IDAHO TREATMENT COURT BEST PRACTICE STANDARDS VOLUME I

July 21, 2025

Contents

Introduction

Idaho recognizes that drug courts reduce substance use, related crime and recidivism. Nationally drug courts utilize many evidence-based practices such as random and frequent drug testing, incentives and sanctions to shape behavior, close and coordinated supervision of offenders, specific substance use and cognitive behavioral treatment approaches, and ongoing judicial monitoring. As the research basis for drug court practice has grown, key practices that lead to desired outcomes have become clear. These practices continue to fall within the original ten key components which define drug courts and ultimately account for their success.

Drug Courts in Idaho

Treatment courts in Idaho were officially recognized by the State Legislature in March of 2001 with passage of the Idaho Drug Court Act and accompanying appropriations. The intent of Statewide Standards is to assure that scarce public resources are used in ways that ensure the greatest positive return on the investment. Research has now clearly shown that certain operational practices are essential to achieve cost-beneficial outcomes and the DCMHCCC has identified such practices as Standards of Operation. Because of the variations in communities and their available resources, it is recognized that achieving total compliance with the Standards must be an ongoing process over a reasonable period of time. However, how a court "measures up" to these practices and makes a good faith effort to achieve full compliance will become the foundation for receiving ongoing state funding.

As always, the Supreme Court is committed to providing guidance and support to enable all treatment courts to become and remain fully compliant with approved Standards.

Statutory Framework

Title 19 Criminal Procedure Chapter 56 Idaho Drug Court and Mental Health Court Act 19-5603. Drug Court – Establishment. The district court in each county may establish a drug court which shall include a regimen of graduated sanctions and rewards, substance use disorder treatment, close court monitoring and supervision of progress, educational or vocational counseling as appropriate, and other requirements as may be established by the district court, in accordance with standards developed by the Idaho supreme court drug court and mental health court coordinating committee.

Standards Description

The purpose of this document is to set forth required standards both to provide a sound and consistent foundation for the operation and for the evaluation of Idaho's treatment courts. These standards articulate evidence-based practices, now well established by a substantial body of research, as well as broadly accepted consensus practices that are correlated with positive and cost- effective outcomes.

These standards are not rules of procedure and have no effect of law. They are not the basis of appeal by any treatment court participant and lack of adherence to any standard is not the basis for withholding any sanction or readmitting a participant who is terminated for any cause.

The standards provide a basis for each treatment court to establish written policies and procedures that reflect the standards, the needs of participants, and the resources available in the community.

The standards are based on principles gleaned from current research and credible published resources in the areas of criminal justice and addiction treatment, with specific focus on treatment courts. The

standards were developed and refined through input from Idaho treatment court professionals and stakeholders, as well as acknowledged national experts, and represent a consensus about appropriate practice guidance.

Aspirational and Obligatory

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

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

Scope

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

New practices will be added to the standards as additional studies are completed.

I. Target Population

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

A. Objective Eligibility and Exclusion Criteria

Eligibility and exclusion criteria are defined objectively, specified in writing, and communicated to potential referral sources including judges, law enforcement, defense attorneys, prosecutors, treatment professionals, and community supervision officers. The Treatment Court team does not apply subjective criteria or personal impressions to determine participants' suitability for the program. No one who is otherwise eligible should be denied participation solely because of inability to pay. No person has a right to be admitted into treatment court according to Idaho statute.

B. High Risk and High Need Participants

The Treatment Court targets offenders for admission who are addicted to illicit drugs or alcohol and are at substantial risk for reoffending or failing to complete a less intensive disposition, such as standard probation or pretrial supervision. These individuals are commonly referred to as high- risk and high-need offenders. The recommended range of LSI-R composite score is between 18 and 40.

C. Validated Eligibility Assessments

Candidates for the Treatment Court are assessed for eligibility using validated risk-assessment and clinical-assessment tools. The risk-assessment tool has been demonstrated empirically to predict criminal recidivism or failure on community supervision and is equivalently predictive for women and racial or ethnic minority groups that are represented in the local arrestee population. The clinical-assessment tool evaluates the formal diagnostic symptoms of severe substance use disorder or addiction. Evaluators are trained and proficient in the administration of the assessment tools and interpretation of the results.

D. Criminal History Disqualifications

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

E. Clinical Disqualifications

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

F. Admission Timeline

Each treatment court shall identify eligible individuals quickly, screen them as soon as possible, educate them about the program and the merits of participating, and place them promptly in the treatment court in order to capitalize on a triggering event, such as

sentencing or a probation violation disposition. Research suggests that admitting participants into treatment court within 50 days of arrest shows improved outcomes and reduced costs.

COMMENTARY

A. Objective Eligibility and Exclusion Criteria

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

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

B. High-Risk and High-Need Participants

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

It may not always be feasible for Drug Courts to target high-risk and high-need offenders. To gain the cooperation of prosecutors or other stakeholders, some Drug Courts may need to begin by treating less serious offenders and then expand their eligibility criteria after they have proven the safety and effectiveness of their programs. In addition, some Drug Courts may not have statutory authorization or adequate resources to treat high-risk or high-need offenders. Under such circumstances, research indicates the programs should modify their services to provide a lower intensity of supervision, substance use disorder treatment, or both.

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

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

C. Validated Eligibility Assessments

Standardized assessment tools are significantly more reliable and valid than professional judgment for

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

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

D. Criminal History Disqualifications

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

Mixed outcomes have been reported for violent offenders in Drug Courts. Several studies found that participants who were charged with violent crimes or had histories of violence performed as well or better than nonviolent participants in Drug Courts (Carey et al., 2008, 2012; Saum & Hiller, 2008; Saum et al., 2001). However, two meta-analyses reported significantly smaller effects for Drug Courts that admitted violent offenders (Mitchell et al., 2012; Shaffer, 2010). The most likely explanation for this discrepancy is that some of the Drug Courts might not have provided adequate services to meet the need and risk levels of violent offenders. If adequate treatment and supervision are available, there is no empirical justification for routinely excluding violent offenders from participation in Drug Courts.

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

E. Clinical Disqualifications

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

It is unclear how severe the mental health problems were in the above-referenced studies because psychiatric diagnoses were not reported. A Mental Health Court, Co-Occurring Disorder Court or other psychiatric specialty program might be preferable to a Drug Court for treating an individual with a major psychiatric

disorder, such as a psychotic or bipolar disorder. Research does not provide a clear indication of how to make this determination. The best course of action is to carefully assess offenders along the dimensions of risk and need and match them to the most suitable programs that are available in their community. It is not justifiable to have an across-the-board exclusion from Drug Court for addicted offenders who are suffering from mental health problems or conditions.

Finally, numerous controlled studies have reported significantly better outcomes when addicted offenders received medically assisted treatments including opioid antagonist medications such as naltrexone, opioid agonist medications such as methadone, and partial agonist medications such as buprenorphine (Chandler et al., 2009; Finigan et al., 2011; National Institute of Drug Abuse, 2006). Therefore, a valid prescription for such medications should not serve as the basis for a blanket exclusion from a Drug Court (Parrino, 2002). A unanimous resolution of the NADCP Board of Directors4 provides that Drug Courts should engage in a fact-sensitive inquiry in each case to determine whether and under what circumstances to permit the use of medically assisted treatments. This inquiry should be guided in large measure by input from physicians with expertise in addiction psychiatry or addiction medicine [see also Standard V, Substance Use Disorder Treatment]

REFERENCES

Andrews, D.A., & Bonta, J. (2010). *The Psychology of Criminal Conduct* (5th ed.). New Providence, NJ: Anderson.

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

Belenko, S., Fabrikant, N., & Wolff, N. (2011). The long road to treatment: Models of screening and admission into Drug Courts. *Criminal Justice & Behavior*, *38*(12), 1222–1243.

Bhati, A.S., Roman, J.K., & Chalfin, A. (2008). *To treat or not to treat: Evidence on the prospects of expanding treatment to drug-involved offenders.* Washington, DC: Urban Institute.

Carey, S.M., Finigan, M.W., & Pukstas, K. (2008). *Exploring the key components of drug courts: A comparative study of 18 adult drug courts on practices, outcomes and costs*. Portland, OR: NPC Research. *Available at* http://www.npcresearch.com/Files/NIJ_Cross-site_Final_Report_0308.pdf.

Carey, S.M., Mackin, J.R., & Finigan, M.W. (2012). What works? The ten key components of drug court: Research-based best practices. *Drug Court Review*, *8*(1), 6–42.

Carey, S.M., & Perkins, T. (2008). *Methamphetamine users in Missouri Drug Courts: Program elements associated with success* (Final report). Submitted to the Missouri Office of the State Court Administrator.

Casey, P.M., Warren, R.K., & Elek, J.K. (2011). *Using offender risk and needs assessment information at sentencing*. Williamsburg, VA: National Center for State Courts. *Available at*http://ncsc.contentdm.oclc.org/cgi-bin/showfile.exe?CISOROOT=/criminal&CISOPTR=196.

Chandler, R.K., Fletcher, B.W., & Volkow, N.D. (2009). Treating drug abuse and addiction in the criminal justice system: Improving public health and safety. *Journal of the American Medical Association, 301*,(2) 183–190.

Cissner, A., Rempel, M., Franklin, A.W., Roman, J.K., Bieler, S., Cohen, R., & Cadoret, C.R. (2013, March). *A statewide evaluation of New York's adult drug courts: Testing which policies work best*. Paper presented at the New York Association of Drug Treatment Court Professionals Training. Available at http://www.nyadtcp.org/userfiles/file/presentation/The%202012%20New%20York%20State%20Drug%20Court%20Evaluation.pdf.

DeMatteo, D.S., Marlowe, D.B., & Festinger, D.S. (2006). Secondary prevention services for clients who are low risk in drug court: A conceptual model. *Crime & Delinquency, 52*(1),114–134.

Downey, P.M., & Roman, J.K. (2010). *A Bayesian meta-analysis of drug court cost-effectiveness*. Washington, DC: Urban Institute.

Fielding, J.E., Tye, G., Ogawa, P.L., Imam, I.J., & Long, A.M. (2002). Los Angeles County drug court programs: Initial results. *Journal of Substance Abuse Treatment, 23*(3),217–224.

Finigan, M.W., Perkins, T., Zold-Kilbourn, P., Parks, J., & Stringer, M. (2011). Preliminary evaluation of extended-release naltrexone in Michigan and Missouri drug courts. *Journal of Substance Abuse Treatment*, *41*(3),288–293.

Greenfield, S.F., & Hennessy, G. (2008). Assessment of the patient. In M. Galanter & H.D. Kleber (Eds.)., *Textbook of substance abuse treatment* (4th ed., pp. 55–78). Washington, DC: American Psychiatric Publishing.

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*(4),383–398.

Lowenkamp, C.T., Holsinger, A.M., & Latessa, E.J. (2005). Are drug courts effective: A meta-analytic review. *Journal of Community Corrections, 15*(1), 5–28.

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.

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*(2), 263–290.

Marlowe, D.B. (2009). Evidence-based sentencing for drug offenders: An analysis of prognostic risks and criminogenic needs. *Chapman Journal of Criminal Justice, 1*(1), 167–201.

Marlowe, D.B., Festinger, D.S., Dugosh, K.L., Arabia, P.L., & Kirby, K.C. (2008). An effectiveness trial of contingency management in a felony preadjudication drug court. *Journal of Applied Behavior Analysis, 41*(4),565–577.

McCord, J. (2003). Cures that harm: Unanticipated outcomes of crime prevention programs. *Annals of the American Academy of Political & Social Science, 587*(1), 16–30.

Meyer, W.G. (2011). Constitutional and legal issues in drug courts. In D.B. Marlowe & W.G. Meyer (Eds.), *The drug court judicial benchbook* (pp. 159–180). Alexandria, VA: National Drug Court Institute. *Available at* http://www.ndci.org/sites/default/files/nadcp/14146_NDCI_Benchbook_v6.pdf.

Miller, J.M., & Shutt, J.E. (2001). Considering the need for empirically grounded drug court screening mechanisms. *Journal of Drug Issues, 31*(1), 91–106.

Mitchell, O., Wilson, D.B., Eggers, A., & MacKenzie, D.L. (2012). Assessing the effectiveness of drug courts on recidivism: A meta-analytic review of traditional and nontraditional drug courts. *Journal of Criminal Justice, 40*(1),60–71.

National Association of Drug Court Professionals (1997). *Defining drug courts: The key components* (NCJ No. 205621). Washington, DC: Author.

National Institute on Drug Abuse. (2006). *Principles of drug abuse treatment for criminal justice populations* [NIH Pub. No. 06-5316]. Bethesda, MD: Author.

Parrino, M.W. & McNicholas, L. (2002). Methadone maintenance and other pharmacotherapeutic interventions in the treatment of opioid dependence. *NDCI Drug Court Practitioner Fact Sheet 3*(1), 1–4.

Petrosino, A., Turpin-Petrosino, C., & Finckenauer, J.O. (2000). Well-meaning programs can have harmful effects! Lessons from experiments of programs such as Scared Straight. *Crime & Delinquency, 46*(3), 354–379.

Rempel, M., Green, M., & Kralstein, D. (2012). The impact of adult drug courts on crime and incarceration. *Journal of Experimental Criminology, 8*(3), 165–192.

Rossman, S.B., Rempel, M., Roman, J.K., Zweig, J.M., Lindquist, C.H., Green, M., Downey, P.M., Yahner, J., Bhati, A.S., & Farole, D.J. (2011). *The multisite adult drug court evaluation: The impact of drug courts, vol. 4.* Washington, DC: Urban Institute Justice Policy Center. *Available at* https://www.ncjrs.gov/pdffiles1/nij/grants/237112.pdf.

Rossman, S.B., Willison, J.B., Mallik-Kane, K., Kim, K., Debus-Sherrill, S., & Downey, P.M. (2012). *Criminal justice interventions for offenders with mental illness: Evaluation of mental health courts in Bronx and Brooklyn, New York*. Washington, DC: Urban Institute.

Saum, C.A., & Hiller, M.L. (2008). Should violent offenders be excluded from drug court participation? An examination of the recidivism of violent and nonviolent drug court participants. *Criminal Justice Review, 33*(3), 291–307.

Saum, C.A., Scarpitti, F.R., & Robbins, C.A. (2001). Violent offenders in drug court. *Journal of Drug Issues, 31*(1), 107–128.

Sevigny, E. L., Pollack, H. A., & Reuter, P. (2013). Can drug courts help to reduce prison and jail populations? *Annals of the American Academy of Political & Social Science, 647*,190-212.

Shaffer, D.K. (2006). Reconsidering drug court effectiveness: A meta-analytic review (Doctoral dissertation, University of Cincinnati, 2006). *Dissertation Abstracts International*, 67, 09A (AAT No. 3231113).

Shaffer, D.K. (2010). Looking inside the black box of drug courts: A meta-analytic review. *Justice Quarterly, 28*(3)*, 493–521.*

Skeem, J.J., Manchak, S., & Peterson, J.K. (2011). Correctional policy for offenders with mental illness: Creating a new paradigm for recidivism reduction. *Law & Human Behavior, 35*(2), 110–126.

Stewart, S.H. (2009). Dependence and diagnosis. In P.M. Miller (Ed.), *Evidence-based addiction treatment* (pp. 77–88). New York: Elsevier.

Szalavitz, M. (2010, July 16). Does teen drug rehab cure addiction or create it? *Time Magazine: On-Line. Available at* http://time.com/time/printout/0,8816,2003160,00.html.

Wexler, H.K., Melnick, G., & Cao, Y. (2004). Risk and prison substance abuse treatment outcomes: A replication and challenge. *The Prison Journal, 84*(1), 106–120.

Wormith, J.S., & Goldstone, C.S. (1984). The clinical and statistical prediction of recidivism. *Criminal Justice & Behavior, 11*(1), 3–34.

Zweig, J.M., Lindquist, C., Downey, P.M., Roman, J., & Rossman, S.B. (2012). Drug court policies and practices: How program implementation affects offender substance use and criminal behavior outcomes. *Drug Court Review*, 8(1), 43–79.

II. Roles and Responsibilities of the Judge

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

A. Professional Training

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

B. Length of Term

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

C. Consistent Docket

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

D. Participation in Pre-Court Staff Meetings

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

E. Frequency of Status Hearings

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

F. Length of Court Interactions

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

G. Judicial Demeanor

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

H. Judicial Decision Making

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

COMMENTARY

A. Professional Training

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

Judges in Drug Courts have a professional obligation to remain abreast of legal, ethical and constitutional requirements related to Drug Court practices (Meyer, 2011; Meyer & Tauber, 2011). In addition, outcomes are significantly better when the Drug Court judge attends annual training conferences on evidence-based practices in substance use and mental health treatment and community supervision (Carey et al., 2008, 2012; Shaffer, 2010). A national study of twenty-three adult Drug Courts, called the Multisite Adult Drug Court Evaluation (MADCE), found that Drug Courts produced significantly greater reductions in crime and substance abuse when the judges were rated by independent observers as being knowledgeable about substance use disorder treatment (Zweig et al., 2012). Similarly, a statewide study in New York reported significantly better outcomes when Drug Court judges were perceived by the participants as being open to learning about the disease of addiction (Farole & Cissner, 2007).

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

B. Length of Term

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

C. Consistent Docket

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

D. Participation in Pre-Court Staff Meetings

Studies have found that outcomes were significantly better in Drug Courts where the judges regularly attended pre-court staff meetings (Carey et al., 2008, 2012). Pre-court staff meetings are where team members share their observations and impressions about each participant's performance in the program and

propose consequences for the judge to consider (McPherson & Sauder, 2013). The judge's presence at the staff meetings ensures that each team member's perspective is taken into consideration when important decisions are made in the case. Observational studies suggest that when judges do not attend pre-court staff meetings, they are less likely to be adequately informed or prepared when they interact with the participants during court hearings (Baker, 2012; Portillo et al., 2013).

E. Frequency of Status Hearings

A substantial body of experimental and quasi-experimental research establishes the importance of scheduling status hearings no less frequently than every two weeks (biweekly) during the first phase of a Drug Court. In a series of experiments, researchers randomly assigned Drug Court participants to either appear before the judge every two weeks for status hearings or to be supervised by their clinical case managers and brought into court only in response to repetitive rule violations. The results revealed that high-risk participants12 had significantly better counseling attendance, drug abstinence, and graduation rates when they were required to appear before the judge every two weeks (Festinger et al., 2002). This finding was replicated in misdemeanor and felony Drug Courts serving urban and rural communities (Jones, 2013; Marlowe et al., 2004a, 2004b). It was subsequently confirmed in prospective matching studies in which the participants were assigned at entry to biweekly hearings if they were determined to be high risk (Marlowe et al., 2006, 2007, 2008, 2009, 2012).

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

F. Length of Court Interactions

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

G. Judicial Demeanor

Studies have consistently found that Drug Court participants perceived the quality of their interactions with the judge to be among the most influential factors for success in the program (Farole & Cissner, 2007; Goldkamp et al., 2002; Jones & Kemp, 2013; National Institute of Justice, 2006; Satel, 1998; Saum et al., 2002; Turner et al., 1999). The MADCE study found that significantly greater reductions in crime and substance use were produced by judges who were rated by independent observers as being more respectful, fair, attentive, enthusiastic, consistent and caring in their interactions with the participants in court (Zweig et al., 2012).

Similarly, a statewide study in New York reported significantly better outcomes for judges who were perceived by the participants as being fair, sympathetic, caring, concerned, understanding and open to learning about the disease of addiction (Farole & Cissner, 2007). In contrast, outcomes were significantly poorer for judges who were perceived as being arbitrary, jumping to conclusions, or not giving participants an opportunity to explain their sides of the controversies (Farole & Cissner, 2007; Zweig et al., 2012).

Program evaluations have similarly reported that supportive comments from the judge were associated with significantly better outcomes in Drug Courts (Senjo & Leip, 2001) whereas stigmatizing, hostile, or shaming comments from the judge were associated with significantly poorer outcomes (Miethe et al., 2000).

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

but rather how the decision was reached and how the participant was treated during the interaction.

H. Judicial Decision Making

Due process and judicial ethics require judges to exercise independent discretion when resolving factual controversies, administering sanctions or incentives that affect a participant's fundamental liberty interests, or ordering the conditions of supervision (Meyer, 2011). A Drug Court judge may not delegate these responsibilities to other members of the Drug Court team. For example, it is not permissible for a Drug Court team to vote on what consequences to impose on a participant unless the judge considers the results of the vote to be merely advisory. Judges are, however, required to consider probative evidence or relevant information when making these determinations. Because judges are not trained to make clinical diagnoses or select treatment interventions, they ordinarily require expert input from treatment professionals to make treatment-related decisions. The collaborative nature of the Drug Court model brings together experts from several professional disciplines, including substance use disorder treatment, to share their knowledge and observations with the judge, thus enabling the judge to make rational and informed decisions (Hora & Stalcup, 2008).

REFERENCES

Baker, K.M. (2012). Decision making in a hybrid organization: A case study of a southwestern drug court treatment program. *Law & Social Inquiry, 38*(1),27–54.

Burke, K.S. (2010). Just what made drug courts successful? *New England Journal on Criminal & Civil Confinement, 36*(1),39–58. Burke, K., & Leben, S. (2007). Procedural fairness: A key ingredient in public satisfaction [White paper]. *Court Review, 44*,4– 24.

Carey, S.M., Finigan, M.W., & Pukstas, K. (2008). *Exploring the key components of drug courts: A comparative study of 18 adult drug courts on practices, outcomes and costs*. Portland, OR: NPC Research. *Available at* http://www.npcresearch.com/Files/NIJ_Cross-site_Final_Report_0308.pdf.

Carey, S.M., Mackin, J.R., & Finigan, M.W. (2012). What works? The ten key components of drug court: Research-based best practices. *Drug Court Review, 8*(1), 6–42.

Farole, D.J., & Cissner, A.B. (2007). Seeing eye to eye: Participant and staff perspectives on drug courts. In G. Berman, M. Rempel & R.V. Wolf (Eds.), *Documenting Results: Research on Problem-Solving Justice* (pp. 51–73). New York: Center for Court Innovation.

Festinger, D.S., Marlowe, D.B., Lee, P.A., Kirby, K.C., Bovasso, G., & McLellan, A.T. (2002). Status hearings in drug court: When more is less and less is more. *Drug & Alcohol Dependence, 68*(2), 151–157.

Finigan, M., Carey, S.M., & Cox, A. (2007). *The impact of a mature drug court over 10 years of operation: Recidivism and costs*. Portland, OR: NPC Research. *Available at* http://www.npcresearch.com/Files/10yr_STOP_Court_Analysis_Final_Report.pdf.

Frazer, M.S. (2006). *The impact of the community court model on defendant perceptions of fairness: A case study at the Red Hook Community Justice Center*. New York: Center for Court Innovation. *Available at* http://www.courtinnovation.org/sites/default/files/Procedural_Fairness.pdf.

Goldkamp, J.S., White, M.D., & Robinson, J.B. (2002). An honest chance: Perspectives on drug courts. *Federal Sentencing Reporter, 14*(6)*,* 369–372.

Hora, P.F., & Stalcup, T. (2008). Drug Treatment Courts in the twenty-first century: The evolution of the revolution in problem-solving courts. *Georgia Law Review, 42*(3),717–811.

Jones, C. G. (2013). Early-phase outcomes from a randomized trial of intensive judicial supervision in an Australian drug court. *Criminal Justice & Behavior, 40*,453-468.

Jones, C.G., & Kemp, R.I. (2013). The strength of the participant-judge relationship predicts better drug court outcomes. *Psychiatry, Psychology and Law* (Online). doi:10.1080/13218719.2013.798392

Marlowe, D.B. (2006). Judicial supervision of drug-abusing offenders. *Journal of Psychoactive Drugs, 38*(Suppl. 3),323–331.

Marlowe, D.B., Festinger, D.S., Arabia, P.L., Dugosh, K.L., Benasutti, K.M., & Croft, J.R. (2009). Adaptive interventions may optimize outcomes in drug courts: A pilot study. *Current Psychiatry Reports*, *11*(5), 370–376.

Marlowe, D.B., Festinger, D.S., Arabia, P.L., Dugosh, K.L., Benasutti, K.M., Croft, J.R., & McKay, J.R. (2008). Adaptive interventions in drug court: A pilot experiment. *Criminal Justice Review, 33*(3), 343–360.

Marlowe, D.B., Festinger, D.S., Dugosh, K.L., Benasutti, K.M., Fox, G. & Croft, J.R. (2012). Adaptive programming improves outcomes in drug court: An experimental trial. *Criminal Justice & Behavior, 39*(4), 514–532.

Marlowe, D.B., Festinger, D.S., Dugosh, K.L., Lee, P.A., & Benasutti, K.M. (2007). Adapting judicial supervision to the risk level of drug offenders: Discharge and six-month outcomes from a prospective matching study. *Drug & Alcohol Dependence, 88*(Suppl. 2), S4–S13.

Marlowe, D.B., Festinger, D.S., & Lee, P.A. (2004a). The judge is a key component of drug court. *Drug Court Review, 4*(2),1–34.

Marlowe, D.B., Festinger, D.S., & Lee, P.A. (2004b). The role of judicial status hearings in drug court. In K. Knight & D. Farabee (Eds.), *Treating addicted offenders: A continuum of effective practices* (pp. 11-1–11-8). Kingston, NJ: Civic Research Institute.

Marlowe, D.B., Festinger, D.S., Lee, P.A., Dugosh, K.L., & Benasutti, K.M. (2006). Matching judicial supervision to clients' risk status in drug court. *Crime & Delinquency, 52*(1), 52–76.

McPherson, C. M., & Sauder, M. (2013). Logics in action: Managing institutional complexity in a drug court. *Administrative Science Quarterly, 58*(2), 165-196.

Meyer, W.G. (2011). Ethical obligations of judges in drug courts. In D.B. Marlowe & W.G. Meyer (Eds.), *The drug court judicial benchbook* (pp. 195–215). Alexandria, VA: National Drug Court Institute. *Available at* http://www.ndci.org/publications/more-publications/-drug-court-judicial-benchbook.

Meyer, W.G., & Tauber, J. (2011). The roles and responsibilities of the drug court judge. In D.B. Marlowe & W.G. Meyer (Eds.), *The drug court judicial benchbook* (pp. 45–61). Alexandria, VA: National Drug Court Institute. *Available at* http://www.ndci.org/publications/more-publications/-drug-court-judicial-benchbook.

Miethe, T.D., Lu, H., & Reese, E. (2000). Reintegrative shaming and recidivism risks in Drug Court: Explanations for some unexpected findings. *Crime & Delinquency, 46*(4)*,* 522–541.

Mitchell, O., Wilson, D.B., Eggers, A., & MacKenzie, D.L. (2012). Assessing the effectiveness of drug courts on recidivism: A meta-analytic review of traditional and nontraditional drug courts. *Journal of Criminal Justice, 40*(1),60–71.

National Institute of Justice. (2006, June). *Drug courts: The second decade* [Special report, NCJ 211081]. Washington, DC: Office of Justice Programs, U.S. Dept. of Justice.

Portillo, S., Rudes, D.S., Viglione, J., & Nelson, M. (2013). Front-stage stars and backstage producers: The role of judges in problem-solving courts. *Victims & Offenders, 8* (1), 1–22.

Satel, S. (1998). Observational study of courtroom dynamics in selected drug courts. *National Drug Court Institute Review, 1*(1), 43–72.

Saum, C.A., Scarpitti, F.R., Butzin, C.A., Perez, V.W., Jennings, D., & Gray, A.R. (2002). Drug court participants' satisfaction with treatment and the court experience. *Drug Court Review, 4*(1), 39–83.

Senjo, S.R., & Leip, L.A. (2001). Testing and developing theory in drug court: A four-part logit model to predict program completion. *Criminal Justice Policy Review, 12*(1), 66–87.

Shaffer, D.K. (2010). Looking inside the black box of drug courts: A meta-analytic review. *Justice Quarterly, 28*(3)*, 493–521.*

Turner, S., Greenwood, P. Fain, T., & Deschenes, E. (1999). Perceptions of drug court: How offenders view ease of program completion, strengths and weaknesses, and the impact on their lives. *National Drug Court Institute Review, 2*(1), 61–85.

Zweig, J.M., Lindquist, C., Downey, P.M., Roman, J., & Rossman, S.B. (2012). Drug court policies and practices: How program implementation affects offender substance use and criminal behavior outcomes. *Drug Court Review, 8*(1), 43–79.

III. Incentives, Sanctions, and Therapeutic Adjustments

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

A. Advance Notice

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

B. Opportunity to Be Heard

Participants are given an opportunity to explain their perspectives concerning factual controversies and the imposition of incentives, sanctions, and therapeutic adjustments. If a participant has difficulty expressing him or herself because of such factors as a language barrier, nervousness, or cognitive limitation, the judge permits the participant's attorney or legal representative to assist in providing such explanations. Participants receive a clear justification for why a particular consequence is or is not being imposed.

C. Equivalent Consequences

Participants receive consequences that are equivalent to those received by other participants who are engaged in comparable conduct.

D. Professional Demeanor

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

E. Progressive Sanctions

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

F. Licit Addictive or Intoxicating Substances

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

G. Therapeutic Adjustments

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

H. Incentivizing Productivity

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

I. Phase Promotion

Phase promotion is predicated on the achievement of realistic and defined behavioral objectives, such as completing a treatment regimen or remaining drug-abstinent for a specified period of time. As participants advance through the phases of the program, sanctions for infractions may increase in magnitude, rewards for achievements may decrease, and supervision services may be reduced. Treatment is reduced only if it is determined clinically that a reduction in treatment is unlikely to precipitate a relapse to substance use. If a participant must be returned temporarily to the preceding phase of the program because of a relapse or related setback, the team develops a remedial plan together with the participant to prepare for a successful phase transition.

J. Jail Sanctions

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

K. Termination

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

L. Consequences of Graduation and Termination

Graduates of the Treatment Court avoid a criminal record, avoid incarceration, or receive a substantially reduced sentence or disposition as an incentive for completing the program. Participants who are terminated from the Treatment Court receive a sentence or disposition for the underlying offense that brought them into the Treatment Court. Participants are informed in advance of the circumstances under which they may receive an augmented

sentence for failing to complete the Treatment Court program.

COMMENTARY

A. Advance Notice

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

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

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

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

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

B. Opportunity to Be Heard Equivalent Consequences Professional Demeanor

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

In the MADCE study, outcomes were significantly better when participants perceived the judge as fair and when independent observers rated the judge's interactions with the participants as respectful, fair, consistent, and predictable (Rossman et al., 2011). In contrast, outcomes were significantly poorer for judges who were

rated as being arbitrary or not giving participants an opportunity to explain their side of the controversy (Farole & Cissner, 2007; Rossman et al., 2011). Stigmatizing, hostile, and shaming comments from the judge have also been associated with significantly poorer outcomes in Drug Courts (Gallagher, 2013; Miethe et al., 2000).

C. Equivalent Consequences
See Commentary B above.

D. Professional Demeanor
See Commentary B above.

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

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

F. Licit Addictive or Intoxicating Substances
Consequences should be imposed for the nonmedically indicated use of intoxicating and addictive substances, including alcohol, cannabis (marijuana), and prescription medications, regardless of the licit or illicit status of the substance. Ingestion of alcohol and cannabis gives rise to further criminal activity (Bennett et al., 2008; Boden et al., 2013; Friedman et al., 2001; Pedersen & Skardhamar, 2010; Reynolds et al., 2011), precipitates relapse to other drugs of abuse (Aharonovich et al., 2005), increases the likelihood that participants will fail out of Drug Court (Sechrest & Shicor, 2001), and reduces the efficacy of rewards and sanctions that are used in Drug Courts to improve participants' behaviors (Lane et al., 2004; Thompson et al., 2012). Permitting the continued use of these substances is contrary to evidence-based practices in substance use disorder treatment and interferes with the central goals of a Drug Court. The use of any addictive or intoxicating substance should be authorized only if it is determined by competent medical evidence to be medically indicated, if safe and effective alternative treatments are not reasonably available, and if the participant is carefully monitored by a physician with training in addiction psychiatry or addiction medicine. There is a serious risk of morbidity, mortality, or illegal diversion of medications when addiction medications are prescribed by general medical practitioners for addicted patients (Bazazi et al., 2011; Bohnert et al., 2011; Daniulaityte et al., 2012; Johanson et al., 2012).

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

alcohol use.

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

Alternatively, the team might discover that the participant was willfully failing to apply him or herself in treatment. Under those circumstances, it would be appropriate to apply punitive sanctions for the willful failure to comply with treatment.

H. Incentivizing Productivity

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

It is essential to recognize that punishment and positive reinforcement serve different, but complementary, functions. Punishment is used to reduce undesirable behaviors, such as substance use and crime, whereas positive reinforcement is used to increase desirable behaviors, such as treatment attendance and employment. Therefore, they are most likely to be effective when administered in combination (DeFulio et al., 2013). The effects of punishment typically last only as long as the sanctions are forthcoming, and undesirable behaviors often return precipitously after the sanctions are withdrawn (Marlowe & Kirby, 1999; Marlowe & Wong, 2008). For this reason, Drug Courts that rely exclusively on punishment to reduce drug abuse and crime will rarely produce lasting gains after graduation.

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

I. Phase Promotion

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

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

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

J. Jail Sanctions

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

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

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

K. Termination

Participants may be terminated from the Drug Court if they pose an immediate risk to public safety, are unwilling or unable to engage in treatment, or are too impaired to benefit from the treatments that are available in their community. If none of these conditions are met, then in most cases the most effective course of action will be to adjust a nonresponsive participant's treatment or supervision requirements or apply escalating sanctions. Drug Courts have significantly poorer outcomes and are considerably less cost-effective when they terminate participants for drug or alcohol use. In a multisite study, Drug Courts that had a policy of terminating participants for positive drug tests or new arrests for drug possession offenses had 50% higher criminal recidivism and 48% lower cost savings than Drug Courts that responded to new drug use by increasing treatment or applying sanctions of lesser severity (Carey et al., 2012). The results of another meta-analysis similarly revealed significantly poorer outcomes for Drug Courts that had a policy of terminating participants for positive drug tests (Shaffer, 2010). Because termination from Drug Court for continued substance use is costly and does not improve outcomes, participants should be terminated only when necessary to protect public safety or if continued efforts at treatment are unlikely to be successful.

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

L. Consequences of Graduation and Termination

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

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

REFERENCES

Aharonovich, E., Liu, X., Samet, S., Nunes, E., Waxman, R., & Hasin, D. (2005). Postdischarge cannabis use and its relationship to cocaine, alcohol, and heroin use: A prospective study. *American Journal of Psychiatry, 162*(8)*,* 1507–1514.

American Psychiatric Association. (2000). *Diagnostic and statistical manual of mental disor*ders (4th ed., text rev.). Washington, DC: American Psychiatric Press.

American Society of Addiction Medicine. (2011). *Public policy statement: Definition of addiction*. *Available at* http://www.asam.org/for-the-public/definition-of-addiction.

Baler, R.D., & Volkow, N.D. (2006). Drug addiction: The neurobiology of disrupted self-control. *Trends in Molecular Medicine, 12*(12), 559–566.

Bazazi, A.R., Yokell, M., Fu, J.J., Rich, J.S., & Zaller, N.D. (2011). Illicit use of buprenorphine/naloxone among injecting and noninjecting opioid users. *Journal of Addiction Medicine, 5*(3), 175–180.

Bennett, T., Holloway, K., & Farrington, D. (2008). The statistical association between drug misuse and crime: Ameta-analysis. *Aggression & Violent Behavior, 13*(2), 107–118.

Boden, J.M., Fergusson, D.M., & Horwood, L.J. (2013). Alcohol misuse and criminal offending: Findings from a 30-year longitudinal study. *Drug & Alcohol Dependence, 128*(1–2), 30–36.

Bohnert, A.S., Valenstein, M., Bair, M.J., Ganoczy, D., McCarthy, J.F., Ilgen, M.A., & Blow, F.C. (2011). Association between opioid prescribing patterns and opioid overdose-related deaths. *Journal of the American Medical Association, 305*(13), 1315-1321.

Bowers, J. (2007). Contraindicated drug courts. *UCLA Law Review, 55*, 783-831.

Budney, A.J., Higgins, S.T., Mercer, D.E., & Carpenter, G. (1998). *A community reinforcement approach: Treating cocaine addiction* [NIH Pub. No. 98-4309]. In series *Therapy manuals for drug abuse: Manual 2.* Rockville, MD: National Institute on Drug Abuse. *Available at* http://archives.drugabuse.gov/TXManuals/CRA/CRA1.html.

Burdon, William M., John M. Roll, Michael L. Prendergast, & Richard A. Rawson. (2001). Drug courts and contingency management. *Journal of Drug Issues, 31*(1)*,*73–90.

Burke, K., & Leben, S. (2007). Procedural fairness: A key ingredient in public satisfaction [White paper]. *Court Review, 44*(1–2), 4–25.

Burns, S.L., & Peyrot, M. (2008). Reclaiming discretion: Judicial sanctioning strategy in court-supervised drug treatment. *Journal of Contemporary Ethnography, 37*(6),720–744.

Carey, S.M., Finigan, M.W., & Pukstas, K. (2008a). *Exploring the key components of drug courts: A comparative study of 18 adult drug courts on practices, outcomes and costs*. Portland, OR: NPC Research. *Available at* http://www.npcresearch.com/Files/NIJ_Cross-site_Final_Report_0308.pdf.

Carey, S.M., Mackin, J.R., & Finigan, M.W. (2012). What works? The ten key components of Drug Court: Research-based best practices. *Drug Court Review*, *8*(1), 6–42.

Carey, S.M., Pukstas, K., Waller, M.S., Mackin, R.J., & Finigan, M.W. (2008b). *Drug courts and state mandated drug treatment programs: Outcomes, costs and consequences*. Portland, OR: NPC Research. *Available at* http://www.npcresearch.com/Files/Prop36_Drug_Court_Executive_Summary_0308.pdf.

Chandler, R.K., Fletcher, B.W., & Volkow, N.D. (2009). Treating drug abuse and addiction in the criminal justice system: Improving public health and safety. *Journal of the American Medical Association, 301*(2), 183–190.

Cheesman, F.L., & Kunkel, T.L. (2012). *Virginia Adult Drug Treatment Courts: Cost benefit analysis*. Williamsburg, VA: National Center for State Courts.

Cissner, A., Rempel, M., Franklin, A.W., Roman, J.K., Bieler, S., Cohen, R., & Cadoret, C.R. (2013, March). *A statewide evaluation of New York's adult drug courts: Testing which policies work best*. Paper presented at the New York Association of Drug Treatment Court Professionals Training. *Available at* http://www.nyadtcp.org/userfiles/file/presentation/The%202012%20New%20York%20State%20Drug%20Court%20Evaluation.pdf.

Collins, L.R., & Lapp, W.M. (1991). Restraint and attributions: Evidence of the abstinence violation effect in alcohol consumption. *Cognitive Therapy & Research, 15*(1), 69–84.

Dackis, C., & O'Brien, C. (2005). Neurobiology of addiction: Treatment and public policy ramifications. *Nature Neuroscience, 8*(11), 1431–1436.

Daniulaityte, R., Falck, R., & Carlson, R. G. (2012). Illicit use of buprenorphine in a community sample of young adult non-medical users of pharmaceutical opioids. *Drug and Alcohol Dependence, 122*(3), 201–207.

DeFulio, A., Stitzer, M., Roll, J., Petry, N., Nuzzo, P., Schwartz, R.P., & Stabile, P. (2013). Criminal justice referral and incentives in outpatient substance abuse treatment. *Journal of Substance Abuse Treatment, 45*(1), 70–75.

Farole, D.J., & Cissner, A.B. (2007). Seeing eye to eye: Participant and staff perspectives on drug courts. In G. Berman, M. Rempel & R.V. Wolf (Eds.), *Documenting Results: Research on Problem-Solving Justice* (pp. 51–73). New York: Center for Court Innovation.

Frazer, M.S. (2006). *The impact of the community court model on defendant perceptions of fairness: A case study at the Red Hook Community Justice Center.* New York: Center for Court Innovation. *Available at* http://www.courtinnovation.org/sites/default/files/Procedural_Fairness.pdf.

Friedman, A.S., Glassman, K., & Terras, A. (2001). Violent behavior as related to use of marijuana and other drugs. *Journal of Addictive Diseases, 20*(1), 49–72.

Gallagher, J.R. (2013). African American participants' views on racial disparities in drug court outcomes. *Journal of Social Work Practice in the Addictions, 13*(2),143–162.

Gendreau, P. (1996). The principles of effective intervention with offenders. In A. Harland (Ed.), *Choosing correctional options that work* (pp. 117–130). Thousand Oaks, CA: Sage.

Godley, M.D., & Godley, S.H. (2008). *Adolescent Community Reinforcement Approach (A-CRA). Available at* http://nrepp.samhsa.gov/ViewIntervention.aspx?id=41.

Goldkamp, J.S., White, M.D., & Robinson, J.B. (2001). Do Drug Courts work? Getting inside the Drug Court black box. *Journal of Drug Issues, 31*(1), 27–72.

Gottfredson, D.C., Najaka, S.S., & Kearley, B., (2003). Effectiveness of drug treatment courts: Evidence from a randomized trial. *Criminology & Public Policy, 2*(2), 171–196.

Griffith, J.D., Rowan-Szal, G.A., Roark, R.R., & Simpson, D.D. (1999). Contingency management in outpatient methadone treatment: A meta-analysis. *Drug & Alcohol Dependence, 58*(1), 55–66.

Harrell, A., Cavanagh, S., & Roman, J. (1999). *Findings From the Evaluation of the D.C. Superior Court Drug Intervention Program: Final Report.* Washington, DC: The Urban Institute.

Harrell, A., & Roman, J. (2001). Reducing drug use and crime among offenders: The impact of graduated sanctions. *Journal of Drug Issues, 31*(1), 207–231.

Hawken, A., & Kleiman, M. (2009). *Managing drug involved probationers with swift and certain sanctions: Evaluating Hawaii's HOPE* (NCJRS No. 229023). Washington, DC: National Institute of Justice. *Available at* http://www.ncjrs.gov/pdffiles1/nij/grants/229023.pdf.

Hepburn, J.R., & Harvey, A.N. (2007). The effect of the threat of legal sanction on program retention and completion: Is that why they stay in drug court?. *Crime & Delinquency, 53*(2), 255–280.

Johanson, C., Arfken, C. L., di Menza, S., & Schuster, C. R. (2012). Diversion and abuse of buprenorphine: Findings from national surveys of treatment patients and physicians. *Drug and Alcohol Dependence, 120*(1),190–195.

Justice Policy Institute. (2011). *Addicted to courts: How a growing dependence on drug courts impacts people and communities*. Washington, DC: Author.

Kilmer, B., Nicosia, N., Heaton, P., & Midgette, G. (2012). Efficacy of frequent monitoring with swift, certain, and modest sanctions for violations: Insights from South Dakota's 24/7 Sobriety Project. *American Journal of Public Health, 103*(1), e37–e43.

Lane, S.D., Cherek, D.R., Pietras, C.J., & Tcheremissine, O.V. (2004). Acute marijuana effects on response–reinforcer relations under multiple variable-interval schedules. *Behavioural Pharmacology*, *15*(4),305–309.

Longshore, D.L., Turner, S., Wenzel, S.L., Morral, A.R., Harrell, A., McBride, D., Deschenes, E., & Iguchi, M.Y. (2001). Drug Courts: A conceptual framework. *Journal of Drug Issues 31*(1), 7–25.

Lussier, J.P., Heil, S.H., Mongeon, J.A., Badger, G.J., & Higgins, S.T. (2006). A meta-analysis of voucher-based reinforcement therapy for substance use disorders. *Addiction, 101*(2),192–203.

Marlatt, G.A. (1985). Cognitive factors in the relapse process. In G. A. Marlatt & J. R. Gordon (Eds.), *Relapse prevention: Maintenance strategies in the treatment of addictive behaviors* (pp. 128-200). New York: Guilford.

Marlatt, G.A., & Witkiewitz, K. (2005). Relapse prevention for alcohol and drug problems. In G. A. Marlatt & D. M. Donovan (Eds.), *Relapse prevention: Maintenance strategies in the treatment of addictive behaviors* (2nd ed.; pp. 1-44). New York: Guilford.

Marlowe, D.B. (2007). Strategies for administering rewards and sanctions. In J.E. Lessenger & G.F. Roper (Eds.), *Drug courts: A new approach to treatment and rehabilitation* (pp. 317–336). New York: Springer.

Marlowe, D.B. (2011). Applying incentives and sanctions. In B. Marlowe & W.G. Meyer (Eds.), *The drug court judicial benchbook* (pp.139–157). Alexandria, VA: National Drug Court Institute. *Available at* http://www.ndci.org/sites/default/files/nadcp/14146_NDCI_Benchbook_v6.pdf.

Marlowe, D.B., Festinger, D.S., Foltz, C., Lee, P.A., & Patapis, N.S. (2005). Perceived deterrence and outcomes in drug court. *Behavioral Sciences & the Law, 23*(2), 183–198.

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),1–31.

Marlowe, D.B., & Wong, C.J. (2008). Contingency management in adult criminal drug courts. In S.T. Higgins, K. Silverman, & S.H. Heil (Eds.), *Contingency management in substance abuse treatment* (pp. 334–354). New York: Guilford Press.

McLellan, A. T., Lewis, D. L., O'Brien, C. P., & Kleber, H. D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association, 284*, 1689-1695.

Meyer, W.G. (2011). Constitutional and legal issues in drug courts. In D.B. Marlowe & W.G. Meyer (Eds.), *The drug court judicial benchbook* (pp. 159–180). Alexandria, VA: National Drug Court Institute. Available at http://www.ndci.org/sites/default/files/nadcp/14146_NDCI_Benchbook_v6.pdf.

Miethe, T.D., Lu, H., & Reese, E. (2000). Reintegrative shaming and recidivism risks in Drug Court: Explanations for some unexpected findings. *Crime & Delinquency, 46*(4)*,* 522–541.

Mitchell, O., Wilson, D.B., Eggers, A., & MacKenzie, D.L. (2012). Assessing the effectiveness of drug courts on recidivism: A meta-analytic review of traditional and nontraditional drug courts. *Journal of Criminal Justice, 40*(1),60–71.

Nagin, D.S., & Pogarsky, G. (2001). Integrating celerity, impulsivity, and extralegal sanction threats into a general deterrence: Theory and evidence. *Criminology, 39*(4), 865–892.

National Association of Criminal Defense Lawyers. (2009). *America's problem-solving courts: The criminal costs of treatment and the case for reform*. Washington, DC: Author.

National Institute on Drug Abuse. (2006). *Principles of drug abuse treatment for criminal justice populations* (NIH Pub. No. 06–5316). Bethesda, MD: Author.

Pedersen, W., & Skardhamar, T. (2010). Cannabis and crime: Findings from a longitudinal study. *Addiction, 105*(1), 109–118.

Rempel, M., & DeStefano, C.D. (2001). Predictors of engagement in court-mandated treatment: Findings at the Brooklyn Treatment Court, 1996–2000. *Journal of Offender Rehabilitation, 33*(4), 87–124.

Reynolds, M.D., Tarter, R.E., Kirisci, L., & Clark, D.B. (2011). Marijuana but not alcohol use during adolescence mediates the association between transmissible risk for substance use disorder and number of lifetime violent offenses. *Journal of Criminal Justice,* 39(3), 218-223.

Rossman, S.B., Rempel, M., Roman, J.K., Zweig, J.M., Lindquist, C.H., Green, M., Downey, P.M., Yahner, J., Bhati, A.S., & Farole, D.J. (2011). *The multisite adult drug court evaluation: The impact of drug courts, vol. 4.* Washington, DC: Urban Institute Justice Policy Center. *Available at* https://www.ncjrs.gov/pdffiles1/nij/grants/237112.pdf.

Rusch, F.R., & Kazdin, A.E. (1981). Toward a methodology of withdrawal designs for the assessment of response maintenance. *Journal of Applied Behavior Analysis, 14*(2), 131–140.

Sechrest, D.K., & Shicor, D. (2001). Determinants of graduation from a day treatment drug court in California: A preliminary study. *Journal of Drug Issues, 31*,129–147.

Senjo, S.R., & Leip, L.A. (2001). Testing and developing theory in Drug Court: A four-part logit model to predict program completion. *Criminal Justice Policy Review, 12*(1), 66–87.

Shaffer, D.K. (2006). Reconsidering drug court effectiveness: A meta-analytic review (Doctoral dissertation, University of Cincinnati, 2006). *Dissertation Abstracts International*, 67, 09A (AAT No. 3231113).

Shaffer, D.K. (2010). Looking inside the black box of drug courts: A meta-analytic review. *Justice Quarterly, 28*(3),493–521.

Stephens, R.S., Curtin, L., Simpson, E. E., & Roffman, R.A. (1994). Testing the abstinence violation effect construct with marijuana cessation. *Addictive Behaviors, 19*(1), 23–32.

Stitzer, M.L. (2008). Motivational incentives in drug courts. In C. Hardin & J.N. Kushner (Eds.), *Quality improvement for drug courts: Evidence-based practices* (pp. 97–105). Alexandria, VA: National Drug Court Institute.

Thompson, L.L., Claus, E.D., Mikulich-Gilbertson, S.K., Banich, M.T., Crowley, T., Krmpotich, T., Miller, D., & Tanabe, J. (2012). Negative reinforcement learning is affected in substance dependence. *Drug & Alcohol Dependence, 123*(1), 84–90.

Tyler, T.R. (2007). Procedural justice and the courts. *Court Review, 44* (1–2), 26–31.

Wodahl, E.J., Garland, B., Culhane, S.E., & McCarty, W.P. (2011). Utilizing behavioral interventions to improve supervision outcomes in community-based corrections. *Criminal Justice & Behavior, 38*(4), 386–405.

Wolfer, L. (2006). Graduates speak: A qualitative exploration of drug court graduates' views of the strengths and weaknesses of the program. *Contemporary Drug Problems, 33*(2), 303–320.

Young, D., & Belenko, S. (2002). Program retention and perceived coercion in three models of mandatory drug treatment. *Journal of Drug Issues,* 22(1),297–328.

Zweig, J.M., Lindquist, C., Downey, P.M., Roman, J., & Rossman, S.B. (2012). Drug court policies and practices: How program implementation affects offender substance use and criminal behavior outcomes. *Drug Court Review*, *8*(1), 43–79.

IV. Substance Use Disorder Treatment

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

A. Continuum of Care

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

B. In-Custody Treatment

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

C. Team Representation

One or two treatment agencies are primarily responsible for managing the delivery of treatment services for Treatment Court participants. Clinically trained representatives from these agencies are core members of the Treatment Court team and regularly attend team meetings and status hearings.

D. Treatment Dosage and Duration

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

E. Treatment Modalities

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

F. Evidence-Based Treatments

Treatment providers administer behavioral or cognitive-behavioral treatments that are documented in manuals and have been demonstrated to improve outcomes for addicted persons involved in the criminal justice system. Treatment providers are proficient at

delivering the interventions and are supervised regularly to ensure continuous fidelity to the treatment models.

G. Medications

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

H. Provider Training and Credentials

Treatment provider agencies are licensed or certified to deliver substance use disorder treatment, have substantial experience working with criminal justice populations, and are supervised regularly to ensure continuous fidelity to evidence-based practices. Treatment providers enter contractual agreements with companies who manage state and Medicaid approved SUD services.

I. Peer Support Groups

Participants regularly attend self-help or peer support groups in addition to professional counseling. The peer support groups follow a structured model or curriculum such as the 12-step or Smart Recovery models. Treatment providers use a preparatory intervention, to prepare the participants for what to expect in the groups and assist them to gain the most benefits from the groups.

J. Continuing Care

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

COMMENTARY

A. Continuum of Care

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

Significantly better results are achieved when substance use patients are assigned to a level of care based on a standardized assessment of their treatment needs as opposed to relying on professional judgment or discretion (Andrews & Bonta, 2010; Babor & Del Boca, 2002; Karno & Longabaugh, 2007; Vieira et al., 2009). The most commonly used placement criteria are the American Society of Addiction Medicine

Patient Placement Criteria for the Treatment of Substance-Related Disorders (ASAM-PPC; Mee-Lee et al., 2001). Studies have confirmed that patients who received the indicated level of care according to the ASAM-PPC had significantly higher treatment completion rates and fewer instances of relapse to substance use than patients who received a lower level of care than was indicated by the ASAM-PPC (for example, patients who received outpatient treatment when the ASAM-PPC indicated a need for residential treatment; De Leon et al., 2010; Gastfriend et al., 2000; Gregoire, 2000; Magura et al., 2003; Mee-Lee & Gastfriend, 2008). Patients who received a higher level of care than was indicated by the ASAM-PPC had equivalent or worse outcomes than those receiving the indicated level of care, and the programs were rarely cost- effective (Magura et al., 2003).

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

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

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

B. In-Custody Treatment

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

Placing a participant in custody might be appropriate to protect public safety or to punish willful infractions such as intentionally failing to attend treatment sessions; however, in-custody treatment will rarely serve the goals of treatment effectiveness or cost-effectiveness. Some Drug Courts may place participants in jail as a means of providing detoxification services or to keep them "off the streets" when adequate treatment is unavailable in the community. Although this practice may be necessary in rare instances to protect participants from immediate self-harm, it is inconsistent with best practices, unduly costly, and unlikely to produce lasting benefits. As soon as a treatment slot becomes available, the participant should be released

immediately from custody and transferred to the appropriate level of care in the community.

C. Team Representation

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

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

D. Treatment Dosage and Duration

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

E. Treatment Modalities

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

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

For groups that are treating externalizing or acting-out behaviors, such as crime and substance use, two facilitators are often needed to monitor and control the group interactions (Sobell & Sobell, 2011). The main facilitator can direct the format and flow of the sessions, while the cofacilitator may set limits on disruptive participants, review participants' homework assignments, or take part in role-plays such as illustrating effective drug-refusal strategies. Although the main facilitator should be a trained and certified treatment

professional, the cofacilitator may be a trainee or recent hire to the program. Using trainees or inexperienced staff members as cofacilitators can reduce the costs of having two facilitators and provides an excellent training opportunity for the new staff members.

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

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

F. Evidence-Based Treatments

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

Behavioral treatments reward offenders for desirable behaviors and sanction them for undesirable behaviors. The systematic application of graduated incentives and sanctions in Drug Courts is an example of a behavior therapy technique (Defulio et al., 2013; Marlowe & Wong, 2008). Cognitive-behavioral therapies (CBT) take an active problem-solving approach to managing drug- and alcohol-related problems. Common CBT techniques include correcting participants' irrational thoughts related to substance use (e.g., "I will never amount to anything anyway, so why bother?"), identifying participants' triggers or risk factors for drug use, scheduling participants' daily activities to avoid coming into contact with their triggers, helping participants to manage cravings and other negative affects without recourse to substance use, and teaching participants effective problem-solving techniques and drug-refusal strategies.

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

Registry of Evidence-Based Programs and Practices (NREPP).22 Drug Court professionals can search the NREPP Web site, free of charge, to identify substance use disorder treatments that have been demonstrated to improve outcomes for addicted offenders.

Outcomes from CBT are enhanced significantly when counselors are trained to deliver the curriculum in a reliable manner as specified in the manual (Goldstein et al., 2013; Southam-Gerow & McLeod, 2013). A minimum of three days of pre-implementation training, periodic booster sessions, and monthly individualized supervision and feedback are required for probation officers and treatment providers to administer evidence-based practices reliably (Bourgon et al., 2010; Edmunds et al., 2013; Robinson et al., 2012; Schoenwaldet al., 2013). In addition, outcomes are better when counselors give homework assignments to the participants that reinforce the material covered in the sessions (Kazantzis et al., 2000; McDonald & Morgan, 2013).

Examples of homework assignments include having participants keep a journal of their thoughts and feelings related to substance use, requiring participants to develop and follow through with a preplanned activity schedule, or having them write an essay on a drug-related topic (Sobell & Sobell, 2011).

G. Medications

Medically assisted treatment (MAT) can significantly improve outcomes for addicted offenders (Chandler et al., 2009; National Center on Addiction & Substance Abuse, 2012; National Institute on Drug Abuse, 2006). Buprenorphine or methadone maintenance administered prior to and immediately after release from jail or prison has been shown to significantly increase opiate-addicted inmates' engagement in treatment; reduce illicit opiate use; reduce rearrests, technical parole violations, and reincarceration rates; and reduce mortality and hepatitis C infections (Dolan et al., 2005; Gordon et al., 2008; Havnes et al., 2012; Kinlock et al., 2008; Magura et al., 2009). These medications are referred to as agonists or partial agonists because they stimulate the central nervous system (CNS) in a similar manner to illicit drugs. Because they can be addictive and may produce euphoria in nontolerant individuals, they may be resisted by some criminal justice professionals.

Positive outcomes have also been reported for antagonist medications, such as naltrexone, which are nonaddictive and nonintoxicating. Naltrexone blocks the effects of opiates and partially blocks the effects of alcohol without producing psychoactive effects of its own. Studies have reported significant reductions in heroin use and rearrest rates for opiate-addicted probationers and parolees who received naltrexone (Cornish et al., 1997; Coviello et al., 2012; O'Brien & Cornish, 2006). In addition, at least two small-scale studies reported better outcomes in DWI Drug Courts or DWI probation programs for alcohol-dependent participants who received an injectable form of naltrexone called Vivitrol (Finigan et al., 2011; Lapham & McMillan, 2011).

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

H. Provider Training and Credentials

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

As was previously discussed, treatment providers must be supervised regularly to ensure continuous fidelity to evidence-based treatments. Providers are better able to administer evidence-based practices when they receive three days of pre-implementation training, periodic booster trainings, and monthly individualized supervision and feedback (Bourgon et al., 2010; Edmunds et al., 2013; Robinson et al., 2012). Finally, research suggests treatment providers are more likely to be effective if they have substantial experience

working with criminal offenders and are accustomed to functioning in a criminal justice environment (Lutze & van Wormer, 2007).

I. Peer Support Groups

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

Simply attending self-help groups is not sufficient to achieve successful outcomes. Sustained benefits are more likely to be attained if participants engage in recovery-relevant activities such as developing a sober-support social network (Kelly et al., 2011a), engaging in spiritual practices (Kelly et al., 2011b; Robinson et al., 2011), and learning effective coping skills from fellow group members (Kelly et al., 2009). Because it is very difficult for Drug Courts to mandate and monitor compliance with these types of recovery activities, they must find other means of encouraging and reinforcing participant engagement in recovery- related exercises. Evidence-based interventions have been developed, documented in treatment manuals, and proven to improve participant engagement in self-help groups and recovery activities. Examples of validated interventions include 12-step facilitation therapy (Ries et al., 2008), which teaches participants about what to expect and how to gain the most benefits from 12-step meetings. In addition, intensive referrals improve outcomes by assertively linking participants with support-group volunteers who may escort them to the groups, answer any questions they might have, and provide them with support and camaraderie (Timko & DeBenedetti, 2007).

J. Continuing Care

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

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

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

Studies have also examined ways to remain in contact with participants after they have been discharged from a treatment program. For example, researchers have extended the benefits of substance use disorder treatment by making periodic telephone calls to participants (McKay, 2009a), although not all studies have reported success with this approach (McKay et al., 2013). In addition, treatment benefits have been extended by inviting participants back to the program for brief recovery management check-ups (Scott &Dennis, 2012), providing assertive case management involving periodic home visits (Godley et al., 2006), and reinforcing participants with praise or small gifts for continuing to attend aftercare sessions (Lash et al., 2004). The aftercare strategies that have been successful typically continued for at least 90 days and had

trained counselors, nurses, or case managers contact the participants briefly to check on their progress, probe for potential warning signs of an impending relapse, offer advice and encouragement, and make suitable referrals if a return to treatment appeared warranted (McKay,2009b).

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

REFERENCES

Andrews, D.A., & Bonta, J. (2010). *The psychology of criminal conduct* (5th ed.). Waltham, MA: Anderson Publishing.

Andrews, D.A., Zinger, I., Hoge, R.D., Bonta, J., Gendreau, P., & Cullen, F.T. (1990). Does correctional treatment work? A clinically relevant and psychologically informed meta-analysis. *Criminology, 28*(3),369–404.

Arfken C., Agius E., Dickson M., Anderson H., Hegedus A. (2005). Clinicians' beliefs and awareness of substance abuse treatments in research and nonresearch-affiliated programs. *Journal of Drug Issue*s, 35(3), 547–558.

Babor, T., & Del Boca, F. (Vol. Eds.) (2002). *Treatment matching in alcoholism: International research monographs in the addictions.* In G. Edwards (Series Ed.). Cambridge, UK: Cambridge University Press.

Bahr, S.J., Masters, A.L., & Taylor, B.M. (2012). What works in substance abuse treatment programs for offenders? *The Prison Journal, 92*(2), 155–174.

Banks, D., & Gottfredson, D.C. (2003). The effects of drug treatment and supervision on time to rearrest among drug treatment court participants. *Journal of Drug Issues*, *33*(2),385–412.

Bazazi, A.R., Yokell, M., Fu, J.J., Rich, J.S., & Zaller, N.D. (2011). Illicit use of buprenorphine/naloxone among injecting and noninjecting opioid users. *Journal of Addiction Medicine, 5*(3), 175–180.

Bohnert, A.S., Valenstein, M., Bair, M.J., Ganoczy, D., McCarthy, J.F., Ilgen, M.A., & Blow, F.C. (2011). Association between opioid prescribing patterns and opioid overdose-related deaths. *Journal of the American Medical Association, 305*(13), 1315- 1321.

Bourgon, G., & Armstrong, B. (2005). Transferring the principles of effective treatment into a "real world" prison setting. *Criminal Justice & Behavior, 32*(1), 3–25.

Bourgon, G., Bonta, J., Rugge, T., Scott, T.L., & Yessine, A. (2010). The role of program design, implementation, and evaluation in evidence-based 'real world' community supervision. *Federal Probation, 74*(1), 2–15.

Bowers, J. (2007). Contraindicated drug courts. *UCLA Law Review, 55*(4),783–831.

Brabender, V. (2002). *Introduction to group therapy*. New York: John Wiley & Sons.

Brown, B.S., O'Grady, K.E., Battjes, R.J., Farrell, E.V., & Smith, N.P., & Nurco, D.N., (2001). Effectiveness of a stand-alone aftercare program for drug-involved offenders. *Journal of Substance Abuse Treatment*, *21*(4),185–192.

Burek, E. (2011, Fall). The importance of Drug Court alumni groups. *AllRise Magazine*, p. 21.

California Substance Abuse and Crime Prevention Act. (2000). 2000 Cal. Legis. Serv. Prop 36 (West), codified in Cal. Penal Code § 1210 *et seq*.

Carey, S.M., Finigan, M.W., & Pukstas, K. (2008). *Exploring the key components of drug courts: A comparative study of 18 adult drug courts on practices, outcomes, and costs*. Portland, OR: NPC Research. *Available at https://www.ncjrs.gov/pdffiles1/nij/grants/223853.pdf*.

Carey, S.M., Mackin, J.R., & Finigan, M.W. (2012). What works? The 10 key components of Drug Court: Research-based best practices. *Drug Court Review*, *8*(1), 6–42.

Chandler, R.K., Fletcher, B.W., & Volkow, N.D. (2009). Treating drug abuse and addiction in the criminal justice system: Improving public health and safety. *Journal of the American Medical Association, 301*(2), 183–190.

Cheesman, F.L., & Kunkel, T.L. (2012). *Virginia adult drug treatment courts: Cost benefit analysis*. Williamsburg, VA: National Center for State Courts.

Cornish, J.W., Metzger, D., Woody, G.E., Wilson, D., McLellan, A.T., Vandergrift, B., & O'Brien, C.P. (1997). Naltrexone pharmacotherapy for opioid dependent federal probationers. *Journal of Substance Abuse Treatment, 14*(6),529–534.

Coviello, D.M., Cornish, J.W., Lynch, K.G., Boney, T.Y., Clark, C.A., Lee, J.D., et al. (2012). A multisite pilot study of extended-release injectable naltrexone treatment for previously opioid-dependent parolees and probationers. *Substance Abuse, 33*(1), 48–59.

Cullen, A.E., Clarke, A.Y., Kuipers, E., Hodgins, S., Dean, K., & Fahy, T. (2012). A multisite randomized trial of a cognitive skills program for male mentally disordered offenders: Violence and antisocial behavior outcomes. *Journal of Consulting& Clinical Psychology, 80*(6), 1114–1120.

Daniulaityte, R., Falck, R., & Carlson, R. G. (2012). Illicit use of buprenorphine in a community sample of young adult non-medical users of pharmaceutical opioids. *Drug and Alcohol Dependence, 122*(3), 201–207.

DeFulio, A., Stitzer, M., Roll, J., Petry, N., Nuzzo, P., Schwartz, R.P., & Stabile, P. (2013). Criminal justice referral and incentives in outpatient substance abuse treatment. *Journal of Substance Abuse Treatment, 45*(1), 70–75.

De Leon, G., Melnick, G., & Cleland, C.M. (2010). Matching to sufficient treatment: Some characteristics of undertreated (mismatched) clients. *Journal of Addictive Diseases, 29*(1), 59–67.

DeMatteo, D. S., Marlowe, D. B., & Festinger, D. S. (2006). Secondary prevention services for clients who are low risk in drug court: A conceptual model. *Crime & Delinquency, 52*, 114-134.

Dolan, K.A., Shearer, J., White, B., Zhou, J., Kaldor, J., & Wodak, A.D. (2005). Four-year follow-up of imprisoned male heroin users and methadone treatment: Mortality, reincarceration and hepatitis C infection. *Addiction, 100*(6),820–828.

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

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*(1), 123–138.

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*(2), 179–187.

Edmunds, J.M., Beidas, R.S., & Kendall, P.C. (2013). Dissemination and implementation of evidence-based practices: Training and consultation as implementation strategies. *Clinical Psychology Science and Practice, 20*(2),152–165.

Ferguson, L.M., & Wormith, S. (2012). A meta-analysis of Moral Reconation Therapy. *International Journal of Offender Therapy & Comparative Criminology: OnLineFirst*. doi: 10.1177/0306624X12447771

Finigan, M.W., Perkins, T., Zold-Kilbourn, P., Parks, J., & Stringer, M. (2011). Preliminary evaluation of extended-release naltrexone in Michigan and Missouri drug courts. *Journal of Substance Abuse Treatment*, *41*(3),288–293.

Fulkerson, A., Keena, L.D., & O'Brien, E. (2012). Understanding success and nonsuccess in the Drug Court. *International Journal of Offender Therapy & Comparative Criminology: OnLineFirst.* doi: 10.1177/0306624X12447774

Gallagher, J.R. (2013). African American participants' views on racial disparities in drug court outcomes. *Journal of Social Work Practice in the Addictions, 13*(2),143–162.

Gastfriend, D.R., Lu, S., & Sharon, E. (2000). Placement matching: Challenges and technical progress. *Substance Use &Misuse*, *35*(12–14), 2191–2213.

Gendreau, P. (1996). Offender rehabilitation: What we know and what needs to be done. *Criminal Justice & Behavior, 23*(1), 144–161.

Godley, M.D., Godley, S.H., Dennis, M.L., Funk, R.R., & Passetti, L.L. (2006). The effect of assertive continuing care linkage, adherence, and abstinence following residential treatment for adolescents with substance use disorders. *Addiction*, *102*(1), 81– 93.

Goldstein, N.E., Kemp, K.A., Leff, S.S., & Lochman, J.E. (2013). Guidelines for adapting manualized interventions for new target populations: A step-wise approach using anger management as a model. *Clinical Psychology: Science & Practice, 19*(4), 385–401.

Gordon, M.S., Kinlock, T.W., Schwartz, R.P., & O'Grady, K.E. (2008). A randomized clinical trial of methadone maintenance for prisoners: Findings at 6 months post-release. *Addiction, 103*(8), 1333–1342.

Gottfredson, D.C., Kearley, B.W., & Bushway, S.D. (2008). Substance use, drug treatment, and crime: An examination of intra- individual variation in a drug court population. *Journal of Drug Issues*, *38*(2),601–630.

Gottfredson, D.C., Kearley, B.W., Najaka, S.S., & Rocha, C.M. (2007). How drug treatment courts work: An analysis of mediators. *Journal of Research on Crime & Delinquency, 44*(1), 3–35.

Gregoire, T.K. (2000). Factors associated with level of care assignments in substance abuse treatment. *Journal of Substance Abuse Treatment*, *18*(3), 241–248.

Grella, C. (2008). Gender-responsive drug treatment services for women: A summary of current research and recommendations for drug court programs. In C. Hardin & J.N. Kushner (Eds.), *Quality improvement for drug courts: Evidence-based practices* (Monograph Series No. 9; pp. 63–74). Alexandria, VA: National Drug Court Institute.

Gutierrez, L., & Bourgon, G. (2012). Drug treatment courts: A quantitative review of study and treatment quality. *Justice Research & Policy, 14*(2), 47–77.

Havnes, I., Bukten, A., Gossop, M., Waal, H., Stangeland, P., & Clausen, T. (2012). Reductions in convictions for violent crime during opioid maintenance treatment: A longitudinal national cohort study. *Drug and Alcohol Dependence, 124*(3), 307–310.

Heck, C. (2008). MRT: Critical component of a local drug court program. *Cognitive Behavioral Treatment Review*, *17*(1), 1–2. Hollins, C.R. (1999). Treatment programs for offenders: Meta-analysis, "what works," and beyond. *International Journal of Law & Psychiatry, 22*(3–4), 361–372.

Howard, D.L. (2003). Culturally competent treatment of African American clients among a national sample of outpatient substance abuse treatment units. *Journal of Substance Abuse Treatment, 24*(2)*,* 89–102.

Huebner, B.M., & Cobbina, J. 2007). The effect of drug use, drug treatment participation, and treatment completion on probationer recidivism. *Journal of Drug Issues, 37*(3),619–641.

Humphreys, K., Kaskutas, L.A., & Weisner, C. (1998). The relationship of pretreatment Alcoholics Anonymous affiliation with problem severity, social resources, and treatment history. *Drug & Alcohol Dependence, 49*(2), 123–131.

Integrated Substance Abuse Programs. (2007, April 13). *Evaluation of the Substance Abuse and Crime Prevention Act: Final report*. Los Angeles, CA: UCLA. *Available at* http://www.uclaisap.org/Prop36/documents/SACPAEvaluationReport.pdf.

Janku, A.D., & Yan, J. (2009). Exploring patterns of court-ordered mental health services for juvenile offenders: Is there evidence of systematic bias? *Criminal Justice & Behavior, 36*(4), 402–419.

Johanson, C., Arfken, C. L., di Menza, S., & Schuster, C. R. (2012). Diversion and abuse of buprenorphine: Findings from national surveys of treatment patients and physicians. *Drug and Alcohol Dependence, 120*(1),190–195.

Justice Policy Institute. (2011). *Addicted to courts: How a growing dependence on drug courts impacts people and communities*. Washington, DC: Author.

Karno, M.P., & Longabaugh, R. (2007). Does matching matter? Examining matches and mismatches between patient attributes and therapy techniques in alcoholism treatment. *Addiction, 102*(4), 587–596.

Kazantzis, N., Deane, F.P., & Ronan, K.R. (2000). Homework assignments in cognitive and behavioral therapy: Ameta- analysis. *Clinical Psychology: Science & Practice, 7*(2), 189–202.

Kelly, J.F., Magill, M., & Stout, R.L. (2009). How do people recover from alcohol dependence? A systematic review of the research on mechanisms of behavior change in Alcoholics Anonymous. *Addiction Research & Theory, 17*(3), 236–259.

Kelly, J.F., & Moos, R. (2003). Dropout from 12-step groups: Prevalence, predictors, and counteracting treatment influences. *Journal of Substance Abuse Treatment, 24*(3),241–250.

Kelly, J.F., Stout, R.L., Magill, M., & Tonigan, J.S. (2011a). The role of Alcoholics Anonymous in mobilizing adaptive social network changes: A prospective lagged meditational analysis. *Drug & Alcohol Dependence*, *114*(2), 119–126.

Kelly, J.F., Stout, R.L., Magill, M., Tonigan, J.S., & Pagano, M.E. (2011b). Spirituality in recovery: A lagged mediational analysis of Alcoholics Anonymous' principal theoretical mechanism of behavior change. *Alcoholism: Clinical & Experimental Research, 35*(3), 454–463.

Kelly, J.F., Stout, R., Zywiak, W., & Schneider, R. (2006). A 3-year study of addiction mutual-help group participation following intensive outpatient treatment. *Alcoholism: Clinical & Experimental Research, 30*(8), 1381–1392.

Kerwin, M.E., Walker-Smith, K., & Kirby, K.C. (2006). Comparative analysis of state requirements for the training of substance abuse and mental health counselors. *Journal of Substance Abuse Treatment, 30*(3), 173–181.

Kinlock, T.W., Gordon, M.S., Schwartz, R.P., & O'Grady, K.E. (2008). A study of methadone maintenance for male prisoners: Three-month post release outcomes. *Criminal Justice & Behavior, 35*(1)*,* 34–47.

Kirchner, R.A., & Goodman, E. (2007). Effectiveness and impact of the Thurston County, Washington Drug Court program. *Cognitive Behavioral Treatment Review*, *16*(2), 1–4.

Koob, J., Brocato, J., & Kleinpeter, C. (2011). Enhancing residential treatment for drug court participants. *Journal of Offender Rehabilitation, 50*(5), 252–271.

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. *Crime & Delinquency, 55*(3), 442–471.

Landenberger, N.A., & Lipsey, N.W. (2005). The positive effects of cognitive-behavioral program for offenders: Ameta-analysis of factors associated with effective treatment. *Journal of Experimental Criminology*, 1(4),451–476.

Lapham, S.C., & McMillan, G.P. (2011). Open-label pilot study of extended-release naltrexone to reduce drinking and driving among repeat offenders. *Journal of Addiction Medicine, 5*(3), 163–169.

Lash, S.J., Burden, J.L., Monteleone, B.R., & Lehmann, L.P. (2004). Social reinforcement of substance abuse treatment aftercare participation: Impact on outcome*. Addictive Behaviors*, *29*(2), 337–342.

Liang, B., & Long, M.A. (2013). Testing the gender effect in drug and alcohol treatment: Women's participation in Tulsa County drug and DUI programs. *Journal of Drug Issues*, *43*(3), 270–288.

Lindquist, C.H., Krebs, C.P., Warner, T.D., & Lattimore, P.K. (2009). An exploration of treatment and supervision intensity among drug court and non-drug court participants*. Journal of Offender Rehabilitation, 48*(3),167–193.

Lipsey, M.W., Chapman, G.L., & Landenberger, N.A. (2001). Cognitive-behavioral programs for offenders. *Annals of the American Academy of Political & Social Science, 578*(1), 144–157.

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*(4),383–398.

Lowenkamp, C.T., Flores, A.W., Holsinger, A.M., Makarios, M.D., & Latessa, E.J. (2010). Intensive supervision programs: Does program philosophy and the principles of effective intervention matter? *Journal of Criminal Justice, 38*(4), 368–375.

Lowenkamp, C.T., Hubbard, D., Makarios, M., & Latessa, E. (2009). A quasi-experimental evaluation of Thinking For a Change: A real world application. *Criminal Justice & Behavior*, 36(2),137–146.

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: Assessment Issues for Managers,* pp. 3–8.

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*(2), 263–290.

Lowenkamp, C.T., Latessa, E.J., & Smith, P. (2006). Does correctional program quality really matter? The impact of adhering to the principles of effective intervention. *Criminology & Public Policy, 5*(3), 575–594.

Lutze, F.E., & van Wormer, J.G. (2007). The nexus between drug and alcohol treatment program integrity and drug court effectiveness: Policy recommendations for pursuing success. *Criminal Justice Policy Review, 18*(3), 226–245.

Magura, S., Lee, J.D., Hershberger, J., Joseph, H., Marsch, L., Shropshire, C., & Rosenblum, A. (2009). Buprenorphine and methadone maintenance in jail and post-release: A randomized clinical trial. *Drug & Alcohol Dependence, 99*(1), 222–230.

Magura, S., Staines, G., Kosanke, N., Rosenblum, A., Foote, J., DeLuca, A., & Bali, P. (2003). Predictive validity of the ASAM patient placement criteria for naturalistically matched vs. mismatched alcoholism patients. *American Journal on Addictions*, *12*(5), 386–97.

Marinelli-Casey, P., Gonzales, R., Hillhouse, M., Ang, A., Zweben, J., Cohen, J., Hora, P.F., & Rawson. R.A. (2008). Drug court treatment for methamphetamine dependence: Treatment response and posttreatment outcomes. *Journal of Substance Abuse Treatment*, 34(2), 242–248.

Marlatt, G.A. (1985). Relapse prevention: Theoretical rationale and overview of the model. In G.A. Marlatt & J.R. Gordon (Eds.), *Relapse Prevention* (pp. 3–70). New York: Guilford Press.

Marlowe, D.B., & Wong, C.J. (2008). Contingency management in adult criminal drug courts. In S.T. Higgins, K. Silverman, & S.H. Heil (Eds.), *Contingency management in substance abuse treatment* (pp. 334–354). New York: Guilford Press.

Martin, S.S., Butzin, C.A., Saum, C.A., & Inciardi, J.A. (1999). Three-year outcomes of therapeutic community treatment for drug-involved offenders in Delaware: From prison to work release to aftercare. *The Prison Journal, 79*(3), 294–320.

Matusow, H., Dickman, S.L., Rich, J.D., Fong, C., Dumont, D.M., Hardin, C., Marlowe, D., & Rosenblum, A. (2013). Medication assisted treatment in U.S. drug courts: Results from a nationwide survey of availability, barriers and attitudes. *Journal of Substance Abuse Treatment*. *44*(5),473–480.

McCord, J. (2003). Cures that harm: Unanticipated outcomes of crime prevention programs. *Annals of the American Academy of Political & Social Science, 587*(1), 16–30.

McDonald, B. R., & Morgan, R. D. (2013). Enhancing homework compliance in correctional psychotherapy. *Criminal Justice & Behavior, 40*(7), 814–828.

McKay, J.R. (2005). Is there a case for extended interventions for alcohol and drug use disorders? *Addiction, 100*(11), 1594–1610.

McKay, J.R. (2009a). Continuing care research: What we have learned and where we are going. *Journal of Substance Abuse Treatment, 36*(2), 131–145.

McKay, J.R. (2009b). *Treating substance use disorders with adaptive continuing care*. Washington, DC: American Psychological Association.

McKay, J.R., Van Horn, D., Ivey, M., Drapkin, M.L., Rennert, L., & Lynch, K.G. (2013). Enhanced continuing care provided in parallel to intensive outpatient treatment does not improve outcomes for patients with cocaine dependence. *Journal of Studies on Alcohol, 74*, 642-651.

McKee, M. (2010). *San Francisco drug court transitional housing program outcome study*. San Francisco: SF Collaborative Courts. *Available at* http://www.sfsuperiorcourt.org/sites/default/files/pdfs/2676%20Outcome%20on%20SF%20Drug%20Court%20Transitional%20Housing%20Program.pdf.

McLean, A. (2012, Fall). The value of alumni groups: A graduate's viewpoint. *AllRise Magazine*, Fall, p. 27.

McLellan, A.T., Carise, D., & Kleber, H.D. (2003). Can the national addiction treatment infrastructure support the public's demand for quality care? *Journal of Substance Abuse Treatment, 25*(2), 117–121.

McLellan, A.T., Lewis, D.C., O'Brien, C.P., & Kleber, H.D. (2000). Drug dependence, a chronic medical illness: Implications for treatment, insurance, and outcomes evaluation. *Journal of the American Medical Association, 284*(13), 1689–1695.

Mee-Lee, D., & Gastfriend, D.R. (2008). Patient placement criteria. In M. Galanter & H.D. Kleber (Eds.), *Textbook of Substance Abuse Treatment* (4th Ed., pp. 79–91). Arlington, VA: American Psychiatric Publishing.

Mee-Lee, D., Shulman, G.D., Fishman, M., Gastfriend, D.R., & Griffith, J.H. (Eds.). (2001). *ASAM patient placement criteria for the treatment of substance-related disorders* (2nd ed.-revised). Chevy Chase, MD: American Society of Addiction Medicine. *Available at* http://www.asam.org/publications/patient-placement-criteria/ppc-2r.

Mendoza, N.S., Trinidad, J.R., Nochajski, T.H., & Farrell, M.C. (2013). Symptoms of depression and successful drug court completion. *Community Mental Health Journal* (Online). doi: 10.1007/s10597-013-9595-5

Messina, N., Calhoun, S., & Warda, U. (2012). Gender-responsive drug court treatment: A randomized controlled trial. *Criminal Justice & Behavior, 39*(12), 1539–1558.

Meyer, W.G. (2011). Constitutional and legal issues in Drug Courts. In D.B. Marlowe & W.G. Meyer (Eds.), *The drug court judicial benchbook* (pp. 159–180). Alexandria, VA: National Drug Court Institute. Available at http://www.ndci.org/sites/default/files/nadcp/14146_NDCI_Benchbook_v6.pdf.

Milkman, H., & Wanberg, K. (2007). *Cognitive-behavioral treatment: A review and discussion for corrections professionals* (NIC No. 021657). Washington, DC: National Institute of Corrections, U.S. Dept. of Justice.

Mills, K.L., Teesson, M., Back, S.E., Brady, K.T., Baker, A.L., Hopwood, S., Sannibale, C., Barrett, E.L., Merz, S., Rosenfeld, J., & Ewer, P.L. (2012). Integrated exposure-based therapy for co-occurring posttraumatic stress disorder and substance dependence: A randomized controlled trial. *Journal of the American Medical Association, 308*(7),690–699.

Mitchell, O., Wilson, D.B., & MacKenzie, D.L. (2007). Does incarceration-based drug treatment reduce recidivism? A meta-analytic synthesis of the research. *Journal of Experimental Criminology, 3*(4),353–375.

Moos, R.H., & Timko, C. (2008). Outcome research on 12-step and other self-help programs. In M. Galanter & H.D. Kleber (Eds.), *Textbook of Substance Abuse Treatment* (4th Ed., pp. 511–521). Arlington, VA: American Psychiatric Publishing.

National Association of Criminal Defense Lawyers. (2009). *America's problem-solving courts: The criminal costs of treatment and the case for reform*. Washington, DC: Author.

National Center on Addiction and Substance Abuse. (2012). *Addiction medicine: Closing the gap between science and practice*. New York: Columbia University.

National Institute on Drug Abuse. (2006). *Principles of drug abuse treatment for criminal justice populations: A research-based guide* (NIH Publication No. 06-5316). Bethesda, MD: Author.

O'Brien, C.P., & Cornish, J.W. (2006). Naltrexone for probationers and parolees. *Journal of Substance Abuse Treatment*, *31*(2), 107–111.

Olmstead, T.A., Abraham, A.J., Martino, S., & Roman, P.M. (2012). Counselor training in several evidence-based psychosocial addiction treatments in private US substance abuse treatment centers. *Drug & Alcohol Dependence, 120*(1), 149–154.

Pearson, F.S., & Lipton, D.S. (1999). A meta-analytic review of the effectiveness of corrections-based treatments for drug abuse. *The Prison Journal, 79*(4), 384–410.

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(3), 476–496.

Pelissier, B., Jones, N., & Cadigan, T. (2007). Drug treatment aftercare in the criminal justice system: A systematic review. *Journal of Substance Abuse Treatment, 32*(3),311—320.

Peters, R.H. (2008). Co-occurring disorders. In C. Hardin & J.N. Kushner (Eds.), *Quality improvement for drug courts: Evidence-based practices* (Monograph Series No. 9; pp. 51–61). Alexandria, VA: National Drug Court Institute.

Peters, R.H., Haas, A.L., & Hunt, W.M. (2002). Treatment "dosage" effects in drug court programs. *Journal of Offender Rehabilitation*, 33(4), 63–72.

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 & the Law*, *30*(6),800–820.

Petrosino, A., Turpin-Petrosino, C., & Finckenauer, J.O. (2000). Well-meaning programs can have harmful effects! Lessons from experiments of programs such as Scared Straight. *Crime & Delinquency, 46*(3), 354–379.

Prendergast, M.L., Pearson, F.S., Podus, D., Hamilton, Z.K., & Greenwell, L. (2013). The Andrews' principles of risk, needs, and responsivity as applied in drug treatment programs: Meta-analysis of crime and drug use outcomes. *Journal of Experimental Criminology: Online First*. doi:10.1007/s11292-013-9178-z

Ries, R.K., Galanter, M., & Tonigan, J.S. (2008). Twelve-Step Facilitation: An adaptation for psychiatric practitioners and patients. In M. Galanter & H.D. Kleber (Eds.), *Textbook of Substance Abuse Treatment* (4th Ed., pp. 373–386). Arlington, VA: American Psychiatric Publishing.

Robinson, C.R., Lowenkamp, C.T., Holsinger, A.M., VanBenschoten, S., Alexander, M., & Oleson, J.C. (2012). A random study of Staff Training Aimed at Reducing Rearrest (STARR): Using core correctional practices in probation interactions. *Journal of Crime & Justice*. *35*(2)167–188.

Robinson, E.A., Krentzman, A.R., Webb, J.R., & Bowler, K.J. (2011). Six-month changes in spirituality and religiousness in alcoholics predict drinking outcomes at nine months. *Journal of Studies on Alcohol & Drugs, 72*(4), 660–668.

Ross, S. (2008). The mentally ill substance abuser. In M. Galanter & H.D. Kleber (Eds.), *Textbook of Substance Abuse Treatment* (4th ed., pp. 537–554). Washington, DC: American Psychiatric Publishing.

Rossman, S.B., Rempel, M., Roman, J.K., Zweig, J.M., Lindquist, C.H., Green, M., Downey, P.M., Yahner, J., Bhati, A.S., & Farole, D.J. (2011). *The multisite adult drug court evaluation: The impact of drug courts, vol. 4.* Washington, DC: Urban Institute Justice Policy Center. *Available at* https://www.ncjrs.gov/pdffiles1/nij/grants/237112.pdf.

Sartor, C.E., McCutcheon, V.V., O'Leary, C.C., Van Buren, D.J., Allsworth, J.E., Jeffe, D.B., & Cottler, L.B. (2012). Lifetime trauma exposure and posttraumatic stress disorder in women sentenced to drug court. *Psychiatry Research, 200*(2–3),602–608.

Schoenwald, S. K., Mehta, T. G., Frazier, S. L., & Shernoff, E. S. (2013). Clinical supervision in effectiveness and implementation research. *Clinical Psychology: Science and Practice, 20*(1), 44–59.

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 & Alcohol Dependence, 125*(1–2), 110–118.

Shaffer, D.K. (2006). Reconsidering drug court effectiveness: A meta-analytic review (Doctoral dissertation, University of Cincinnati, 2006). *Dissertation Abstracts International*, 67, 09A (AAT No. 3231113).

Shaffer, D.K. (2010). Looking inside the black box of drug courts: A meta-analytic review. *Justice Quarterly, 28*(3)*, 493–521.*

Smith, P., Gendreau, P., & Swartz, K. (2009). Validating the principles of effective intervention: A systematic review of the contributions of meta-analysis in the field of corrections. *Victims & Offenders, 4*(2), 148–169.

Sobell, L.C., & Sobell, M.B. (2011). *Group therapy for substance use disorders: A motivational cognitive-behavioral approach*. New York: Guilford.

Southam-Gerow, M. A., & McLeod, B. D. (2013). Advances in applying treatment integrity research for dissemination and implementation science: Introduction to special issue. *Clinical Psychology: Science & Practice, 20*(1), 113.

Sperber, K.G., Latessa, E., & Makarios, M.D. (2013). Examining the interaction between level of risk and dosage of treatment. *Criminal Justice & Behavior, 40*(3), 338–348.

Steenbergh, T.A., Runyan, J.D., Daugherty, D.A., & Winger, J.G. (2012). Neuroscience exposure and perceptions of client responsibility among addiction counselors. *Journal of Substance Abuse Treatment*, *42*(4), 421–8.

Szalavitz, M. (2010, July 16). Does teen drug rehab cure addiction or create it? *Time Magazine: On-Line. Available at* http://time.com/time/printout/0,8816,2003160,00.html.

Taxman, F.S., & Bouffard, J.A. (2005). Treatment as a part of drug court: The impact on graduation rates. *Journal of Offender Rehabilitation, 42*(1), 23–50.

Timko, C., & DeBenedetti, A. (2007). A randomized controlled trial of intensive referral to 12-step self-help groups: One-year outcomes. *Drug & Alcohol Dependence*, 90(2), 270–279.

Titus, J.C., Smith, D., C., Dennis, M.L., Ives, M., Twanow, L, & White, M.K. (2012). Impact of a training and certification program on the quality of interviewer-collected self-report assessment data. *Journal of Substance Abuse Treatment, 42(*2), 201–212.

Velasquez, M.M., Maurer, G.G., Crouch, C., & DiClemente, C.C. (2001). *Group treatment for substance abuse: A stages-of-change therapy manual.* New York: Guilford.

Vieira, T.A., Skilling, T.A., & Peterson-Badali, M. (2009). Matching court-ordered services with treatment needs: Predicting treatment success with young offenders. *Criminal Justice & Behavior, 36*(4), 385–401.

Wanberg, K.W., & Milkman, H.B. (2006). *Criminal conduct & substance abuse treatment: Strategies for self-improvement and change* (2nd ed.). Thousand Oaks, CA: Sage.

Weiss, R.D., Potter, J.S., & Iannucci, R.A. (2008). Inpatient treatment. In M. Galanter & H.D. Kleber (Eds.), *Textbook of Substance Abuse Treatment* (4th Ed., pp. 445–458). Arlington, VA: American Psychiatric Publishing.

Wexler, H.K., Melnick, G., & Cao, Y. (2004). Risk and prison substance abuse treatment outcomes: A replication and challenge. *The Prison Journal, 84*(1), 106–120.

Wexler, H.K., Melnick, G., Lowe, L., & Peters, J. (1999). Three-year reincarceration outcomes for Amity in-prison therapeutic community and aftercare in California. *The Prison Journal, 79*(3), 321–336.

Wilson, D.B., Bouffard, L.A., & MacKenzie, D.L. (2005). A quantitative review of structured, group-oriented, cognitive-behavioral programs for offenders. *Criminal Justice & Behavior, 32*(2), 172–204.

Wilson, D.B., Mitchell, O. & MacKenzie, D.L. (2006). A systematic review of drug court effects on recidivism. *Journal of Experimental Criminology*, *2*(4), 459–487.

Wilson, J.A., & Davis, R.C. (2006). Good intentions meet hard realities: An evaluation of the Project Greenlight Reentry Program. *Criminology & Public Policy, 5*(2),303–338.

Witbrodt, J., Mertens, J., Kaskutas, L.A., Bond, J., Chi, F., & Weisner, C. (2012). Do 12-step meeting attendance trajectories over 9 years predict abstinence? *Journal of Substance Abuse Treatment*, *43*(1), 30–43.

Yalom, I.D. (2005). *The theory and practice of group psychotherapy* (5th ed.). New York: Basic Books.

Zweig, J.M., Lindquist, C., Downey, P.M., Roman, J., & Rossman, S.B. (2012). Drug court policies and practices: How program implementation affects offender substance use and criminal behavior outcomes. Drug Court Review, *8*(1), 43–79.

V. Complementary Treatment and Social Services

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

A. Scope of Complementary Services

The Treatment Court provides or refers participants for treatment and social services to address conditions that are likely to interfere with their response to substance use disorder treatment or other Treatment Court services (responsivity needs), to increase criminal recidivism (criminogenic needs), or to diminish long-term treatment gains (maintenance needs).

Depending on participant needs, complementary services may include housing assistance, mental health treatment, trauma-informed services, criminal-thinking interventions, family or interpersonal counseling, vocational or educational services, and medical or dental treatment. Participants receive only those services for which they have an assessed need.

B. Sequence and Timing of Services

In the first phase of Treatment Court, participants receive services designed primarily to address responsivity needs such as deficient housing, mental health symptoms, and substance- related cravings, withdrawal, or anhedonia (diminished ability to experience pleasure). In the interim phases of Treatment Court, participants receive services designed to resolve criminogenic needs that co-occur frequently with substance use disorder, such as criminal- thinking patterns, delinquent peer interactions, and family conflict. In the later phases of Treatment Court, participants receive services designed to maintain treatment gains by enhancing their long-term adaptive functioning, such as vocational or educational counseling.

C. Clinical Case Management

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

D. Housing Assistance

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

E. Mental Health Treatment

Participants are assessed using a validated instrument for major mental health disorders that co-occur frequently in Treatment Courts, including major depression, bipolar disorder (manic depression), posttraumatic stress disorder (PTSD), and other major anxiety disorders.

Participants suffering from mental illness receive mental health services beginning in the first phase of Treatment Court and continuing as needed throughout their enrollment in the program. Mental illness and addiction are treated concurrently using an evidence-based curriculum that focuses on the mutually aggravating effects of the two conditions. Participants receive psychiatric medication based on a determination of medical necessity or medical indication by a qualified medical provider. Applicants are not denied entry to Treatment Court because they are receiving a lawfully prescribed psychiatric medication [see Standard I, Target Population], and participants are not required to discontinue lawfully prescribed psychiatric medication as a condition of graduating from Treatment Court [see Standard IV, Substance Use Disorder Treatment].

F. Trauma-Informed Services

Participants are assessed using a validated instrument for trauma history, trauma-related symptoms, and posttraumatic stress disorder (PTSD). Participants with PTSD receive an evidence-based intervention that teaches them how to manage distress without resorting to substance use or other avoidance behaviors, desensitizes them gradually to symptoms of panic and anxiety, and encourages them to engage in productive actions that reduce the risk of retraumatization. Participants with PTSD or severe trauma-related symptoms are evaluated for their suitability for group interventions and are treated on an individual basis or in small groups when necessary to manage panic, dissociation, or severe anxiety. Participants receive trauma-related services in gender-specific groups. All Treatment Court team members, including court personnel and other criminal justice professionals, receive formal training on delivering trauma-informed services.

G. Criminal Thinking Interventions

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

H. Family and Interpersonal Counseling

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

I. Vocational and Educational Services

Participants with deficient employment or academic histories receive vocational or educational services beginning in a late phase of Treatment Court. Vocational or educational services are delivered after participants have found safe and stable housing, their substance use disorder and mental health symptoms have resolved substantially, they have completed a criminal-thinking intervention, and they are spending most or all of their time interacting with prosocial and sober peers. Vocational interventions are standardized and cognitive-

behavioral in orientation and teach participants to find a job, keep a job, and earn a better or higher-paying job in the future though continuous self-improvement.

Participants are required to have a stable job, be enrolled in a vocational or educational program, or be engaged in comparable prosocial activity as a condition of graduating from Treatment Court. Continued involvement in work, education, or comparable prosocial activity is a component of each participant's continuing-care plan.

J. Medical and Dental Treatment

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

K. Prevention of Health-Risk Behaviors

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

L. Overdose Prevention and Reversal

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

COMMENTARY

A. Scope of Complementary Services

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

Table 1. Complementary Needs Identified in National and Statewide Studies of Drug Courts .

Complementary Need	Percentage of Participants
Any mental health problem/disorder	63%
Major depression	16%–39%
Posttraumatic stress disorder (PTSD)	10%
Anxiety disorder other than PTSD	9%
Bipolar disorder	8%
Chronic medical condition	26%
Unemployed	54%–72%
Less than a high school diploma or GED	32%–38%
Homeless	11%–47%
Abuse or trauma history	27%–29%

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

Drug Courts are more effective and cost-effective when they offer complementary treatment and social

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

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

B. Sequence and Timing of Services

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

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

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

Criminogenic Needs. Criminogenic needs refer to disorders or conditions that cause or exacerbate crime

(Andrews & Bonta, 2010). Severe substance use disorders are highly criminogenic needs (Bennett et al., 2008; Walters, 2015), which explains why they are the primary focus of most interventions in Drug Courts. Other criminogenic needs that are encountered frequently in Drug Courts include criminal-thinking patterns, impulsivity, family conflict, and delinquent peer affiliations (Green & Rempel, 2012; Hickert et al., 2009; Jones et al., 2015).

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

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

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

C. Clinical Case Management

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

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

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

- *Brokerage Model*—The least intensive form of case management, the brokerage model involves

assessing participants and linking them to indicated services.

- *Generalist or Clinician Model*—In the most common form of case management, the Generalist case manager assesses participant needs and delivers some or all of the indicated services.

- *Assertive Community Treatment (ACT) Model*—The most intensive form of case management, the ACT Model provides around-the-clock access to a multidisciplinary team of professionals that delivers wrap- around services in the community designed to meet an array of treatment and social-service needs.

- *Strengths-Based Model*—A strengths-based philosophy may be applied in the context of any of the above models. It focuses on leveraging participants' natural resources and encouraging participants to take an active role in setting treatment goals and selecting treatment options.

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

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

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

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

Regardless of which model of case management is applied, outcomes are superior when case managers administer reliable and valid needs-assessment instruments (Andrews & Bonta, 2010; Andrews et al., 2006). Whether needs assessments should be administered repeatedly during the course of treatment is an open question. Although evidence suggests changes in need scores correlate with progress in treatment (Greiner et

al., 2015; Serin et al., 2013; Vose et al, 2013; Wooditch et al., 2013), little guidance is available to determine when or how to alter treatment conditions in light of changing scores (Serin et al., 2013). Until such guidance is available, Drug Courts are advised to rely on objective indices of participant progress, such as drug test results and treatment attendance rates, to make decisions about adjusting treatment and social services.

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

D. Housing Assistance

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

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

E. Mental Health Treatment

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

Mental illness and substance use disorder may co-occur in a given case for several reasons. Substance use may trigger or exacerbate mental illness, mentally ill individuals may abuse substances in a misguided effort to self-medicate psychiatric symptoms, or the two disorders may emerge independently in a person who has a generalized vulnerability to stress-related illness (Ross, 2008). Causality aside, treating either disorder alone without treating both disorders simultaneously is rarely, if ever, successful.

Addiction and mental illness are reciprocally aggravating conditions, meaning that continued symptoms of one disorder are likely to precipitate relapse in the other disorder (Chandler et al., 2004; Drake et al., 2008). For example, formerly depressed person who continues to abuse drugs is likely to experience a resurgence of depressive symptoms. Conversely, a person recovering from addiction who continues to suffer from depression is at risk for relapsing to drug abuse. For this reason, best practice standards for Drug Courts and other treatment programs require mental illness and addiction to be treated concurrently as opposed to consecutively (Drake et al., 2004; Kushner et al., 2014; Mueser et al., 2003; Osher et al., 2012; Peters, 2008; Steadman et al., 2013). Whenever possible, both disorders should be treated in the same facility by the same

professional(s) using an integrated treatment model that focuses on the mutually aggravating effects of the two conditions. The Substance Abuse and Mental Health Services Administration (SAMHSA, 2010) has published therapist toolkits to assist in delivering evidence-based integrated treatments for co-occurring substance use and mental health disorders.

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

F. Trauma-Informed Services

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

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

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

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

In a randomized controlled experiment, female Drug Court participants with trauma histories who received manualized cognitive-behavioral PTSD treatments—Helping Women Recover (Covington, 2008) or Beyond Trauma (Covington, 2003)—in gender-specific groups were more likely to graduate from Drug Court, were less likely to receive a jail sanction in the program, and reported more than twice the reduction in PTSD symptoms than participants with trauma histories who did not receive PTSD treatment (Messina et al.,

2012). In another study, female Drug Court participants who received similar interventions—trauma-focused cognitive-behavioral therapy or abuse-focused cognitive-behavioral therapy—reported substantial reductions in substance use and mental health symptoms as well as improvements in housing and employment (Powell et al., 2012). Given the design of these studies, separating the effects of the PTSD treatments from the effects of the gender-specific groups is not possible. Studies have reported superior outcomes when women in the criminal justice system received various types of substance use disorder treatment in female-only groups (Grella, 2008; Kissin et al., 2013; Liang & Long, 2013; Morse et al., 2013). Given the current state of knowledge, the best practice is to deliver trauma-related services for women in female-only groups because this combination of services clearly enhances outcomes for these participants.

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

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

- Staff members should strive continually to avoid inadvertently retraumatizing participants. For example, responding angrily to participant infractions, ignoring participants' fears or concerns, maintaining a chaotic or noisy group-counseling environment, or performing urine drug testing in a public or disrespectful manner may reawaken feelings of shame, fear, guilt, or panic in formerly traumatized individuals.

- Staff should remain true to their word, including following policies and procedures as described in the program manual and applying incentives and sanctions as agreed. Too much flexibility, no matter how well-intentioned, may seem unfair and unpredictable to persons who have fallen victim to unexpected dangers in the past.

- Staff should provide clear instructions in advance to participants concerning behaviors that are expected and prohibited in the program. Individuals with trauma histories need to understand the rules and to be prepared for what will occur in the event of an accomplishment or infraction.

- Staff should start and end counseling sessions, court hearings, and other appointments on time, at the agreed-upon location, and according to an agreed-upon structure and format. If participants cannot rely on staff to follow a basic itinerary, relying on those same staff persons for trustworthy support, feedback, and counseling may prove difficult for participants.

- Participants with PTSD or severe trauma-related symptoms, such as panic or dissociation (feeling detached from one's surroundings), may not be suitable candidates for group interventions, especially in the early stages of treatment (Yalom & Leszcz, 2005). Such individuals may need to be treated on an individual basis or in small groups with carefully selected group members who are non-threatening and non-predatory. As was noted earlier, female participants with trauma histories are especially well suited for gender-specific groups (Liang & Long, 2013; Messina et al.,2012).

- Participants with histories of childhood-onset abuse or neglect may be at risk for developing a severe personality disorder such as borderline personality disorder. These individuals may have considerable difficulty trusting others, controlling overwhelming feelings of anger or depression, and containing their impulses. Manualized cognitive-behavioral treatments, such as dialectical behavior therapy (Linehan, 1996), have been shown to improve outcomes in these difficult cases

(Dimeff & Koerner, 2007; Linehan et al., 1999). These complicated treatments require specialized training and continuous supervision to help staff deal with uncomfortable and confusing reactions that are commonly engendered in these challenging cases.

G. Criminal Thinking Interventions

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

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

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

H. Family and Interpersonal Counseling

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

Most studies of family treatments in Drug Courts have been conducted in the context of Family Drug Courts or Juvenile Drug Courts. Results have demonstrated consistently superior outcomes when manualized, cognitive-behavioral family interventions were added to the Drug Court curriculum, including Strengthening Families and Celebrating Families! (Brook et al., 2015) and modified versions of multidimensional family therapy (Dakof et al., 2009, 2010, 2015), multisystemic therapy (Henggeler et al., 2006), and functional family therapy (Datchi & Sexton, 2013). Each of these treatments focuses on lessening familial conflict, reducing interactions with drug-using and antisocial peers and relatives, improving communication skills, and enhancing problem-solving skills. In the beginning of treatment, prosocial and drug-free family members, friends, or daily acquaintances are trained by staff to monitor participant behavior reliably, reinforce prosocial activities, respond appropriately and helpfully to problematic behaviors, reduce tension and conflict, and de-escalate confrontations. As therapy progresses, treatment focuses on teaching all parties effective communication and problem-solving skills.

Studies have not determined when delivering family or interpersonal counseling in Drug Courts is most beneficial. Given the powerful association between family functioning and criminal justice outcomes, these services should be delivered as soon as practicable. Outcomes in substance use disorder treatment are significantly better when at least one reliable and prosocial family member, friend, or close acquaintance is enlisted early in treatment to help the participant arrive on time for appointments and comply with other obligations in the program, such as following a curfew, adhering to prescribed medications, and avoiding

forbidden locations like bars (Meyers et al., 1998; Roozen et al., 2010). The same individual may be enlisted to provide helpful observations to staff about the participant's conduct outside of treatment (Kirby et al., 1999). After participants are stabilized clinically, family interventions should focus on improving communication skills, altering maladaptive interactions, reinforcing prosocial behaviors, and reducing interpersonal conflicts.

I. Vocational and Educational Services

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

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

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

Studies have not determined when administering vocational or educational interventions is most beneficial. For high-risk and high-need individuals, these services are best introduced late in the course of Drug Court after participants have secured safe and stable housing, their addiction and mental health symptoms have resolved substantially, they have completed a criminal-thinking intervention, and they are spending most or all of their time interacting with prosocial, sober, and supportive peers (Magura et al., 2004; Platt, 1995). For many high-risk and high-need participants, this preparatory process may require at least six months of treatment, and twelve months may be needed for individuals with serious substance use disorders or mental illness (Gottfredson et al., 2007; Peters et al., 2002).

J. Medical and Dental Treatment

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

No study has determined when addressing medical or dental concerns in Drug Courts is most appropriate. Needless to say, conditions that are life-threatening or may cause long-term disability should be treated immediately. However, waiting until later phases of Drug Court to treat nonessential or nonacute conditions that are exacerbated or maintained by substance use disorder may be prudent. Outcomes may be better if

medical or dental services are delivered after participants have achieved sobriety and relinquished other antisocial behaviors. For example, participants who abuse methamphetamine often have serious dental problems (American Dental Association, n.d.). If these dental problems are not causing acute distress, it might be appropriate to wait until the participant has stopped using methamphetamine before attempting dental repairs. Continued substance use risks undoing dental efforts and may cause a participant to discontinue dental treatment prematurely. A more efficient use of resources may be to address nonessential dental or medical treatment in a late phase of Drug Court or as part of a participant's continuing-care plan so as to maintain and extend the Drug Court's beneficial effects. A logical first step is to refer participants for routine medical and dental checkups to establish relationships with health care providers and begin a long-term process of preventive and routine medical and dental care.

K. Prevention of Health-Risk Behaviors

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

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

L. Overdose Prevention and Reversal

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

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

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

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

Some Drug Court professionals may fear this practice could give the unintended message to participants that continued drug use is acceptable or anticipated. On the contrary, educating participants about drug overdose

delivers a clear message about the potentially fatal consequences of continued drug abuse. Moreover, drug-abstinent participants may find themselves in the position of needing to save the life of a non-sober family member or acquaintance. Preparing participants to respond effectively in such circumstances delivers the prosocial message that they have a responsibility to help others.

REFERENCES

American Dental Association. (n.d.). Oral health topics: Meth mouth. Retrieved from http://www.ada.org/en/member-center/oral-health-topics/meth-mouth

Andrews, D.A., & Bonta, J. (2010). *The psychology of criminal conduct* (5th ed.). New Providence, NJ: Anderson.

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.

Andrews, D.A., Zinger, I., Hoge, R.D., Bonta, J., Gendreau, P., & Cullen, F.T. (1990). Does correctional treatment work? A clinically relevant and psychologically informed meta-analysis. *Criminology, 28*(3),369–404.

Anglin, D.M., Longshore, D., & Turner, S. (1999). Treatment alternatives to street crime: An evaluation of five programs. *Criminal Justice and Behavior, 26*(2), 168–195.

Aos, S., Miller, M., & Drake, E. (2006). *Evidence-based public policy options to reduce future prison construction, criminal justice costs, and crime rates.* Olympia: Washington State Institute for Public Policy.

Barton, E.D., Ramos, J., Colwell, C., Benson, J., Baily, J., & Dunn, W. (2002). Intranasal administration of naloxone by paramedics. *Prehospital Emergency Care, 6*(1), 54–58.

Bath, H. (2008). The three pillars of trauma-informed care. *Reclaiming Children and Youth, 17*(3),17–21.

Belenko, S., Langley, S., Crimmins, S., & Chaple, M. (2004). HIV risk behaviors, knowledge, and prevention education among offenders under community supervision: A hidden risk group. *AIDS Education and Prevention, 16*(4), 367–385.

Benish, S.G., Imel, Z.E., & Wampold, B.E. (2008). The relative efficacy of bona fide psychotherapies for treating post-traumatic stress disorder: A meta-analysis of direct comparisons. *Clinical Psychology Review, 28*(5), 746–758.

Bennett, T., Holloway, K., & Farrington, D. (2008). The statistical association between drug misuse and crime: A meta-analysis. *Aggression & Violent Behavior, 13*(2), 107–118.

Berg, M.T., & Huebner, B.M. (2011). Reentry and the ties that bind: An examination of social ties, employment, and recidivism. *Justice Quarterly, 28*(2), 382–410.

Bisson, J.I., Ehlers, A., Matthews, R., Pilling, S., Richards, D., & Turner, S. (2007). Psychological treatments for chronic post-traumatic stress disorder: Systematic review and meta-analysis. *British Journal of Psychiatry, 190*, 97–104. doi:10.1192/bjp.bp.106.021402

Bonta, J., Law, M., & Hanson, R.K. (1998). The prediction of criminal and violent recidivism among mentally disordered offenders: A meta-analysis. *Psychological Bulletin, 123*(2), 123–142.

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.

Braude, L. (2005). The Cook County Mental Health Court: Development, implementation, and initial implications. *Offender Substance Abuse Report, 5*(5), 67–76.

Brook, J., Akin, B.A., Lloyd, M.H., & Yan, Y. (2015). Family drug court, targeted parent training and family reunification: Did this enhanced service strategy make a difference? *Juvenile and Family Court Journal, 66*(2), 35–52.

Carey, S.M., Mackin, J.R., & Finigan, M.W. (2012). What works? The ten key components of drug court: Research-based best practices. *Drug Court Review, 8*(1), 6–42.

Centers for Disease Control and Prevention. (2012). Community-based opioid overdose prevention programs providing naloxone—United States, 2010. *Morbidity and Mortality Weekly Report, 61*(6), 101–105.

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 & the Law, 22*(4), 431–448.

Cheesman, F.L., & Kunkel, T.L. (2012). *Virginia Adult Drug Treatment Courts: Cost benefit analysis*. Williamsburg, VA: National Center for State Courts.

Cissner, A.B., Rempel, M., Franklin, A.W., Roman, J.K., Bieler, S., Cohen, R., & Cadoret, C.R. (2013). *A statewide evaluation of New York's adult drug courts: Identifying which policies work best*. New York: Center for Court Innovation.

Clark, C.B., McCullumsmith, C.B., Redmond, N., Hardy, S., Waesche, M.C., Osula, G., & Cropsey, K.L. (2013). Factors associated with rapid failure in a Treatment Alternatives for Safer Communities (TASC) program. *Journal of Substance Abuse Treatment, 45*(4), 376–380.

Clark, V.A. (2014, November 12). Predicting two types of recidivism among newly released prisoners: First addresses as "launch pads" for recidivism or reentry success. *Crime & Delinquency: Online*. doi:10.1177/0011128714555760

Cook, F. (2002). Treatment accountability for safer communities: Linking the criminal justice and treatment systems. In C.G. Leukefeld, F. Tims, and D. Farabee (Eds.), *Treatment of drug offenders: Policies and issues* (pp. 105–110). New York: Springer.

Cook, P.J., Kang, S., Braga, A.A., Ludwig, J., & O'Brien, M.E. (2014, December 20). An experimental evaluation of a comprehensive employment-oriented prisoner re-entry program. *Journal of Quantitative Criminology: Online*. doi:10.1007/s10940-014-9242-5

Coviello, D.M., Zanis, D.A., & Lynch., K. (2004). Effectiveness of vocational problem-solving skills on motivation and job- seeking action steps. *Substance Use and Misuse, 39*(13-14), 2309–2324.

Covington, S. (2003). *Beyond trauma: A healing journey for women. Facilitator's guide*. Center City, MN: Hazelden.

Covington, S.S. (2008). *Helping women recover: A program for treating substance abuse—Special edition for use in the criminal justice system* (Facilitator's guide, Rev. ed.). San Francisco: Jossey-Bass.

Covington, S.S., Griffin, D., & Dauer, R. (2011). *A man's workbook: Helping men recover: A program for treating addiction—Special edition for use in the criminal justice system*. San Francisco: Jossey-Bass.

Cresswell, L.S, & Deschenes, E.P. (2001). Minority and non-minority perceptions of drug court program severity and effectiveness. *Journal of Drug Issues, 31*(1), 259–291.

Cullen, A.E., Clarke, A.Y., Kuipers, E., Hodgins, S., Dean, K., & Fahy, T. (2012). A multisite randomized trial of a cognitive skills program for male mentally disordered offenders: Violence and antisocial behavior outcomes. *Journal of Consulting and Clinical Psychology, 80*(6), 1114–1120.

Dakof, G.A., Cohen, J.B., & Duarte, E. (2009). Increasing family reunification for substance-abusing mothers and their children: Comparing two drug court interventions in Miami. *Juvenile and Family Court Journal, 60*(4), 11–23.

Dakof, G.A., Cohen, J.B., Henderson, C.E., Duarte, E., Boustani, M., Blackburn, A., Hawes, S. (2010). A randomized pilot study of the Engaging Moms program for family drug court. *Journal of Substance Abuse Treatment, 38*(3), 263–274.

Dakof, G.A., Henderson, C.E., Rowe, C.L., Boustani, M., Greenbaum, P.E., Wang, W., Liddle, H.A. (2015). A randomized clinical trial of family therapy in juvenile drug court. *Journal of Family Psychology, 29*(2), 232–241.

Datchi, C.C., & Sexton, T.L. (2013). Can family therapy have an effect on adult criminal conduct? Initial evaluation of functional family therapy. *Couple and Family Psychology: Research and Practice, 2*(4), 278–293.

Deschenes, E.P., Ireland, C., & Kleinpeter, C.B. (2009). Enhancing drug court success. *Journal of Offender Rehabilitation, 48*(1), 19–36.

DeVall, K.E., & Lanier, C.L. (2012). Successful completion: An examination of factors influencing drug court completion for white and non-white male participants. *Substance Use and Misuse, 47*(10), 1106–1116.

Dimeff, L.A., & Koerner, K. (Eds.) (2007). *Dialectical behavior therapy in clinical practice: Applications across disorders and settings*. New York: Guilford Press.

Dolan, K.A., Shearer, J., White, B., Zhou, J., Kaldor, J., & Wodak, A.D. (2005). Four-year follow-up of imprisoned male heroin users and methadone treatment: Mortality, reincarceration and hepatitis C infection. *Addiction, 100*(6), 820–828.

Drake, R.E., Mueser, K.T., Brunette, M.F., & McHugo, G.J. (2004). A review of treatments for people with severe mental illnesses and co-occurring substance use disorders. *Psychiatric Rehabilitation Journal, 27*(4), 360–374.

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*(1), 123–138.

Elbogen, E.B., & Johnson, S.C. (2009). The intricate link between violence and mental disorder: Results from the National Epidemiologic Survey on Alcohol and Related Conditions. *Archives of General Psychiatry, 66*(2), 152–161.

Elbogen, E.B., Sullivan, C.P., Wolfe, J., Wagner, H.R., & Beckham, J.C. (2013). Homelessness and money mismanagement in Iraq and Afghanistan veterans. *American Journal of Public Health, 103*(S2), S248–S254.

Elliott, D.E., Bjelajac, P., Fallot, R.D., Markoff, L.S., & Reed, B.G. (2005). Trauma-informed or trauma-denied: Principles and implementation of trauma-informed services for women. *Journal of Community Psychology, 33*(4), 461–477.

Farabee, D., Zhang, S.X., & Wright, B. (2014). An experimental evaluation of a nationally recognized employment-focused offender reentry program. *Journal of Experimental Criminology, 10*(3), 309–322.

Fergusson, D.M., Swain-Campbell, N.R., & Horwood, L.J. (2002). Deviant peer affiliations, crime and substance abuse: A fixed effects regression analysis. *Journal of Abnormal Child Psychology, 30*(4), 419–430.

Festinger, D.S., Dugosh, K.L., Metzger, D.S., & Marlowe, D.B. (2012). The prevalence of HIV risk behaviors among felony drug court participants. *Drug Court Review, 8*(1), 131–146.

Frescoln, K.P. (2014). *Engaging with the Affordable Care Act: Implications and recommendations for adult drug court professionals*. Alexandria, VA: National Association of Drug Court Professionals.

Gallagher, J.R. (2013a). African American participants' views on racial disparities in drug court outcomes. *Journal of Social Work Practice in the Addictions, 13*(2), 143–162.

Gallagher, J.R. (2013b). Drug court graduation rates: Implications for policy advocacy and future research. *Alcoholism Treatment Quarterly, 31*(2), 241–253.

Gallagher, J.R., Nordberg, A., Deranek, M.S., Ivory, E., Carlton, J., & Miller, J.W. (2015). Predicting termination from drug court and comparing recidivism patterns: Treating substance use disorders in criminal justice settings. *Alcoholism Treatment Quarterly*, *33*(1), 28–43.

Gendreau, P., Little, T., & Goggin, C. (1996). A meta-analysis of the predictors of adult offender recidivism: What works! *Criminology, 34*(4), 575–608.

Gottfredson, D.C., Kearley, B.W., Najaka, S.S., & Rocha, C.M. (2007). How Drug Treatment Courts work: An analysis of mediators. *Journal of Research on Crime & Delinquency, 44*(1), 3–35.

Gray, A.R., & Saum, C.A. (2005). Mental health, gender and drug court completion. *American Journal of Criminal Justice, 30*(1), 55–69.

Green, M., & Rempel, M. (2012). Beyond crime and drug use: Do adult drug courts produce other psychosocial benefits? *Journal of Drug Issues, 42*(2), 156–177.

Greiner, L.E., Law, M.A., & Brown, S.L. (2015). Using dynamic factors to predict recidivism among women: A four-wave prospective study. *Criminal Justice and Behavior, 42*(5), 457–480.

Grella, C. (2008). Gender-responsive drug treatment services for women: A summary of current research and recommendations for drug court programs. In C. Hardin & J.N. Kushner (Eds.), Q*uality improvement for drug courts: Evidence-based practices* (Monograph Series no. 9, pp. 63–74). Alexandria, VA: National Drug Court Institute.

Guastaferro, W.P. (2012). Using the Level of Service Inventory-Revised to improve assessment and treatment in drug court. *International Journal of Offender Therapy and Comparative Criminology, 56*(5), 769–789.

Gutierrez, L., & Bourgon, G. (2012). Drug treatment courts: A quantitative review of study and treatment quality. *Justice Research and Policy, 14*(2), 47–77.

Heck, C. (2008). MRT: Critical component of a local drug court program. *Cognitive Behavioral Treatment Review, 17*(1), 1–2.

Helmond, P., Overbeek, G., Brugman, D., & Gibbs, J.C. (2015). A meta-analysis on cognitive distortions and externalizing problem behavior: Associations, moderators, and treatment effectiveness. *Criminal Justice and Behavior, 42*(3), 245–262.

Henggeler, S.W., Halliday-Boykins, C.A., Cunningham, P.B., Randall, J., Shapiro, S.B., & Chapman, J.E. (2006). Juvenile drug court: Enhancing outcomes by integrating evidence-based treatments. *Journal of Consulting and Clinical Psychology, 74*(1), 42–54.

Hesse, M., Vanderplasschen, W., Rapp, R., Broekaert, E., & Fridell, M. (2007). Case management for persons with substance use disorders. *Cochrane Database of Systematic Reviews*, 4, CD006265.

Hickert, A.O., Boyle, S.W., & Tollefson, D.R. (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*(2), 149–162.

Hubbard, D.J., & Pealer, J. (2009). The importance of responsivity factors in predicting reductions in antisocial attitudes and cognitive distortions among adult male offenders. *Prison Journal, 89*(1),79–98.

Johnson, J.E., O'Leary, C.C., Striley, C.W., Abdallah, A.B., Bradford, S., & Cottler, L.B. (2011). Effects of major depression on crack use and arrests among women in drug court. *Addiction, 106*(7), 1279–1286.

Jones, C.G., Fearnley, H., Panagiotopoulos, B., & Kemp, R.I. (2015, June 18). Delay discounting, self-control, and substance use among adult drug court participants. *Behavioural Pharmacology: Online*.

Karno, M.P., & Longabaugh, R. (2007). Does matching matter? Examining matches and mismatches between patient attributes and therapy techniques in alcoholism treatment. *Addiction, 102*(4), 587–596.

Keefer, Q.A.W. (2013). Employment type and length of stay in substance abuse treatment: Economic factors and gender specific effects. *International Journal of Social Science Studies, 1*(2), 219–229.

Kilmer, B., & Sussell, J. (2014). *Does San Francisco's Community Justice Center reduce criminal recidivism?* Santa Monica, CA: RAND Corp. & Superior Court of California, County of San Francisco.

Kim, D., Irwin, K.S., & Khoshnood, K. (2009). Expanded access to naloxone: Options for critical response to the epidemic of opioid overdose mortality. *American Journal of Public Health, 99*(3), 402–407.

Kirby, K.C., Marlowe, D.B., Festinger, D.S., & LaMonaca, V. (1999). Community reinforcement training for family and significant others of drug abusers: A unilateral intervention to increase treatment entry of drug users. *Drug and Alcohol Dependence, 56*(1), 85–96.

Kirchner, R.A., & Goodman, E. (2007). Effectiveness and impact of Thurston County, Washington drug court program. *Cognitive Behavioral Treatment Review, 16*(2), 1–4.

Kissin, W.B., Tang, Z., Campbell, K.M., Claus, R.E., & Orwin, R.G. (2014). Gender-sensitive substance abuse treatment and arrest outcomes for women. *Journal of Substance Abuse Treatment, 46*(3), 332–339.

Knight, D.K., & Simpson, D.D. (1996). Influences of family and friends on client progress during drug abuse treatment. *Journal of Substance Abuse, 8*(4), 417–429.

Knight, K., Garner, B.R., Simpson, D.D., Morey, J.T., & Flynn, P.M. (2006). An assessment for criminal thinking. *Crime and Delinquency, 52*(1), 159–177.

Kushner, J.N., Peters, R.H., & Cooper, C.S. (2014). *A technical assistance guide for drug court judges on drug court treatment services*. Washington, DC: American University.

Lee, C.G., Cheesman, F.L., Rottman, D.B., Swaner, R., Lambson, S., Rempel, M., & Curtis, R. (2013). *A community court grows in Brooklyn: A comprehensive evaluation of the Red Hook Community Justice Center, Final Report*. Williamsburg, VA: National Center for State Courts.

Leukefeld, C., Webster, J.M., Staton-Tindall, M., & Duvall, J. (2007). Employment and work among drug court clients:12- month outcomes. *Substance Use & Misuse, 42*(7),1109–1126.

Liang, B., & Long, M.A. (2013). Testing the gender effect in drug and alcohol treatment: Women's participation in Tulsa County drug and DUI programs. *Journal of Drug Issues, 43*(3), 270–288.

Lidz, V., Sorrentino, D.M., Robison, L., & Bunce, S. (2004). Learning from disappointing outcomes: An evaluation of prevocational interventions for methadone maintenance patients. *Substance Abuse & Misuse, 39*(13–14), 2287–2308.

Linehan, M.M. (1996). Dialectical behavior therapy for borderline personality disorder. In B. Schmitz (Ed.), *Treatment of personality disorders* (pp. 179–199). Munich, Germany: Psychologie Verlags Union.

Linehan, M.M., Schmidt, H., Dimeff, L.A., Craft, J.C., Kanter, J., & Comtois, K.A. (1999). Dialectical behavior therapy for clients with borderline personality disorder and drug-dependence. American Journal of Addiction, 8(4), 279–292.

Lowenkamp, C.T., Hubbard, D., Makarios, M.D., & Latessa, E.J. (2009). A quasi-experimental evaluation of Thinking for a Change: A "real-world" application. *Criminal Justice & Behavior, 36*(2), 137–146.

Lowenkamp, C.T., Pealer, J., Smith, P., & Latessa, E.J. (2006). Adhering to the risk and need principles: Does it matter for supervision-based programs? *Federal Probation, 70*(3), 3–8.

Lutze, F.E., Rosky, J.W., & Hamilton, Z.K. (2014). Homelessness and reentry: A multisite outcome evaluation of Washington State's Reentry Housing Program for high risk offenders. *Criminal Justice and Behavior, 41*(4),471–491.

Magura, S., Staines, G.L., Blankertz, L., & Madison, E.M. (2004). The effectiveness of vocational services for substance users in treatment. *Substance Use & Misuse, 39*(13-14), 2165–2213.

Manchak, S.M., Sullivan, C.C., Schweitzer, M., & Sullivan, C.J. (2014). The influence of co-occurring mental health and substance use problems on the effectiveness of juvenile drug courts. *Criminal Justice Policy Review*.

Marlowe, D.B., & Wong, C.J. (2008). Contingency management in adult criminal drug courts. In S.T. Higgins, K. Silverman, & S.H. Heil (Eds.), *Contingency management in substance abuse treatment* (pp. 334–354). New York: Guilford Press.

Mateyoke-Scrivner, A., Webster, J.M., Staton, M., & Leukefeld, C. (2004). Treatment retention predictors of drug court participants in a rural state. *American Journal of Drug and Alcohol Abuse, 30*(3),605–625.

McLellan, A.T., Hagan, T.A., Levine, M., Gould, F., Meyers, K., Bencivengo, M., & Durell, J. (1998). Supplemental social services improve outcomes in public addiction treatment. *Addiction, 93*(10), 1489–1499.

McLellan, A.T., Hagan, T.A., Levine, M., Meyers, K., Gould, F., Bencivengo, M., Jaffe, J. (1999). Does clinical case management improve outpatient addiction treatment. *Drug and Alcohol Dependence, 55*(1–2),91–103.

Mendoza, N.S., Trinidad, J.R., Nochajski, T.H., & Farrell, M.C. (2013). Symptoms of depression and successful drugcourt completion. *Community Mental Health Journal, 49*(6), 787–792.

Messina, N., Calhoun, S., & Warda, U. (2012). Gender-responsive drug court treatment: A randomized controlled trial. *Criminal Justice and Behavior, 39*(12), 1539–1558.

Meyer, R., Patel, A.M., Rattana, S.K., Quock, T.P., & Mody, S.H. (2014). Prescription opioid abuse: A literature review of the clinical and economic burden in the United States. *Population Health Management, 17*(6),372–387.

Meyers, R.J., Miller, W.R., Hill, D.E., & Tonigan, J.S. (1998). Community reinforcement and family training (CRAFT): Engaging unmotivated drug users in treatment. *Journal of Substance Abuse, 10*(3),291–308.

Milkman, H., & Wanberg, K. (2007). *Cognitive-behavioral treatment: A review and discussion for corrections professionals*. Washington, DC: National Institute of Corrections.

Mills, K.L., Teesson, M., Back, S.E., Brady, K.T., Baker, A.L., Hopwood, S., Ewer, P.L. (2012). Integrated exposure-based therapy for co-occurring posttraumatic stress disorder and substance dependence: A randomized controlled trial. *Journal of the American Medical Association, 308*(7), 690–699.

Monchick, R., Scheyett, A., & Pfeiffer, J. (2006). *Drug court case management: Role, function, and utility* (Monograph Series no. 7). Alexandria, VA: National Drug Court Institute.

Morse, D.S., Cerulli, C., Bedell, P., Wilson, J.L., Thomas, K., Mittal, M.., Chin, N. (2014). Meeting health and psychological needs of women in drug treatment court. *Journal of Substance Abuse Treatment, 46*(2), 150–157.

Morse, D.S., Silverstein, J., Thomas, K., Bedell, P., & Cerulli, C. (2015). Finding the loopholes: A cross-sectional qualitative study of systemic barriers to treatment access for women drug court participants. *Health and Justice, 3*(12). doi:10.1186/s40352-015-0026-2.

Mueser, K.T., Noordsy, D.L., Drake, R.E., & Fox, L. (2003). *Integrated treatment for dual disorders: A guide to effective practice*. New York: Guilford Press.

National Institute on Drug Abuse (2014). Nora's Blog: Naloxone—A potential lifesaver. *Retrieved from* http://www.drugabuse.gov/about-nida/noras-blog/2014/02/naloxone-potential-lifesaver.

Osher, F., D'Amora, D.A., Plotkin, M., Jarrett, N., & Eggleston, A. (2012). *Adults with behavioral health needs under correctional supervision: A shared framework for reducing recidivism and promoting recovery*. New York: Council of State Governments Justice Center.

Peters, R.H., Haas, A.L., & Hunt, W.M. (2002). Treatment "dosage" effects in drug court programs. *Journal of Offender Rehabilitation, 33*(4), 63–72.

Peters, R.H. (2008). Co-occurring disorders. In C. Hardin & J.N. Kushner (Eds.), *Quality improvement for drug courts: Evidence-based practices* (Monograph Series no. 9, pp. 51–61). Alexandria, VA: National Drug Court Institute.

Peters, R.H., Haas, A.L., & Murrin, M.R. (1999). Predictors of retention and arrest in drug courts. *National Drug Court Institute Review, 2*(1), 33–60.

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, 30*(6), 800–820.

Peters, R.H., & Osher, F.C. (2004). *Co-occurring disorders and specialty courts* (2nd ed.). Delmar, NY: National GAINS Center.

Peters, R.H., Wexler, H.K., & Lurigio, A.J. (2015). Co-occurring substance use and mental disorders in the criminal justice system: A new frontier of clinical practice and research. *Psychiatric Rehabilitation Journal, 38*(1), 1–6.

Peterson, J.K., Skeem, J., Kennealy, P., Bray, B. & Zvonkovic, A. (2014). How often and how consistently do symptoms directly precede criminal behavior among offenders with mental illness? *Law and Human Behavior, 38*(5), 439–449.

Phillips, H.K., Gray, N.S., MacCulloch, S.I., Taylor, J., Moore, S.C., Huckle, P., & MacCulloch, M.J. (2005). Risk assessment in offenders with mental disorders: Relative efficacy of personal demographic, criminal history, and clinical variables. *Journal of Interpersonal Violence, 20*(7), 833–847.

Platt, J.J. (1995). Vocational rehabilitation of drug abusers. *Psychological Bulletin, 117*(3), 416–433.

Platt, J.J., Husband, S.D., Hermalin, J., Cater, J., & Metzger, D. (1993). A cognitive problem-solving employment readiness intervention for methadone clients. *Journal of Cognitive Psychotherapy, 7*(1),21–33.

Powell, C., Stevens, S., Dolce, B.L., Sinclair, K.O., & Swenson-Smith, C. (2012). Outcomes of a trauma-informed Arizona family drug court. *Journal of Social Work Practice in the Addictions, 12*(3),219–241.

Prendergast, M.L., Pearson, F.S., Podus, D., Hamilton, Z.K., & Greenwell, L. (2013). The Andrews' principles of risk, needs, and responsivity as applied in drug treatment programs: Meta-analysis of crime and drug use outcomes. *Journal of Experimental Criminology, 9*(3), 275–300.

Prins, S.J., Skeem, J.L., Mauro, C., & Link, B.G. (2015). Criminogenic factors, psychotic symptoms, and incident arrests among people with serious mental illnesses under intensive outpatient treatment. *Law and Human Behavior, 39*(2), 177–188.

Quirouette, M., Hannah-Moffat, K., & Maurutto, P. (2015). 'A precarious place': Housing and clients of specialized courts. *British Journal of Criminology*.doi:10.1093/bjc/azv050.

Rapp, R.C., Van Den Noortgate, W., Broekaert, E., & Vanderplasschen, W. (2014). The efficacy of case management with persons who have substance abuse problems: A three-level meta-analysis of outcomes. *Journal of Consulting and Clinical Psychology, 82*(4), 605–618.

Read, J.P., Brown, P.J., & Kahler, C.W. (2004). Substance use and posttraumatic stress disorders: Symptom interplay and effects on outcome. *Addictive Behaviors, 29*(8), 1665–1672.

Rezansoff, S.N., Moniruzzaman, A., Gress, C., & Somers, J.M. (2013). Psychiatric diagnoses and multiyear criminal recidivism in a Canadian provincial offender population. *Psychology, Public Policy, and Law, 19*(4), 443–453.

Ritsher, J.B., McKellar, J.D., Finney, J.W., Otilingam, P.G., & Moos, R.H. (2002). Psychiatric comorbidity, continuing care, and mutual help as predictors of five-year remission from substance use disorders. *Journal of Studies on Alcohol and Drugs, 63*(6), 709–715.

Robertson, A.A., St. Lawrence, J.S., & McCluskey, D.L. (2012). HIV/STI risk behavior of drug court participants. *Journal of Offender Rehabilitation, 51*(7), 453–473.

Rodriguez, P.F. (2011). Case management for substance abusing offenders. In C. Leukefeld, T.P. Gullotta & J. Gregrich (Eds.), *Handbook of evidence-based substance abuse treatment in criminal justice settings* (pp. 173–181). New York: Springer.

Roll, J.M., Prendergast, M., Richardson, K., Burdon, W., & Ramirez, A. (2005). Identifying predictors of treatment outcome in a drug court program. *American Journal of Drug and Alcohol Abuse, 31*(4), 641–656.

Roozen, H.G., De Waart, R., Van Der Kroft, P. (2010). Community reinforcement and family training: An effective option to engage treatment-resistant substance-abusing individuals in treatment. *Addiction, 105*(10), 1729–1738.

Ross, S. (2008). The mentally ill substance abuser. In M. Galanter & H.D. Kleber (Eds.), *Textbook of substance abuse treatment* (4th ed.) (pp. 537–554). Arlington, VA: American Psychiatric Publishing.

Sadeh, N., & McNiel, D.E. (2015). Posttraumatic stress disorder increases risk of criminal recidivism among justice-involved persons with mental disorders. *Criminal Justice and Behavior, 42*(6), 573–586.

Saladin, M.E., Back, S.E., Payne, R.A., Schumm, J., Goldsmith, R.J., & Chard, K.M. (2014). Posttraumatic stress disorder and substance use disorder comorbidity. In R.K. Ries, D.A. Fiellin, S.C. Miller & R. Saitz, *The ASAM principles of addiction medicine* (5th ed., pp. 1403–1417). Philadelphia: Wolters Kluwer.

Samenow, S. (2014). *Inside the criminal mind* (Rev. & upd. ed.). New York: Broadway Books.

Sartor, C.E., McCutcheon, V.V., O'Leary, C.C., Van Buren, D.J., Allsworth, J.E., Jeffe, D.B., & Cottler, L.B. (2012). Lifetime trauma exposure and posttraumatic stress disorder in women sentenced to drug court. *Psychiatry Research, 200*(2), 602–608.

Schaeffer, C.M., Henggeler, S.W., Chapman, J.E., Halliday-Boykins, C.A., Cunningham, P.B., Randall, J., & Shapiro, S.B. (2010). Mechanisms of effectiveness in juvenile drug court: Altering risk processes associated with delinquency and substance abuse. *Drug Court Review, 7*(1), 57–94.

Seligman, M.E.P. (1975). *Helplessness: On depression, development, and death*. New York: W.H. Freeman.

Serin, R.C., Lloyd, C.D., Helmus, L., Derkzen, D.M., & Luong, D. (2013). Does intra-individual change predict offender recidivism? Searching for the Holy Grail in assessing offender change. *Aggression and Violent Behavior, 18*(1), 32–53.

Shaffer, D.K. (2006). Reconsidering drug court effectiveness: A meta-analytic review (Doctoral dissertation, University of Cincinnati). *Retrieved from* https://etd.ohiolink.edu/ap:10:0::NO:10:P10_ACCESSION_NUM:ucin1152549096

Shannon, L.M., Jackson, A., Newell, J., Perkins, E., & Neal, C. (2015). Examining factors associated with treatment completion in a community-based program for individuals with criminal justice involvement. *Addiction Science and Clinical Practice, 10*(Supp. 1), A60.

Smith, P., Gendreau, P., & Swartz, K. (2009). Validating the principles of effective intervention: A systematic review of the contributions of meta-analysis in the field of corrections. *Victims & Offenders, 4*(2), 148–169.

Somers, J.M., Moniruzzaman, A., Rezansoff, S.N., & Patterson, M. (2014). Examining the impact of case management in Vancouver's Downtown Community Court: A quasi-experimental design. *PLoS One, 9*(3), e90708. doi:10.1371/journal.pone0090708

Spaulding, A.C., Seals, R.M., Page, M.J., Brzozowski, A.K., Rhodes, W., & Hammet, T.M. (2009). HIV/AIDS among inmates of and releasees from US correctional facilities, 2006: Declining share of epidemic but persistent public health opportunity. *PLoS One, 4*(11), e7558. doi:10.1371/journal.pone0007558

Steadman, H.J., Peters, R.H., Carpenter, C., Mueser, K.T., Jaeger, N.D., Gordon, R.B., Hardin, C. (2013). Six steps to improve your drug court outcomes for adults with co-occurring disorders. *NDCI Drug Court Practitioner Fact Sheet, 8*(1),1–27.

Strang, J. (2015). Death matters: Understanding heroin/opiate overdose risk and testing potential to prevent deaths. *Addiction, 110*(S2), 27–35.

Strang, J., Bird, S.M., Dietze, P., Gerra, G., & McLellan, A.T. (2014). Take-home emergency naloxone to prevent deaths from heroin overdose. *British Medical Journal, 349*, g6580. doi:10.1136/bmjg6580

Strang, J., Kelleher, M., Best, D., Mayet, S., & Manning, V. (2006). Emergency naloxone for heroin overdose: Should it be available over the counter? *British Medical Journal, 333*(7569), 614–615.

Substance Abuse and Mental Health Services Administration. (2010). *Integrated treatment for co-occurring disorders: Evidence-based practices (EBT) KIT*. Rockville, MD: Author. Available at http://store.samhsa.gov/product/SMA08-4367

Tolou-Shams, M., Houck, C.D., Nugent, N., Conrad, S.M., Reyes, A., & Brown, L.K. (2012). Alcohol use and HIV risk among juvenile drug court offenders. *Journal of Social Work Practice in the Addictions, 12*(2), 178–188.

Tong, L.S.J., & Farrington, D.P. (2006). How effective is the "Reasoning and Rehabilitation" programme in reducing reoffending? A meta-analysis of evaluations in four countries. *Psychology, Crime & Law, 12*(1), 3–24.

Turpin, D., & Wheeler, G. (2012). *HEAT: Habilitation, Empowerment, Accountability Therapy*. Louisville, KY: Pinwheel Group.

Underhill, K., Dumont, D., & Operario, D. (2014). HIV prevention for adults with criminal justice involvement: A systematic review of HIV risk-reduction interventions in incarceration and community settings. *American Journal of Public Health, 104*(11), e27–e53. doi:10.2105/AJPH.2014.302152

Ventura, A.L., & Lambert, E.G. (2004). Recidivism 12 months after TASC. *Journal of Offender Rehabilitation, 39*(1),63–82.

Vieira, T.A., Skilling, T.A., & Peterson-Badali, M. (2009). Matching court-ordered services with treatment needs: Predicting treatment success with young offenders. *Criminal Justice and Behavior, 36*(4), 385–401.

Viglione, J., Rudes, D.S, & Taxman, F.S. (2015). Misalignment in supervision: Implementing risk/needs assessment instruments in probation. *Criminal Justice and Behavior, 42*(3),263–285.

Vito, G.F., & Tewksbury, R.A. (1998). The impact of treatment: The Jefferson County (Kentucky) drug court program. Fe*deral Probation, 62*(2), 46–51.

Vose, B., Smith, P., & Cullen, F.T. (2013). Predictive validity and the impact of change in total LSI-R score on recidivism. *Criminal Justice and Behavior, 40*(12), 1383–1396.

Walters G.D. (2003). Predicting institutional adjustment and recidivism with the Psychopathy Checklist factor scores: Ameta-analysis. *Law and Human Behavior, 27*(5),541.

Walters, G.D. (2015). Recidivism and the "worst of both worlds" hypothesis: Do substance misuse and crime interact or accumulate? *Criminal Justice and Behavior, 42*(4), 435–451.

Wilson, D.B., Gallagher, C.A., & MacKenzie, D.L. (2000). A meta-analysis of corrections-based education, vocation, and work programs for adult offenders. *Journal of Research in Crime and Delinquency, 37*(4), 347–368.

Winn, J.L., Shealy, S.E., Kropp, G.J., Felkins-Dohm, D., Gonzales-Nolas, C., & Francis, E. (2013). Housing assistance and case management: Improving access to substance use disorder treatment for homeless veterans. *Psychological Services, 10*(2), 233– 240.

Wooditch, A., Tang, L.L., & Taxman, F.S. (2014). Which criminogenic need changes are most important in promoting desistance from crime and substance use? *Criminal Justice and Behavior, 41*(3), 276–299.

Wright, J.P., & Cullen, F.T. (2004). Employment, peers, and life-course transitions. *Justice Quarterly, 21*(1), 183–205.

Yalom, I.D., & Leszcz, M. (2005). The theory and practice of group psychotherapy (5th ed.). New York: Basic Books. Young, D., & Belenko, S. (2002). Program retention and perceived coercion in three models of mandatory drug treatment. *Journal of Drug Issues, 32*(1), 297–328.

Zweig, J.M., Lindquist, C., Downey, P.M., Roman, J.K., & Rossman, S.B. (2012). Drug Court policies and practices: How program implementation affects offender substance use and criminal behavior outcomes. *Drug Court Review, 8*(1), 43–79