 2d 1029, 1036 [E.D. Wis 2001] stating that the choices needed to be made known to the participant."

ROLE OF SUPPORT GROUPS **APPLICATION TO DRUG COURT PRACTICE**
• *Frequent and regular participation in support groups should be an integral component of drug court programs and recovery support services, starting as soon as possible after program entry.* • *Relationships with support groups established during the period of drug court participation provide a critical foundation for supporting the individual's recovery after he/she leaves the structure of the drug court program*

IV. ADDRESSING THE NEEDS OF SPECIAL POPULATIONS

Drug court participants come from a variety of socio-economic and vocational backgrounds, are multi-cultural, have different levels of intellectual and cognitive capabilities, and reflect very different levels of social/family support and problems related to substance use, mental disorders, and other health-related disorders. By their design, drug courts also involve a diverse cross-section of society, including many individuals who either themselves and/or their families have not had particularly positive experiences with the criminal justice system and other settings. To effectively serve this diverse population, it is important for drug courts to recognize the unique needs and perspectives of different groups of participants, to provide requisite specialized interventions and staff training, and to hire staff who are experienced in working with the unique needs and issues presented by these diverse populations. (See also: National Association of Drug Court "Best Practice Standards": Standard Two).

Below are discussed six "special populations" most drug courts frequently serve – or need to serve –and

relevant issues relating to evidence based practices that apply.

A. PROVIDING SPECIALIZED DRUG COURT SERVICES FOR PARTICIPANTS WITH CO-OCCURRING MENTAL HEALTH AND SUBSTANCE USE DISORDERS

A disproportionately high number of persons in drug courts and other criminal justice settings have co-occurring mental and substance use disorders (CODs). A 2009 report, for example, on jail populations noted that 17% of males and 34% of females have a major depressive disorder, a bipolar disorder, a psychotic spectrum disorder, or a posttraumatic stress.[77] Over 70% of offenders who have mental disorders also have co-occurring substance use disorders.[78] Extrapolating from these studies, approximately 12% of males and 24% of females in drug courts and other criminal justice settings have CODs. These rates are significantly higher than those found in the general.[79]

Persons with CODs tend to cycle through the criminal justice system, are at higher risk for arrest, and stay in jail longer than those without CODs.[80] These individuals are often difficult to engage in treatment, are unemployed, and lack stable housing and social or financial supports[81] - all factors leading to higher drop-out rates in drug courts and other substance abuse treatment settings.[82]

Few persons with CODs have received specialized (e.g., integrated) behavioral health services, either in the general community [83] or in the criminal justice system.[84] Although having a mental disorder is not in itself a risk factor for recidivism, persons with CODs in the justice system have elevated levels of criminal risk and criminogenic needs, and thus are appropriate targets for drug court programs that provide specialized and integrated COD treatment services. Due to their elevated criminal risk and more pronounced service needs (e.g., mental health, housing, employment, education, social/family support), drug courts must adapt different approaches to achieve successful outcomes for persons with CODs.

Integrated treatment for CODs that simultaneously addresses mental and substance use disorders has been found to be more effective than ‘parallel’ or ‘serial’ models of treatment[85], and has produced sus-

[77] Disorder; See also PTSD; Steadman, H.J., Osher, F.C., Robbins, P.C., Case, B., & Samuels, S. (2009). *Prevalence of serious mental illness among jail inmates*. Psychiatric Services, 60(6), 761-765.

[78] Baillargeon, J., Penn, J.V., Knight, K., Harske, A.J., Baillargeon, G., & Becker, E.A. (2010). *Risk of reincarceration among prisoners with co-occurring severe mental illness and substance use disorder*s; See also U.S. Department of Justice (2006). *Justice and Mental Health Collaboration Program*: FY 2006 competitive grant announcement # BJA-2006-1381. Retrieved on November 15, 2006 from Bureau of Justice Assistance Programs: http://www.ojp.usdoj.gov/BJA/grant/06MIOsol.pdf

[79] Population; See also Compton, W.M., Dawson, D., Duffy, S.Q., & Grant, B.F. (2010). *The effect of inmate populations on estimates of DSM-IV alcohol and drug use disorders in the United States*. American Journal of Psychiatry, *167*(4), 473-474; See also Kessler, R.C., McGonagle, K.A., Zhao, S., Nelson, C.B., Hughes, M., Eshleman, S., Wittchen, H.U., & Kendler, K.S. (1994). *Lifetime and 12-month prevalence of DSM-III-R psychiatric disorders in the United States: Results from the National Comorbidity Survey.* Archives of General Psychiatry, 51, 8-19.

[80] Baillargeon, J., Penn, J.V., Knight, K., Harske, A.J., Baillargeon, G., & Becker, E.A. (2010). *Risk of reincarceration among prisoners with co-occurring severe mental illness and substance use disorders*. Administration and Policy in Mental Health, 37, 367-374; See also Monahan, J, Steadman, H., Robbins, P., Appelbaum, P., Banks, S., Grisso, T., Heilbrun, K., Mulvey, E., Roth, L., & Silver, E. (2005). *An actuarial model of violence risk assessment for persons with mental disorders.* Psychiatric Services, *56*(7), 810-815; See also Peters, R.H., Sherman, P.B. & Osher, F.C. (2008). *Treatment in jails and prisons*. In K.T. Mueser & D.V. Jeste (Eds.), Clinical Handbook of Schizophrenia (pps. 354-364). New York: Guilford Press.

[81] Chandler, R.K., Peters, R.H., Field, G., & Juliano-Bult, D. (2004). *Challenges in implementing evidence-based treatment practices for co-occurring disorders in the criminal justice system.* Behavioral Sciences and the Law, *22*(4), 431-448; See also Peters, R.H. (2008). *Co-occurring disorders.* In C. Hardin & J.N. Kushner (Eds.), Quality Improvement for Drug Courts: Evidence-Based Practices (pps. 51-61). Alexandria, Virginia: National Drug Court Institute, National Association of Drug Court Professionals.

[82] Gray, A., & Saum, C. (2005). *Mental health, gender, and drug court completion.* American Journal of Criminal Justice*, 30*, 55-69; See also Hickert, A., Boyle, S., & Tollefson, D. (2009). *Factors that predict drug court completion and drop out: Findings from an evaluation of salt lake county's adult felony drug court.* Journal of Social Service Research*, 35,* 149-162; See also Lang, M., & Belenko, S. (2000). *Predicting retention in a residential drug treatment alternative to prison program.* Journal Of Substance Abuse Treatment*, 19*, 145-160; See also Peters, R.H. (2008). *Co-occurring disorders*. In C. Hardin & J.N. Kushner (Eds.), Quality Improvement for Drug Courts: Evidence-Based Practices (pps. 51-61). Alexandria, Virginia: National Drug Court Institute, National Association of Drug Court Professionals.

[83] Substance Abuse and Mental Health Services Administration (SAMHSA, 2009). *Results from the 2008 National Survey on Drug Use and Health: National findings* (Office of Applied Studies, NSDUH Series H-36, HHS Publication No. SMA 09-4434). Rockville, MD.

[84] See Footnote 79.

[85] Drake, R.E., O'Neal, E.L., & Wallach, M.A. (2008). *A systematic review of psychosocial research on psychosocial interventions for people with co-occurring severe mental and substance use disorders.* Journal of Substance Abuse Treatment, 34, 123-138; See also Mueser, K.T., Drake, R.E., Digmon, S.C., & Brunette, M. (2005). *Psychosocial interventions for adults with severe mental illnesses and co-occurring substance use disorders: A review of specific intervention.* Journal of Dual Diagnosis, 1, 57-82; See also Tiet, Q.Q., & Mausback, B. (2007). *Treatments for patients with dual diagnosis:*

tained post-treatment effects for up to 10 years.[86] Integrated treatment typically provides mental health and substance abuse services by a single set of staff in the same setting, and provides tailoring and adaptation of these services for persons with CODs.[87] Other psychosocial interventions that are effective for CODs include cognitive-behavioral treatment, behavioral skills training, group counseling, family interventions, motivational interventions, contingency management, relapse prevention, and psychotropic medication.[88] Case management also enhances retention in COD treatment.[89]

PROVIDING SPECIALIZED DRUG COURT SERVICES
APPLICATION TO DRUG COURT PRACTICE

Specialized clinical approaches for CODs and modifications in the approach of the judge and drug court team have been implemented in a growing number of drug courts, mental health courts, and freestanding COD dockets.[90] The following modifications of treatment services and other drug court practices to accommodate CODs have been successfully implemented in drug courts:

- *All drug court participants are screened and assessed for mental and substance use disorders, cognitive and functional impairment, PTSD/ trauma, and criminal risk level.*[91]
- *Small, frequent, and immediate incentives are used to reinforce positive behaviors.*
- *Jail as a sanction is avoided if possible, with less punitive responses used to sanctionable behaviors.*[92]
- *Staff and peers make greater use of supportive feedback in both individual and group settings.*
- *Expectations related to abstinence, adherence to other program guidelines, and to the level of accomplishments are adjusted for persons with CODs; as are the use of sanctions, incentives, and criteria for phase advancement and graduation.*
- *Supervised peer mentors and peer support groups are utilized.*
- *Programs include treatment modules on criminal thinking, medication management, symptom management, regulation of mood, and aspects of CODs that may reduce risk for relapse.*
- *PTSD, trauma, and history of violence are addressed through use of gender-specific groups.*
- *12-step groups with a specialized focus on CODs, such as Dual Diagnosis Anonymous and Double Trouble are utilized.*
- *Specialized techniques are used to address memory problems or other areas of cognitive impairment.*[93]

Several structural/programmatic modifications for participants with CODs have also been successfully implemented in drug courts, including:

- *Special 'tracks' or dockets (e.g., COD courts) for persons with different levels of CODs and treatment needs*[94]*;*
- *Early stage interventions that focus on ambivalence, motivation, and treatment engagement;*
- *Extended treatment duration of up to 24 months;*
- *Use of a highly structured daily treatment schedule;*
- *Shortened duration of group treatment sessions;*
- *Use of case managers to provide outreach, broker services, monitor involvement in community services, and provide transition planning;*
- *Use of dually credentialed staff, and cross-training of staff in COD issues;*
- *Less formal status hearings, with fewer participants and a more individualized approach;*

A review. Alcoholism: Clinical and Experimental Research, *31*(4), 1-24.

[86] Drake, R.E., McHugo, G.J., Xie, H., Fox, M., Packard, J., & Helmstetter, B. (2006). *Ten-year recovery outcomes for clients with co-occurring schizophrenia and substance use disorders*. Schizophrenia Bulletin, *32*(3), 464-473.

[87] See Footnote 83.

[88] Cleary, M., Hunt, G.E., Mateson, S., & Walter, G. (2008). *Psychosocial treatments for people with co-occurring severe mental illness and substance misuse: systematic review.* Journal of Advanced NursinG, 238-258; See also Center for Substance Abuse Treatment (2007). *Understanding evidence-based practices for co-occurring disorders.* COCE Overview Paper 5. DHHS Publication No. (SMA) 07-4278. Rockville, MD: Substance Abuse and Mental Health Services Administration, and Center for Mental Health Services; See also Footnote 83.

[89] See Footnote 83.

[90] Peters, R.H., Kremling, J., Bekman, N.M., & Caudy, M.S. (2012). *Co-occurring disorders in treatment-based courts: Results of a national survey*. Behavioral Sciences and the Law, 60, 800-820.

[91] One purpose of a comprehensive assessment of CODs is to alert the drug court team to special needs that can't be fully addressed using the traditional drug court approach, and that may require specialized COD services, such as involvement in COD groups, tracks, or dockets; or more intensive supervision and/or monitoring.

[92] If mental health symptoms have worsened for a drug court participant, the purpose of punitive sanctions may not be fully understood, and thus the impact of the sanctions to deter future behavior will be reduced.

[93] For example, 'task sheets' to remind participants what must be completed before their next court appearance, and daily calendars to facilitate tracking of appointments and medications.

[94] Persons with serious mental illness (e.g., bipolar disorder, major depression, psychotic disorders) have been successfully involved in drug courts that provide specialized COD services.

- *More frequent judicial monitoring, case management, and community supervision to ensure participation in treatment and medication adherence;*
- *Specialized community supervision teams with smaller caseloads;*
- *Training in CODs provided to drug court judges, prosecutors, defense attorneys, and community supervision officers.*

B. Dealing With Victims Of Trauma

The topic of *trauma* has received significant attention recently as we have come to recognize the tremendous impact which traumatic experiences in the past can continue to play in the way victims respond to otherwise routine events in the present. The importance of understanding the role which trauma has played in the lives of most, if not all, the individuals who participate in a drug court program cannot be overstated and should frame the interpretation of and responses to the behavior of individuals who participate in the program. Snap decisions therefore should be cast aside for more seasoned probing of the background and history that has brought the individual to drug use and to current involvement with the criminal justice system. Persons who have experienced traumatic events in their lives may react seemingly irrationally to relatively routine events when, in fact, they are reacting quite rationally if one understood the trauma they had experienced and how its memories now trigger their current behavior.

It is common, for example, for persons who have been sexually or otherwise abused as children, to resist going to sleep in a detention situation and thereby be labelled disciplinary problems when, in fact, they are reliving past trauma and trying to protect themselves against reoccurrence. Similarly, individuals may resist being searched, or being observed during drug testing - or even reporting for drug tests - because of past sexual abuse they may have suffered and the memories triggered by having to be observed while providing a urine specimen. Involvement in the criminal justice system itself is traumatic for anyone, let alone an individual who may have had past negative encounters with law enforcement and/or witnessed violent confrontations within their family and/or neighborhood, or, associate the court process with losing a parent sentenced to prison. The whole gamut of drug court operations should therefore be reviewed with a 'trauma informed" perspective. A recent guide relating to judicial practice and potential implications for victims of trauma has been prepared by SAMHSA[95]and highlights many common situations that may trigger "trauma" driven responses.

Trauma has been defined as an event or series of events experienced by an individual that is physically and/or emotionally harmful and has lasting adverse effects on the individual's functioning and well-being. It is the individual's experience of these events and the lasting effect that they have that determines whether they are "traumatic".[96] *Post-traumatic stress disorder* (**PTSD**) is a severe condition that may develop after a person is exposed to one or more traumatic events, such as sexual assault, serious injury or the threat of death, and presents symptoms characterized by disturbing recurring flashbacks, avoidance and/or numbing of memories of the event and can develop after a person has experienced or witnessed a traumatic or terrifying event in which serious physical harm occurred or was threatened. For most people, the effects of these events diminish over time. For a person with PTSD, however, these feelings become intensified over time and can be so strong that they keep the person from living a normal life.

The severity and duration of the effects of trauma vary. Symptoms generally fall into three categories:

- <u>Reliving</u> the ordeal through thoughts and memories of the trauma. These may include flashbacks, hallucinations, and nightmares;
- <u>Avoiding certain</u> people, places, thoughts, or situations that may remind them of the trauma, which can lead to feelings of detachment and isolation from family and friends, as well as a loss of interest in activities that the person once enjoyed; and
- <u>Increased arousal, including</u> excessive emotions; problems relating to others, including feeling or showing affection; difficulty falling or staying asleep; irritability; outbursts of anger; difficulty concentrating; and being "jumpy" or easily startled. A trauma victim may also suffer physical symptoms, such as increased blood pressure and heart rate, rapid breathing, muscle tension, nausea, and diarrhea.

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[95] Substance Abuse and Mental Health Services Administration (SAMHSA). (2013 draft). *Essential components of trauma-informed judicial practice: What every judge needs to know about trauma*.
[96] Substance Abuse and Mental Health Services Administration (SAMHSA). (2012).*Working definition of trauma.* Retrieved from: www.samhsa.gov/traumajustice/traumadefinition.

Persons with a history of trauma are frequently depressed, and their symptoms, may make it difficult to communicate with others or to deal with stressful situations. These individuals can be particularly sensitive to feeling controlled, humiliated, or criticized by authority figures – situations which can occur in a drug court setting -- and may be hyper vigilant to the tone of voice, body language, words, pace of speech, and facial expressions of those with whom they come in contact.

Persons with a history of trauma frequently have other mental disorders (e.g., anxiety, depression) as well as co-occurring substance use disorders.[97] In many cases, individuals try to numb their suffering from trauma with drug and/or alcohol use. Eventually, these efforts to mask the pain, shame, and symptoms may lead to pronounced substance use disorders. Substance use may initially work to dampen the pain of trauma, but also prevents the individual's ability to address the past traumatic events and to heal.

Without involvement in specialized services, drug court participants with trauma histories are likely to have more difficulty engaging in addiction treatment and in responding to program requirements. These participants are also likely to experience "triggers" (e.g., people, objects, places, feelings) related to their past traumatic events that may cause anxiety, depression, and drug cravings. These triggers are often linked to substance addiction relapse and need to be identified and addressed during drug court treatment.

The majority of female and male offenders who are in addiction treatment have histories of trauma and violence.[98] Among female offenders, sexual violence is the most frequently reported traumatic event, followed by intimate partner violence.[99] High rates of trauma and violence are also reported among male offenders.[100] Thus, it should be expected that most drug court participants will have a history of trauma. Many of these persons will have childhood histories of parental abandonment, parental substance addiction, physical abuse, sexual abuse, emotional abuse and/or physical neglect.

Failure to detect trauma at an early stage of drug court involvement can impede treatment progress, and can lead to dropout or early termination from treatment, and emotional and behavior problems (e.g., isolation, depression, continued alcohol and other drug use, defensiveness, anger and hostility) that may be misattributed to lack of motivation, antisocial personality characteristics, and unsuitability for treatment. Lack of screening and assessment also prevents rapid involvement in specialized services for PTSD/trauma, which would otherwise serve to reduce relapse and recidivism.

Once a history of trauma is identified, drug court participants should be referred for a more comprehensive assessment that is conducted by a mental health professional. This assessment needs to examine the full range of traumatic events experienced in the past, consequences of these events, and diagnoses. Mental health professionals should work closely with the drug court team to review the prior history of violence and trauma, and to discuss how current behaviors and substance addiction are affected by the trauma history.

A wide range of trauma/PTSD screening and assessment instruments are available that have demonstrated reliability and validity.[101] Evidence-based screening instruments include:

- The Primary Care PTSD Screen (PC-PTSD), a 4-item screen used extensively by the Veterans Administration (VA);

[97] Rojas, J.I., Brand, M., & Li, J. (2013). *Empirical examination of a Venn diagram heuristic for understanding the relationship between addiction, psychiatric comorbidity and trauma.* Mental Health and Substance Use, http://dx.doi.org/10.1080/17523281.2013.775959.

[98] Cohen, J.B., Dickow, A., Horner, K., Zweben, J.E., Balabis, J., Vandersloot, D., & Reiber, C. (2004). *Abuse and violence history of men and women in treatment for methamphetamine dependence.* American Journal on Addictions, *13*, 377-385; See also Miller, N.A., & Najavits, L.M. (2012*). Creating trauma-informed correctional care: a balance of goals and environment. Clinical Practice Article*, European Journal of Psychotraumatology, 3: 17246 – DOI: 10.3402/ejpt.v3i0.17246; See also Najavits, L.M., Weiss, R.D., & Shaw, S.R. (1997). *The link between substance abuse and post-traumatic stress disorder in women: A research review.* American Journal on Addictions, 6, 273-283; See also Sartor, C.E., McCutcheon, V.V., O'Leary, C.C., Van Buren, D.J., Allsworth, J.E., Jeffe, D.B., & Cottler, L.B. (2012). *Psychiatry Research*, *200*, 602-608.

[99] Miller, N.A., & Najavits, L.M. (2012*). Creating trauma-informed correctional care: a balance of goals and environment. Clinical Practice Article*, European Journal of Psychotraumatology, 3: 17246 – DOI: 10.3402/ejpt.v3i0.17246; See also Zlotnick, C., Najavits, L. M., Rohsenow, D. J., & Johnson, D. M. (2003). *A cognitive-behavioral treatment for incarcerated women with substance abuse disorder and posttraumatic stress disorder: Findings from a pilot study.* Journal of Substance Abuse Treatment, *25*, 99-105.

[100] Powell, T. A., Holt, J. C., & Fondacaro, K. M. (1998*). The prevalence of mental illness among inmates in a rural state.* Law and Human Behavior, *21*(4), 427-437.

[101] Brewin, C.R. (2005). *Systematic review of screening instruments for adults at risk of PTSD.* Journal of Traumatic Stress, *18*(1), 53-62.

- The PTSD Checklist – Civilian Version (PCL-C), a 17-item screen that corresponds to the symptoms of PTSD;
- The Trauma Symptom Inventory (TSI); and
- The Impact of Events Scale – Revised (IES-R).

Several other evidence-based screens are also being used to describe the history of trauma events, including:

- The Stressful Life Events Screening Questionnaire – Revised
- The Life Events Checklist
- The Life Stressor Checklist; and
- The Trauma History Screen.

Other instruments are available to provide a diagnostic assessment of PTSD, including the Clinician-Administered PTSD Scale for DSM-IV (CAPS) and the Post-Traumatic Diagnostic Scale (PDS). The CAPS is available from the Veterans Administration through an on-line request form (http://www.ptsd.va.gov/professional/pages/assessments/caps.asp; http://www.ptsd.va.gov/professional/pages/assessments/ncptsd-instrument-request-form.asp), while the PDS is commercially available through Pearson Clinical Assessment, Inc.

Several treatments have been shown to be effective in addressing trauma and substance abuse.[102] These include: cognitive-behavioral therapy (CBT), which examines shame, guilt, and other maladaptive beliefs related to the traumatic events, and provides mechanisms to cope with physiological consequences of trauma, and help to develop other skills to cope with trauma and PTSD. Another evidence-based treatment for trauma and PTSD is exposure therapy[103], which provides guided exposure to past traumatic events in order to practice coping skills, and to reduce arousal, anxiety, and fear related to these events. Eye movement desensitization and reprocessing (EMDR) is a type of exposure therapy that has proven to be effective among persons who have PTSD.[104]

Several evidence-based treatment curricula have been developed that target both substance abuse and trauma/PTSD. Frequently used treatment curricula include *Seeking Safety*[105] and *Integrated Cognitive Behavioral Treatment for Trauma and Substance Abuse*.[106]

DEALING WITH VICTIMS OF TRAUMA
APPLICATION TO DRUG COURT PRACTICE

- *Given the high rates of trauma and PTSD in drug courts, universal screening for these disorders should be provided for all drug court participants;*
  - ✓ *Several evidence-based trauma screens include the Primary Care PTSD Screen (PC-PTSD), the PTSD Checklist – Civilian Version (PCL-C), the Trauma Symptom Inventory (TSI), and the Impact of Events Scale – Revised (IES-R).*
  - ✓ *Other companion screening instruments should be considered to explore the history of traumatic events, including the Stressful Life Events Screening Questionnaire – Revised, the Life Events Checklist, and the Life Stressor Checklist, and the Trauma History Screen.*
  - ✓ *Screening can be conducted by counselors without specialized training in PTSD and trauma issues, although screening staff should be aware of specialized treatment services that are available within the drug court program and in other community settings.*
  - ✓ *Drug court participants should be given the option of not answering questions related to trauma and PTSD.*
- *Assessment should be conducted by a trained mental health professional/ clinician for drug court participants who receive a positive screen for PTSD and trauma. The assessment should examine the interaction between trauma history and substance use disorders, and provide the foundation for then referring the participant to specialized services, including individual counseling, treatment groups, and consultation for use of*

[102] Bisson, J., & Andrew, M. (2009). *Psychological treatment of post-traumatic stress disorder (PTSD) – Review*. The Cochrane Collaboration Library, Issue 1. New York: John Wiley; See also Bisson, J.I., Ehlers, A., Matthews, R., Pilling, S., Richards, D., & Turner, S. (2007). *Psychological treatments for chronic post-traumatic stress disorder: Systemic review and meta-analysis*. BRITISH JOURNAL OF PSYCHIATRY, *190*, 97-104; See also Bradley, R., Greene, J., Russ, E., Dutra, L., & Westen, D. (2005). *A multidimensional meta-analysis of psychotherapy for PTSD*. AMERICAN JOURNAL OF PSYCHIATRY, *162*(2), 214-227; See also Institute of Medicine (2007). *Treatment of PTSD: An assessment of the evidence*. Report Brief, October 2007. Washington, D.C.

[103] Ibid (2009).

[104] Seidler, G.H., & Wagner, F.E. (2006*). Comparing the efficacy of EMDR and trauma-focused cognitive-behavioral therapy in the treatment of PTSD: a meta-analytic study.* PSYCHOLOGICAL MEDICINE, *36*, 1515-1522.

[105] Najavits, L.M. (2002). *Seeking Safety: A treatment manual for PTSD and substance abuse*. New York: Guilford Press.

[106] McGovern, M.P., Lambert-Harris, C., Acquilano, S., Zie, H., Alterman, A.I., & Weiss, R.D. (2009). *A cognitive behavioral therapy for co-occurring substance use and posttraumatic stress disorders.* ADDICTIVE BEHAVIORS, *34*(10), 892–897.

psychiatric medications. The assessment should also review situations, which may be 'retraumatizing' for drug court participants (e.g., being watched, for example, in the drug testing process), and strategies that can be used to calm the participant when he/she is upset (e.g., exercise, meditation);

- *Coordination of treatment services for trauma/PTSD should include referral of participants to specialized treatment services within the drug court or in affiliated community provider agencies. The drug court program should identify all possible community resources to maximize and leverage the necessary services and supports for participants who have a history of trauma, although specialized trauma services may be limited in scope in some communities. Some drug courts have utilized mentors (e.g., 'Mentor Moms'; etc.) to supplement team member support for persons with trauma histories;*
- *Drug court participants who have histories of trauma and PTSD should be involved in integrated and evidence-based treatment that addresses the interaction of trauma/PTSD and substance addiction. Treatment should include cognitive-behavioral therapy and may also include exposure therapy. Treatment should include individual counseling (essential in providing exposure therapy) and gender-specific group treatment. Other mental health services should be available, including consultation for psychiatric medication;*
- *Counselors who provide trauma/PTSD treatment services should attend drug court staffings and status hearings. This allows sharing of key information about the effects of trauma/PTSD on substance addiction, and participation in addiction treatment and other aspects of the drug court program. This strategy will also assist the drug court team in developing appropriate sanctions, which demonstrate to participants that the team works together to make decisions about their care, and is invested in creating a safe and protective environment;.*
- *Sanctions should take into consideration behaviors that are precipitated by the trauma/PTSD, such as noncompliance with drug testing due to associated fears related to being observed, and memories of sexual abuse. Some sanctions, such as detention, may also lead to re-traumatization of drug court participants. The drug court team should review the effects of trauma/PTSD on participant behaviors when making decisions about sanctions;*
- *Incentives and support for engagement in drug court services should be augmented for participants who have a history of trauma and PTSD. Incentives may include praise and words of encouragement from the judge, and assistance with budgeting, and job training. It is essential to build upon participants' strengths and their desire to regain independence, skills, and competencies;*
- *Status hearings may be structured differently for participants who have a history of trauma/PTSD, for example, by having them appear at the start or end of the docket to enhance confidentiality of information shared and to provide a less formal environment. The drug court judge can help to ensure that status hearings are supportive and focused on rehabilitation, and are less confrontational and adversarial for persons with a history of trauma. Status hearings for these drug court participants should also focus on their support and safety in the community, and on recognizing and building on personal strengths that can assist in the recovery process;*
- *The entire drug court process should be reviewed from the perspective of seemingly routine procedures potentially triggering non-routine responses in victims of trauma, including the way verbal communication is phrased, the way program requirements are explained, and, most important, the responses to what may be initially deemed non-compliant behavior[107];*
- *Training should be provided for all drug court staff on the relationships between trauma and substance use disorders. It is important for drug court staff to understand that the court experience can be confusing, intimidating, disempowering, and, at times, re-traumatizing.*

C. Persons With Cognitive And Intellectual Disabilities

An estimated 53 million persons (17%) have a disability that inhibits their functioning, including physical, cognitive, and intellectual impairment.[108] These disabilities include, although are by no means limited to, persons who have extremely limited reading ability. Rates of substance abuse among persons with cognitive and development disabilities are two to four times higher than those for the general population.[109] These symptoms are often undetected unless a comprehensive assessment is conducted that focuses on cognitive functioning. As with victims of trauma, persons with cognitive impairments may be mischaracterized as having low motivation or resistant to treatment, or to complying with drug court program

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[107] Substance Abuse and Mental Health Services Administration. (Draft.2013). *Essential Components of Trauma-informed Judicial Practice. What Every Judge Needs to Know about Trauma*.
[108] Center for Substance Abuse Treatment. (2006b). *Substance Abuse: Clinical issues in intensive outpatient treatment*. Treatment Improvement Protocol (TIP) Series 47. DHHS Publication No. (SMA) 06-4182. Rockville, MD: Substance Abuse and Mental Health Services Administration.
[109] National Association on Alcohol, Drugs and Disability (1999). *Access limited - Substance abuse services for people with disabilities: A national perspective.* San Mateo, CA: Author.

conditions when they actually do not fully comprehend them.

Many individuals eligible for drug court programs have intellectual or cognitive disabilities – often the product of or exacerbated by drug use -- which are undiagnosed. These disabilities can result in their being routinely excluded or terminated from drug courts and mental health courts because they are deemed unable to meet basic program requirements, and/or have difficulties in keeping pace with other participants, do not progress through treatment phases and towards graduation in the same manner as other participants

Many addiction treatment programs are ill-equipped to address the unique needs of persons who have cognitive and intellectual disabilities. In drug courts and other treatment settings, participants' disabilities are often associated with functional impairment that affects their involvement in individual and group counseling and other core treatment activities.[110]

Upon encounters with law enforcement, persons with these disabilities are also likely to communicate and behave in ways that increase the possibility of arrest and punishment.[111] As a result, these individuals are more likely to be arrested, to receive technical violations on community supervision, to receive punishment instead of treatment, and to serve longer terms in jail and prison. When appearing in court, persons with intellectual and cognitive disabilities often exhibit delays in language development, deficits in memory skills, difficulty in learning and following rules, difficulty with problem-solving skills, lack of social inhibition, and delays in learning adaptive behaviors such as self-care skills and participation in AA and NA.

Persons with these disabilities present challenges to drug courts which need to be addressed so that they are not excluded from the potential benefits the intensive drug court oversight, monitoring, and services can provide.

Screening and assessment instruments used to examine intellectual, cognitive, and other areas of functional disabilities include the Montreal Cognitive Assessment (MOCA), the Mini-Mental State Examination, 2nd Edition (MMSE-2), the Beta-III, the WAIS-Abbreviated Scale of Intelligence (WASI), and the Role Functioning Scale. The latter instrument reviews four areas of adult functioning: work productivity, independent living and self-care, immediate social-network relationships, and extended social-network relationships. Instruments used to examine trauma and PTSD include the Primary Care PTSD Screen (PC-PTSD), the PTSD Checklist-Civilian Version (PCL-C), and the Stressful Life Events Screening Questionnaire-Revised (SLESQ-R). The SLESQ-R can be used to identify the history of traumatic events, and the PTSD screens (e.g., PC-PTSD, PCL-C) can then be used to examine the current level of impairment related to each of these events.

PERSONS WITH COGNITIVE AND INTELLECTUAL DISABILITIES
APPLICATION TO DRUG COURT PRACTICE

- *All drug court program materials (participant agreements, treatment workbooks, etc.) should be reviewed to determine whether the information would be comprehensible to a person of limited reading ability, communication skills, and cognitive functioning and revise, as necessary;*
- *Supervision should be modified to address the needs of the participant, and to maximize engagement in the drug court program;*
- *Supervision case plans should be individualized, and should focus on small and incremental steps towards recovery goals, rather than on "standard conditions" of probation;*
- *Community supervision caseloads should be small to accommodate the need for enhanced personal contacts, home visits, and monitoring of engagement in a range of service;*
- *Participants identified as having intellectual and cognitive disabilities should receive specialized assessment that addresses mental and substance use disorders, cognitive and functional impairment, history of trauma/violence and, deficits related to daily living skills, and criminal risk level. Several instruments are available to examine intellectual and cognitive deficits, as previously noted;*
- *Behavioral treatment curricula should be considered that focus on basic skills development;*
- *The duration of the drug court program may need to be extended beyond 12 months;*
- *Group treatment sessions should be shorter in duration and should focus on only a few content areas per session;*
- *Efforts should be made to minimize the need for abstraction (e.g., through use of concrete examples), instructions should be brief and included in written form, and audiovisual aids should be used whenever possible;*

[110] Ibid (2006b).
[111] Perske, R. (1991). *Unequal Justice*. Nashville: Abingdon press

- *Time to complete homework should be provided during the treatment session. Participants with intellectual and cognitive deficits should demonstrate skills through short and focused role plays;*
- *Participants with cognitive and intellectual disabilities may benefit from smaller, more individualized, and less formal hearings;*
- *Jail time should be used sparingly as a sanction;*
- *Training on intellectual and cognitive disabilities should be provided to the entire drug court team;*
- *The program should coordinate with law enforcement and the public defender, in particular, regarding any perceived limitations they note in terms of the participant's ability to comprehend and respond to questions that are asked and instructions that are given to identify potential cognitive impairments that warrant attention.*
- *The individual's educational record should also be reviewed early on, with particular attention to his/her literacy status;*
- *Treatment services for participants with intellectual and cognitive disabilities should be more individualized and supportive in comparison to traditional drug court approaches.*
- *In addition to addiction treatment, the following types of services are needed for persons with cognitive and/or intellectual disabilities participating in the drug court program:*
  - ✓ *Intensive case management*
  - ✓ *GED or other educational services*
  - ✓ *Crisis services*
  - ✓ *Supported housing*
  - ✓ *Highly structured day treatment services*
  - ✓ *Independent life skills training*
  - ✓ *Training and involvement of caregivers/ family members*
  - ✓ *Medication management*
  - ✓ *Mental health treatment*
  - ✓ *Focus on expanding positive social/peer networks*
  - ✓ *Identification of abusive situations and past victimization and trauma*
  - ✓ *Help in obtaining financial benefits*

D. Racial And Ethnic Populations: Cultural Proficiency

Culturally competent drug court services bring together a combination of attitudes, skills and knowledge that allows drug court professionals to better understand and respond to the wide range of attitudes, beliefs, experiences, and other factors that shape a participant's orientation to the program and receptivity to the services being provided. Providing culturally competent drug court treatment and other services requires an understanding on the part of all personnel involved with the program of the attitudes, backgrounds, religious beliefs, experiences, social relationships, values, and other factors that shape the "cultural" orientation of the participants in the drug court and the application of that understanding to the program's operations and services. Stigma related to substance abuse and mental health disorders, for example, is a significant issue among some racial/cultural populations, as these disorders are often seen to reflect poorly on the family and to reduce opportunities for vocational advancement and for marriage.

While this section focuses on racial and ethnic population groups generally, clearly there are important subsets within these groups and the drug court population as a whole for which special strategies and services also need to be developed (See, for example, Section A: Persons with Co-Occurring Disorders, Section B: Victims of Trauma: Sections E: Gender; and Section F: and Young Adults.).

First and foremost, drug courts must demonstrate an understanding of the racial/ethnic composition of their program and the larger target population they seek to serve. Instruments are available to assess the drug court program's cultural competence.[112] These assessments consider factors such as program policies and procedures, staff diversity, staff training and supervision needs, screening and assessment techniques, treatment interventions, and overall program design. A multi-component cultural competency assessment process for drug courts is described by Osborne[113] that addresses data to be collected by the program, a review of training needs, staffing characteristics (e.g., racial/ethnic composition, bilingual/multilingual capability), and drug court "performance patterns" that are likely to enhance engage-

[112] Center for Substance Abuse Treatment (2006a). *Substance abuse: Administrative issues in outpatient treatment.* Treatment Improvement Protocol (TIP) Series 46. DHHS Publication No. (SMA) 06-4151. Rockville, MD: Substance Abuse and Mental Health Services Administration; See also Osborne, A. (2008). *Cultural competency in drug court treatment.* In C. Hardin & J.N. Kushner (Eds.), Quality Improvement for Drug Courts: Evidence-Based Practices (pps. 51-61). Alexandria, Virginia: National Drug Court Institute, National Association of Drug Court Professionals.
[113] Ibid (2008).

ment among participants from special racial and ethnic population groups.

Based on results of a cultural competence self-assessment, the drug court program can proceed to identify staff training and development needs, explore staff attitudes, beliefs, and values related to serving cultural minorities; locate culturally valid screening and assessment instruments, and to adapt treatment interventions such as culturally-sensitive substance abuse treatment curricula. Drug courts can also identify barriers to treatment for cultural minorities, and work to remove these barriers (e.g., translating program handbooks and treatment manuals for participants who speak English as a second language). As developing cultural competency and proficiency is an ongoing process, drug courts should continue to monitor the composition of their population, their training needs, related program services, and outcomes among special population groups.

There is no single, universally accepted approach to providing culturally competent addiction treatment that is applicable for all drug courts, as the composition of drug courts varies widely, as does the level of resources and community services. Treatment adaptations for drug courts may include providing individual counseling that addresses issues related to special cultural populations, or groups for persons with limited fluency in English, or persons who have difficulties with self-esteem, identity, and alienation related to their racial/ethnic background.[114]

RACIAL AND ETHNIC POPULATIONS
APPLICATION TO DRUG COURT PRACTICE

- *Important culturally relevant substance abuse treatment topics to consider in individual or group interventions include the following (CSAT, 2006a; Osborne, 2008):*
  - ✓ *Spiritual beliefs, customs, and rituals*
  - ✓ *Relationships with the extended family*
  - ✓ *Beliefs about accepting help from professional caregivers for personal problems*
  - ✓ *Respect and personal dignity*
  - ✓ *Trust and disclosure with authority figures*
  - ✓ *Gender roles*
  - ✓ *Child-rearing roles and expectations*
- *Drug court treatment staff should consider the participant's cultural background in conducting the addiction treatment assessment and developing a treatment plan. In general, the more acculturated the person is, the less likely that drug court treatment services need to be modified. However, having been born in the U.S. is no guarantee that a drug court participant is fully acculturated[115];*
- *Data should be maintained and regularly reviewed to permit the program to determine whether special racial or ethnic populations have a higher/lower frequency of (a) entering the program; (b) remaining in the program; and/or (c) completing the program . Any anomalies identified should be promptly investigated.*

E. GENDER-SPECIFIC SERVICES

Historically, addiction treatment services were developed with male clients in mind because the vast majority of admissions to substance abuse treatment programs have men. More recently, specialized addiction treatment programs and interventions have been developed for both women and men, recognizing that programs with gender-specific groups have better outcomes.[116] Mixed gender groups for addiction treatment for the most part have generally not been as successful as gender specific groups. Gender-specific treatment services are now the accepted norm within the addiction treatment field, and have been implemented across the country

Regardless of age or race, men use alcohol and drugs more frequently and in greater quantities than women (SAMHSA's 2008 National Survey of Drug Use and Health (NSDUH)). Reflecting these differences in use, American men are two to five times more likely to develop a substance use disorder than women although women take a shorter amount of time from their first use of alcohol and other drugs to demonstrate "dependency" (substance use disorder) symptoms.

Men's and women's responses to substance use and addiction treatment also differ. These insights have improved treatment for women and they can also improve treatment for men. "Men die at a younger age on average than women; men are also more likely than women to have a substance use disorder, to be incarcerated, to be homeless as adults, to die of sui-

[114] Ibid (2006a).

[115] Ibid (2006a).

[116] Substance Abuse and Mental Health Services Administration. (2013). *Addressing the Specific Behavioral Health Needs of Men*. Treatment Improvement Protocol (TIP) Services 56. HHS Publication No. (SMA) 13-4736. Rockville, Maryland. Substance Abuse and Mental Health Services Administration, 2013, p. 1. (Substance Abuse and Mental Health Administration [SAMHSA]. Office of Applied Studies [OAS] 2007d).

cide, and to be victims of violent crime. Conversely, men are less likely than women to seek medical help or behavioral health counseling for any of the problems they face."[117] Additionally when men do seek help, "additional negative consequences may arise, such as stress, anxiety, shame, rejection, low self-esteem, depression, and other mental problems that have been sedated or disguised by the substance use."[118]

1. *Special Services For Women*

Given their higher rates of arrest and incarceration in recent years, women with substance use disorders are increasingly being referred to treatment under court supervision. Women involved with the criminal justice system have serious problems across multiple domains (e.g., educational, employment, family, legal, mental and physical health, substance use). [119] Women offenders also typically report more severe problems as compared with men, e.g., higher rates of substance use disorders, injection drug use, drug-related problems, mental health problems, and physical health problems.[120] Few studies have specifically evaluated the outcomes of women participating in drug court[121] although one study showed lower rates of recidivism among women methamphetamine users than men in drug court.[122]

A growing body of research supports the provision of "gender specific" or "gender responsive" treatment for women offenders that is tailored to their treatment needs. Several comprehensive reviews have shown that women have higher rates of treatment completion and better outcomes when they are treated in: (1) women-only programs, including women counselors, (2) residential programs that have live-in accommodations for children, and (3) outpatient programs that provide child care, parenting services, transportation, and other comprehensive services.[123] Provision of women-specific groups enables women to discuss issues that are unique to them (e.g., trauma and abuse, loss of children, involvement in sex work, relationships) without shame or stigma that may occur in mixed-gender groups.[124]

Women offenders with substance use disorders typically also have mental health problems, most commonly anxiety and depression. About half of women on probation or parole have a past-year mental disorder, which is approximately twice the rate of women in the general population.[125] Given their high rates of trauma exposure, women offenders also have high rates of post-traumatic stress disorder (PTSD). Rates of lifetime PTSD among women offenders typically range from one quarter to one third.[126] Incarcerated women are especially at risk for trauma re-exposure and PTSD if they engage in prostitution.[127]

Women offenders also typically have limited employment skills and work[128], and may require vocational services, including basic education and GED preparation. Because many women have repeated prior arrests and incarcerations, they often have been separated from their children for significant periods and issues concerning family reunification need to be addressed. Such women often lack basic parenting skills and appropriate parental attitudes.[129]

[117] Tip 56, Substance Abuse and Mental Health Services Administration, page xiii.

[118] Tip 56, Substance Abuse and Mental Health Services Administration, page xiv.

[119] Grella, C. E., & Greenwell, L. (2007). *Treatment needs and completion of community-based aftercare among substance-abusing women offenders*. Women's Health Issues, *17*(4), 244-255.

[120] Belenko, S., & Houser, K. (2012). *Gender differences in engagement in prison-based drug treatment.* International Journal of Offender Therapy And Comparative Criminology*, 56*(5), 790-810.

[121] Shaffer, D. K., Hartman, J. L., & Listman, S. J. (2009). *Drug abusing women in the community: The impact of drug court involvement on recidivism.* JOURNAL OF DRUG ISSUES, *39*(4), 803-827.

[122] Hartman, J. L., Listwan, S. J., & Schaffer, D. K. (2007). *Methamphetamine users in a community-based drug court: Does gender matter?* Journal of Offender Rehabilitation, *45*(3-4), 109-130.

[123] Grella, C. E. (2008). *From generic to gender-responsive treatment: Changes in social policies, treatment services, and outcomes of women in substance abuse treatment*. Journal of Psychoactive Drugs, SARC Supplement *5,* 327-343.

[124] Beckerman, A., & Fontana, L. (2002). *Issues of race and gender in court-ordered substance abuse treatment*. Journal of Offender Rehabilitation*, 33*(4), 45-61.

[125] National Survey on Drug Use and Health (NSDUH). (2012). *Half of women on probation or parole experience mental illness.* Rockville, MD: Center for Behavioral Health Statistics and Quality: Data Spotlight, Substance Abuse & Mental Health Services Administration.

[126] Hutton, H. E., Treisman, G. J., Hunt, W. R., Fishman, M., Kendig, N., Swetz, A., & Lyketsos, C. G. (2001). *HIV risk behaviors and their relationship to posttraumatic stress disorder among women prisoners.* Psychiatric Services*, 52*(4), 508-513.

[127] Millay, T. A., Satyanarayana, V. A., O'Leary, C. C., Crecelius, R., & Cottler, L. B. (2009). *Risky business: Focus-group analysis of sexual behaviors, drug use and victimization among incarcerated women in St. Louis.* Journal of Urban Health*, 86*(5), 810-817.

[128] Langan, N. P., & Pelissier, B. (2001). *Gender differences among prisoners in drug treatment.* Journal of Substance Abuse*, 13*(3), 291-301; See also Pelissier, B., & Jones, N. (2005). *A review of gender differences among substance abusers.* Crime & Delinquency, *51*(3), 343-372.

[129] Grella, C. E., & Greenwell, L. (2006). *Correlates of parental status and attitudes toward parenting among substance-abusing women offenders*. The Prison Journal, *86*(1), 89-113.

Women offenders also often have physical health problems that stem from the effects of their substance addiction and associated unhealthy behaviors, which are exacerbated by their lack of access to or utilization of health care services.[130] Women offenders have high rates of sexual risk behaviors, which make them vulnerable to HIV and other STDs[131] sexual risk behaviors are particularly high among women with greater alcohol use and psychiatric severity.[132]

SPECIAL SERVICES FOR WOMEN
APPLICATION TO DRUG COURT PRACTICE

- Drug courts should provide substance abuse treatment services that include components tailored to address women's needs, including:
  - ✓ *Pregnancy-related services, including prenatal and post-natal, comprehensive case management, and supportive services; [studies have shown that the higher costs associated with these services are offset by improvements in pregnancy and birth-related outcome][133];*
  - ✓ *Parenting-related service needs, parenting skills training, family-focused services, and, if appropriate, coordination between treatment and child welfare services;*
  - ✓ *Services to address issues relating to intimate partner relationships and problems related to domestic violence or partner substance use/criminal behavior involvement;*
  - ✓ *Training in relationship skills, including assertiveness and skills for negotiating safer sex;*
  - ✓ *Mental health screening and assessment and, when indicated, integration of mental health treatment within addiction treatment;*
  - ✓ *Screening for history of trauma and the ongoing effects of exposure to trauma, violence, and victimization, including post-traumatic stress disorder (PTSD) and trauma/PTSD groups or services;*
  - ✓ *Referrals for educational services (e.g., literacy training, GED equivalence) and employment services (e.g., pre-vocational and vocational assessments, interviewing, job search);*
  - ✓ *Health screening, including for infectious diseases, chronic health problems, dental issues, and reproductive-health problems or needs, and referral for needed health services*
  - ✓ *Other services consistent with evidence-based approaches specifically adapted for use with women.*

2. Special Services For Males

It is reported that 68.2 percent of admissions to substance abuse treatment programs receiving State agency funds were men[134]; however, data from 2005 show that only 25 percent of programs offered any type of specialized services for adult men.[135]

Stereotypes of masculine behavior have a lot to do with shaping men's behavior. These stereotypes push men to restrict their emotional responsiveness, and to be more competitive, aggressive, and self-reliant. These roles may hinder men from seeking needed treatment as well as fully participating in that treatment. Men also are likely to be ambivalent about seeking alcohol and other drug addiction treatment, and may perceive treatment involvement as a sign of 'weakness' or vulnerability, and these issues should be discussed with them. Men are also typically embarrassed or reluctant to talk about feelings and often require a more concrete objective, goal specific plan. Men may have problems expressing emotion and some may feel excessive shame, both problems for men in substance use disorder treatment.

Treatment professionals and drug court team members should recognize the reasons that men enter treatment (arrest and conviction for drug related crimes, referrals from health resources, and family or work-related pressure and the resentment and anger that can go along with it), and different motivations for involvement in treatment. Specialized gender-specific approaches to treatment are often needed

[130] Staton, M., Leukefeld, C., & Logan, T. K. (2001). *Health service utilization and victimization among incarcerated female substance users.* Substance Use & Misuse, *36*(6-7), 701-716.
[131] Guydish, J., Chan, M., Bostrom, A., Jessup, M. A., Davis, T. B., & Marsh, C. (2011). *A randomized trial of probation case management for drug-involved women offenders.* Crime & Delinquency, *57*(2) 167-198; See also
Scott, C. K., & Dennis, M. L. (2012). *The first 90 days following release from jail: Findings from the Recovery Management Checkups for Women Offenders (RMCWO) experiment.* Drug and Alcohol Dependence, *125*(1-2), 110-118.
[132] Brooks, A., Meade, C. S., Potter, J. S., Lokhnygina, Y., Calsyn, D. A., & Greenfield, S. F. (2010). *Gender differences in the rates and correlates of HIV risk behaviors among drug abusers.* Substance Use & Misuse, *45*(14), 2444-2469.
[133] Svikis, D.S., Golden, A.S., Huggins, G.R., Pickens, R.W., McCaul, M.E., Velez, M.L., Rosendale, C.T., Brooner, R.K., Gazaway, P.M., Stitzer, M.L., & Ball, C.E. (1997). *Cost-effectiveness of treatment for drug-abusing pregnant women*. Drug and Alcohol Dependence, *45*, 105-113
[134] According to Treatment Improvement Protocol (TIP) 56 (*Addressing the Specific Behavioral Health Needs of Men*).
[135] Substance Abuse and Mental Health Services Administration (2013). *Addressing the specific behavioral health needs of men. Treatment Improvement Protocol (TIP) Series 56*. HHS Publication No. (SMA) 13-4736. Rockville, MD.

for men. For example, men are often ambivalent about seeking help for alcohol and other drug problems as well as related health problems and this, too, requires special approaches and careful establishment of trust and rapport with the drug court participant.

Important elements/issues for men's discussion in treatment may include:

- Discussion of "The Rules of Being a Man" and how men have spent their lives trying to be "certain kinds" of men;
- Who they think they are now and their expectations of being in recovery that can often feel quite "unmanly."
- Getting men to open up in group and small group discussions of men only**.**
- Talking about sex and sexuality (not feeling comfortable with engaging in sex while sober, fear of sex, and discomfort with themselves sexually, pain from sexual trauma, body image, the growing awareness of unhealthy dependency in relationships, sex versus intimacy and social bonding).
- Homophobia and the fear of men and getting close and having a relationship with other men.

Both male and female counselors have their advantages and programs need to consider the specific client as well as a range of other counselor-and program-related factors in assigning the most appropriate counselor for any given drug court participant. For example, men may be more comfortable with a female counselor and showing their weakness to female therapists, who they believe are less likely to judge them for their failures, real or imagined; they may believe that women are more sensitive and better able to address emotional problems; or they may have had negative experiences with male counselors in the past.[136] If someone does not appear to be working out, a change of gender may be a consideration.

Anger is a common problem for men with substance use disorders and can be exacerbated by the stress of early recovery. Because of men's socialization, anger is one of the only emotions that many men feel comfortable expressing—thus, they often use it to cover up emotions (e.g. fear, grief, sadness) that they feel inhibited about expressing (Lyme et al. 2008). Once a male enters treatment, they may discover that they lack basic parenting skills. This could have been a problem all along but they did not recognize it when they were using.

All male groups may be beneficial from several aspects: provides an opportunity for men to relate to other men without being distracted into game playing to impress women; promotes caring and friendship with other men; provides an opportunity for men to discuss sensitive topics (such as dating, cohabiting, child custody) more freely; provides an opportunity for men to discuss with other men issues relating to relationships with women and learn how other men relate to women; and provides an opportunity to discuss male health problems more freely.

SPECIAL SERVICES FOR MALES
APPLICATION TO DRUG COURT PRACTICE

- *Use of motivational interviewing and other techniques to promote engagement and retention of men in treatment may be particularly important since men in general, regardless of age or cultural background, are less likely than women to seek treatment and more likely to leave treatment early. These skills should receive primary attention in training programs for all drug court personnel.*
- *The assessment for men should pay particular attention to:*
  - ✓ *Employment status (work history, education, vocational goals and training needs),*
  - ✓ *Housing status and needs (if housing adequate, explore risk of losing housing and whether there drug use in the house),*
  - ✓ *Criminal justice involvement and legal issues*
  - ✓ *Health status/physical health (last physical, aches and pains, lab work for hepatitis C and HIV/AIDS, cirrhosis and pancreatitis, etc.),*
  - ✓ *Functional limitations (co-occurring physical and/or cognitive disabilities)*
  - ✓ *Co-occurring mental disorders, trauma histories, relapse risk and recovery support (risk factors for relapse and supports for recovery, family history of substance abuse and family strengths, childhood abuse and neglect.*

SAMHSA's *TIP 56* provides advice to clinicians to help men seeking professional assistance. Drug Court team members should understand these suggestions as well:

- *Establish rapport and trust with the client;*

[136] Johnson, S. L., van de Ven, J. T. C., & Grant, B. A. (2001). *Institutional methadone maintenance treatment: Impact on release outcome and institutional behaviour* (Research Rep. No. 119). Ottawa: Research Branch, Correctional Service of Canada.

- *Since male clients may feel threatened by or uncomfortable with the help-seeking process, consider spending some time initially talking with them about neutral topics;*
- *Determine what set of circumstances prompted the help-seeking behavior;*
- *Engage the client in discussions of his life and situation;*
- *Acknowledge common fears related to relationships, health, abandonment, career, and financial issues;*
- *Since men are typically socialized to be goal-directed and action-oriented, be clear at the end of a session as to what will occur next. Be concrete;*
- *Give men something to do to prepare for the next step, (e.g., a telephone call to arrange a session with a significant other, make an appointment to resolve a health problem, meet with a family member, get a letter of verification of attendance) which can support their sense of confidence, control and usefulness;*
- *Emphasize options and the importance of free choice, even when choices are limited, generally support men's need for a sense of independence and autonomy;*
- *Avoid arguments and use a more subtle, less confrontational manner;*
- *Reframe coming to treatment as a success and sign of strength and courage;*
- *When discussing emotions, monitor intensity, and don't push clients to a point of being overwhelmed;*
- *Consider the role that gender may play in selecting a primary counselor in treatment;*
- *Query your drug court treatment program regarding their capability of delivering anger management counseling for individuals exhibiting a high level of anger;*
- *Query your drug court treatment program regarding their ability to include a component around the development of basic parenting skills for drug court participants;*
- *Consider some level of gender specific-group treatment for males*[137]

3. *Other Issues Relating To Gender: Gender Identification And Sexual Orientation*

This section has provided an overview of common issues relating to the provision of gender-specific services as a framework for drug court programs to further develop appropriate services for their participants. It should be recognized, however, that there are many additional issues that need to be addressed to adequately respond to the gender issues drug court participants may be dealing with. These include: gender identification; and sexual orientation (lesbian, bi-sexual, gay, straight).

F. Young Adult Males

A unique subpopulation of young adults, primarily, 18 to 25 year old male offenders, who are primarily recreational marijuana users or have cannabis use disorder, are either not served by drug courts or, if admitted, are frequently unsuccessfully terminated. The reason is that, although they are *high risk* to reoffend, they are *low risk* for treatment and so, do not meet the *high risk/high need* definition. This population is also frequently involved in drug sales and may also be gang affiliated, negating their eligibility for many adult drug courts. Many also may have low self-esteem, appearing uncooperative, disinterested and distracted.

These young adults need to be recognized as a high cost to society cohort and as such need to be served in a tailored drug court track/program. It is a disservice to the community as well as to these young men to exclude them from drug courts because they are a high risk group to reoffend, and will potentially cycle in and out of the criminal justice system for the rest of their lives once they pick up a felony.

Longitudinal research from the National Institute of Mental Health[i] has demonstrated that brain development, and specifically, that area in the brain that is related to reasoning and problem solving, is the later to mature, as late as age 25. As noted by the lead author of this study, Dr. Jay Giedd "the part of the brain that is helping organization, planning and strategizing is not done being built yet."[138] The implications of this finding are notable: organization, planning and strategizing are exactly the skills needed to successfully function in the community. Young adults need a broad range of diversified services at earlier stages to assist them in this regard. Drug education and treatment (depending on level of treatment need), enhanced by psychosocial programming and other supported services and case management provided by drug courts, can substantially increase and improve outcomes with this target population.

If the young adult males are not treated appropriately in the drug court, the potential for a long history of

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[137] The TIP 56 consensus panel believes that the curriculum entitled*, "Time Out! For Men" shows promise.*

[138] Geidd, J. (2002). *Inside the teen brain*. Interview with PBS Frontline. Retrieved online at www.pbs.org/wgbh/pages/frontline/shows/teenbrain/.

criminal offenses and incarcerations may be the norm, as Dr. Doug Marlowe stated (Drug Court Practitioner Fact Sheet entitled*, Alternative Tracks in Adult Drug Courts: Matching Your Program to the Needs of Your_Clients*), "If low-risk or not-addicted individuals are ineligible for drug court, they may have no other option but to face prosecution, and possibly incarceration, without an opportunity to be diverted into an effective rehabilitative disposition." Marlowe continues: for the high risk (to reoffend) and low need (for intensive treatment), "the emphasis should be on closely monitoring their behavior, holding them accountable for their conduct and teaching them prosocial life skills."

YOUNG ADULT MALES
APPLICATION TO DRUG COURT PRACTICE

Programming for young drug court participants should have as a goal replacing participants' former street-life activities, especially selling drugs, with other activities. Engagement in the kinds of activities described below in the regimen of regular drug court can provide an alternative to further involvement in drug distribution, drug use and other criminal activities.

Listed below are the core components of effective approaches got effectively working with Young Males;

- ***Validated Screening Instruments** –Drug Courts should use a validated risk/needs assessment instrument to establish initial prognostic risk and criminogenic need to determine level of treatment needed, if any, and supervision needed for the young drug court participant. If the need for formal treatment is not indicated, providing early intervention groups (psycho-educational) rather than treatment for the young drug court participant may be necessary as formal substance abuse treatment can lead to higher rates of drug usage[139];*
- ***Early And Comprehensive Initial Assessment**: A thorough assessment should be performed at the outset to determine the most appropriate track for each participant, any individualized treatment that may be needed, any underlying disorders that the individual may be using drugs to mask or control (e.g. ADHD, depression, more serious mental illnesses such as bipolar disorder and schizophrenia, etc.);*
- ***Develop Activities That Promote A Broad Range Of Skill Development**: A re-orienting of daily activities away from drug-related peers and events will be necessary. Examples of constructive activities as part of this re-orientation might include: reviewing current event activities requiring use of local newspapers, the Internet, and the local library, advancing their academic levels, part-time work, classes/speakers on the following topics: anger-management, budgeting and finance, drugs & society and the role of fathers, child support, manhood problems, impulse control, AIDS, male-female relationships, positive parenting, risk and protective factors, youth oriented and youth led self-help / 12-step activities;*
- ***Promote Engagement In Pro-Social Recreational/ Leisure Activities**: Engage young participants in recreational activities at local gyms (YMCA, etc.) and provide field trips to museums, libraries, historical landmarks and restaurants for the purpose of practicing etiquette;*
- ***Build Rapport**: The Drug Court judge and other team members should take advantage of all interactions with the participant as opportunities to reinforce the participant's accomplishments, progress, and self-worth and create a constructive environment for their participation in the program;*
- ***Promote Opportunities For Educational Advancement**: Completion of the GED Degree and the opportunity to take the test and receive a high school diploma equivalent is most important for eventual employment. Drug court team members should also encourage participants to obtain a trade or complete vocational opportunities and some to go to college;*
- ***Drug Education**: Drug education should be provided so that participants learn about the biology of addiction and the impact of drugs on the brain. Consider having participants take responsibility for teaching other class members specific components through peer learning. This process can serve to reinforce their own knowledge of the material and enhance self-esteem by allowing them to assume a positive leadership role;*
- ***Group Therapy**: Although manualized curricula should be utilized, participants should not be continually held to a predefined list of topics to address. As a group, they can also present and decide upon what issues they view as priorities for discussion in addition to subject matter covered in curricula;*
- ***Life Skills Mentoring**: Consider linking participants to a mentor or advocate in the community at the outset of drug court participation who can serve as a resource and guide as they negotiate and acquire new social and coping skills. Drug Court alumni can serve as a pool of possible mentors;*
- ***Occupational Mentoring**: As part of their road to employment, have participants select a vocation in which they would like to receive instruction and training. Participants can be paired with a mentor in that vocation*

[139] Lovins, L.B., Lowenkamp, C.T., Latessa, E.J. & Smith, P. (2007). *Application of the risk principle to female offenders*. Journal of Contemporary Criminal Justice, 23, 383–398; See also Lowenkamp, C.T., & Latessa, E.J. (2005). *Increasing the effectiveness of correctional programming through the risk principle: Identifying offenders for residential placement.* Criminology & Public Policy, 4, 263-290; See also Szalavitz, M. (2010). *Does teen drug rehab cure addiction or create it?* Time Magazine On-Line, at http://time.com/time/printout/0,8816,2003160,00.html.

who can serve as their personal teacher and resource to enhance their chances of employment once they have completed the program. As part of their vocational training, participants should also receive guidance in completing employment applications, creating a resume, job seeking, and interview skills;

- ***Manhood/Womanhood Training:*** *Offer participants the opportunity to explore myths, stereotypes and misconceptions of manhood/ womanhood. Participants can offer their definitions and perceptions of power, responsibility and what being a man or woman means to them, their families, their communities and the greater society. From that vantage point, they can collectively reassess their images and beliefs surrounding manhood/ womanhood. They can separate fact from fiction and begin to examine how mainstream images, including Hip Hop and other forms of popular entertainment, advertisers, and the news media depict young people, and shape society's and their own perceptions of themselves. They can then examine and deconstruct these images in relation to their own self-image and decide on what they should keep and what should discard;*
- ***Strength-Based Treatment Models:*** *These models focus on the special strengths of 18- 25 year olds, offering examples of their community resilience in the face of trauma. Setting the stage for the treatment experience, the strength-based approach focuses on the young person's will, determination, spirit, and intellect to confront and overturn huge barriers to success and accomplishment. This approach is especially important for this population who may have experienced fear, failure, trauma, and frustration. Clinically this is sometimes labeled as acute stress disorder. A model promoting a strength-based image may be the first time that these young persons have been offered a socially sanctioned, positive view of themselves which tells them that they are competent, capable, smart, and worthy. This, in and of itself, may serve as the strongest incentive for program completion.*

The drug court should also utilize recovery support/continuing care services, which are effective with the young adult male population. These services should be equipped to address ambivalence, early stages of readiness to change and heavy denial that is very prevalent as well as on-going peer pressures.

V. OTHER TREATMENT-RELATED ISSUES

A. "Incentives And Sanctions": The Underlying Concept And How It Is Applied

Positive reinforcement methods have received much attention because of their ability to promote sustained behavior change in a positive, supportive way. Dr. Steve Higgins developed the original intervention using a voucher system in which treatment clients could receive points each time they provided negative urine. Retail goods could be purchased with these points but the process was costly and labor intensive. Dr. Nancy Petry developed a variation to incentivizing treatment through a prize-based "Fishbowl" system, where clients could draw a slip from a bowl each time they submitted drug-free urine, with the chance of winning prizes that were kept and displayed on-site. Both voucher and prize-based reinforcement systems targeting drug abstinence have been repeatedly shown to be efficacious interventions in controlled research studies conducted in drug treatment programs.[140]

The principles of positive reinforcement (rewards) and sanctions have been readily translated for use within drug court programs to promote desired behavior of clients while at the same time foster a more positive atmosphere within the system. Rewards and sanctions serve different, but complementary, functions. Rewards are used to increase desirable behaviors, such as going to work or school, whereas sanctions are used to reduce undesired behaviors, such as engaging in crime or drug use. When used together, they can have synergistic effects that produce better outcomes than applying either technique alone.[141]

"Incentives And Sanctions"
Application To Drug Court Practice

Dr. Douglas B. Marlowe, Chief of Science, Policy and Law, at the National Association of Drug Court Professionals in the *Drug Court Practitioner Fact Sheet* makes the following recommendations to drug courts regarding the use of sanctions and incentives:

- *Balance positive reinforcement with punishment to reduce undesired behaviors and replace them with desired prosocial behaviors (If participants may be punished for missing a counseling session, then they should also be able to earn a reward for attending a counseling session;*
- *The more consistently participants receive rewards for accomplishment and sanctions for infractions, the more effective the program will be. Therefore, (1) conduct urine or saliva drug tests no less than twice per*

[140] Lussier, J. P., Heil, S. H., Mongeon, J. A., et al. (2006*). A meta-analysis of voucher-based reinforcement therapy for substance use disorders*. Addiction, 101, 192 -203; See also Stitzer, M. (2006), Contingency management and the addictions. Addiction, 101: 1536–1537. doi: 10.1111/j.1360-0443.2006.01644.

[141] Marlowe, D.B., & Kirby, K.C. (1999). *Effective use of sanctions in drug courts: lessons from behavioral research.* National Drug Court Institute Review*, 2*, 1

week; (2) Conduct testing on a truly random basis including weekends and holidays; (3) Do not reduce the testing frequency in the last phases of the program as other requirements are reduced; (4) Extend the drug court reach into the community by conducting random home visits, verifying employment and school attendance, enforcing restrictions, monitoring curfews compliance, or performing bar sweeps;

- *The effects of rewards and sanctions begin to decline within only a few hours or days after a participant has engaged in a target behavior; therefore, schedule status hearings no less frequently than twice per month and ensure noncompliant participants are brought in for a court hearing quickly after a serious infraction;*
- *Where rewards can be effective at low to moderate magnitudes (verbal praise, certificates of recognition, gift cards), sanctions tend to be least effective at the lowest and highest magnitudes and most effective within the intermediate range. Sanctions that are too harsh can lead to resentment, avoidance reactions, and ceiling effects, in which the team runs out of sanctions before treatment has had a chance to take effect;*
- *Stretch program resources by incentivizing participants with opportunities to draw rewards from a fishbowl. Most of the rewards may be of low or no dollar value, but a few should be highly desirable to participants;*
- *Drug Courts have better outcomes when their policies and procedures regarding incentives and sanctions are in a written program handbook or manual;*
- *Drug courts should allow participants a reasonable chance to explain their side of any dispute and apply sanctions with respect and dignity;*
- *For drug-dependent participants, administer treatment-oriented consequences for drug use early in the program, such as increasing the required number of counseling sessions, transferring the individual to a more intensive level of care, or evaluating the participant for possible medication. Once a participant with addiction has engaged in treatment and achieved an initial and sustained sobriety, begin applying escalating sanctions for drug use (decisions to increase the intensity of treatment, however, should not be considered a punishment but a positive and helping way to eliminate drug use);*
- *Rely on the clinical expertise of duly trained treatment professionals when ordering changes to the treatment regimen.*

B. Confidentiality And Communication

The close working collaboration of treatment providers and drug court team members that has developed brings with it the need to ensure confidentiality protections for program participants that are provided under Federal and State laws to participants in drug treatment programs.

42 C.F.R.: What Does It Require And To Whom Does It Apply?

The requirements of 42 Code of Federal Regulations (CFR), Part 2 must be built into the daily operations of drug courts. These confidentiality laws, applicable to a “treatment program”, date back, for the most part, to the 1970’s and were created to encourage the rehabilitation of people with substance use disorders who might otherwise not enter treatment due to concerns that their substance addiction would become public knowledge and law enforcement would take action. Thus, Congress required heightened protection of the identity of individuals receiving addiction treatment as well as protection of the content and nature of information that was communicated regarding that treatment.

> “The Federal laws and regulations define a “treatment program” as an individual or entity that provides diagnosis of chemical dependency and referral to treatment in addition to providing actual rehabilitative services. Therefore, when an employee of a drug court performs an assessment (i.e., diagnosis) of chemical dependency of a drug court participant, for example, and/or a referral to treatment, that drug court is considered a ‘treatment program’ for purposes of the application of the Federal confidentiality regulations (42 CFR Section 2.11).”[142]

Even though these confidentiality requirements are very stringent regarding substance abuse treatment, drug court team members can operate proficiently with proper precautions.

> “Treatment programs [drug courts] may release information or records concerning any person who has been assessed, diagnosed, or treated only with the specific written consent of that client [drug court participant] “or under certain very limited exceptions. [143]

The requirements of 42 C.F.R .encompass any information regarding the individual's treatment as well as any information that would identify the individual, directly or indirectly, as a person with a substance use disorder or one who is receiving substance abuse treatment. Therefore, a treatment program may not

[142] Holland, Rebecca S. (1999). *Practical Guide for Applying Federal Confidentiality Laws to Drug Court Operations*
[143] (42 CFR, Section 2.4).

even acknowledge that an individual is a client to anyone who is not specifically authorized by the client's written consent to receive that information, since such acknowledgment would effectively identify the individual as a person with substance use disorder.

This requirement is particularly important when information regarding a drug court participant is discussed in a staffing. Each participant must execute a waiver of their confidentiality rights to permit treatment information to be discussed about them in a staffing and the waiver must identify each person who is authorized by the participant to receive this information. Each person participating in that staffing must be listed on the individual's waiver form.

Drug court team members who violate client confidentiality are subject to fines of up to $500 for a first offense and up to $5,000 for every subsequent offense (42 CFR, Section 2.4).

Drug court team members may not re-disclose confidential information regarding a defendant's treatment except to carry out their official duties "with regard to the individual's conditional release or other action in connection with which the consent was given" (42 CF, Section 2.35(d)).

Files and other written documents containing confidential information regarding addiction treatment must be protected from access by unauthorized users and should be stored in locked cabinets in plain view and/or with sufficient firewalls if stored electronically.

Exceptions to this general prohibition against disclosure of confidential client information include the following:

- Written consent of the client:

An individual's treatment information may be disclosed when the individual has given informed consent, in writing, for the disclosure). The names of the individuals to whom consent is given should be specified. The duration of the consent may be based exclusively on the passage of 'a specified amount of time or the occurrence of a specified, ascertainable event.' Most participants in substance abuse treatment may revoke their consent for disclosure at will at any time. However, individuals who have been mandated to receive treatment by a court *as a condition of the disposition of a criminal proceeding,* such as through probation, parole, sentencing, an agreement for dismissal of charges, or an order for release from imprisonment*, may not revoke* their consent (42 CFR, Section 2.31). In a drug court, a participant may revoke consent but then cannot remain in the drug court;

- Internal treatment program communications;
- Information that does not identify the client;
- Medical emergency—confidential information about a participant may be disclosed to medical personnel in the event of a bona fide medical emergency;
- A properly authorized court order;
- Information relating to a crime performed on the treatment program premises or against program personnel: information regarding crimes on the premises may be reported and limited to the circumstances of the crime, the accuser's name and address, and his or her last know whereabouts (42CFR, Section 2.12(5));
- Suspicion of child abuse or neglect: information may be released where it is required by State law to do so. Only the initial report to the appropriate State or local authority is allowed;
- Qualified service organization agreements (QSOA): treatment programs for substance abuse may enter into agreements with individuals or organizations that provide necessary support services, e.g. urinalysis, vocational services, etc., however the service provider must agree to protect the confidential information of each client to the same extent required by the treatment provider;
- Research and audit: treatment information may be shared with researchers without written permission provided the researchers ensure secure storage of information and do not disclose information that reveals the name or identity of a treatment participant; and
- Veterans' Administration or Armed Forces records: these records and their confidentiality are covered by Title 38 of the United States Code and by regulations promulgated by the Administrator of Veterans Affairs.[144]

Information Disclosed During A Staffing Vs. Open Court

There is both confidential material and personal material that may be disclosed in staffing but not in open court. As a practical matter, everyone who attends

[144] Ibid (42 CFR, Section 2.4).

staffing should be reminded that they may not disclose this information. The exception would be test results and failures to attend or participate in treatment. That information would, obviously, be disclosed during the court review. Personal information such as a history of sexual abuse or health status should not be disclosed in open court. In staffing, confidential information will be disclosed to those individuals for whom the participant has provided written consent. If/when a visitor attends a staffing, the visitor should be asked to sign a non-disclosure agreement. Samples of such waivers are available from American University, Office of Justice Programs, Drug Court Project.

INFORMATION ENTERED IN THE COURT FILE

The clerk should simply enter the participant's presence and any criminal disposition such as the imposition of jail time. The court coordinator will keep track of other information discussed at the court hearing and any sanctions and incentives applicable. The judge should keep separate notes for the drug court participants since the court files are part of the public record.

Prospective drug court participants should be informed about their right to confidentiality at the time of their initial screening or assessment and asked to sign consent that will permit disclosure to and exchanges of information between the judge, prosecutor, defense counsel, the probation officer, or other relevant parties, and the treatment provider that will be providing direct services. Drug court policy should specify that failure to sign the consent form is grounds for exclusion from drug court participation.

Federal regulations require that the scope of the disclosures be limited to information necessary to carry out the purpose of the disclosures (42 CFR, Section 2.13(a)). To conform to this requirement, drug court consent forms should narrow the scope of disclosure to "report(s) of…treatment attendance, compliance and progress in accordance with drug court monitoring criteria which are necessary for and pertinent to hearings or reports concerning the participant's [charges/indictment/termination of parental rights, etc.]." Consent forms should never permit a treatment provider to turn over the entire client file to anyone.[145]

HIPAA

The Health Insurance Portability and Accountability Act of 1996 (HIPAA); Pub.L. 104–191, 110 Stat. 1936, enacted August 21, 1996,requires pursuant to Title II the establishment of national standards for electronic health care transactions. Providers must have a signed disclosure from the individual being treated before giving out any information on provided health care to anyone, including parents.

Even though HIPAA does not apply to drug treatment courts, many team members are familiar with and abide by its provisions. As recommended by Chapter 9 of The Drug Court Judicial Benchbook[146], the Court should have in place an administrative order requiring treatment providers to disclose information to the drug treatment court team. The Court should also require a written consent from each participant that covers HIPAA as well as 42 C.F.R. Part 2. Since treatment providers must comply with a valid court order, they must disclose treatment data and participant progress to the team. Having a court order in place should protect otherwise covered entities when they do disclose.

The Court should also issue an administrative order regarding disclosure, open courtroom communications and the voluntariness of the waivers.[147] These documents should also prohibit re-disclosure.

GROUP COMMUNICATIONS

Increasingly, programs are also requiring drug court participants involved in drug court treatment groups to sign confidentiality agreements acknowledging that discussions within the group will remain confidential.

CONFIDENTIALITY AND COMMUNICATION **APPLICATION TO DRUG COURT PRACTICE**
• *Use a checklist to make sure the program has in place all documents relating to disclosure and waiver of confidentiality required by applicable law. These should include:* ✓ *Participant's waiver of confidentiality under 42 C.F. R* ✓ *Team members acknowledgment of non-disclosure obligations*

[145] Ibid (42 CFR, Section 2.4).

[146] Marlowe, D. B., & Meyer, W. G. (2011). *The drug court judicial benchbook*. National Drug Court Institute. Retrieved from http://d20j7ie7dvmqo0.cloudfront.net/sites/default/files/nadcp/14146_NDCI_Benchbook_v6.pdf.

[147] Ibid (2011).

- ✓ *Confidentiality/Non-disclosure Agreement for other individuals attending court staffings or other meetings at which participant treatment information is discussed.*
- *Update participant releases every time there is a change in personnel and/or review as a part of phase advancement.*
- *Make sure firewalls are in place for electronic reporting. Is all information password protected? Is access limited to the bare minimum?*
- *Make sure that written records that have protected health information are kept under lock and key. No one who is not listed on the disclosure form should have access.*
- *Consider appointing a team member as the "Confidentiality Compliance Officer" as suggested in the* ***Drug Court Judicial Benchbook***
- *Document the program's privacy policies in writing in the program's operations manual and client handbook.*
- *Provide continuing education for all team members on confidentiality requirements.*

C. "Coerced Treatment" And The Role Of "Motivation"

A common myth is that addiction treatment is only effective for persons who acknowledge the need for behavior change or who voluntarily seek treatment[148]-- e.g. are "motivated". In reality, persons who are mandated to treatment by the criminal justice system and who are not yet committed to long-term recovery experience at least as good outcomes (e.g., reduced substance use and recidivism) as persons seeking treatment voluntarily.[149]

Within the framework of the "stages of change" model related to addictive disorders[150], most drug court participants are in the "precontemplation" or "contemplation" stage as they enter treatment, and are not initially committed or 'motivated' to behavior change. Individuals who are in these early stages of change have little awareness of their substance use problems and often do not intend to quit using alcohol or other drugs, or to avoid future criminal behavior. Participants who are just beginning in drug court are often ambivalent about making the major lifestyle changes required by the intensive demands of drug court and treatment, and may lack confidence that they can successfully complete such a rigorous program of treatment and supervision. In addition, many who have had previous negative experiences with the justice system, are victims of trauma or have cognitive disabilities may appear resistant to efforts to engage them in the drug court.

As a result, initial interventions should address ambivalence and reasons for making lifestyle changes, and should provide supportive counseling and incentives to reinforce attendance in treatment, court hearings, and involvement in drug testing and other required program activities. Motivation levels in drug court are expected to change over time, and participants often cycle through several different stages of change during the recovery process. Due to the chronic relapsing nature of recovery from substance use disorders, movement through stages of change is not a linear process.[151]

Several specialized interventions have been developed to enhance motivation among substance-involved populations, including *Motivational Interviewing* (MI[152]); and the related *Motivational Enhancement Therapy* (MET); and *Contingency Management* (CM), an incentive-based behavioral strategy, described earlier. Motivational strategies such as MET, MI, and CM are useful for substance-involved offenders because they avoid punitive responses, labeling, and confrontation that are often are counterproductive and that lead to entrenched resistance to change.[153]

Drug courts should not exclude persons who initially demonstrate low motivation for changing their addictive behaviors, but should consider this information in tailoring initial phases of treatment, court monitoring,

[148] Farabee, David, Prendergast, Michael, and Anglin, M. Douglas (1998). *The effectiveness of coerced treatment for drug-abusing offenders*. Federal Probation, *62(1*), 3-10; See also Peters, R.H., & Young, S. (2011) *Coerced drug treatment*. In M. Kleiman, J. Hawdon, & G. Golson (Eds.), Encyclopedia of Drug Policy (pps. 142-145). Thousand Oaks, CA: Sage Publishers.

[149] Kelly, J.F., Finney, J.W., & Moos, R. (2005*). Substance use disorder patients who are mandated to treatment: Characteristics, treatment process, and 1- and 5-year outcomes.* JOURNAL OF SUBSTANCE ABUSE TREATMENT, *28*, 213-223.

[150] Prochaska, J. O., & DiClemente, C. C. (1982). *Transtheoretical therapy: Toward a more integrative model of change.* Psychotherapy: Theory, Research & Practice, 19(3), 276.

[151] Miller, W.R., & Rollnick, S. (2002). *Motivational Interviewing: Preparing People for Change* (2nd Ed.). New York, NY: Guilford Press.

[152] Ibid (2013).

[153] Farbring, C.A., & Johnson, W.R. (2008). *Motivational interviewing in the correctional system: An attempt to implement Motivational Interviewing in criminal justice.* In H. Arkowitz, H.A. Westra, W.R. Miller, & S. Rollnick (Eds.). Motivational Interviewing In The Treatment Of Psychological Problems, pps. 304-323. New York: Guilford Press.

and community supervision. Several instruments have been developed to screen and assess for motivation related to changing addictive behaviors.[154] These include standardized instruments such as the Circumstances, Motivation, Readiness, and Suitability Scale[155], the Readiness to Change Questionnaire[156], the Stages of Change Readiness and Treatment Eagerness Scale[157], the TCU Treatment Motivation Scales[158] and the University of Rhode Island Change Assessment Scale.[159] These screening instruments have been validated for use with a wide range of populations, including several that have been used and validated with offenders.

All members of the drug court team, including treatment staff, the drug court judge, community supervision officers, and case managers should be trained in motivational interventions.

"COERCED TREATMENT" AND THE ROLE OF "MOTIVATION"
APPLICATION TO DRUG COURT PRACTICE

All drug courts should recognize the importance of motivating participants to achieve goals of abstinence, involvement in long-term treatment, and adherence to other treatment plan goals. Although most drug court participants enter the program with only modest recognition of their own problems, and with limited motivation to change their substance use and criminal behavior, motivation can change over time, and in most cases improves significantly over the course of involvement in drug court. Drug courts should consider the following issues and strategies related to motivation and engagement in treatment:

- *Although the apparent level of participants' motivation is expected to be quite modest if at all at the point of entry to drug court, low motivation should not exclude persons from admission to drug court, but should be addressed during early stages of the program.*
- *Drug court assessments should routinely examine 'stages of change' and participant's level of motivation.*
- *Reassessment of motivation level should be provided on a periodic basis, in recognition that motivation waxes and wanes over the course of drug court participation, and that sudden reductions in motivation may be accompanied by elevated risk for relapse and criminal behavior.*
- *Information from motivational assessment should be incorporated into treatment, supervision, drug court team staffing and other case plans. Targeted interventions for participants who have low motivation for recovery and treatment should be provided in early phases of the drug court program.*
- *Motivational interventions should be built into each phase of the drug court program, including later phases, in which participants may become overconfident about their abilities to manage the recovery process, or conversely, in which they may become fearful of consequences related to leaving the structure and support of the drug court.*
- *Drug courts should consider offering Contingency Management interventions (e.g., point systems with non-cash vouchers, or 'fishbowl' techniques involving drawing for prizes of different value) to help motivate participants to become abstinent, to attend treatment, and to achieve other targeted behaviors.*
- *All drug court team members should receive training in MET/MI and Contingency Management (CM) techniques.*

D. DRUG TESTING IN A DRUG COURT ENVIRONMENT[160]

Drug testing remains the cornerstone of the drug court's capacity to monitor the drug use of participants and, where instances of continued use are identified, promptly determine the appropriate response. Drug tests should be seen as a clinical tool – much like a thermometer – to determine whether the treatment plan is working and, if not, situations warranting prompt action. Drug tests in a drug court setting are not designed to "catch" those continuing to use drugs or to develop grounds for prosecuting an individual for drug possession but, rather, to detect situations in which continued or resumed use triggers the immediate need for the court's response to determine the circumstances surround the new/continued drug use

[154] Peters, R.H., Bartoi, M.G., & Sherman, P.B. (2008). *Screening and assessment of co-occurring disorders in the justice system*. Delmar N.Y: The National GAINS Center.
[155] DeLeon, G., & Jainchill, N. (1986). *Circumstance, motivation, readiness and suitability as correlates of treatment tenure.* Journal Of Psychoactive Drugs, 18(3), 203-208.
[156] Rollnick, H., Heather, N., Gold, R., & Hall, W. (1992). *Development of a short 'readiness to change' questionnaire for use in brief, opportunistic interventions among excessive drinkers.* British Journal Of Addiction, *87*, 743-754.
[157] Miller, W. R., & Tonigan, J. S. (1996). *Assessing drinkers' motivation for change: The Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES).* Psychology Of Addictive Behaviors, *10*, 81-89.
[158] Simpson, D.D., & Joe, G.W. (1993). *Motivation as a predictor of early dropout from drug abuse treatment.* Psychotherapy, *30*, 357-368.
[159] DiClemente, C. C., & Hughes, S. O. (1990). *Stages of change profiles in outpatient alcoholism treatment.* Journal Of Substance Abuse, *2*, 217-235.
[160] Jones & Robinson. (2000). *Drug Testing In A Drug Court Environment: Common Issues To Address*. BJA Drug Court Clearinghouse. American University. Office of Justice Programs, U.S. Department of Justice.

and adjustments in the treatment plan that may be needed. Drug tests should therefore be used as a prime mechanism for monitoring the effectiveness of the treatment program and promptly identifying the need for modifications – much as blood tests may be used to monitor diabetics. Specimens should not be considered "dirty" or "clean" but rather simply whether they do or do not indicate the presence of drugs and/or drug metabolites. The tests themselves should not be seen as punitive, although responses to positive tests may include punitive measures.

There are several drug testing options available to drug courts, including a variety of testing technologies, testing locations as well as a variety of specimens, each with its own utility.

Drug Testing Procedures: Overview

Drug testing utilizes "cutoffs" for determining if a test result is considered "positive" or "negative". These cutoffs have been administratively established to comport with test technology capabilities, allow for effective identification of recent drug use, and minimize the risks of responding to "false positives." Commonly used cutoffs are those established for federal workplace drug testing programs.

However, it is important to note that cutoffs deemed appropriate for workplace drug testing may not be optimal for drug testing in drug court settings where the requirement is for *no drug or alcohol use* – not any drug or alcohol use above a certain level. It is therefore important to remember that a "negative" test result may not mean "no drug"; only that a drug was not detected at or above the administratively chosen cutoff. It should also be noted that it is possible for drug tests to be performed at concentrations much lower than the administrative cutoffs and drug courts may be able to choose to use lower cutoffs depending upon the test technologies are being used. Some analyzer-based test technologies can allow for the demonstration that a "negative" test result is nonetheless not consistent with a drug-free specimen.

Drug testing is often carried out as a two-step procedure, with an initial test which, if positive, is followed up with a second more specific test called a confirmation test. Confirmation testing may be mandated by regulation, statute or case law, as is the case for federal workplace drug testing as well as drug testing under the U.S. federal courts' probation statutes. Local drug courts, however, may not be required to use confirmation testing. Since first introduced decades ago, the science of drug testing has developed to the point where it is considered highly accurate and reliable, with case law precedents recognizing its accuracy sufficient for probation revocation (at least when initial testing is performed on an automated analyzer).

In addition to tests for drugs and their metabolites, tests for specimen validity (e.g., chain of custody, contamination, etc.) should also be performed. These tests ensure that a valid specimen has been obtained which accurately reflects the drug use status of the donor.

Technologies Commonly Used

There are two principal technologies utilized in drug testing. The first, generally used in initial screening, utilizes immunoassays, which uses specifically-developed antibodies to recognize the molecular shape of drugs and their metabolites, like a lock-and-key fit. These immunoassays have been developed over decades for each of numerous drugs and drug classes and are highly reliable. These immunoassays may be performed on automated analyzers, both at a laboratory or on-site, as well as by using simple visually-read devices (cups/dipsticks), principally for urine specimens. Initial immunoassays, at least when performed on an automated analyzer, have numerous case law precedents holding that they have demonstrated accuracy when properly performed and fulfill the due process requirements for use in probation revocations, even without subsequent confirmation testing. On the other hand, the simple visually-read immunoassays using cups or dipsticks have not yet established such a record of case law support for their use without additional laboratory confirmation.

The second principal technology utilized in drug testing involves sophisticated and sensitive mass spectrometry methods (e.g. gas chromatography/mass spectrometry, GC/MS, or more recently, liquid chromatography/mass spectrometry, LC/MS). These laboratory-based methods provide a true molecular identity and quantization of the amount of drug present in the specimen. While an initial immunoassay may detect an opiate, for example, it may not identify which specific opiate(s) are present or provide an exact quantization of its concentration. In contrast, mass spectrometry confirmation methods will define which specific opiate(s) was detected and its exact concentration. Confirmation may not be formally re-

quired for decision-making in a drug court setting, especially when initial immunoassays are performed on analyzers. That said, confirmation provides extra assurance that the initial test results are completely accurate.

TESTING LOCATION OPTIONS

In addition to the two principal technologies described above, there are two testing location options available: on-site testing and laboratory-based testing. And for on-site testing there are two further options: using bench-top analyzers and using simple visually-read test devices (cups or dipsticks).

- Laboratory-Based Testing

Laboratory-based testing offers the highest accuracy and reliability, especially when performed at a certified laboratory. These laboratories represent very high standards of accuracy and reliability. There are currently about 35 of these federally-certified laboratories throughout the U.S. Drug testing standards applied for federal workplace testing may not necessarily apply to drug courts unless by statute and such workplace testing requirements may not be optimum for testing within the drug court environment for the reasons cited earlier.

For the moment, federal workplace drug testing standards utilize only urine for drug testing which is still the most common specimen used in drug court settings, although breath and oral fluid (saliva) are used for alcohol testing. There are also other suitable drug testing laboratories such as those certified by the College of American Pathologists under their Forensic Urine Drug Testing program. These certified laboratories offer both initial immunoassay screening on automated analyzers as well as any necessary subsequent confirmation of initial positive test results. Although confirmation testing is required under federal workplace drug testing regulations, it may not necessarily be required for drug testing within a drug court setting, depending upon the type of initial testing performed and any relevant regulations, statutes, and case law precedents.

- On-Site Testing

On-site testing offers the key benefit of immediate (within a few minutes) test results without the delay incurred when collected specimens are transported to a distant laboratory for testing. On-site testing can be performed either using bench-top automated analyzers, similar to those used in certified laboratories, or simple to use visually-read test cups or dipstick-type test devices. On-site analyzers have the benefit of providing objective numerical test results, with the capability of direct data transfer into a program database. In contrast, the simple visually-read devices provide only a visually-determined subjective positive or negative test result. The simple test devices are read visually and the presence or absence of a colored line indicates whether the test result is considered positive or negative, similar to say a home pregnancy test. Automated analyzers make the most sense for programs that have a relatively large number of specimens, while the simple tests make sense when remote testing locations are involved testing only a few specimens at a time.

SPECIMENS FOR DRUG TESTING

Virtually every body specimen that can be collected has been tested for drugs and/or their metabolites. What is detected in each specimen may be different depending on what drug was taken, its chemical properties and the chemical properties of the specimen. Thus, for some specimens the original "parent" drug is what is primarily detected, while for other specimens it is primarily the metabolite(s) that is detected, and, for some specimens, both. Each specimen has a different "window of detection", that is, how long after drug use that use may be detected, which is drug dependent as well as cutoff dependent. It is important to note that the length of time a drug may be "detected" is different from the length of time a user may test positive at a specified cutoff.

- Urine

Urine is the specimen most widely used and least costly for drug testing. It is readily available in relatively large amounts and can indicate a relatively high concentration of drugs and/or metabolites because of the concentrating effect of the kidney. Urine analytical methods have long been established, have well-established regulatory recognition, and have ample supporting case law precedent (at least when urine drug testing is performed on an analyzer). Cutoffs for reporting test results as positive or negative have been established, although, as noted earlier, these have been primarily chosen for federal workplace testing programs and may not be the optimum cutoffs for drug court settings. Using these standard cutoffs, drug tests for many drugs will generally remain positive for one-three days after last use (except after chronic use of marijuana where test results may re-

main positive for two-three weeks). Testing positive at a specified cutoff, however, is not the same as drug use being "detectable".

It is important for drug courts to ensure that the drug testing process adheres to established standards and protocols relating to collection, chain of custody documentation, and analysis, and includes specific safeguards to protect against adulteration/contamination of the sample, misreporting of results, and other factors that can jeopardize the integrity of the drug testing process. Urine specimens may also be adulterated by the addition of chemicals or even substituted specimens, and proper specimen collection procedures, are therefore, essential, including direct observation. Urine dilution through excess fluid consumption prior to specimen donation can also present challenges to effective urine drug testing, as excess fluid consumption can dilute urine specimens by a factor of ten or twenty or so, thereby possibly reducing drug concentrations to below established cutoffs. When using urine as a specimen, therefore, it is important to include specimen validity testing for dilution (using clinically established urine dilution biomarkers such as creatinine or specific gravity) to ensure that the test result accurately reflects the drug use status of the donor. Such urine specimen validity tests are available for both analyzer as well as visually-read test devices.[161]

- <u>Sweat Patch</u>

Also available is a sweat patch for continuous 24/7 monitoring of drug use over a period of one week or so. The sweat patch, currently provided by a single company, is effectively a Band-Aid like collection device which is applied to the arm or torso and any drugs used and excreted in the sweat are absorbed into the pad where they are retained over the period of patch wear. After the period of patch wear, typically one week or so, the patch is removed and sent to the laboratory for testing. The benefit of the sweat patch is its ability to monitor the wearer continuously 24/7 over the one week wear period. Any attempts by the subject to remove and later reapply the patch are readily observable to a trained collector. The sweat patch has a well-established scientific foundation and case law support for its accuracy and reliability. There have been a few challenges to the accuracy of the sweat patch arguing that drugs from the environment could possibly migrate through the patch outer membrane, or that drugs could reside in the skin from prior drug use or skin contamination and later migrate out into the patch. Both of these arguments for potential inaccuracies have been successfully refuted repeatedly in sweat patch cases.

- <u>Hair</u>

Hair (primarily head hair) has long been used as a specimen for drug testing if not as widely as urine. Hair drug testing should not be confused with hair follicle testing. The distinction is that in hair drug testing the hair shaft is cut from the surface of the scalp, while hair follicle testing involves testing hair that is below the scalp surface i.e. hair that has been pulled from the scalp and accordingly contains that portion of the hair beneath the scalp which can contain intact cells which allows for DNA analysis. When drugs are used, drugs in the blood can be incorporated into the growing hair shaft originating beneath the scalp. After 1 week or so, that drug-exposed hair has grown out to above the scalp surface and can be cut from the scalp and tested at the laboratory.

Hair drug testing has the benefit of the longest window of detection for prior drug use, effectively going back as long as the length of the hair specimen collected. Head hair typically grows at a rate of about 1 cm/month with typically utilized hair specimens of 3 cm in length, thus testing for about the previous three-month period. However, one or even two-time drug use may not be detected when testing an entire 3-month segment of hair. Hair specimens from other body sources have been used such as beard, under arm, chest and even pubic hair, although each of these specimens has different growth patterns and accordingly different issues for interpretation of time frames of use.

The two major issues with hair as a specimen are (1) that the specimen is open to the environment and accordingly external contamination must be accounted for in the testing process and distinguished from drugs incorporated into the hair shaft during growth; and (2) the donor has ready access to their specimen and thus has the opportunity to attempt to manipulate the specimen in an effort to reduce the amount of any drug. There are relatively few hair testing laboratories, but some have developed sophisticated procedures to eliminate environmental contamination from consideration. There is ample scientific literature on drug incorporation and testing in hair and case law supporting the accuracy of hair testing.

[161] Ibid (2000).

- <u>Oral Fluid (Saliva)</u>

Oral fluid has been receiving much attention recently as a specimen for detecting drug use, primarily for application to roadside DUI drug testing where the collection of urine would be impractical. Oral fluid drug testing offers the primary advantage of gender neutral and specialized facility-free specimen collection. Currently such oral fluid specimens are collected with an absorbent mouth swab and after absorption of sufficient specimen the swab is inserted into a transport buffer tube for transport to a laboratory for testing. There have also been on-site devices developed (visually-read or using a small electronic reader) but these have only recently begun to meet the sensitivity and performance expected from the toxicology community. Two issues presented with drug testing using oral fluids are: (1) generally relatively low drug concentrations, requiring high sensitivity assays; and (2) low specimen volume, perhaps limiting the ability to perform repeat testing and/or confirmation testing for multiple drugs.

Alcohol Testing

Testing for alcohol (ethanol) use can be easily accomplished through the use of on-site breath alcohol test devices. Many of these devices have been performance tested and are on a Conforming Products List published by the National Highway Traffic and Safety Administration. The limitation of breath alcohol testing (and any testing for ethanol itself) is that ethanol is so rapidly eliminated from the body that its detection window is relatively short (measured in hours). Alcohol use can also be detected through transdermal 24/7 monitoring, e.g. with an ethanol-detecting ankle bracelet, which has established case law.

There has also recently been the development of urine tests to detect longer-lived metabolites of alcohol, such as ethyl glucuronide (EtG) and ethyl sulfate (EtS). These analyses can allow for detection of alcohol use for up to a few days, depending on the extent of use and the cutoff chosen. However, a sufficiently high cutoff (i.e. 500 ng/mL) must be used to avoid positive test results from innocent exposure to ethanol in everyday life (e.g. hand sanitizers, mouthwash, cold medications, and food sources). There has now been much research into the use of these minor ethanol metabolites for the detection of alcohol use with case law precedents being established.

Interpreting Test Results

Challenges have been raised to both the accuracy of the analytical results as well as to the interpretation of those results. These should be recognized as separate processes. Drug court testing programs should have staff available with appropriate training and experience in providing clinically-accurate interpretation of test results. Laboratories may be willing to offer such clinical interpretation in addition to testing and such clinical interpretation services should be specifically contracted for. It is probably best if the drug court team has someone with the appropriate toxicology training to assist the court when interpretation of test results is an issue.

Maintaining the Integrity of the Drug Testing Program

A credible drug testing program is a cornerstone of drug court program operations. The functioning of all drug courts relies on the integrity and accuracy of the drug testing process as well as the immediacy with which drug testing services are accessed and the reliability of results obtained. Drug testing is a complex science that requires the guidance and oversight of appropriately trained forensic scientists.

The effective operation of a drug court program is premised upon having the capacity to:

- Conduct both *frequent* (often two to three times per week) and *random* drug tests of participants;
- Obtain test results immediately; and
- Maintain a high degree of accuracy in test results

The reliability of a drug court drug testing system is dependent upon sample integrity. To insure sample integrity, effective techniques must be instituted – and practiced – regarding sample collection, testing, and adulteration detection. Establishment of an airtight chain of custody process, documented in writing, ensures test results in which the drug court judge can have confidence.

The drug court's drug testing component, regardless of the methodology used, should be staffed by appropriately qualified and trained personnel. Staff should be specifically -- and adequately --trained to perform the duties to which they are assigned and be prepared to provide testimony in court, if necessary, regarding the testing process and protocols used. Two types of witnesses may be required: *lay* and *expert*. A *lay* witness may be called to testify about ob-

jective facts (e.g., the procedures used to collect specimens, etc.) and is generally not asked to interpret test results or to give an opinion. The *expert* witness, on the other hand, may be called upon to voluntarily share some specialized knowledge which may aid the court in determining the validity of the testing procedure or interpreting the test results.

Key elements essential to maintaining the integrity of the drug testing process include:

- Ensuring Chain Of Custody

Regardless of methodology, the drug testing process must maintain its integrity: Chain of custody procedures must be developed and followed regarding the collection of specimens, the transport of those specimens through the testing process, and the validity of the test results. These procedures must assure that specimens are, in fact, collected from the named client and provide the capacity to detect adulteration (see below), such as through water loading, use of bleach, and submission of substituted specimens. The chain of custody procedures must also account for the actions of all individuals who handle the specimens. Specimens should be kept in a limited access security area.

- Detecting Adulteration

Even assuring that the specimen collected is, in fact, the urine of the client, there are a variety of techniques that can be used to adulterate the specimen to achieve am erroneous reading. While adulteration detection procedures may not assure complete detection in every instance, they can alert staff to the most common methods that may be employed and can significantly promote the integrity of the drug testing process. Common adulteration techniques observed by drug courts include:

✓ Waterloading

Waterloading — diluting the urine by self-administration of large volumes of fluids, usually water -- is one of the most common adulteration techniques and one of the most difficult to detect unless the technician is experienced in detecting waterloaded specimens. Running parallel tests for creatinine concentration levels can detect waterloading.

✓ Tampering With A Specimen Through Addition Of Common Household Products

Tampering with a specimen by introducing common household products such as bleach, Drano, and peroxide, in an effort to alter the chemical composition of the urine, can produce a false negative. However, skilled forensic experts can often detect these attempts at adulteration. Bleach, for example, will give off a recognizable odor. Drano may make the urine more basic and may also make it unusually warm — even bubbly. Metal shavings may also be detected.

✓ Submission Of Another's Specimen

Carefully designed and documented observation and chain of custody procedures are critical to detecting situations in which a participant may attempt to substitute the urine of another person for his or her own.

✓ Use Of Diuretics

A number of teas, milkshakes, fruit juices, and other concoctions act as diuretics that can potentially decrease the retention time for drugs in the system. Most of these products also require the ingestion of large amounts of water, which, may in itself result in diluting the urine to such a degree that the presence of drugs falls below drug testing cutoff levels.

There are a variety of other adulteration techniques that clients use from time to time. A number of publications have been written with suggested adulteration strategies and several webpages have been devoted to the topic. Program officials need to recognize that, despite their most conscientious efforts, some adulteration may occur undetected. However, the careful interpretation of drug test results, coupled with observations of potential clinical signs of drug use, it is unlikely that adulteration can occur with any frequency.

Standard procedures should be instituted to detect evidence of monitoring at the time of initial collection of the specimen, including **observing the color, appearance and odor** of the sample. Urine should be a light to golden yellow, free from foreign materials , and have a slight ammonia odor. Samples that are colorless or very pale yellow should be suspect. The average **temperature** for a freshly voided urine sample is 90-100 degrees Fahrenheit (32.2-37.8 degrees Celsius). Samples outside of this range should be suspect. Normal urine has a pH of 5-8; specimens above or below this value should be suspect. Specific gravity should also be measured. Samples with specific gravi-

ty under 1.003 should be suspect. Creatinine should also be measured. Values less than 20 md/dL may be an indication of waterloading.

A few additional tips for drug court officials to avert adulteration include requiring:

- Observed monitoring of all submissions[162]
- Minimal volume requirements
- Establishing set time limits for providing a specimen one hour or less from the time of test notification to the time of collection, for example) to minimize the possibility of internal dilution; and
- Limiting the amount of fluids provided

DRUG TESTING IN A DRUG COURT ENVIRONMENT
APPLICATION TO DRUG COURT PRACTICE

- Drug testing remains the cornerstone of the drug court's capacity to monitor the drug use of participants and determine whether the treatment plan is working and, if not, situations warranting prompt action.
- Drug tests in a drug court setting are not designed to "catch" those continuing to use drugs or to develop grounds for prosecuting an individual for drug possession but, rather, to detect situations in which continued or resumed use triggers the immediate need for the court's response to determine the circumstances surround the new/continued drug use and adjustments in the treatment plan that may be needed.
- Specimens should not be considered "dirty" or "clean" but rather simply whether they do or do not indicate the presence of drugs and/or drug metabolites.
- Although drug testing practices generally utilize "cutoffs" for determining if a test result is considered "positive" or "negative" for workplace drug testing purposes, these cutoffs may not be relevant for drug testing in drug court settings where the requirement is for *no drug or alcohol use* – not any drug or alcohol use above a certain level.
- The most widely used bodily substance used for testing for the presence of drugs is **urine** which is the least costly for drug testing, which is readily available in relatively large amounts and can indicate a relatively high concentration of drugs and/or metabolites because of the concentrating effect of the kidney.
- A **sweat patch** can be used for continuous 24/7 monitoring of drug use over a period of one week or so.
- **Hair** (primarily head hair) has long been used as a specimen for drug testing although not as widely as urine. Hair drug testing has the benefit of the longest window of detection for prior drug use, effectively going back as long as the length of the hair specimen collected. The two major issues with hair as a specimen are (1) that the specimen is open to the environment and accordingly external contamination must be accounted for in the testing process and distinguished from drugs incorporated into the hair shaft during growth; and (2) the donor has ready access to their specimen and thus has the opportunity to attempt to manipulate the specimen in an effort to reduce the amount of any drug.
- **Oral fluid (saliva)** has been receiving much attention recently as a specimen for detecting drug use, primarily for application to roadside DUI drug testing where the collection of urine would be impractical. Oral fluid drug testing offers the primary advantage of gender neutral and specialized facility-free specimen collection. Two issues presented with drug testing using oral fluids are: (1) generally relatively low drug concentrations, requiring high sensitivity assays; and (2) low specimen volume, perhaps limiting the ability to perform repeat testing and/or confirmation testing for multiple drugs.

Alcohol Testing can be easily accomplished through the use of on-site breath alcohol test devices.

MAINTAINING THE INTEGRITY OF THE DRUG TESTING PROGRAM

- A credible drug testing program must operate with integrity and accuracy and be premised upon having the capacity to:
  - ✓ Conduct both *frequent* (often two to three times per week) AND *random* drug tests of participants;
  - ✓ Obtain test results immediately; and
  - ✓ Maintain a high degree of accuracy in test results
- The reliability of a drug court drug testing system is dependent upon sample integrity. To insure sample integrity, effective techniques must be instituted – and practiced – regarding:
  - ✓ Ensuring Chain of Custody
  - ✓ Detecting Adulteration, including:
    - → Waterloading
    - → Tampering with a specimen through addition of common household products
    - → Submission of another's specimen
    - → Use of Diuretics
  - ✓ Additional tips to avert adulteration:
    - → Observed monitoring of all submissions (by gender)
    - → Minimal volume requirements
    - → Establishing set time limits for providing a specimen (one hour or less from the time of

[162] Observation should be by an individual of the same gender as the individual providing the specimen.

test notification to the time of collection, for example) to minimize the possibility of inter-dilution; and

→ Limiting the amount of fluids provided

E. DRUG COURT PROGRAM PHASES: HOW SHOULD THEY BE STRUCTURED?

Key Component #1 provides:

"Drug courts usually employ a multiphase treatment process, generally divided into a stabilization phase, an intensive treatment phase, and a transition phase. The stabilization phase may include a period of substance abuse detoxification, initial treatment assessment, education, screening for other needs. The intensive treatment phase typically involves individual and group counseling and other core and adjunctive therapies as they are available. The transition phase may emphasize social reintegration, employment and education, housing services, and other aftercare activities."[163]

Recovery from substance use disorders follows certain phases that include different levels of motivation/engagement in treatment, ability to maintain abstinence, ability to adhere to drug court rules, identification of realistic life goals, and the ability to understand addiction and develop a plan to address the potential for relapse. Drug Court phases should be structured to move an individual through this process, geared to achieving realistic milestones as they progress in their recovery rather than enrollment for a set period of time. The drug court phase structure allows for participants and drug court team members to recognize at what stage a person is at in their recovery and to adjust expectations accordingly.

Phase advancement provides important and unique reinforcement/recognition for positive participant progress toward recovery and an opportunity for the drug court team to formally recognize the accomplishment of each participant. The phase structure also allows for other drug court participants to be made aware of their peers and their progress and demonstrate that graduation and movement to recovery are attainable goals.

[163] U.S. Department of Justice. (1997). *Defining Drug Courts: The Key Components.* Bureau of Justice Assistance, U.S. Department of Justice, Office of Justice Programs, Drug Courts Resource Series, January 1997, Reprinted October 2004, p. 9.

DRUG COURT PROGRAM PHASES
APPLICATION TO DRUG COURT PRACTICE

- *Design drug court phases with specific criteria articulated for moving from one phase to the next (minimum period of participation; frequency of self-help attendance, frequency of status hearing attendance, urinalysis requirements, case manager meetings, payment of fees, finding a sponsor, becoming or maintaining employment, period of maintenance of sobriety, etc.);*
- *Distinguish between* proximal *and distal goals or criteria for each phase of the drug court program. Proximal criteria include behaviors that participants are already capable of performing and are necessary for long-term objectives to be achieved while distal goals are the behaviors that are ultimately desired, but will take some time for participant to accomplish and are for later phases;*
- *Consider a brief "orientation phase" with short-term, achievable goals for early participant success;*
- *Define the recognition/rewards that will occur upon achievement of each phase by the drug court participant;*
- *Consider de-linking drug court phases from treatment phases for two reasons: (1) De-linking provides multiple opportunities for recognition and rewards; and (2) Criteria for phase advancement are different for drug courts compared with treatment programs because movement in treatment phases is usually based upon the treatment plan and associated objectives while drug court phases are much broader: e.g., attending self-help meetings; consistently providing urine tests: appearing in court; gaining employment; avoiding serious sanctions; and length of clean time;*
- *Try to be consistent and predictable in the application of criteria for phase advancement with all drug court participants. Remind all participants about requirements for the phase advancement and what new challenges await the individual as they advance in phases. Review the process of phase advancement in court and explain to all participants the implications of moving from one phase to another.*

VI. PAYING FOR TREATMENT SERVICES: BARRIERS AND OPPORTUNITIES

During the course of our technical assistance services to local drug court programs we have found a wide array of approaches being used to pay for drug court treatment services, highlighting the critical need for the court to be overseeing this complex area. Drug Courts need to have Memorandum of Understanding (MOU's) with local treatment provider(s) who provide services for drug court clients that specify how the

level of care will be determined and extent of services that will be provided, the costs entailed, and the entity paying these costs.

Currently, some programs work only with providers who will agree to accept Medicaid or other coverage that participants may have. In these situations, depending upon the state, the extent of services covered by Medicaid may vary and it is important for the courts to ensure that policy makers who determine the availability of treatment and mental health services are aware of the extent and duration of services drug court participants may likely require so that adequate Medicaid coverage is available. Other programs, however, rely on local treatment providers who generally charge participants a fee for services – which can vary significantly and, in some instances, present a barrier to full-scale participation in the drug court program even though a "sliding scale" is purportedly utilized. In some programs, participants cannot advance to another phase or graduate until all of the fees are paid – a situation that has raised concern on a number of levels..

The situation becomes further complicated by non-treatment agencies providing services, such as drug testing, probation supervision, and others, each applying a fee for the participant to pay. Efforts to identify the total fees assessed on a drug court participant have indicated that there is often no central point for collecting, reporting, monitoring, and/or depositing the fees charged to drug court participants and that there are often a range of personnel involved -- court coordinators, case managers, treatment agency staff, probation staff and/or therapists --corroborating comments commonly made by drug court participants that the amount of program required fees is not clearly known at the time of program entry.

The advent of the Patient Protection and Affordable Care Act (ACA), enacted in 2010, should expand access to health care services for persons who are presently uninsured and/or with low incomes, particularly in those states where Medicaid expansion has taken place. The ACA requires that all qualified health plans and small group plans provide ten categories of essential health benefits, including benefits for mental health and substance use disorder services. The ACA clearly includes individuals involved with the criminal justice system and potential drug court participants who are not in jail or prison and who need services to address chronic and often communicable diseases as well as substance use and mental health disorders. It is of critical importance that Court representatives, along with those of other justice agencies, work with policymakers determining how the ACA as well as the federal parity law[164] will be implemented in their respective states, to make known the range and extent of treatment, mental health, and related services which drug court participants need.[165]

Challenges for Drug Courts and their treatment provider partners may include the following:

1. There will be a new focus on" medical necessity" needed and the continued provision of treatment services as well as the need for medically assisted treatment. Residential treatment services will be aggressively managed under this new system.
2. Medicaid/insurance company billing is complex and smaller treatment providers may find it difficult to meet the accreditation and administrative records requirements.
3. Under Medicaid, individuals are guaranteed "provider choice." This could mean that drug court participants may choose providers with less experience or expertise in treating court-involved addicted individuals. Plans may also select treatment providers for their in-network treatment services that have never worked with a drug court before.
4. New treatment providers may be unwilling to participate in treatment court and staffing."
5. Medical Necessity" requirements and how they are implemented could mean the difference between drug court participants receiving an adequate dose (length of treatment) of evidence-based treatment or a minimal ineffective dose of treatment.

To ensure that the treatment services drug courts need for participants are, in fact, available, the courts must be "at the table" now, engaged in discussions with key policymakers now -- including the state's Insurance Commissioner and the state agency in charge of managing Medicaid and Medicare (often called the Division of Medical Assistance and/or Services.

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[164] The federal parity act mandates that MH/SUD coverage cannot have financial requirements and treatment limitations on benefits that are more restrictive than those imposed on other medical/surgical benefits covered by the plan.

[165] See *Implications of The Affordable Care Act on People Involved with the Criminal Justice System*. Justice Center. The Council of State Governments. February 2013

VII. Drug Courts in Rural Areas: Responses to Special Challenges

Rural Drug Courts have experienced special issues that have required creative thinking and persistence to overcome. While alcohol abuse has been a significant problem in rural areas, illicit drugs have infiltrated towns of every size and adults and young teens in rural areas today are just as likely to abuse substances as those in larger metropolitan areas. Expansion of drug courts and related treatment are now critical components of dealing with rural alcohol and other drug abuse problems and the related offenses.
Characteristics of rural communities that often set them apart from their urban counterparts include:

- A problem-solving orientation that entails the use of practical approaches for addressing a wide range of day to day issues
- A tradition of performing multiple tasks and roles simultaneously, rather than the specialization of roles and functions more common to urban areas
- Very close working relationships among branches of government, local agencies and local officials
- Personal familiarity with citizens whose ties to the community often go back generations.

The Treatment Episodes Data Report (TEDS DATA) issued in 2012 draws the following conclusions when comparing Rural and Urban Substance Abuse Treatment Admissions:

- Rural admissions were younger and less racially and ethnically diverse than urban admissions
- Rural admissions were more likely than urban admissions to report primary abuse of alcohol (49.5 vs. 36.1 percent) or non-heroin opiates (10.6 vs. 4.0 percent); urban admissions were more likely than rural admissions to report primary abuse of heroin (21.8 vs. 3.1 percent) or cocaine (11.9 vs. 5.6 percent)
- Rural admissions were more likely than urban admissions to be referred by the criminal justice system (51.6 vs. 28.4 percent) and less likely to be self- or individually referred (22.8 vs. 38.7 percent)

While rural drug courts may not have the resources that urban/suburban courts do, many have developed creative solutions to common problems through cooperative efforts and determination. The following list of special challenges -- and responses -- have been compiled by the BJA Drug Court Technical Assistance Project during the course of working with drug court programs in rural areas.

SPECIAL CHALLENGES AND RESPONSES

A. Lack Of Treatment Capacity And Available Continuum Of Services

Challenge: LACK OF TREATMENT CAPACITY, ACCESS TO A FULL CONTINUUM OF TREATMENT SERVICES AND HAVING ACCESS TO ADEQUATE WRAP AROUND SERVICES.

RESPONSES:

1. Most geographic areas of the country have some type of alcohol and other drug abuse treatment program that contracts with the Single State Agency (SSA) for Drug Abuse Prevention and Treatment. The SSA receives federal block grant funds and, in many cases, state funds and/or alcohol tax funds for prevention and treatment programs. Consider asking your local legislator to accompany you to meet with the SSA Director and ask why there are little or no services in your area and what can be done about it.
2. Some rural drug courts have linked up with a qualified provider who may be distant but is willing to contract to do services using Skype or teleconferencing. This type of linking could allow a drug court provider to offer Intensive Outpatient (IOP) services with the supplement of teleconferencing.
3. Drug courts also need access to more than one service level of care. Drug court treatment providers may need to have service agreements with providers of other levels of care on a regional or statewide basis.
4. Outpatient withdrawal management may be a necessity in rural areas and may be managed by a home health care nurse with consultation from a physician. The nurse will provide ongoing monitoring of: blood pressure, respiration, temperature, medication management and progression of withdrawal. For drug court participants to utilize residential treatment capacity, s/he may have to travel.
5. Counseling space (office space) could be available at little or no cost through a local faith-based organization or a community hospital that may be seeing a number of patients with addiction admitted or seen in their emergency rooms. Group meeting rooms may be available in a church

basement, local hospital, community support program office, 4-H club, community center or local school building.

6. If only one professional is available to serve a large geographic area, one solution could be "circuit-riding" where the professional travels to each community on a regular basis.
7. Treatment groups should be open rather than closed to permit admission of new clients whenever they are admitted to the drug court. In one of Montana's rural courts, a contracted treatment provider (treatment counselor) from a larger community drives to a very rural location and holds group sessions both before and after the drug court docket; individual treatment sessions are scheduled as needed before court so participants maximize their time and the use of the travel dollars.
8. Use of Telehealth Technologies (Proposed by the National Frontier and Rural ATTC[166])

For drug court participants residing in rural and remote areas who do not have access to a full continuum of treatment services, the National Frontier and Rural Addiction Technology Transfer Center (ATTC), which is one of four national focus area centers in SAMHSA's ATTC network[167], recommends that drug court personnel work with addiction treatment providers to consider expanding their services to include using telehealth technologies. Currently, there are addiction treatment providers that offer a variety of treatment services using video-conferencing, email, messaging (text and chat), and telephone. Many treatment providers currently offering video conferencing, email, and messaging have created secure HIPAA compliant portals that require clients to have internet access and use a secure log-in password. In addition, other treatment providers are using computer-based interventions, interactive voice response (telephone), and mobile apps. Minimally, treatment providers could easily and with little expense conduct sessions using the telephone. Training would be necessary for counselors but no other equipment would be required as counseling could be conducted from the main office. Finally, Single State Agencies (SSA) in each state should be aware of treatment providers that are using telehealth technologies so that drug court coordinators could contact the SSA in their state to find providers utilizing telehealth technologies.

The following lists provide a summary of a brief literature review regarding telehealth technologies that have a strong research base.

a. <u>Telephone Continuing Care For Individuals With Substance Use Disorders (Suds): Program Descriptions</u>

This list provides examples of telephone-based services for continuing care:

- Telephone Monitoring and Adaptive Counseling (TMAC)
- Focused Continuing Care (FFC) (Betty Ford Clinic)
- Telephone Enhancement of Long Term Engagement (TELE)[168]
- Individual Therapeutic Brief Phone Contact (ITBPC)[169]
- Telephone Case Monitoring (TCM)[170]
  Telephone Continuing Care (TCC)[171]

b. <u>Computer-Based Interventions For Individuals With Suds</u>

Three seminal studies have been conducted on the efficacy of using computer-based interventions with individuals with SUDs. Results from a large randomized control trial will be coming out soon from NIDA. Listed below are the researchers and their innovations.

- CBT4CBT (Cognitive Behavioral Therapy, Carroll. et al., 2008) Outpatient clients
- TES (Therapeutic Education System, Marsch and Bickel as lead researchers)

[166] National Frontier and Rural ATTC. (2013). Retrieved online at http://www.attcnetwork.org/regcenters/index_nfa_frontierrural.asp

[167] Others include the National American Indian and Alaska Native Addiction Technology Transfer Center; the National Hispanic and Latino ATTC, and the National Screening, Brief Intervention and Referral to Treatment ATTC.

[168] Hubbard, Robert L. Ph.D. (2007). *Telephone Enhancement of Long-term Engagement (TELE) in Continuing Care for Substance Abuse Treatment: A NIDA Clinical Trials Network (CTN) study.* The American Journal On Addictions, Volume 16, Issue 6, pages 495–502, November-December 2007.

[169] Individual Therapeutic Brief Phone Contact (ITBPC), Kaminer & Napolt no, Adolescents. (2004). *One-year Outcomes of Telephone Case Monitoring for Patients with Substance Use Disorder.*

[170] McKellar J, et al, Oct 2012, *Addict Behavior*, 37(10):1069-74.

[171] Mark D. Godley, Ph.D., Victoria H. Coleman-Cowger, Ph.D., Janet C. Titus, Ph.D., Rodney R. Funk, B.S., Matthew G. Orndorff, M.A. (2010*). A Randomized Controlled Trial of Telephone Continuing Care*. Journal Of Substance Abuse Treatment, Volume 38, Issue 1, January 2010, Pages 74–82.

- Community Reinforcement Approach + Incentives
- HIV/AIDS Intervention-Opioid treatment clients (2004) Marsch, et al.
- Outpatient Opioid Treatment- TAU + TES (2008) - Bickel, et al.
- Outpatient Treatment-2hrs per week of TES + TAU (2012) Campbell, et al.

c. Interactive Voice Response (IVR)

This technology uses automated interventions via the phone for clients to use as an adjunct to treatment services. These fully automated systems allow clients to access support and educational modules 24/7. Many of the educational modules designed for IVR are less than 15 minutes in length and are easy to understand as they require no reading literacy. For example, a new 'Recovery Line' IVR program is being studied, with preliminary results showing positive effects regarding improvement in clients' coping skills (Moore, et al., in Press).

d. Mobile Phone Apps

While there are numerous smart phone apps available to provide health information and support, there is one mobile phone app that is currently being studied. The 'Alcohol-Comprehensive Health Enhancement Support System' (ACHESS) is designed to help clients develop competence in coping with drug/alcohol cravings, social support, and motivation.[172]

e. Virtual Counseling

A number of treatment providers have begun to offer recovery related counseling services and educational courses online. Avatar assisted therapy "virtual world counseling" or "virtual therapy" is one of the new technologies being used to provide treatment services and has undergone testing in rural drug courts in Missouri. The use of virtual world counseling appears to be a feasible way to increase access to treatment services. Preliminary results indicate no significant difference in program retention between the virtual world counseling group and a matched comparison group. However, to date, it is considered as an adjunct to available counseling services, not a replacement.

Challenge: INABILITY TO FIND AND HIRE QUALIFIED DRUG COURT AND TREATMENT STAFF

RESPONSES:

1. Request assistance from the Single State Agency for substance abuse prevention and treatment in your state. Ask if that agency is invested in expanding treatment opportunities in under-resourced areas. There needs to be incentives for agencies to establish satellite offices and to invest in work force development. In the latter case, one approach is to emphasize the use of manualized treatment approaches that can be easily trained and used by less experienced and sophisticated counselors. Partner with a local community college to help in the development of qualified counselors and provide internships in the local treatment agency and the drug court.
2. Once again, providing treatment services using telehealth technologies may be helpful in addressing workforce issues. Telehealth has been a force multiplier (Rheuban, 2012, Institute of Medicine Report) as it can create access to the existing workforce. In addition, drug courts may want to develop partnerships with the VA as it is the largest provider of telemental health services.
3. Some drug court clients may already be receiving VA services and drug treatment services could be provided by the VA. Treatment compliance and outcome issues can then be shared with the drug court.
4. The use of evidence based treatment curriculum can provide a framework for ensuring consistency and quality of the treatment services and a readily available guide for training individuals in to deliver the curriculum who may not have extensive clinical backgrounds.

Challenge: TURNOVER AMONG TREATMENT PROGRAM STAFF

RESPONSE:

This issue can be remediated somewhat if treatment program supervisory level personnel are engaged with and invested in the drug court process so that when turnover does occur, there is a secondary person who is knowledgeable about the drug court and can provide some continuity for the drug court partic-

[172] Gustafson, D.H., Shaw, B.R., Isham, A., Baker, T., Boyle, M.G., & Levy, M. (2011). *Explicating an evidence-based, theoretically informed, mobile technology-based system to improve outcomes for people in recovery for alcohol dependence.* Substance Use And Misuse, 46(1), 96-111.

ipants and team. This person may even be known to the participants.

Challenge: <u>INCONSISTENCY OF TREATMENT PROVIDER SERVICES</u>

RESPONSE:

A written Memorandum of Agreement (MOA) can provide a foundation for consistency, coupled with an initial meeting of the Court with the Treatment Provider to review the stipulations in the MOA. The meeting between the Court and the treatment provider should include all team members in attendance so everyone knows what the expectations include. The MOA should require a quarterly report from the treatment provider stating how they have met the expectations outlined in the MOA and this report should be reviewed in meetings outside of staffing of the docket.

Requirements to consider for consistency include:

- Designated therapist(s) who will work with drug court participants to maintain consistency both with drug court participants and drug court team members,
- Regular communications with the court, including: a written and verbal report from the treatment provider(s) at each staffing that includes:
    1. Attendance of the drug court participant at treatment appointments,
    2. Compliance (to include level of participation and completion of assignments, etc.) and Progress (is participant moving forward in achieving treatment plan goals and objectives,
    3. Recommendations: recommendations by the treatment provider concerning:

        (a) Current treatment services and any modifications needed, (is the participant is doing well and making progress in treatment?), (b) concerns, (if the participant is not progressing) suggested improvements or sanctions if warranted, and (c) additional direction, (recommendations for other services or action).
    4. A summary of material covered in treatment in order for the judge to ask the participant open-ended questions about their treatment and progress.

B. Use Of Medication-Assisted Treatment

Challenge: <u>LOCATING PHYSICIANS TO PROVIDE MEDICATIONS</u>

RESPONSES:

1. As discussed in Section III A, the U.S. Food and Drug Administration (FDA) has approved a variety of medications as safe and effective for the treatment of alcohol and opioid dependence. The use of these medications has been shown to reduce opioid use and drinking and should be considered as a first line treatment for drug court participants with alcohol and/or opioid dependence, used in conjunction with the psycho-social and other treatment services drug courts provide and following protocols developed. The use of these medications, under the supervision of a physician, permits the drug court participant to curtail their use of alcohol or opioids and to more effectively engage in other evidence-based substance abuse treatment services the drug court is providing.
2. In rural areas, where long distances might be required to travel for this treatment, it is possible for a physician to become licensed as a medication unit to administer medication from the physician's office through an application to the state substance abuse authority and the federal Drug Enforcement Agency. Approved physicians can provide buprenorphine prescriptions, for example, in whatever setting they practice, affording an advantage in rural areas.
3. For drug courts in rural areas and other jurisdictions with few available substance abuse treatment services, it may also be useful to connect with physicians who are certified by the American Society of Addiction Medicine and/or the American Academy of Addiction Psychiatry (see *"Sources and Links"* section in this guideline). Each state's substance abuse authority/office and the above-mentioned professional societies can help to connect drug courts to these providers.
4. In rural areas, it may also be possible for an ASAM certified physician in the state to collaborate with a local licensed physician through telemedicine.

C. Quality Of Treatment Program: Staff Training And Turnover

Challenge: LACK OF ADEQUATE TRAINING FOR DRUG COURT TEAM

With more than 2,600 drug courts across the country and more on the way, the need to train judges, lawyers and court professionals is greater than ever. It is also expensive and difficult given the array of individuals needing training on both the drug court process and addiction generally, as well as the turnover in the personnel involved.

RESPONSES:

1. The New York City-based Center for Court Innovation, with support from the Bureau of Justice Assistance, has developed a free online training course through its new National Drug Court Online Learning System (http://www.drugcourtonline.org/). Most drug court professionals learn on the job or through conferences and training. But that's changing. "Remote learning has become a much more common method of learning and training," says Valerie Raine, Director of the Center. "They can go to this site on their own time and at their own pace and get a pretty good handle on drug court." The Center has also gone to great lengths to assure that these course offerings are relevant to rural drug court personnel.
   The Center's online training offerings include video lessons from national experts on the following topics: Understanding Drug Use and Addiction, Treatment Modalities, Cultural Competency, Essential Components of a Successful Drug Testing Program, Sanctions and Incentives, Confidentiality, Trauma Informed Care Responses for Drug Courts, Legal Representation of the Non-Citizen, Maximizing Participant Interactions: "Transference" Revealed, Prescription Medication Abuse: Knowledge and Skills for Drug Court Practitioners, Changing the Direction of Methamphetamine Addiction. Courses are continually being updated and new ones developed. There are also interviews with practitioners and guided tours of drug courts, as well as a resource library of documents and reference tools.

2. Additionally, there are numerous webinars covering a wide range of drug court-relevant topics posted on the websites of the National Drug Court Institute (NDCI.org) and the BJA Drug Court Technical Assistance Project at American University (www.american.edu/justice) and the Tribal Law and Policy (www. tribal-institute.org).

3. On-site technical assistance is also available through the BJA Drug Court Technical Assistance Collaborative (American University, National Association of Drug Court Professionals, Tribal Law and Policy Institute, and Center for Court Innovation). Additional resources include: the National Rural Institute on Alcohol and Drug Abuse, Children and Family Futures, and other organizations. Other resources include: Treatment Improvement Protocols (monograph publications from the Substance Abuse and Mental Health Services Administration-Center for Substance Abuse Treatment), regional Addiction Treatment and Training Centers, state drug court associations, local colleges and universities.

D. Dealing With Co-Occurring Disorders Of Drug Court Participants

Challenge: THE DRUG COURT CANNOT FIND RESOURCES TO DEAL WITH CO-OCCURRING CLIENTS AND ACCESS MENTAL HEALTH SERVICES

RESPONSES:

1. Drug court team and treatment providers should understand that co-occurring clients are in their drug courts and that their success is largely dependent on addressing the client's mental health needs as well as treating their addiction. Most treatment providers are aware of best practices in treating people with a co-occurring disorder (e.g., integrated treatment).

2. Local community mental health centers may be willing to partner and co-lead groups with co-occurring drug court participants and help with individual counseling and other services helpful to the participant, e.g. case management, monitoring of prescription, etc.

3. In some instances, there may be grief, trauma, marital issues or other problems not addressed in substance abuse counseling. One District refers the participant to local private counselors and pays for the services through private donations, as the State Drug Court grant will not include that service.

4. Many private providers of mental health services will discount services to drug courts or bill at the reduced Medicaid rate. Many women's shelters will offer free counseling for women who are vic-

tims of domestic violence as well as the local YWCA.

E. Need For Wrap Around Services

Challenge: LACK OF ACCESS TO ADEQUATE WRAP AROUND SERVICES FOR DRUG COURT PARTICIPANTS

RESPONSES:

1. Many states have job training centers, employment state agency offices and vocational rehabilitation offices nearby. Ask them to visit a drug court staffing, docket, and graduation. Ask them to assign a single point of contact (SPOC) to the drug court for consistency and show them how drug court can help them achieve their performance objectives of completion of training programs and completion of employment placements. Inviting the SPOC to attend staffing, dockets and graduations will help develop an understanding and commitment to drug court.
2. Faith-based organizations have a long history of reaching and aiding individuals and families in need, and these organizations often fill or are willing to fill service gaps. Faith-based organizations offer or support a variety of outreach and service provisions that are available to drug court participants in need, including: rental assistance, emergency housing support, food and clothing banks, transportation assistance, conflict resolution education, free lunch programs, free medical clinics, yard work assistance, elderly assistance, college student services/counseling, daycare for those who cannot afford it, open and affirming support for the gay, bisexual, lesbian, and transgender communities, circles of support and accountability groups, various 12-step meetings and active programs to assist recovery clients in spiritual growth. In return faith-based organizations need education regarding alcohol and other drug abuse, addiction as a brain disease, addiction treatment processes and correctional procedures.

Challenge: FINDING EMPLOYMENT

RESPONSES:

1. Although it does not pay the bills, even if participants cannot find jobs, it is important for them to be engaged in community service or an educational program, like a GED or Adult Education. Many drug courts require unemployed drug court participants to provide a list of where applications for employment have been submitted and spend half their time doing community service until they become employed. This provides a good incentive for participants to take any job available at least as a starting point.
2. Employers should be reminded that bonding through the U.S. Department of Labor Bonding Program is available to encourage them to take a risk with felons.

Challenge: ACCESS TO MEDICAL/DENTAL SERVICES

RESPONSES:

1. If a state has a dental school, free clinics can be set up in remote areas using dental students.
2. Federally qualified health centers are intended for under-served areas and can be of significant benefit to rural drug court participants.
3. Many local physicians/dentists will provide services pro bono if asked or, at a minimum, bill at a reduced or Medicaid rate.
4. One drug court steered participants to a local dentist who saw disadvantaged clients for free one day every three months.
5. One District included a dentist as a mentor previously who is a recovering alcoholic. He provided services for a minimum cost.
6. One Idaho drug court has a doctor on their drug court team who also facilitates medical services for drug court participants.

F. Housing

Challenge: LACK OF ALCOHOL AND DRUG FREE HOUSING FOR DRUG COURT PARTICIPANTS

Many rural communities lack safe and affordable rental housing.

RESPONSE:

Strengthening community support and direct relationships with landlords is helpful. Landlords are often willing to prioritize renting to drug court participants once they understand the requirements and intense supervision that accompanies the drug court process.

G. Transportation

Challenge: <u>TRANSPORTATION; DRUG COURT PARTICIPANTS ARE UNABLE TO GET TO MEETINGS/WORK/SCHOOL DUE TO LACK OF DRIVER'S LICENSE AND OTHER BARRIERS</u>

RESPONSES:

1. Request bicycles from local law enforcement that are left unclaimed.
2. Ask the local church if it could help with transportation by using their vans or busses.
3. A strong 12-step network and drug court alumni group can help as well in terms of networking and support.
4. For participants with Medicaid, many states pay for transportation to medical appointments, including counseling, which can be scheduled in conjunction with court appearances.
5. One District uses mentors who offer rides to participants.
6. If an individual has transportation problems and asks to live in an outlying area, the court will deny the request which forces the person to live in the homeless shelter in town, find a suitable roommate, apply at the men's sober house, one of the women's shelter programs, or save enough from their job to get their own place in town.
7. In Oswego County, New York, local officials contracted with a local taxi company to provide transportation.
8. One of the tribes purchased a van/bus for drug court participants.
9. In another drug court, the judge decided to hold court in a location that was more convenient for participants, rather than always in his designated courthouse.
10. In one Iowa community the treatment provider delivered services in the drug court participant's home rather than the provider's offices. Before counselors go to a family's home, basic training for safety includes a variety of approaches, such as safety information from other providers and referral sources and ensuring every counselor has a cell phone at all times. Any time a counselor feels uncomfortable or unsafe, he or she should leave the situation. In addition to providing treatment, the agency personnel were able to see the interaction that goes on in a real setting rather than an office and were able to deal with a lot of family problems like anger, frustration and other feelings regarding the addiction.
11. Taking programs to communities instead of expecting people to come to an office can go a long way away in overcoming client reluctance to deal with bureaucracies and "the government."

H. Family Services

Challenge: <u>DRUG COURT PARTICIPANT ENMESHED IN FAMILY DRUG USE</u>

RESPONSES:

1. Among the possible responses to this situation, the most direct would be to do an intervention with the family and try to move them into treatment emphasizing how important this will be to the drug court participant.
2. If the immediate family will not consider supporting the drug court participant by entering treatment and not using, consideration might be given to finding alternative living arrangement for the individual and developing a plan with the drug court participant regarding how s/he will not be around family members when they are using.
3. Consideration could also be given to transferring the individual to another drug court in the state, if that is feasible.
4. The participant could also be referred to Al-Anon, a companion program to AA that focuses on dealing with co-dependency by learning new behaviors and boundaries, especially with intimate relationships. (See also No. 4 "Housing" below).

Challenge: <u>LACK OF PARENTING CLASSES</u>

RESPONSES:

1. Consider asking the local Agricultural Extension Office to collaborate with the drug court to provide participants parenting classes.
2. Additionally, many treatment providers offer parenting classes as part of their array of services.
3. The local YWCA may also offer these classes.
4. In Montana, area Human Resource Development Councils are potential resources for parent training as well as faith-based organizations, some domestic violence crisis shelters, homes for teen mothers, foster care organizations and homes for troubled youth.

Challenge: <u>PROVIDING CHILD CARE FOR DRUG COURT PARTICIPANTS WITH YOUNG CHILDREN</u>

<u>RESPONSES:</u>

1. Rural residents often rely on family and friends for child care as professional child care is scarce and expensive.
2. Consideration should be given to approaching local churches for help with child care while drug court participants attend treatment or 12-step meetings especially if held in the church.

I. Drug Testing

Challenge: <u>DIFFICULTIES AND ASSOCIATED COSTS ENTAILED IN CONDUCTING ALCOHOL AND OTHER DRUG TESTS</u>

Rural drug courts often require a robust travel budget for case managers or other drug testers to travel as participants may not have a reliable vehicle or money for gasoline.

<u>RESPONSES</u>:

1. Law enforcement agencies and local health departments can be very helpful as they typically test other offenders for drug use (24/7 programs, probationers, truck drivers, etc.).
2. Many probation officers consider conducting urinalysis as part of their duties and responsibilities for public safety. It is critical, however, that urinalysis be done randomly and observed. Partnerships are crucial to ensure back-up capability for drug testing observation (e.g. when the drug court coordinator is on vacation, or the probation officer is sick), and to ensure the appropriate gender is available to do observation when participants provide urine samples. In some rural areas, saliva swabs are used to overcome the gender observation problem.

J. Self-Help Meetings

Challenge: <u>COMMUNITY LACKS CONSISTENT 12-STEP MEETINGS FOR DRUG COURT PARTICIPANTS TO ATTEND</u>

<u>RESPONSES:</u>

1. Drug court graduates can assist in strengthening self-help meetings and often get to the point where they chair such meetings.
2. Approaching the dedicated 12 step leadership in your community and expressing the problem and asking how drug court staff and participants can help, may lead to more consistency of meetings.
3. Some courts substitute religious meetings for 12-step meetings or other self-help meetings. Online meetings are available at http://www.aaonline.net/

Challenge: <u>NEED FOR DRUG COURT TO VERIFY DRUG COURT PARTICIPANT ATTENDANCE AT SELF-HELP MEETINGS</u>

<u>RESPONSES</u>:

1. Provide drug court participants with a validation process that includes a sign–in sheet/card indicating meeting attendance.
2. Meet with the local chair(s) of self-help meetings and ask them to verify the attendance of drug court participants at self-help meetings by signing the sheet/card as well as encourage the provision of sponsors. Ask them to attend a drug court docket/graduation so they can experience the intensity of the drug court experience and explain the mission, goals, and policy and procedures of the drug court to them.

CHALLENGE: <u>LACK OF 12-STEP MEETINGS FOR YOUTH</u>

<u>RESPONSES:</u>

1. Ask recovery community to develop a 12 step meeting geared to youth. Consider using Marijuana Anonymous materials and format for the young drug court participants.
2. <u>Suggestions by the National Frontier and Rural ATTC: attending online meetings</u>

   Currently, there are several reputable websites for online Alcoholic/Narcotics Anonymous meetings, chats, and forums. If drug court participants have access to the internet and a valid email address they would be able to attend these online meetings or chats and possibly get documentation of their attendance. In addition, there are other online support groups offered that are not AA affiliated (e.g., SMART Recovery, Women for Sobriety, and others). The following URL addresses represent some of these online support group meetings and chats.

   http://aa-intergroup.org

   www.AlcoholHelpCenter.net

   www.smartrecovery.org

   http://www.cyberrecovery.net/forums/
   http://www.addictiontribe.com/

www.NAChatroom.org

http://womenforsobriety.org/beta2/group-info/internet-chat/

3. In addition, there are free recovery support podcasts and radio shows available online. Drug court participants can be assigned to listen to these podcasts or radio shows as part of their homework for drug court. Listed below are examples of podcasts and radio shows that are available through iTunes. A drug court participant could set up a free iTunes account and subscribe to these podcasts and radio shows. Next, Drug Court Personnel could record these podcasts, burn them on CD-ROMs, and distribute them to drug court participants (not difficult to do and inexpensive). They could listen to the podcasts and radio shows and complete questions related to the audio-recordings as part of their homework. Drug Court personnel could review participants' responses to ensure compliance with homework assignments.

4. Finally, drug court participants could listen to recovery focused podcasts or radio shows as they drive home from treatment sessions or other appointments. Here is a sample of podcasts and radio shows that are recovery-focused.

   www.12stepradio.com

   https://itunes.apple.com/us/podcast/aa-on-air-wellington/id465173613?mt=2

   https://itunes.apple.com/us/podcast/smart-recovery-podcasts/id433764979?mt=2

   https://itunes.apple.com/us/podcast/online-recovery-support/id317380341?mt=2

   https://itunes.apple.com/us/podcast/getting-to-recovery/id455357559?mt=2

K. Confidentiality

Challenge: MAINTAINING CONFIDENTIALITY OF DRUG COURT PARTICIPANTS IN A RURAL SETTING

Maintaining confidentiality can be a problem for anyone living in a rural community. Drug courts need to deal assertively with violations of confidentiality up to and including termination from the court.

RESPONSE:

Providing specific training and education to drug court staff and participants on this issue and related sanctions for violation of the Federal Confidentiality regulations will help emphasize the importance of the maintaining the confidentiality of participant information.

L. Community Supervision

Challenge: LACK OF PERSONNEL TO MAINTAIN CLOSE SUPERVISION OF DRUG COURT PARTICIPANTS INCLUDING HOME VISITS

RESPONSES:

1. Ask the drug court judge to request additional probation/parole resources.

2. Contact local law enforcement agencies and enlist their support, provide them with an updated list of drug court participants and request help in client supervision including home visits (include this possibility in the Confidentiality Waiver and Participant contract signed by the participant).

M. Local Support Resources

Challenge: LACK OF FUNDING AVAILABLE TO INITIATE AND MAINTAIN A RURAL DRUG COURT

RESPONSES:

1. Rural drug courts have found many different revenue streams to help offset the expenses of drug court. These revenue streams exist at every level of government and with foundations and other not-for-profit agencies.

   At the federal level funding is currently available through the Department of Justice (Bureau of Justice Assistance and Office of Juvenile Justice and Delinquency Prevention), Substance Abuse and Mental Health Services Administration (Center for Substance Abuse Treatment).

   At the state level, funding is often available through the Office of the Court Administrator/Supreme Court, Single State Agency for Drug Abuse Prevention, State Department of Justice or Governor's Office (federal block grant funds/Justice Assistance Grant (JAG)), Department of Corrections (Community Corrections) and the state Department of Transportation (particularly for DUI court/drug courts).

   At the local governmental level, county and municipal government often provide funding.

2. Other funding sources that have been used to fund drug courts include: United Way, Medicaid, health insurance, forfeiture funds through local law enforcement, beer, wine and liquor tax

funds, drug court participant fees, local foundation funding, establishment of 501 (C)(3) corporations, DUI Task Forces, and donations from local businesses.

Challenge: THE DRUG COURT CANNOT FIND COMMUNITY SERVICE OPTIONS FOR PARTICIPANTS

RESPONSES:

1. Community service is a valuable tool for teaching pro-social behaviors, and also serves as a non-jail sanction for the Judge to impose if the person is non-compliant. However, in some rural communities, there are few or no organized options for community service. Another limiting factor can be the cost of insurance (liability) coverage for the participants while they are engaging in the community service. Worker's Compensation insurance coverage can usually be secured through the city or county government at a very low rate. If the city or county is not willing to bear the cost, the participant fees can be used to pay for the coverage.
2. Establishing new community service options will involve finding who (not-for-profit organizations) in the community has a need for free labor, and working with them to establish a process.
3. Potential sources of collaboration include:
   - County weed maintenance crew-pull noxious weeds from roadsides
   - Animal shelters-walk animals and assist in bathing and cleaning their pens
   - Area agency on aging (http://www.n4a.org/) – during the summer, provide assistance to the elderly with mowing, weeding, fence/house painting, shovel snow in the winter
   - Road maintenance crews – pick up litter along the highway
   - Cemeteries – assist in weeding, mowing, and litter pick-up
   - Litter pick-up in any location that needs it
   - Provide services to the blind, e.g. read articles from the daily newspaper or a novel
   - Senior living complexes – assist with setting up chairs for special events, provide entertainment (if the offender has skills in playing a musical instrument, etc.) helping with arts/crafts sessions
   - Chamber of Commerce-offer to help keep business/public areas clean and in order
   - County fairgrounds board – offer to direct traffic at county fairs, rodeos, music concerts, etc.
   - Work with maintenance person at courthouse to keep up the building and grounds
   - Plant flowers in public areas and planters around town
   - Help staff a recycling center

Challenge: LACK OF MEANINGFUL REWARDS/RECOGNITION FOR THOSE DOING EXCEPTIONALLY WELL IN DRUG COURT

RESPONSES:

1. While tangible rewards have value, particularly early on in drug court participation, research indicates that the relationship with and recognition from the judge is of critical importance.
2. In some courts, the case managers or other team members (not judges) solicit small contributions from the community. If they have funds, they may offer to match what a business can provide.
3. Some small drug courts have developed 501(C)(3) corporations run by members of the community to raise funds for incentives and related drug court expenditures.
4. The court can provide frameable certificates to honor the movement from one drug court phase to the next – an inexpensive but a meaningful gesture to participants, involving special attention from the judge and applause from the team and other participants.
5. Keep the media informed of the drug court's progress with regular news releases and invitations to attend drug court events. This will help build community support and the possibility of donations of incentives for drug court participants.

Challenge: DEVELOPING BUY-IN FROM OTHER COMMUNITY AGENCIES

RESPONSES:

1. Efforts to enlist and maintain community support through public presentations by the judge and other team members, as well as media coverage of graduations and other positive events are important.

2. Generally, judges and specifically drug court judges are very well respected in the community and auxiliary agencies will be represented at meetings called by the judge and, in most cases, very willing to cooperate if they know that the judge is very dedicated to drug court.
3. Agencies also need to see data that demonstrates cost effectiveness and improved public safety. Agency representatives need to see how drug courts address their self-interests and performance as well as the strength of collaboration versus contending over scarce resources.
4. A small drug court in Kentucky has initiated a monthly meeting of community agency representatives with the drug court coordinator. This meeting has evolved into the development of a 501 (C)(3) that now has a primary objective of benefiting drug court participants monetarily as well as incentives. The 501(C)(3) now has the ability to make small loans with no interest to participants with poor credit scores for emergency situations such as doctor's visits, medication or car maintenance just to list a few. The loan process often is a knowledge and life skill enhancement for the drug court participant through the planning of a projected budget for loan fulfillment and associated plan to repay the loan prior to drug court graduation.

N. Judicial Leadership/Resources To Institute And Sustain A Drug Court Program

Challenge: LACK OF JUDICIAL RESOURCES TO TAKE A LEADERSHIP ROLE AND INITIATE THE OPERATION OF A DRUG COURT

RESPONSES:

1. Data and analysis indicating that there is a substantial alcohol and other drug abuse problem in the district should be gathered, along with the recidivism frequency for these individuals, to demonstrate the need for the program. Substantial data now exists that drug courts are the most effective strategy for reducing recidivism of high risk-high need offenders.
2. Drug court staffings and dockets do not need to be held every week. A reduced schedule with the support of a strong team can work very well.
3. Some rural states now have video capability in every courthouse which helps facilitate face-to-face interchange between judges/drug court teams and drug court participants over long distances.
4. To convince a sitting judge that s/he needs to become involved in the drug court process, have them visit an existing drug court staffing, docket and graduation and talk to the drug court judge and team in that jurisdiction. Their satisfaction and results will help enlist judicial oversight of the drug court process.

O. Sustaining Operations Of The Drug Court Program

Challenge: NEED FOR IMPROVING TEAM MEMBER COMMUNICATION AND THEIR SUPPORT FOR THE DRUG COURT PROCESS**.**

RESPONSES:

1. Consider formal process meetings to discuss policies, procedures and perhaps provide training/speakers for the team on a regular basis, i.e. programs less than one year old hold a formal process meeting monthly, programs that are one to two years old hold a process meeting every quarter, programs two years and older hold a formal process meeting twice yearly. Some courts hold their meetings after-hours with dinner or a pot-luck. This allows for a setting outside of the courtroom to build more cohesive relationships and help counter hidden agendas by team members. A strong agenda based on a needs assessment of team members for each meeting will keep team members on board and involved with a sense of accomplishment and time well spent.
2. Team building exercises at process meetings can be beneficial as well.

Challenge: DIFFICULTIES IN LOCATING, INSTALLING AND LEARNING A DATA MANAGEMENT SYSTEM

RESPONSES:

1. With the increasing availability of free "off the shelf" systems, it is much easier to establish an MIS than in the past. The need for expertise to customize and maintain a system will still be needed.
2. If a state has a unified court system, it may be convinced to make some investment in this.
3. American University can provide the Buffalo MIS system and technical assistance for customization and implementation. This service has been provided too many drug courts in the past.

VIII. THE ROLE OF THE DRUG COURT JUDGE IN ENSURING EVIDENCE-BASED TREATMENT SERVICES FOR PARTICIPANTS

The drug court judge not only presides over the drug court hearing but is responsible for overseeing the many "moving parts" that make up the drug court program. The drug court judge's role is therefore both *inside* and *outside* the courtroom.

In terms of the judge's role *inside* the courtroom, the drug court judge plays a key role in motivating each participant to continue in the treatment program and in developing and sustaining the multi-disciplinary drug court team effort to provide evidence-based services to each participant.

Outside the courtroom, the drug court judge must keep all of the "moving parts" together, heading in the same direction, providing the necessary multi agency leadership, coordination and practical support to sustain the program despite changes in agency policy, leadership, and fiscal and other commitments that inevitably will occur.

Most drug courts are utilizing the services of multiple providers, most of whom are not accustomed to working together let alone under the coordination of the court. The drug court judge should convene regular meetings of the providers to provide orientation regarding the mission of the drug court, how it may differ from non-drug court treatment services, and the nature of communication, information, weekly reporting and other interaction the drug court needs from the providers. These meetings will also provide an opportunity for the providers to describe briefly what each is doing and exchange information regarding common issues they are encountering.

WHAT ARE THE ADVANTAGES OF WORKING WITH THE DRUG COURT FOR A TREATMENT PROVIDER?

Here are a few:

- Drug court clients stay in treatment considerably longer and complete treatment in higher percentages than comparison groups;
- Drug court participants make treatment appointments at considerably higher rates than other treatment clients;
- Drug court participants enter recovery and complete treatment at higher rates than other clients;
- Treatment provider employees receive the satisfaction of more frequent positive client outcomes associated with working with the drug court and working with the drug court team;
- Drug courts help treatment programs meet performance criteria, i.e. National Outcome Measures;
- Drug court oversight supports treatment services; and
- The criminal justice system becomes educated about cost effective options to jail and punishment and the importance of treatment.

The drug court judge must ensure that everyone is on the "same page", particularly when multiple treatment providers are involved

For most judges, serving as a drug court judge introduces both a dramatically new role and the need for knowledge about addiction, brain chemistry, behavior modification, and motivational skills not called upon in traditional judicial assignments, and a major paradigm shift in terms of relying on the treatment process to ultimately effectuate the judge's "orders". As Judge Stephen Manley has noted on a number of occasions:

> "…. judges need a basic understanding of addiction, substance abuse, the effects of drugs and alcohol, commonly used drugs, brain chemistry; these are all important and basic. However, in my view, the biggest hurdle for a judge to overcome is to understand that substance abuse and co-occurring disorders are relapsing medical conditions. You have to understand that an offender with a disease and a condition that requires chronic care will not get better when we utilize our usual role of giving orders, setting conditions with expectations that the offender will either do what they've been told to do or they will pay the price for not doing so. And that's what we need to understand. I think we need to understand that what works is treatment. The role of the judge is to engage people in treatment, motivate them in treatment, and be willing to reengage them when they slip and fall and fail without doing blame. This is a tough job, but I think it's one of the most fulfilling assignments that any judge can ever find."[173]

[173] Manley, Judge Stephen. (November 3, 2011). *Applying Evidence-based Substance Abuse Treatment Practices to Drug Court Programs*. NCSC/AU Webinar. Santa Clara County, California Drug Court. BJA/NIJ Research to Practice Initiative.

A major responsibility of the drug court judge and the drug court team is therefore to insure that evidence-based treatment and related practices are implemented in all aspects of the program's operations but, particularly, in the treatment and related services provided. To ensure that this happens, the drug court judge must become an informed consumer of these services, able to delve into the "black box", ask the right questions, and hold the various moving parts accountable.

The core of the drug court model is the continuum of treatment services provided; if these do not reflect the most advanced research findings on effective substance abuse treatment, the program can have little effect. The drug court judge must therefore be well educated about what constitutes evidence-based treatment practices and how these should be delivered. When services are contracted for through a local provider(s), the contract should be structured to stipulate the types of evidence-based practices, intensity of treatment, and other aspects of best practices that will be provided, consistent with the focus and structure of the local drug court program. Developing this expertise – that combines practical experience with continuing education regarding emerging research -- is a process that occurs over time, augmented through interdisciplinary training, use of expert consultants and technical assistance opportunities, attendance at professional webinars and conferences, visits to exemplary drug courts, and ensuring that the team members and service providers are staying abreast of research findings relevant to their respective disciplines.

As a complement to the BJA Drug Court Technical Assistance Project's current effort to strengthen the leadership role of drug court judges in promoting the use of evidence-based treatment practices within their respective programs, as reflected in this *Guide*, a parallel effort is being undertaken through the project's *Judicial Leadership Initiative* to strengthen the leadership role of the drug court judge generally. (See Appendix D, *Drug Court Judicial Leadership Initiative: Guiding Principles*).[174]

ROLE OF THE DRUG COURT JUDGE
APPLICATION TO DRUG COURT PRACTICE

- *The Judge and drug court team members should make regular personal site visits and inspections at the geographic location where treatment is being provided to drug court participants.*
- "There is no substitute for regular personal inspection and discussion about treatment components (evidence-based practices) with treatment programs that serve as major referral sites for drug court participants."[175]

Such visits permit the judge to learn more specifically about the nature of the treatment services being provided as well as demonstrate to the treatment provider(s) his/her genuine interest in what they are doing. A checklist included in Appendix A provides a list of issues the judge can consider when visiting the treatment site.

- *The judge should promote development of mechanisms to ensure that eligible participants enter the program and treatment services promptly and that all eligible for the program are provided its services.*

One of the issues that many drug courts deal with constantly is getting drug court participants promptly into treatment and attaching a priority for their admission.[176] The drug court judge plays a pivotal role in ensuring that this does, in fact, occurs. Getting drug court participants into treatment promptly is critical for a number of reasons not the least of which is that, recognizing drug addiction as a chronic brain disease, the quicker treatment begins, the greater the likelihood that the individual will cease their drug use and associated criminal activities and begin the recovery process.

- It is important that all offenders eligible for the drug court program are provided its services. Program eligibility criteria must be clearly articulated and consistently and transparently applied and all who meet these criteria should be permitted to enter the program.
- *The drug court judge must ensure that the court and the drug court team regularly receive information from the treatment provider(s) necessary to adequately oversee the progress of each drug court participant*

Even before the treatment plan is developed, the Drug Court Judge and team need to receive the preliminary results of the assessment for each participant, which can frame the discussions at the initial review hearing. The fol-

[174] See Appendix D: American University. (December 2013). *Judicial Leadership Initiative: Guiding Principles*. BJA Drug Court Technical Assistance Project (draft).

[175] McLellan. (April 2008). *Evaluating the Effectiveness of Addiction Treatment: What Should A Drug Court Team Look for in a Referral Site, Quality Improvement for Drug Courts: Evidence-Based Practices*.

[176] Key Component #3: "Eligible participants are identified early and promptly placed in the drug court program." (National Association of Drug Court Professionals. (1997). *Defining Drug Courts: The Key Components)*

lowing information regarding each participant can be of particular value during the initial review hearing(s):

- ✓ All to the treatment needs identified (e.g., substance use, mental health, neurological, medical, etc.
- ✓ Individual's level of cognitive functioning and understanding
- ✓ Initial treatment services being recommended – e.g., the modality of substance use treatment
- ✓ Existence of mental health needs and, if so how/when they will be treated
- ✓ The participant's living situation: who he/she is living with, and whether housing is an issue
- ✓ Criminogenic needs which should be addressed (e.g., income life skills, employment, etc.
- ✓ Level of supervision needed and whether curfew or stay away orders from certain persons or places are needed.

This information can provide the foundation for the judge's discussion with the participant at the initial drug court hearing(s) regarding the services needed as well as make clear the program requirements before the participant leaves the courtroom. As the initial assessment is subsequently updated to reflect the participant's progress in treatment, or lack thereof, information from the reassessment will continue to be important, addressing what might have gone wrong; whether the participant can identify what needs to be changed; what will be different the next time; and the clinician's recommendations to help the defendant achieve the revised goals and objectives and reach the new milestones set.

- *The drug court judge should elicit information from participants regarding the program's services and their utility*

Information should be solicited regularly from program participants regarding the services being provided by the program, any difficulties they are encountering in terms of complying with program requirements, the progress or lack thereof they feel they are making, and suggestions for improving the program. All participants should complete an 'Exit Survey" when they leave the program, whether successfully or otherwise, that includes questions asking for their suggestions for improving the program. Their perspectives will be invaluable.

- *Accountability and quality assurance: the drug court judge must play a key role to ensure that necessary services are in fact being provided in the manner anticipated*

As noted above, most drug court programs are utilizing multiple service providers who are providing a panoply of services to participants which need to be consistent with the individual's treatment plan as well as evidence-based practices. Mechanisms must be developed to provide the Court with information regularly from each service provider documenting the services being provided and outcomes, as appropriate; drug tests conducted (with results); outpatient services provided, both individual and group; and other measures of service provision. This information needs to be matched with the comments participants provide, outcomes being observed, and periodic observation.

IX. SUMMARY

This *Guide* has been designed to provide drug court judges with a quick overview of major issues relating to drug court treatment to assist them in working with their local treatment providers to ensure evidence-based practices are being utilized. As stated at the outset, while drug court judges are clearly not treatment providers, they need basic information regarding drug court treatment services (a) to work with treatment providers to ensure that drug court participants are receiving services that reflect evidenced based practices and emerging research findings, and (b) to better understand and respond to the treatment and recovery process which they are witnessing daily in their courtrooms.

The ultimate effectiveness of each drug court program is determined, in large part, by the quality of treatment services being provided and the active oversight being exercised by the drug court judge to ensure that all of the 'moving parts' are in sync and working in consort to promote the recovery of drug court participants. Although very few evaluations of drug court programs have factored in the quality of treatment provided to program participants or the degree to which treatment services have been appropriately matched to their needs in the outcomes reported, this is a critical gap that needs to be filled. Hopefully, this *Guide* will provide a tool for beginning to fill that gap.

APPENDIX

Appendix A: **A Checklist Of Evidence-Based Drug Court Treatment Practices**

Appendix B: **Summary Of Research Findings On Effective Substance Addiction Treatment**

Appendix C: **Recovery Support, Relapse Prevention And Continuing Care: Applying Research Findings To Practice**

Appendix D: **Judicial Leadership Initiative: Over-Riding Principles (Draft)**

Appendix A: A Checklist Of Evidence-Based Drug Court Treatment Practices

Note: *This checklist was originally prepared by Dr. Roger Peters as part of the BJA/NIJ Research to Practice Initiative (Grant No. 2009-DC-BX-K004) and revised by Dr. Peters and Jeffrey Kushner as part of the technical assistance services provided by BJA's Drug Court Technical Assistance Project at American University (Cooperative Agreement No. 2010-DC-BX-K087).*

A Checklist of Evidence-Based Drug Court Treatment Practices

(This 18-item checklist is designed to assist drug court team members and treatment providers in conducting a brief review of their evidence-based treatment practices)

___ (1) Are participants placed in treatment immediately following eligibility screening?

___ (2) In the admissions process, is priority given to participants who are at high risk for criminal recidivism and high need for treatment?

___ (3) Does the drug court program use standardized screening and psychosocial assessment instruments that have been validated for use with offenders?

___ (4) Does the program assess all participants for mental disorders and history of trauma/PTSD?

___ (5) Does the program provide a risk assessment for all participants?

___ (6) Is an assessment provided that examines personal strengths, and issues related to family members and significant others?

___ (7) Is the duration of substance abuse treatment at least 6 months and no more than 18 months?

___ (8) Does drug court treatment include the following elements of cognitive-behavioral and social learning models?

- ___ Cognitive Restructuring
- ___ 'Criminal Thinking'
- ___ Problem-Solving
- ___ Self-control/self-management strategies
- ___ Skill-building

___ (9) Does the drug court program focus on the following criminogenic needs, in addition to substance use disorders?

- ___ Antisocial attitudes/personality
- ___ Antisocial peers
- ___ Family/marital problems
- ___ Education
- ___ Employment
- ___ Prosocial leisure activities

____ (10) Does the drug court program use any of the following evidence-based treatment interventions?

- ___ Contingency Management[177]
- ___ Medication-Assisted Treatment[178]
- ___ Motivational Enhancement Therapy/Motivational Interviewing[179]
- ___ Relapse Prevention[180]

What other evidence-based treatment practices are used? _______________

____ (11) Are specialized treatment approaches used for the following?

- ___ Participants who have co-occurring mental disorders
- ___ Participants who have a history of trauma/PTSD
- ___ Participants who are juveniles/young adults
- ___ Gender-specific treatment needs

____ (12) Are manualized curricula used to guide drug court treatment?

____ (13) Is fidelity to evidence-based treatments monitored on a regular basis?

____ (14) Is medication assisted treatment used in the program?

____ (15) Is there a focus on outpatient treatment, with residential treatment reserved for those who have experienced multiple relapses or who are at risk for harm to self or others?

____ (16) Are there aftercare services in place?

____ (17) Does the drug court incorporate elements of recovery-oriented systems[181] of care?

____ (18) Is a Recovery Management Plan (Relapse Prevention Plan or Aftercare Plan) completed primarily by the drug court participant and focused on by the drug court team at least during the last phase of the program? Does the Recovery Management Plan address long-term recovery goals for the period after completion of drug court?

Yes _____ No _____

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[177] *Contingency management*: "Use of non-cash vouchers/incentives to reinforce positive recovery behaviors."

[178] *Medication-assisted treatment*: "Therapeutic medications used for alcohol and opioid dependence that block, or substitute for the pleasurable effects of the substances."

[179] *Motivational enhancement therapy/motivational interviewing*: "Brief interventions used to address ambivalence about recovery and to enhance engagement in treatment."

[180] *Relapse prevention*: "Identification of individualized relapse patterns, and cognitive-behavioral coping strategies to reduce the likelihood of relapse."

[181] Services and strategies that promote resilience and long-term recovery, including telephone follow-up after graduation, peer mentors/coaches, recovery management check-up, sober or supported housing, transportation, child care, legal services, vocational supports, linkage to leisure alcohol and drug free activities, outreach and referral entities, and mutual support/aid groups.

Appendix B: Summary Of Research Findings On Effective Substance Addiction Treatment

"Drug Court Treatment Services: Applying Research Findings to Practice" Issues Commentary and Resource Brief

By Roger Peters, Ph.D.

The following material provides a summary of key information presented during the Research to Practice webinar on "Drug Court Treatment Services: Applying Research Findings to Practice", presented on November 2, 2011. References are provided to important resources in each area.

Effectiveness of Drug Courts
Five recent meta-analyses examining over 150 drug court studies concluded that adult drug courts are effective in reducing recidivism. Each of the studies found significant reductions in recidivism for drug court participants relative to comparisons, averaging from 8-26%. Drug courts can produce reductions in recidivism lasting more than 36 months following program completion. Studies indicate that there is wide variation in the effects on recidivism across different drug court programs. A recent multi-site study sponsored by the National Institute of Justice indicates that participation in drug courts leads to a 20% reduction in substance abuse. Studies indicate that drug courts produce cost benefits of approximately $5,000 per participant.

Immediate Placement in Treatment
Delay in accessing treatment is one of the major causes of program dropout, and is a particular problem among offender programs. Persons screened as eligible for drug court should be immediately placed in treatment to prevent ongoing substance abuse and recidivism. Risk factors for early dropout from drug court include higher 'criminal risk' level (e.g., multiple prior felony arrests), unemployment, cocaine use, and presence of depression, anxiety, or history of psychiatric treatment. The NIATX Resource Center offers a number of strategies to help expedite referral to treatment (http://www.niatx.net/content/contentpage.aspx?NID=65).

Screening and Assessment
Comprehensive assessment has been linked to more favorable drug court outcomes and allows for rapid engagement in appropriate services. Drug court screening and assessment should examine the presence of mental disorders and history of trauma and Post-Traumatic Stress Disorder (PTSD), given the high rates of these disorders among offenders. Assessment of offender risk for recidivism is also recommended to help drug courts target participants who are at higher levels of risk. Offender treatment programs generally have the largest effects in reducing recidivism among 'high risk' populations. Drug courts should use standardized instruments that have been validated for use with criminal justice populations. A variety of inexpensive evidence-based instruments are available, many of which are in the public domain. These include the following:

Mental health screening: Brief Jail Mental Health Screen, Global Appraisal of Individual Needs (Short Screener), Mental Health Screening Form III, MINI Screen;

Substance abuse screening: Addiction Severity Index (Alcohol/Drug Abuse sections), Global Appraisal of Individual Needs (Short Screener), Simple Screening Instrument, Texas Christian University-Drug Screen 2;

Psychosocial assessment: Addiction Severity Instrument, Global Appraisal of Individual Needs (Quick, or Initial), Texas Christian University-Institute for Behavioral Research (Brief Intake Interview, or Comprehensive Intake);

Risk assessment: Historical-Clinical-Risk Management 20, Lifestyle Criminality Screening Form, Level of Service Inventory-Revised, Risk and Needs Triage, Short-Term Assessment of Risk and Treatability.

<u>Coerced Treatment is as Effective as Voluntary Treatment</u>

A common myth is that substance abuse treatment is ineffective for persons who are not voluntarily seeking change. The truth is that persons who are mandated to treatment by the criminal justice system experience similar outcomes related to substance abuse and recidivism as persons seeking treatment voluntarily. Retention in treatment is often higher among persons coerced into treatment, who perform as well as voluntary participants across a range of in-treatment indicators of progress (e.g., self-efficacy, coping skills, clinical symptoms, 12-step involvement, motivation for change).

<u>Sanctions Should be Coupled with Incentives and Involvement in Treatment</u>

Criminal justice supervision and sanctions do not reduce recidivism among substance-involved offenders without involvement in treatment. Substance abuse and criminal behavior is most likely to change when both incentives and sanctions are applied in a certain, swift, and fair manner. Long-term changes in behavior are most strongly influenced by use of incentives. Contingency management approaches that provide systematic incentives for achieving treatment goals have been shown to effectively reduce recidivism and substance abuse.

<u>Optimal Treatment Duration is at least 6 Months and no more than 18 Months</u>

The largest positive effects have come from offender substance abuse treatment programs lasting between 6-12 months. Treatment of less than 90 days generally has negligible effects, and there tends to be diminished returns for intensive treatment programs lasting more than 12 months, though a recent study indicates favorable outcomes for drug court programs of up to 18 months duration. The best outcomes are obtained for participants who graduate from drug court.

<u>Outpatient Treatment is the Most Efficient Program Modality</u>

Both outpatient and residential substance abuse treatment have been shown to be effective in reducing recidivism among offenders. In community settings, outpatient treatment generally yields greater economic benefits and has been shown to be more effective than residential treatment for substance-involved offenders.

<u>Treatment Should be Based on Cognitive-Behavioral and Social Learning Models</u>

Drug court treatment should be based on cognitive-behavioral treatment (CBT) and social learning models, which have been shown to significantly reduce recidivism among offenders. CBT helps to develop a range of drug coping skills and more generalized skills related to self-management and self-control. Social learning approaches include a focus on changing criminal thoughts, attitudes, beliefs, and peers. A range of evidence-based CBT/social learning treatment curricula are available for use with offenders, and treatment effectiveness is enhanced through use of manualized curricula.

<u>Treatment Should Address Major ‘Criminogenic Needs’</u>

Eight major ‘criminogenic needs’ have been identified that contribute to the risk for recidivism among offenders, and that are dynamic, or changeable via programmatic interventions. Reductions in recidivism are proportional to the number of criminogenic needs addressed within offender treatment programs. The 8 major criminogenic needs are as follows:

- *Antisocial attitudes*
- *Antisocial friends and peers*
- *Antisocial personality pattern*
- *Substance abuse*
- *Family and/or marital problems*
- *Lack of education*
- *Poor employment history*
- *Lack of prosocial leisure activities*

Evidence-Based Substance Abuse Treatment Interventions

In addition to evidence-based CBT/social learning treatment curricula, several more narrowly focused therapeutic interventions have proven to be effective with substance-involved offenders, and have been successfully implemented in drug courts. These include the following:

Contingency management: Provides an integrated system of incentives and sanctions to target specific recovery behaviors (e.g., abstinence) through use of vouchers and use of graded reinforcement schedules.

Medication-assisted treatment: Medications such as Buprenorphine, Methadone, and Naltrexone have proven effective in reducing cravings and the reinforcing effects of drugs among substance-dependent populations, including offenders, and are also useful in the detoxification process.

Motivational Enhancement Therapy: MET addresses ambivalence about abstinence and engagement in substance abuse treatment through interpersonal counseling strategies designed to induce rapid and internally motivated change.

Relapse prevention: Addresses the chronic relapsing nature of substance use disorders by examining past relapse events, identifying high-risk situations, developing new drug coping skills, and enhancing self-efficacy.

Specialized Treatment Interventions are needed to address Mental Disorders and Trauma/PTSD

There are particularly high rates of mental disorders, trauma, and Post-Traumatic Stress Disorder (PTSD) among offenders. Without specialized interventions to address these issues, offenders often experience poor outcomes in drug court programs. A range of evidence-based treatment curricula are available to address co-occurring mental disorders and trauma/PTSD.

Aftercare/Continuing Care Services can Reduce Substance Abuse and Recidivism

Community aftercare treatment for offenders can significantly reduce rates of substance use and recidivism. These services may be most important for drug court participants who are at 'high risk' for recidivism. Promising practices that may augment the effectiveness of drug court aftercare services include Recovery Management Checkups and Critical Time Intervention (CTI) programs.

Resources

General Resources

Center for Substance Abuse Treatment (2005). *Substance abuse treatment for adults in the criminal justice system*. Treatment Improvement Protocol (TIP) Series 44. DHHS Publication No. (SMA) 05-4056. Rockville, MD: Substance Abuse and Mental Health Services Administration.

Hardin, C., & Kushner, J.N. (2008). *Quality improvement for drug courts: Evidence-based practices*. Alexandria, Virginia: National Drug Court Institute, National Association of Drug Court Professionals.

Huddleston, W., & Marlowe, D.B. (2011). *Painting the current picture: A national report on drug courts and other problem-solving court programs in the United States*. Alexandria, VA: The National Drug Court Institute.

National Institute on Drug Abuse (2006). *Principles of drug abuse treatment for criminal justice populations: A research-based guide*. Rockville, MD.

Rossman, S.B., Roman, J.K., Zweig, J.M., Lindquist, Rempel, M., C.H., Willison, J.B., Downey, P.M., & Fahrney, K. (2011). *The Multi-Site Adult Drug Court Evaluation: Study overview and design. Final report: Volume 1*. Washington, D.C: Urban Institute.

Effectiveness of Drug Courts

Mitchell, O., Wilson, D.B., Eggers, A., & MacKenzie, D.L. (in press). Drug courts' effects on criminal offending for juveniles and adults. *Campbell Systematic Reviews.*

Rossman, S.B., Roman, J.K., Zweig, J.M., Rempel, M., & Lindquist, C.H. (2011). *The Multi-Site Adult Drug Court Evaluation: The impact of drug courts. Final report: Volume 4*. Washington, D.C: Urban Institute.

Immediate Placement in Treatment

Carr, C.J., Xu, J., Redko, C., Lane, D.T., Rapp, R.C., Goris, J., & Carlson, R.G. (2008). Individual and system influences on waiting time for substance abuse treatment. *Journal of Substance Abuse Treatment*, 34, 192-201.

Screening and Assessment

Hiller, M. L., Belenko, S., Welsh, W., Zajac, G., & Peters, R. H. Screening and assessment: An evidence-based process for the management and care of adult drug-involved offenders. In C. G., Leukefeld, J. Gregrich, & T. Gullotta (Eds.). *Handbook on evidence-based substance abuse treatment practice in criminal justice settings* (pps. 45-62). New York: Springer Publishing.

Peters, R.H., Bartoi, M.G., & Sherman, P.B. (2008). *Screening and assessment of co-occurring disorders in the justice system*. Delmar N.Y: The National GAINS Center.

Coerced Treatment

Kelly, J.F., Finney, J.W., & Moos, R. (2005). Substance use disorder patients who are mandated to treatment: Characteristics, treatment process, and 1- and 5-year outcomes. *Journal of Substance Abuse Treatment*, 28, 213-223.

Sanctions and Incentives

Prendergast, M.L. (2009). Interventions to promote successful re-entry among drug-abusing parolees. *Addiction Science and Clinical Practice* (April), 4-13.

Duration of Treatment

Hubbard, R.L., Craddock, S.G., & Anderson, J. (2003). Overview of 5-year follow-up outcomes in the drug abuse treatment outcome studies (DATOS). *Journal of Substance Abuse Treatment*, 25, 125-134.

Outpatient Treatment

Krebs, C.P., Strom, K.J., Koetse, W.H., & Lattimore, P.K. (2009). The impact of residential and nonresidential drug treatment on recidivism among drug-involved probationers: A survival analysis. *Crime and Delinquency*, *55*(3), 442-471.

Cognitive-Behavioral and Social Learning Models of Treatment

Lipsey, M.W., Landenberger, N.A., & Wilson, S.J. (2007). Effects of cognitive-behavioral programs for criminal offenders. *Campbell Systematic Reviews*, 2007:6; DOI: 10.4073/csr.2007.6.

Pratt, T.C., Cullen, F.T., Sellers, C.S., Winfree, T., Madensen, T.D., Daigle, L.E., Fearn, N.E., & Gau, J.M. (2010). The empirical status of social learning theory: A meta-analysis. *Justice Quarterly*, *27*(6), 765-802.

Targeting 'Criminogenic Needs'

Andrews, D.A., Bonta, J., & Wormith, J.S. (2006). The recent past and near future of risk and/or need assessment. *Crime and Delinquency*, *52*(1), 7-27.

Evidence-Based Substance Abuse Treatment Interventions

Carroll, K.M., & Onken, L.S. (2005). Behavioral therapies for drug abuse. *American Journal of Psychiatry*, *162*(8), 1452-1460.

Dowden, C., Antonowicz, D., & Andrews, D.A. (2003). The effectiveness of relapse prevention with offenders: A meta-analysis. *International Journal of Offender Therapy and Comparative Criminology*, *47*(5), 516-528.

McMurran, M. (2009). Motivational interviewing with offenders: A systematic review. *Legal and Criminological Psychology*, 14, 83-100.

Specialized Treatment Interventions for Mental Disorders and Trauma/PTSD

Peters, R.H., & Osher, F.C. (2003). *Co-occurring disorders and specialty courts*. Delmar N.Y: The National GAINS Center.

Aftercare/Continuing Care Services

Butzin, C.A., O'Connell, D.J., Martin, S.S., Inciardi, J.A. (2006). Effect of drug treatment during work release on new arrests and incarcerations. *Journal of Criminal Justice*, 34, 557-565.

Dennis, M.L., & Scott, C.K. (in press). Four-year outcomes from the Early Re-Intervention (ERI) experiment using Recovery Management Checkups (RMCs). *Drug and Alcohol Dependence*.

Kasprow, W.J, & Rosenheck, R.A. (2007). Outcomes of Critical Time Intervention case management of homeless veterans after psychiatric hospitalization. *Psychiatric Services*, *58*(7), 929-935.

Appendix C: Aftercare, Relapse Prevention And Continuing Care: Applying Research Findings To Practice

"Aftercare, Relapse Prevention and Continuing Care": Applying Research Findings to Practice".

Caroline S. Cooper

The following summary highlights the presentations made during the *Research to Practice* webinar on *"Aftercare, Relapse Prevention and Continuing Care: Applying Research Findings to Practice",* conducted and recorded by the School of Public Affairs at American University and the National Center for State Courts, on September 3, 2013. Webinar panelists were: Jeffrey Kushner (Montana Supreme Court); James McKay, Ph.D., (U. of Penn.); and Judge John Schwartz (Rochester, New York). Caroline Cooper (American University) served as moderator. The webinar is posted on the websites for the Research 2 Practice Project (research2practice.org), American University (www.american.edu/justice) and the National Drug Court Resource Center (ndcr.org). References are provided to key resources at the end of this Webinar Brief.

- **WHY AFTERCARE/RECOVERY SUPPORT SERVICES SHOULD BE AN ESSENTIAL COMPONENT OF DRUG COURT PROGRAMS**

  - Substance addiction is a chronic disease effecting the brain and cognitive functions. The American Society of Addiction Medicine (ASAM) has defined substance addiction as a "… chronic disease of brain reward, motivation, memory and related circuitry….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… [W]ithout treatment or engagement in recovery activities, addiction is progressive and can result in disability or premature death.[182]

  - Research on the treatment of chronic diseases generally – diabetes, hypertension, asthma, for example—indicates that the availability of aftercare services is critical to sustaining the longer term effects of the treatment for chronic diseases that was provided during the acute phase of the disease.

  - With over 2,500 problem solving court programs in the U.S. focusing on substance addiction, and hundreds of individuals graduating from these programs regularly, sound aftercare services must be in place to provide these individuals with the essential chronic care services chronic disease research has shown are essential and necessary to sustain the benefits of the drug court program over the long term

[182] American Society of Addiction Medicine. (April 2011). *Definition of addiction*. Adopted by the ASAM Board of Directors. April 19, 2011. Retrieved from: http://www.asam.org/for-the-public/definition-of-addiction

- **Current Situation: Summary of Research Findings Regarding Recidivism**
  - Drug Court re-offense rates are 8-14% less than other types of supervision (Belenko, MADCE[183]); however, 52% of drug court graduates still report an arrest in the MADCE follow-up after 24 months.

  - Fifty-six percent of Drug Court participants reported using drugs in the year after drug court discharge and 41% reported serious drug use. Twenty-nine percent actually tested positive. (MADCE)

  - Forty percent of drug court participants reported committing a crime in the year after discharge. (MADCE).

  - Clients in publicly funded treatment programs (many of which treat drug court participants) relapse at a 64% rate after 1 to 12 months of abstinence, 35% after 1-3 years of abstinence but less than 14% after 4-7 years of abstinence (Dennis, Foss & Scott).

APPLICATION OF RESEARCH FINDINGS RE RECIDIVISM TO CONTINUING CARE SERVICES FOR DRUG COURT PARTICIPANTS*:*

- While Drug Court graduates recidivate (new drug use and/or new crime) at lower rates than non-drug court graduates, their recidivism rates still leave room for substantial improvement that continuing care services could promote;
- Continuing care/aftercare services need to be initiated during the early stages of drug court program participation and available for at least 24 months and, ideally, longer following graduation; and
- Multiple modalities of aftercare services need to be available, just as with the treatment of the acute phases of substance addiction –one size does not fit all

WHAT IS "RECOVERY?"

- "Recovery" from substance addiction has been defined as "… a process of change through which individuals who have been addicted to substances improve their health and wellness, live a self-directed life, and strive to reach their full potential."[184]

- The recovery process includes four dimensions:
  - **Health**: overcoming or managing the disease,, abstaining from alcohol and nonprescribed medication, and making informed, healthy choices that support physical and emotional well-being
  - **Home:** having a stable and safe place to live
  - **Purpose:** having meaningful daily activities and the independence, income and resources to participate society
  - **Community:** having relationships and social networks that provide support, friendship, love and hope; and, implicitly
  - a **crime free life** and **crime free lifestyle**:

[183] Belenko. (June 2001). *Research on Drug Courts: A Critical Review (Update)*. Retrieved from: http://www.drugpolicy.org/docUploads/2001drugcourts.pdf; See also National Criminal Justice Reference Service (December 2011). *The multi-site adult drug court evaluation*. Retrieved from: https://www.ncjrs.gov/pdffiles1/nij/grants/237112.pdf
[184] Substance Abuse and Mental Health Administration. (2012). *Ten Guiding Principles of Recovery*. Retrieved from: http://store.samhsa.gov/shin/content/PEP12-RECDEF/PEP12-RECDEF.pdf

- **AFTER CARE AND RECOVERY SUPPORT SERVICES: RESEARCH FINDINGS RELEVANT TO DRUG COURTS**

  - Although relatively limited research has been conducted on the effectiveness of aftercare services for persons treated for substance addiction, particularly for individuals in a drug court setting, available research findings suggest that:
    - Interventions are more likely to be effective when they;
      - provide support for 12 months or longer
      - include active efforts to deliver the intervention to the individual rather than rely on the individual to take the initiative –e.g., to come to a clinic each week, for example:

    - Those who benefit most from continuing care services are essentially the "high risk/high need" participants drug courts should target: - e.g.,
      - those who continue to use alcohol or other drugs during their initial period of treatment program participation; and
      - those who have poor social support for recovery

  - **Two Continuing Care Models for which research findings have been produced:**

    - *Adaptive Telephone Continuing Care:*
      Structured 15-30 minute sessions weekly at first, and then graduated to monthly, that include:
      - monitoring of symptoms and progress
      - identifying problems and barriers to recovery
      - focusing on concrete planning and problem solving
      - encouraging the patient to actively take charge of their own recovery

      Results: (Compared with patients in standard care)
      - Participants had higher alcohol abstinence rates (12%) and lower (10-15%) incidence of cocaine use than comparison group

    - *Recovery Management Checkup (RMC)*
      Interview patients every 3 months; if patient determined to be in need of treatment, patient is referred to individual trained in motivational interviewing and knowledge of community resources and treatment who provides personalized feedback; explores possibility of returning to treatment, and then scheduling, arranging transportation, and addressing other potential barriers to returning o treatment

      Results: (Compared with patients in standard care)
      - Reduced time to return to treatment (376 vs. 600 days)
      - Increased total days of treatment: (62 vs. 40 days)
      - Reduced percent of patients in need of treatment after 24 months (43% to 56%)
      - Participants in RMC more likely to return to treatment (70% vs. 51%)
      - Total number of abstinence days over 4 years higher (1,026 days vs. 932)

- **APPLICATION OF RESEARCH FINDINGS ON POSITIVE EFFECT OF CONTINUING CARE MODELS FOR DRUG COURT PRACTICE:**

  - Treatment of substance abuse, like that of other chronic diseases, can benefit from aftercare services after initial treatment services are completed in the drug court program;
  - Drug Courts should ensure that participants develop recovery plans that include provision of aftercare/recovery support services

- **DEVELOPING A RECOVERY MANAGEMENT PLAN FOR/BY THE DRUG COURT PARTICIPANT**

  - **Key Principles:**
    - Many "paths" to recovery; a range of aftercare services should be made available;
    - Keeping people in treatment, in recovery, is the key, not the particular venue
    - Recovery needs to be a "self-directed" process by the patient
    - In preparing participants to participate in aftercare/recovery support services, the Drug Court should ensure that participants transition from the program's *prescribed directed* requirements to a *self-directed* orientation, with the participant taking responsibility for exercising choices/decisions regarding his/her recovery path and goals

  - **Critical Elements of a Recovery Management Plan: Need strategies for**
    - Identifying triggers and avoiding them
    - Managing cravings
    - Identifying health problems and wellness strategies
    - Promoting ways to cope with thinking patterns that lead to relapse, criminal behavior, and other high risk situations
    - Avoiding high risk places, peer pressure to use, and plans to cope with these pressures
    - Identifying high risk times and making plans for dealing with them
    - Managing relapse events and identifying persons for help
    - Developing linkages to support groups, post-treatment recovery support institutions (e.g., recovery homes, ministries, mentors, and others
    - Addressing other life areas (educational and vocational skill deficits, tec.)
    - Assessing family strengths and needs and related services

  - **Aftercare/Recovery Support Resources: Examples**
    - <u>Telephone Follow-Up</u> (see research reported)
      - Can be important recovery management tool for drug courts to use to make contact with drug court participants after graduation.
      - Particularly valuable tool for rural areas and with populations that have a problem with making face-to-face appointments (work in remote areas or on irregular schedules)
      - Can be performed by drug court coordinator, trained clerical staff, and trained peer mentor

    - <u>Recovery Management Checkups</u>:(see research reported)

      Montana:
      - already being used by two drug courts in Montana and a third starting up shortly
      - being administered by drug court coordinator using a short version of the GAIN

      New York State:
      - being implemented by the New York State Office of Alcoholism and Substance Abuse Services (OASAS) statewide;
      - will introduce recovery coaches shortly;

    - <u>Self-help Groups:</u> (extensive anecdotal information available; no formal research available)
      - Majority of people in recovery have fairly extensive histories of participating in self-help groups.
      - Although no formal research available, extensive anecdotal information indicates substantial benefit as an aftercare support
      - Groups vary significantly so participants need to find a group that meets their needs and where they can find a sponsor who will help them

- Drug Court Alumni Groups: (anecdotal information on effectiveness; no formal research available)
  - Can be effective in providing recovery support and linkages to recovery community;
  - For long term sustainability, need to be built into the program structure, with assigned tasks, projects and services; alumni need to feel meaningfully involved

- Trained peer mentors and coaches (anecdotal information on effectiveness; no formal research available)
  - Can augment resources in a number of ways
  - Structured training, role definition, and oversight should be provided

• TRANSLATING RESEARCH INTO PRACTICE: SUMMARY

➢ WHAT DRUG COURTS CAN DO TO PROMOTE AFTERCARE/RECOVERY SUPPORT DURING AND AFTER DRUG COURT GRADUATION

- Access and inventory the community and identify recovery support components and gaps
- Support alcohol and drug free housing
- Include staff training on recovery associated topics and attendance at open 12 Step meetings
- Encourage family member participation throughout drug court process
- Develop information packets for family members and others who support the drug court participant
- Incentivize family counseling participation
- Include family members in recovery events
- Support recovery mentors and coaches
- Support alumni clubs
- Support alcohol and drug free social activities
- Require each participant to develop a recovery Management Plan
- Initiate recovery checkups
- Consider developing mentors to serve after the period of drug court participation

➢ SPECIFIC MEASURES THE DRUG COURT JUDGE CAN TAKE

- Ensure that a vision for long-term recovery is included in drug court materials (policy, participant manual, brochure
- Use a global assessment process, including family and significant others
- Include former drug court participants in the drug court program (advisory boards, mentors/coaches, presenters)
- Participate in activities to reduce stigma and discrimination
- Access the recovery resources available in your area from the beginning of planning your Drug Court e.g. Housing, GED programs, Vocational training and jobs.
- Mandate 12 Step Recovery Program soon after the evaluation is done on your Drug Court Participant. This is something they will take advantage of for the rest of their lives.
- Develop Mentor Programs within your Drug Court.
- Partner with your local Community College to develop a Court-to-College Program. Meet with your local Department of Labor for Vocational training and jobs.
- Get out of the Courthouse and meet with "Recovery Resources" on their home turf. Tell them what you are doing, ask for their help. Make them part of the team. Make them feel important.

- **CLOSING:** *All Panelists:*

  - Ensure that each participant has developed a recovery plan by the time the participant enters the final phase of the drug court program;
  - Provide multiple paths for participants to sustain their recovery and promptly access additional services when/as needed;
  - Develop a simple and short instrument for drug court personnel and peer mentors to use as a follow-up questionnaire.
  - Train staff on Motivational Interviewing is and the associated skills that can be incorporated in post-program contacts with participants;
  - Develop a tickler file to indicate when telephone follow-up contact should occur with each drug court graduate and have a plan in place for responding to the range of needs that may be uncovered, including resumption of treatment if/as needed.

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APPENDIX D: Drug Court Judicial Leadership Initiative: Over-Riding Principles (DRAFT)

BJA DRUG Court Technical Assistance Project
Judicial Leadership Initiative: Over-riding Principles
[Draft: 4/22/14]

While the role of the judge in initiating the formation of a Drug Treatment Court may be readily acknowledged, as these programs have become part of the mainstream, we often lose sight of the importance that continued judicial leadership must play in sustaining these programs, keeping the many "moving parts" working together and moving coherently forward. A few – but by no means all -- aspects of the continued judicial leadership role needed --identified by a committee of drug court judges and others who have been working over the years to implement, expand, and sustain drug court programs in a wide range of jurisdictional environments -- are described below:

LEADERSHIP OF THE DRUG COURT TEAM

I. **The judge needs to continue to renew the team's commitment to the mission of the drug court and to assure adherence to the Key Components. As procedures become routine, people often start to lose that sense of mission that was important in the initial decision to take this path.**

II. **The judge must promote the team's understanding of the therapeutic principles underlying the drug court model and their application in a drug treatment court, particularly when the roles of the team members can become blurred as people or personnel change. In that leadership role the judge must reinforce with program personnel and team members the nature of their role and that of the judge. The judge should also ensure that the team receives cross-discipline training, updates regarding best practices, effective responses to behaviors, and training regarding other relevant topics to enhance the program.**

III. **The Judge and team should develop a working knowledge of all relevant issues, including "addiction", "mental illness" and other "co-occurring disorders", "pharmacology" and "drug testing". This knowledge is particularly relevant to responses to the behavior of participants and interpretation of that behavior within the context of the recovery process, and appropriate therapeutic responses.**

IV. **The judge must provide the leadership to ensure that the Drug Court follows evidence based practices and National Standards and protects participants' constitutional rights. The judge must lead the team in frank discussions about court operations and improvements, as needed. It requires the judge to create an atmosphere inviting opinions from the team and valuing constructive ideas. While the Judge should foster a team concept he/she must not abdicate his/her role as the ultimate "decision maker"**

ENSURING EVIDENCE BASED TREATMENT SERVICES

V. **The Judge and other team members should be aware of and knowledgeable about the services being provided by the treatment provider(s). Depending upon the services available within each state, the guidance of the single state agency for substance abuse and mental health services may be helpful to ensure that evidence based treatment services are being provided by the treatment provider(s). The judge should ensure that the provider(s) are informed regarding the drug court program mission, goals and requirements as well as expectations for communication, delivery of services and collaboration. The court should also schedule opportunities for specific and regular exchanges**.

PROGRAM LEADERSHIP – EXTERNAL RELATIONSHIPS WITH COMMUNITY LEADERS TO EXPAND AND PROMOTE DRUG COURTS BY EDUCATION AND COLLABORATION

VI. **The judge must be a leader and an advocate in the criminal justice community to extend the benefits of Drug Courts to all high risk/high need offenders. There is a continuing need for the judge to inform frequently changing criminal justice practitioners about the drug court's mission and level of support needed to continue its development and growth.**

VII Consistent with ethical requirements, the judge should actively promote public understanding of and support for the Drug Court concept in the community, the media and with elected officials.

VIII Consistent with ethical requirements, the judge should also educate representatives of targeted government and community agencies in an effort to obtain their support and garner resources to maintain and expand Drug Courts.

IX The judge should convene an oversight or advisory committee comprised of community leaders and representatives to provide programmatic support, improve access to services and resources to aid in expansion and sustainability of Drug Courts.

PROGRAM LEADERSHIP: INTERNAL ADMINISTRATION/OVERSIGHT

X The judge should promote ongoing review of the court's caseload to ensure that its eligibility criteria does not have systemic barriers in its entryprocesses that produces racial, ethical and cultural or other disparity in the court's population. The entry process should maximize the program's outreach and service to the volume and nature of all offenders who need the program's services.

XI The judge should ensure that the program operates with consistency and transparency, adheres to its articulated policies and procedures and does so in a manner that is consistent with the effective and responsible stewardship of public resources.

XII The judge should ensure that the program conducts routine and periodic monitoring of the status of the program, instituting improvements as necessary, and conducts external evaluations as well. The judge should also ensure that program materials, documents and forms are revised periodically to reflect current practices and operations.

BJA DRUG Court Technical Assistance Project

Judicial Leadership Initiative: Over-riding Principles

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