



Drug Courts Resource Series

Treatment Services in Adult Drug Courts

Report on the 1999 National Drug Court Treatment Survey

Prepared by National TASC



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Report on the 1999 National Drug
Court Treatment Survey

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National Treatment Accountability for Safer Communities
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and the
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Executive Summary

In October 1999, National TASC (Treatment Accountability for Safer Communities), in cooperation with the Office of Justice Programs, Drug Courts Program Office and the Substance Abuse and Mental Health Services Administration, Center for Substance Abuse Treatment, developed and distributed a questionnaire designed to describe substance abuse treatment services and other treatment services currently used by adult drug courts and to identify significant issues faced by adult drug courts in obtaining and delivering high-quality comprehensive treatment services. Surveys were distributed to 263 operating adult drug courts, and 212 courts (81 percent) responded.

Background

The use of illicit drugs and alcohol is a central factor in the soaring rate of incarceration in the United States. The Bureau of Justice Statistics (1998, 1999c) estimates that two-thirds of Federal and State prisoners and probationers could be characterized as drug involved. Substance abuse treatment has been shown to reduce substance abuse and criminal activity of substance-involved offenders. Drug courts offer a mechanism to provide access to treatment for substance-involved offenders while minimizing the use of incarceration by means of a structure for integrating treatment with justice supervision.

Drug courts operate within the context of larger justice and treatment systems. Thus, they depend on the quality and quantity of services and resources that exist within their local communities. At the same time, drug courts have raised awareness about the treatment and other needs of substance-involved offenders. The courts have served as a catalyst to modify traditional service delivery paradigms and develop more effective strategies for this population. Although drug courts can (and should) influence and inform their communities about their participant populations, the responsibility for financing, managing, and allocating treatment services generally rests with executive agencies. Consequently, the results of this survey must be examined with the understanding that drug courts do not operate in a vacuum but, rather, operate in a political and cultural climate over which they may have limited control.

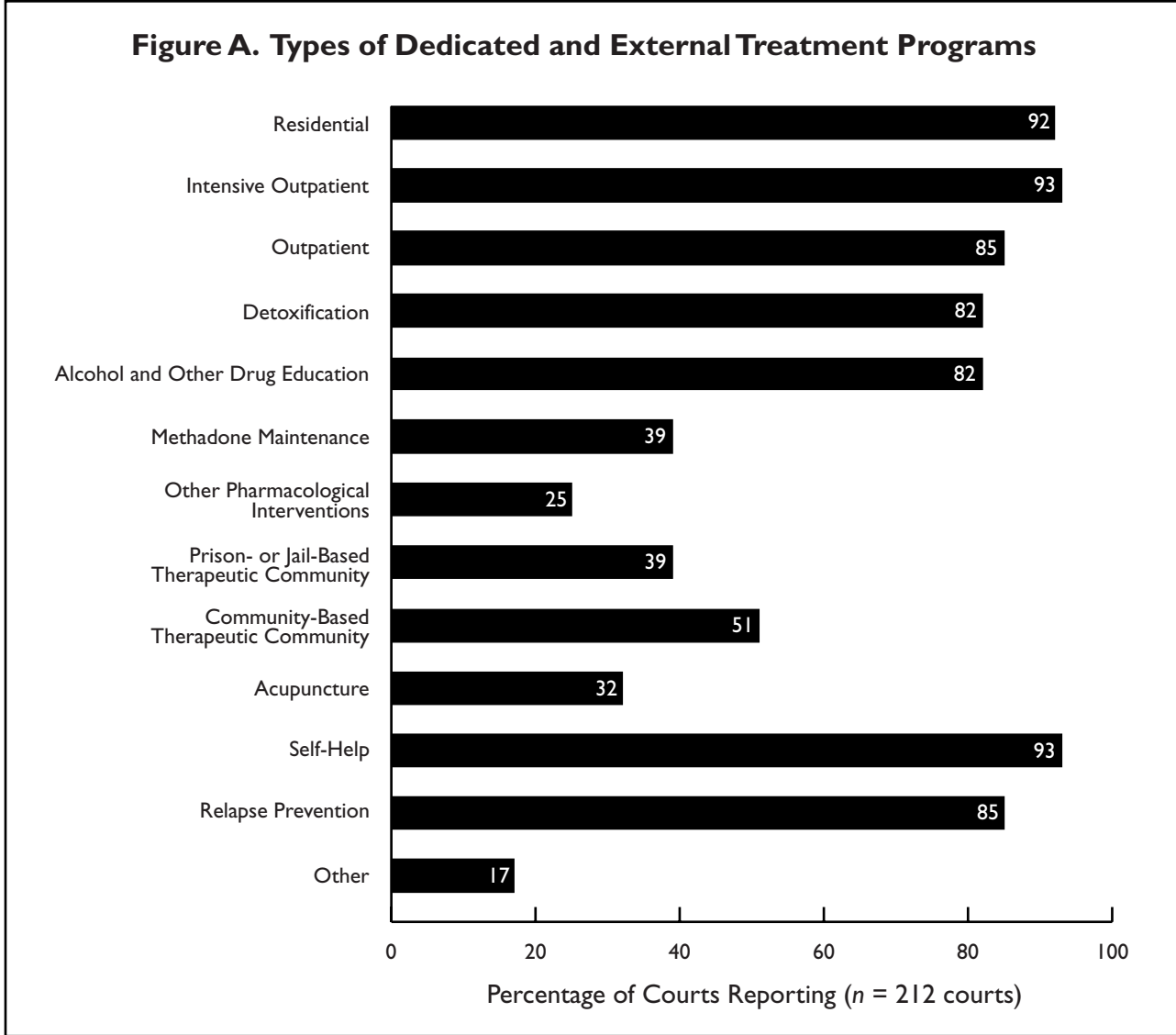
Major Findings

The results of this national survey show clearly that treatment services designed for and used by drug courts comport with scientifically established principles of treatment effectiveness. Overall, the structure of drug court treatment is consistent with the principles established by the National Institute on Drug Abuse (1999) and is delivered according to the Drug Court Key Components and related Performance Benchmarks (Office of Justice Programs, 1997). The standards promulgated in these documents present succinct descriptions of treatment delivery methods that have been effective with offender and other populations and serve as a guide to present survey findings in the context of effective professional practices.

Drug court populations have shifted since drug courts began their proliferation in the early 1990s. The majority of drug courts report that they include adjudicated offenders in their target populations, either exclusively or in addition to diverting low-level and first-time offenders from further justice processing. Adult drug court participants include both felony and misdemeanor offenders, including offenders with drug charges, drug-related offenses, and probation violations. More than 60 percent of drug courts report that they exclude participants with minimal substance involvement and that they reserve drug court slots for participants whose substance abuse and related criminal activity are severe enough to warrant significant interventions. Since drug courts that receive Federal funds are prohibited from admitting offenders with current or prior violent felony convictions, almost all drug courts exclude violent offenders, as demonstrated by the survey findings.

More than a quarter (27 percent) of drug courts have fewer than 50 participants in their program, 42 percent have between 50 and 150 participants, and 31 percent have more than 150 participants. Almost all drug courts report being at or under their stated capacity. Drug courts that were selected for followup interviews report limiting admissions based on availability of treatment and court staff (including judicial staff).

A broad continuum of primary treatment services is available to drug courts (see figure A). Most drug courts report having access to residential (92 percent), intensive outpatient (93 percent), and regular outpatient (85 percent) treatment, and almost all drug courts (93 percent) encourage or require participation in self-help activities, such as Alcoholics Anonymous or Narcotics Anonymous. Almost two-thirds (64 percent) of the courts report that they can provide eight or more treatment interventions. These findings suggest that most drug courts have access to a broad continuum of care.

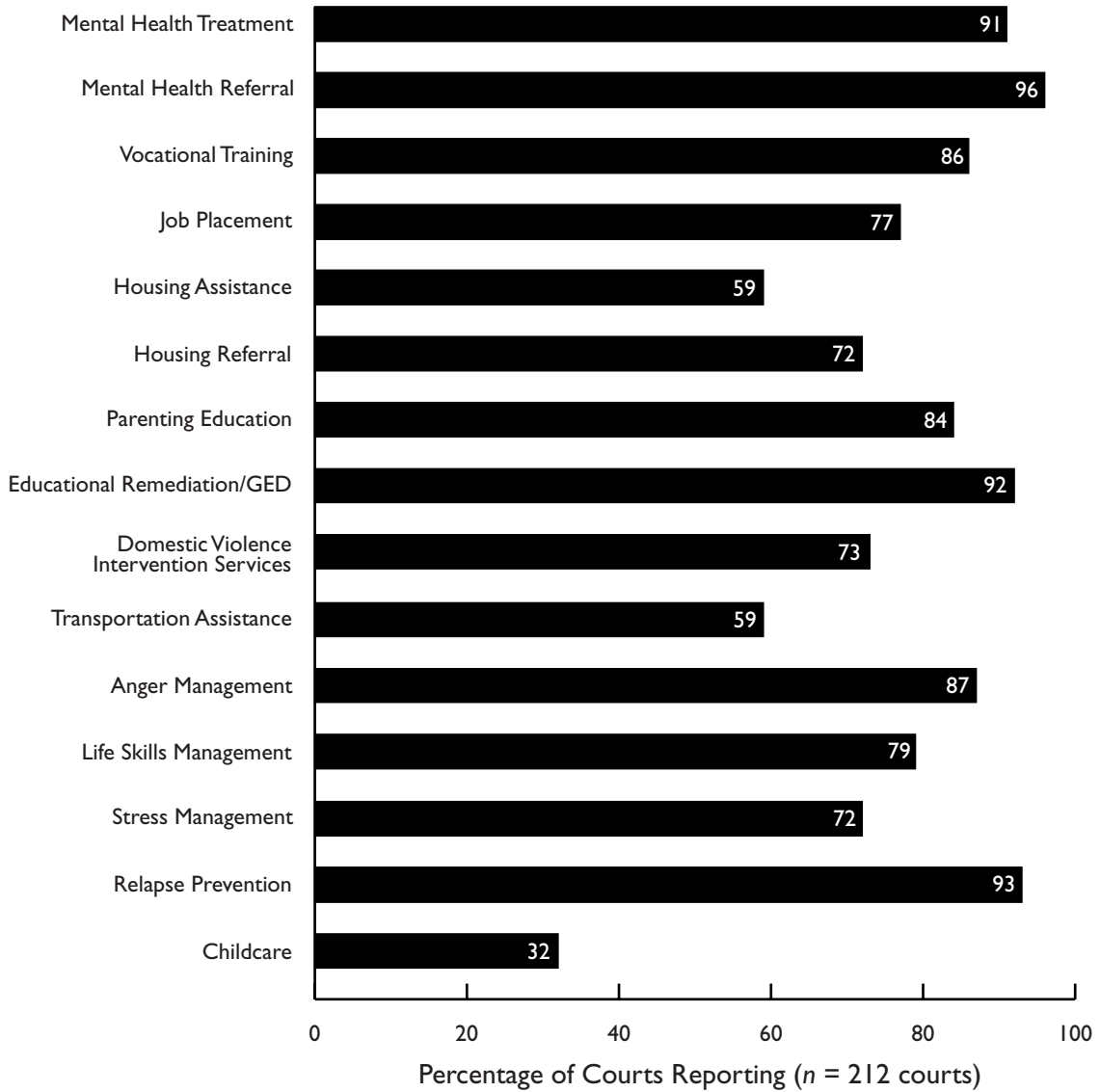


A significant proportion (58 percent) of drug courts report that they can provide culturally competent programming, and 77 percent report that gender-specific and women-only programs are available.

A number of support services are also available to drug courts (see figure B), including the following:

- Mental health treatment (91 percent).
- Capacity to refer to mental health treatment (96 percent).
- Educational remediation/general equivalency diploma (GED) (92 percent).


Figure B. Support Services Available to Program Participants



- Vocational training (86 percent).
- Relapse prevention programming (93 percent).

However, some services that are essential for some clients are less frequently available from drug courts:

- Housing assistance (59 percent).
- Transportation assistance (59 percent).
- Childcare (32 percent).



The greatest frustrations described by drug courts include limited access to residential treatment, treatment for mental health disorders, and specialized services for women, racial and ethnic minorities, and the mentally ill. Problems with client engagement and retention in treatment are also identified. Followup interviews with a sample of respondents suggest that, while services may be available, they may be limited in quantity or otherwise very difficult to access.

Most drug courts report having dedicated services or slots for participants in addition to using services that are external to the drug court program for some participants. Drug courts generally report that their dedicated and external providers meet State or local licensing requirements.

The survey findings indicate that providers dedicated to drug courts use cognitive behavioral approaches and address criminal thinking to a greater extent than external providers. This suggests that dedicated providers are more likely than external service providers to use treatment strategies that address the specific criminal rehabilitation needs of the various offender populations.

Drug courts have informal relationships established with both dedicated and external providers. Thirty-eight percent of drug courts contract for services directly, although 41 percent report participating in decision-making regarding treatment policies and procedures. Fifty percent of drug courts have no formal agreements with external, or nondedicated, treatment providers.

Screening and clinical assessments are routinely conducted in drug courts to identify needs of participants. Drug courts report that screening, assessing, and determining drug court eligibility occur quickly, and most participants are able to enter treatment less than 2 weeks after drug court admission. However, not all drug courts use screening or assessment instruments that have proved reliable and valid, and some do not appear to use appropriate clinically trained staff to conduct assessments.

Objective, professionally accepted criteria and tools are not uniformly used to make treatment placement decisions. Thirty-four percent of drug courts use the American Society of Addiction Medicine Patient Placement Criteria (ASAM-PPC-II). Seventy-four percent of drug courts report that clinical judgment is used to determine the level of care to which participants are assigned, and 51 percent report using clinical judgment only. Most placement decisions are made with input from both justice and treatment professionals, although 74 percent of drug courts indicate the judge can override a clinical recommendation and require program admission.

Drug courts are experiencing a variety of difficulties related to engaging and retaining clients in treatment and clients who are deemed “unmotivated.” Fifty-nine percent of drug courts indicate that “lack of motivation for treatment” is used as a criterion to exclude people from drug court admission. Fifty-six percent of drug courts report that participants are discharged early from treatment because they have a poor attitude or lack motivation. Other reasons for early discharge from treatment include failure to appear in court (59 percent), failure to engage in treatment (70 percent), and missing too many treatment appointments (64 percent).


Most drug courts require participants to be engaged in treatment services for at least 12 months and report using a phased approach, whereby intensive treatment¹ is conducted for the first 3–4 months, followed by less intensive treatment and aftercare.

Counseling interventions (group and individual) are a primary component of drug court treatment, and drug courts report that the majority of counselors in their dedicated and external programming meet State or local licensing or certification requirements. Survey results suggest that counselors in dedicated programs receive more information and training on issues related to criminal justice populations than counselors in external programs.

A number of mechanisms in drug courts continually assess client progress, including drug and alcohol testing, case management, and regular status hearings. Drug courts have implemented a variety of responses, including sanctions and incentives, to modify treatment plans and encourage participant compliance.

Case management services are provided by a wide range of justice and treatment professionals, and the primary functions of case management are well covered. However, most drug courts rely primarily on existing treatment or justice staff for these services. Few drug courts report using objective third-party clinical case managers. This approach can be problematic if philosophical orientation or agency allegiance is too strong in the direction of either justice or treatment.

There appears to be a wide recognition by drug courts that participants may suffer from mental disorders, including co-occurring substance abuse and mental health problems. Sixty-one percent of drug courts report screening for mental health problems. Very few drug courts use a scientifically validated instrument to screen for mental health problems, although it appears that most drug courts refer participants to mental health professionals for clinical assessments. Thirty-seven percent of drug courts report that the presence of a mental disorder is used to exclude people from admission to drug court.



Drug courts report having fairly limited access to methadone maintenance (39 percent) or other pharmacological interventions such as naltrexone (25 percent). Detoxification services are available to 82 percent of drug courts, which use the services in conjunction with additional treatment interventions, not as primary treatment.

Most drug courts do not currently have management information systems to track clients through all drug court processes or to conduct outcome evaluations. Most use client tracking systems designed for microprocessors, and drug court data are not tied into larger justice or treatment management information systems.

Policy Considerations

As the number of drug courts continues to grow, and as the process of integrating substance abuse treatment and criminal justice case processing continues to evolve, the drug court field is confronted with many challenges. Some of these challenges have been identified by this survey and raise issues that must be considered to establish policies consistent with the goal of dealing more effectively with the devastating impact of drugs and drug-related crime. Following are six policy considerations that have emerged as a result of the responses to this survey and a discussion of the implications of each proposed policy for drug courts.

Policy Consideration #1: Drug courts should establish and formalize more effective linkages with local service delivery systems and State and local alcohol and drug agencies.

Most drug courts do have **dedicated** services, generally outpatient, that are tied directly to the drug court program. In addition, all drug courts report using **external** services, services that are available in the mainstream treatment system, for some or all of their participants. Therefore, drug court treatment extends beyond the boundaries of the drug court program itself.

However, the relationship of drug courts to local treatment components does not appear to be well structured. Drug courts have relatively informal relationships with both dedicated and external service providers. Thirty-eight percent of drug courts contract directly for dedicated services, and 23 percent participate in contract development but do not hold funds. Forty-one percent participate in the development of policies and procedures related to treatment, but 13 percent have no formal agreements with their dedicated providers. Eleven percent of drug courts have established qualified service organization agreements with dedicated providers, and 28 percent have memorandums of understanding or other formal agreements in place with dedicated providers.

Fifty percent of drug courts have no formal relationships with external service delivery providers, and few participate in decisionmaking related to treatment policies and procedures. Survey results clearly indicate that all drug courts are dependent on accessing services through local treatment and other service delivery agencies but have not succeeded in formalizing these linkages. In addition, some drug courts are unable to provide a full continuum of services to participants either because the services do not exist in the community or because the drug court has difficulty accessing them.

Implications for drug courts:

Drug courts should focus on establishing linkages with various State and local service delivery agencies and should dedicate resources to formalize and manage these relationships. Treatment administrators, including State and county substance abuse authorities (e.g., single State alcohol and other drug agencies, or SSAs), often have responsibility for contracting with service providers and have considerable expertise designing and monitoring the delivery of treatment services. Collaboration with agencies that have the primary responsibility for funding and managing treatment services can help drug courts clarify their needs and goals, as well as augment current services. In addition, this collaboration can help emphasize why drug court participants should receive a high priority for receiving services. SSA directors and other high-level administrators can help drug courts design service systems and can provide support to drug courts in monitoring and managing treatment services. In addition, treatment administrators can help identify additional funding sources for treatment acquisition, can help drug court participants access medical and behavioral health benefits, and may be able to provide needed education and training for drug court professionals.

TASC programs exist in many communities across the country, and some are integrated with drug courts. One of the hallmarks of TASC is the development and continual updating of written agreements between justice and treatment systems. Drug courts can receive assistance from TASC to develop qualified service organization agreements and memorandums of agreement or understanding to clarify roles, responsibilities, and relationships with both dedicated and external treatment providers, as well as other service providers. These agreements can serve as a basis for continual dialog and program improvements.

Finally, drug courts should advocate for the benefits of collaborative efforts between justice and treatment systems. Close collaboration substantially improves outcomes for participants in terms of reduced substance abuse and reduced criminal activity. Providers need to

understand the benefits of working with drug court and other justice clients, including increased retention so that counselors can use their expertise and knowledge, support through justice leverage, increased client participation, and potentially increased revenues.

Policy Consideration #2: States and localities should explore the development of drug court treatment standards.

Although most drug courts require treatment providers and counselors to meet State and local licensing requirements as a minimum standard for providing services to drug court participants, they also recognize that State or local licensing standards may be inappropriate or insufficient to ensure the adequate provision of services for drug court participants or other offender clients. Cognitive behavioral and social learning models have been demonstrated to be effective in changing the behavior of offenders. Additionally, confronting criminal thinking patterns and teaching offenders problem-solving skills, socialization, prosocial values, and the restructuring of thoughts and actions have proved effective in reducing recidivism (Office of National Drug Control Policy, 2000). Drug courts have incorporated these methods into their programming to a greater extent than the mainstream treatment system.

Drug court treatment primarily consists of individual and group counseling. Outpatient drug court treatment may be supplemented by residential treatment when needed and by a number of additional requirements designed to hold participants accountable. These additional activities may include frequent alcohol and drug testing, reporting to case managers and/or probation officers, attending frequent court status hearings, and participating in other services designed to improve skills and promote social competency and productivity. States and localities should consider establishing drug court treatment standards that recognize that these other activities are essential therapeutic components to achieve positive outcomes for drug court participants.

Drug courts should continue to work toward treatment standards even though the cost restraints of managed care may limit the range and availability of services. It is unlikely that the level and intensity of services required for drug court participants will be supported by managed care. Pressures to reduce treatment expenditures and manage costs associated with Medicaid are driving States to shorten lengths of stay in treatment and increasing the thresholds for admission to intensive treatment.

Implications for drug courts:

Providers, case managers, and substance abuse administrators should work together to deliver services that are most appropriate for drug

court participants. Drug court professionals should stay abreast of the research findings related to effective treatment strategies for justice clients and make sure that policymakers and funders are aware of these findings.

As drug courts proliferate in States and in local jurisdictions, efforts should be made to develop criteria and standards to delineate the components of effective treatment for drug court participants and other offender clients. Traditional treatment criteria simply may not be adequate for treatment delivered in drug courts and other justice system venues.

Those who develop licensing and certification standards should be aware of the clinical techniques that have proved effective for offender clients and of the contribution that nonclinical services can make to positive outcomes. These strategies and techniques should be considered when licensing programs that work primarily with offender clients.

To ensure a full range of appropriate services for participants, drug courts often must supplement core treatment services (services eligible for reimbursement under managed care) with pretreatment, alcohol and other drug testing, case management, and continuing care activities. The St. Louis drug court has developed a comprehensive network of services using managed care principles and blending funds from treatment and justice (Alcoholism and Drug Abuse Weekly, 1999). This type of funding and service model may be of interest to other drug courts attempting to develop and fund a treatment network.

Policy Consideration #3: Drug court professionals and drug court treatment providers need skill-based training and technical assistance to improve engagement and retention of participants.

Responses to the survey across several topic areas indicate that drug courts are struggling with engaging and retaining participants in treatment. Fifty-nine percent of drug courts indicate that lack of motivation for treatment is used as a criterion to exclude people from drug court admission. Fifty-six percent report that participants are discharged early from treatment because they have a poor attitude or lack motivation. Other reasons for early discharge from treatment include failure to appear in court (59 percent), failure to engage in treatment (70 percent), and missing too many treatment appointments (64 percent). Drug court judges and coordinators ranked improving staff skills to engage and retain drug court participants in treatment as the most needed improvement in the court's treatment component.

Implications for drug courts:

Because drug courts can impose sanctions as leverage and provide incentives as encouragement, they can provide the structure to achieve positive results with treatment-resistant clients. Lack of motivation by drug-addicted offenders, short of participants' refusal to enter the program, should be seen as a challenge rather than a justification for excluding or discharging participants. Enhancing the skills of both justice and treatment practitioners may help reduce dropout and treatment discharge rates and improve outcomes.

In addition, a number of studies have shown that case management is effective in retaining clients in treatment. According to Marlatt et al. (1997), case management can also encourage entry into treatment and reduce the time to treatment admission. Case management may be an effective adjunct to substance abuse treatment because (1) case management focuses on the whole individual and stresses comprehensive assessment, service planning, and service coordination to address multiple aspects of a client's life; and (2) a principal goal of case management is to keep clients engaged in treatment and moving toward recovery and independence (Center for Substance Abuse Treatment, 1998b). Studies of TASC case management programs have indicated that TASC clients remain in treatment longer than non-TASC clients, with better posttreatment success (Inciardi and McBride, 1991; Longshore et al., 1998; Hubbard et al., 1989; Hepburn, 1996).

When dealing with drug court participants or other justice clients, treatment providers must strengthen their skills regarding motivational counseling. Justice clients rarely come into treatment because they want to be there. Treatment providers must be able to overcome client resistance and motivate clients to remain in treatment and achieve a drug-free lifestyle. Treatment providers and other drug court professionals also must be aware of new treatment technologies that may improve retention rates of the drug court population. For example, Project MATCH (National Institute on Alcohol Abuse and Alcoholism, 1999) indicates that new technologies like motivational enhancement therapy and other nonconfrontational approaches may work well with this population.

Influencing the delivery of treatment services via treatment network development also supports client engagement and retention. Treatment needs to be available to capitalize on motivational opportunities created by drug courts. In addition, culturally competent approaches, strength-based counseling, gender-specific programming, and more emphasis on wraparound services (job preparation, job placement,

GED tutoring, childcare, domestic violence counseling, etc.) may all improve retention rates and outcomes for certain drug court populations.


Policy Consideration #4: Drug courts should improve the methods and protocols for screening, assessing, and placing participants in treatment.

Survey results indicate that drug courts routinely conduct screening and clinical assessments to identify the treatment and other service needs of participants and to determine eligibility. Drug courts report that screening, assessing, and determining drug court eligibility occur fairly quickly, with most participants entering treatment in less than 2 weeks from admission to the drug court program. However, not all drug courts use screening or assessment instruments that are proved to be reliable and valid. Additionally, some drug courts indicate that they do not use appropriately trained clinical staff to conduct assessments.

Objective, professionally accepted criteria and tools are not uniformly used by drug courts to make treatment placement decisions. Thirty-four percent of drug courts use ASAM–PPC–II. Seventy-four percent report that clinical judgment is used to determine the level of care to which participants are assigned, and 51 percent report using clinical judgment only.

Implications for drug courts:

Screening and assessment in drug courts should be structured to more closely adhere to methods and instruments that have been supported by research. Improvements in this area will also lead to greater transferability of information among and about drug courts. The survey reveals considerable inconsistencies among drug courts in terms of screening and assessment instruments and levels of treatment services, indicating wide variation regarding the substance use severity of participants, as well as the methods for addressing substance abuse. Developing standard definitions and using standardized assessments and rational protocols for addressing substance use in drug courts will enable evaluators and policymakers to better assess the effectiveness of drug courts and suggest and provide support for program improvement. A number of publications by the Center for Substance Abuse Treatment describe appropriate screening and assessment instruments and methods (see Treatment Improvement Protocols (TIPs) 3, 7, and 11), and the Drug Courts Program Office published a *Guide for Drug Courts on Screening and Assessment* (Peters and Peyton, 1998). These documents provide guidance on conducting screening and assessment and provide information (and copies, in some cases) on screening and assessment instruments that have proved effective and are available at low or no cost.



The Addictions Severity Index is the most widely used instrument for assessing substance abuse treatment and other needs of adults; it is in the public domain and, thus, free of charge. A number of screening instruments were examined by Peters et al. (2000) for their appropriateness with justice system populations. The Simple Screening Instrument, also in the public domain, proved highly reliable for use with adult offenders.

The importance of consistent and appropriate participant placement criteria is described in Center for Substance Abuse Treatment TIP 13, *The Role and Current Status of Patient Placement Criteria in the Treatment of Substance Use Disorders*. In addition, ASAM-PPC-II is available from the American Society of Addiction Medicine and should be available through most State alcohol and other drug agencies.

Policy Consideration #5: Drug courts should implement effective management information systems to monitor program activity and improve operations.

The survey indicates that most drug courts do not have management information systems that are capable of tracking participants through all drug court processes or that are adequate to support outcome evaluations. Most drug courts use client tracking systems designed for microprocessors, and drug court data are not tied in with larger justice or treatment management information systems. Although 43 percent of drug courts indicate that they have conducted outcome evaluations, most drug courts report that they are unable to obtain needed information in a format that would allow them to assess ongoing program results.

Implications for drug courts:

Drug courts need to have good management information systems in place to demonstrate program effectiveness, make ongoing operational improvements, and secure scarce resources. The technology exists to develop integrated data systems that can be used to support decisionmaking in drug courts and to support criminal justice and treatment systems and policymakers.

Drug courts should advocate for adequate budgets to cover the costs of automated management information systems, and funders and policymakers should be encouraged to support the development of good information systems for drug courts. Drug courts need the support of judicial, executive, and legislative organizational entities to thrive and continue to improve.


A number of drug court information systems have been developed with Federal support, and commercial products are available. The Buffalo/Jacksonville system is an ACCESS-based PC system. The New York City Treatment Drug Court system is tied to the State criminal justice system and provides client tracking, progress, and outcome information. The State of Delaware is implementing a drug court system that takes case information from the court's automated system and adds information from case managers and treatment providers through secure Internet connections. This system enables any number of agencies to partner with the drug court and makes client activities and status reports available to the court on a real-time basis. Information systems that have been developed in the public domain can be viewed at www.drugcourtech.org.

Policy Consideration #6: To achieve greater impact within the communities they serve, drug courts should strive to expand capacity and demonstrate that they are integral to the justice and substance abuse treatment systems.

Most drug courts work with relatively small populations. Approximately 75 percent of survey respondents report working with fewer than 150 participants. In addition, nearly all drug courts report being at or under their stated capacity. Factors related to capacity are complex and are usually tied to local or Federal restrictions on eligibility criteria, lack of treatment capacity, lack of personnel resources (including judicial time), and other issues. As a result of such challenges, drug courts often are not able to meet their capacity and consequently are having a limited impact on the problems that substance-involved offenders create in the overall justice system and in the community. Another complicating factor relating to drug court capacity is the lack of integration of the drug court approach into existing justice and substance abuse treatment systems. Even though drug courts have expanded from serving less serious adult offenders to working with juveniles, adults charged with drug-related criminal and civil offenses, DUI offenders, and more serious offenders with more complex needs for services, full integration of the drug court approach is limited to a few jurisdictions. In San Bernardino, CA, Las Vegas, NV, Ft. Lauderdale, FL, Denver, CO, and Minneapolis, MN, the drug court approach is applied to all drug and drug-related cases. There are many challenges to meet to achieve acceptance of the drug court approach, stable funding, and integration of drug courts into the mainstream justice and substance abuse treatment systems.

Implications for drug courts:

Drug courts need to systematically examine all issues related to eligibility and capacity in an effort to determine whether and how these



issues are preventing them from reaching as many potential participants as possible. Are the eligibility requirements too stringent, screening out more participants than are screened into the program? If the eligibility criteria are inclusive, are they being applied fairly? Is there a lack of treatment capacity in the community, and, if so, can the drug court partner with other community-based agencies and organizations to increase the availability of and access to treatment and other collateral services? Is the drug court willing and/or able to commit the necessary resources—in funds and staff—to reach its full capacity or to expand its capacity?

Beyond accepting more participants into the drug court program, drug courts need to look at related issues such as the management and staffing necessary to support an expanded program. Since many drug courts operate with existing staff or have added only a single drug court coordinator or case manager, drug courts will likely need to support additional staff to manage the activities related to expanded populations. Working with larger populations may also require additional judicial staff, and some drug courts have addressed this issue by assigning court commissioners or other qualified persons to fulfill some traditional duties of drug court judges.

To gain acceptance and integration of the drug court approach into the mainstream justice and treatment systems, there must be continued concrete efforts to gain support within the justice system and the wider community. Drug courts need to look beyond the core drug court team (judge, prosecutor, treatment provider, defense counsel, coordinator) to other agencies and organizations that can be helpful in planning for and sustaining increased capacity and services. These might include local health and mental health departments, local social service agencies, State alcohol and other drug agencies, probation departments, schools and colleges, local sheriff or police departments, local departments of corrections, community organizations, business leaders, media, and leaders in the faith community.

Efforts must be made to educate judges, justice system personnel, State and local policymakers, the media, and the general public so that there is a clear understanding of drug court concepts, operations, and successes. Similar outreach and education must be extended to substance abuse treatment providers, health officials, and others involved in substance abuse issues so that drug court treatment is seen as closely linked to overall efforts to reduce substance abuse within the community. Results of national and local evaluations must be shared widely, as they become available, to help demonstrate that drug courts are effective. In addition, drug courts can carefully track offender outcomes within their own programs.

To ensure that drug courts continue to follow best practices and produce the best outcomes, drug court professionals must maintain high professional standards by continuing to examine current practice and by developing more tools for continuing education.

Future Research Possibilities

The survey results identify a number of areas for future research, including the following:

- Examination of the actual use of available treatment services.
- Clarification and standardization of treatment and other terminology in drug courts.
- Analysis of the relationship between drug courts and the larger treatment and justice systems, with a focus on developing strategies for integrating drug courts into mainstream funding and decisionmaking cycles.

Conclusion

Drug courts represent a significant collaboration of the justice system, treatment systems, and other partners. This spirit of cooperation, which strengthens the effectiveness and options of all partners, would be even more beneficial if it were carried through to broader systems.

Drug courts can partner with treatment providers and administrators, TASC programs, and other offender management efforts to generate sufficient resources and support at the local, State, and national levels to incorporate drug court activities into a larger strategy for managing substance-involved justice populations. This movement will provide the foundation for an effective, community-based strategy to reduce the drug use and criminal activity of the significant numbers of substance-involved offenders that are burdening our systems and our society.

Drug courts have demonstrated considerable success, and policymakers have been quick to respond to this success by replicating and supporting this model. However, results of this survey indicate that drug courts can be more successful and attain greater impact by continuing to improve operations and expand to larger and more significant populations. Attaining the full potential of drug courts will require continued partnerships and increased sophistication to develop optimal service delivery, funding mechanisms, and information management.

Introduction

Drug courts offer the opportunity to create flexible program models that integrate both criminal justice and rehabilitative treatment to provide coordinated sanctions, rewards, and services for participants. Drug courts have served as a catalyst for treatment and criminal justice professionals to modify traditional service delivery paradigms to develop more effective methods for reducing the drug use and criminal behavior of substance-involved adults charged with or convicted of drug offenses and related crimes. By integrating treatment with sanctions, close monitoring, and regular judicial oversight, both treatment and justice professionals modify their traditional roles to work together, using their combined skills and resources to promote recovery and rehabilitation among substance-involved offender populations.

Substance abuse treatment is a core component of drug courts. Although sanctions or drug testing alone has an effect on reducing drug use (Harrell et al., 1998), most addicted persons need treatment to remain abstinent and maintain a substance-free and productive lifestyle. Although there is a need to be flexible and to challenge traditional assumptions, substance abuse treatment should still be delivered according to best practices, as supported by scientific research on treatment effectiveness. This is often difficult for drug courts that operate in environments characterized by lack of resources, changing practices and methodologies (e.g., managed care), and the often differing goals and perspectives of the larger treatment and justice systems.

Under a cooperative agreement with the Office of Justice Programs (OJP), Drug Courts Program Office (DCPO) and the Substance Abuse and Mental Health Services Administration (SAMHSA), Center for Substance Abuse Treatment (CSAT), National TASC (Treatment Accountability for Safer Communities) developed and distributed a questionnaire designed to elicit information about substance abuse and other treatment services used by adult drug courts and identify significant issues faced by adult drug courts in obtaining and delivering high-quality, comprehensive treatment services. This study is a first step toward systematically examining the relationship between drug courts and the substance abuse treatment system by analyzing the types of services that are available to drug courts and how clients are processed.

Background

The 1990s saw an unprecedented growth in prison and jail populations in the United States. According to the Justice Policy Institute, the number of inmates incarcerated in prisons and jails was projected to reach 2 million in the year 2000, with about half incarcerated for nonviolent crimes (Center on Juvenile and Criminal Justice, 1999). This wave has had a disproportionate impact on minorities, particularly African-American men, and on women (Mauer, 1995; Bureau of Justice Statistics, 1994).

While the impact of current incarceration policies may be debatable (Center on Juvenile and Criminal Justice, 1999), the following facts are generally not disputed:

- Incarceration is expensive. The cost of incarcerating people in Federal and State prisons and jails is expected to exceed \$41 billion this year (Camp and Camp, 1999), and many States spend more money on building prisons than on higher education (Center on Juvenile and Criminal Justice, 1999).
- Almost all those incarcerated are released back into the community. This year, about half a million individuals will be released from State prisons alone, and nearly a quarter of these will be released with no continued supervision (Travis, 1999).
- The use of illicit drugs and alcohol is a central factor driving correctional growth.

According to the Bureau of Justice Statistics, in 1997, 75 percent of State and 80 percent of Federal prisoners could be characterized as drug involved, and 21 percent of State and more than 60 percent of Federal inmates were convicted on drug charges (Bureau of Justice Statistics, 1999c). Nearly 3.2 million adults are on probation in the United States, and about 65 percent are drug involved, with almost 70 percent reporting past drug use (Bureau of Justice Statistics, 1998). Women in State prisons were more likely than men to have used drugs in the month before their offense, and they were more likely to have committed their offenses while under the influence of drugs (Bureau of Justice Statistics, 1999c).

The number of arrestees who test positive for illicit drugs is also high. According to the National Institute of Justice (NIJ) 1998 Arrestee Drug Abuse Monitoring (ADAM) program, the percentage of adult male arrestees testing positive for any illicit drug ranged from 51.4 percent to 80.3 percent, and female arrestees testing positive ranged from 37.6 percent to 80.5 percent, at 35 testing sites in 1997 (National Institute of Justice, 1999). In addition, significant numbers of both women and men tested positive for more than one drug.

Substance abuse treatment has been shown to reduce substance abuse and criminal activity of addicted offenders (Inciardi, 1996; Belenko, 1998), and a number of studies have demonstrated the cost savings associated with substance abuse treatment (California Department of Alcohol and Drug Programs, 1994; Finigan, 1996). As a result, there has been a significant increase in Federal and State efforts to expand treatment services for offender populations, primarily in prisons and jails. Ironically, although there has been an increase in services, the percentage of inmates who reported being treated in both Federal and State prisons declined significantly from 1991 to 1997 (Bureau of Justice of Statistics, 1999c). In addition, the number of persons who participated in some type of treatment program while under jail supervision decreased by half from 1996 to 1998 (Bureau of Justice Statistics, 1999b).

Drug courts offer another mechanism to provide access to treatment for substance-involved offenders while minimizing the use of incarceration. They provide a structure for linking supervision and treatment and hold offenders and both the justice and treatment systems accountable through ongoing judicial oversight and team management. Most drug courts involve participants initially in intensive treatment services followed by ongoing monitoring and continuing care for a lengthy period (generally a year or more).² Outcome studies, which are beginning to emerge, demonstrate reductions in criminal recidivism associated with this approach (see Peters and Murrin, 2000; Belenko, 1998).

However, it is important to recognize that drug courts do not operate in a vacuum. In most jurisdictions, they are dependent on the service array and quality that is already available in the community. Currently, privately and publicly funded treatment services are experiencing significant changes, largely due to the implementation of some form of managed care in most jurisdictions. While these changes are designed to reduce costs and increase professionalization of services by focusing on outcome measures, many providers are struggling to adapt to new requirements and funding mechanisms during this transitional phase. In addition, it is unlikely that the treatment models used in drug courts will be supported by managed care. To a large extent, drug courts must adapt to existing gaps in service or other limitations in the overall substance abuse and mental health treatment system.

Although drug courts may augment existing services with additional funds and encourage the development of more effective treatment strategies for drug court populations through education and leverage, the statutory and financial responsibilities for effective and adequate treatment still rest with executive agencies, primarily State alcohol and other drug (AOD) agencies. The approach taken by drug courts and the experiences they have with justice populations should be examined by policymakers as jurisdictions strive to improve overall treatment delivery.

Survey Approach

The survey was designed to describe treatment services, identify gaps in services, and provide information regarding the management of treatment services from the perspective of the drug court. Efforts were made to avoid duplicating information that was previously gathered in other surveys of drug courts.

The survey was developed for operating adult drug courts in the United States. National TASC, through the DCPO/American University Drug Court Clearinghouse, identified 263 qualifying drug courts for survey distribution. Two instruments were sent to each drug court—one for the judge and one for the drug court coordinator or clerk—although each court was instructed to complete and return only one survey. Most surveys were completed by the drug court judge or the drug court coordinator. Respondents were instructed to have the survey completed by the person best able to describe how substance abuse treatment operates in their drug court. They were encouraged to obtain needed information from treatment providers but were informed that the survey was designed to examine treatment from the court's perspective.

National TASC, in cooperation with DCPO and CSAT, entered into a subcontract with Peyton Consulting Services for the purpose of developing the survey instrument. Elizabeth A. Peyton, in close consultation with DCPO, drafted the survey instrument. The 20-page instrument includes closed and open-ended questions and is included as appendix A. The survey was distributed to eight courts on a pilot basis and was modified based on the comments of these courts, in consultation with Dr. Robert Gossweiler, founding Director of the Policy Studies Resource Laboratories (PSR Labs) at The College of William and Mary.

Completed surveys were mailed back to PSR Labs for data entry. To encourage response, the deadline for reporting was extended, and National TASC sent followup postcards and placed telephone calls to courts that had not responded. PSR Labs received and entered data for 212 valid adult drug courts; this represents a response rate of 81 percent. The data were compiled and provided to National TASC and DCPO, along with a codebook and a digital copy of each survey instrument.

This report focuses primarily on analysis of closed questions, reserving data from open-ended questions for later study (with the exception of questions regarding phases of drug court treatment).

After the initial data analysis, a small sample of drug courts were contacted by telephone to further investigate the funding of treatment services and participant utilization of those services. The telephone questionnaire



is included as appendix B. These interviews describe the initial findings and specific issues faced by some drug courts.

Several important factors should be kept in mind when reviewing and considering the results of the survey:

- In this study, drug courts are the units of analysis—not drug court participants. While services available to drug courts are described, the data do not reveal how many participants use these services. For example, even though most drug courts report they have access to residential services, it should not be assumed that most drug court participants use residential services whenever needed.
- Many survey questions were structured so that respondents could indicate more than one response—they were asked to indicate “all that apply.” Thus, the percentages across these categories may total more than 100.
- Services available to drug courts are numerous and greatly varied. This finding prompted followup interviews so that it could be explored in depth. These followup interviews revealed that there is considerable variation in the ability to access services for participants among drug courts. Most drug courts appear to have treatment readily available because they have augmented existing treatment with Federal funds or with special funds generated at the State or local level. Some services, particularly residential treatment and mental health, are available in many communities, but drug courts may have difficulty placing clients in these services.
- The survey was designed to explore the relationship that drug courts have with treatment providers. As a result, the authors attempted to examine the extent to which drug courts work with providers who have slots or services dedicated to the drug court. Throughout this report, these services are referred to as “dedicated services.” In addition, the report examines the extent to which drug courts use services that are not dedicated to the drug court but are generally available in the local community. This report refers to these nondedicated services as “external services.” Analysis reveals that most drug courts use both dedicated and external treatment services.
- Some questions related to treatment services were designed to assess the types of services drug court participants receive through a typical treatment regimen. Questions related to cultural competency and gender-specific services were included in sections that examined regular services to which most or all drug court participants have access. These questions were included to assess the extent to which the needs of women and various racial or ethnic groups are addressed within

drug court treatment programming. Additional questions were designed to identify and describe services that are provided through referral to community programs. These services are defined as support services, because they are generally used to augment other, more primary treatment interventions.

- Only a few terms are defined in the survey instrument. The difference between screening and assessment, between dedicated and external services, and between services that are part of the regular drug court treatment regimen and those that are part of support services are clearly defined. On other items, responses were given according to each court's understanding of definitions of terms. Terminology related to substance abuse treatment frequently changes as new treatment models are defined and modified. In addition, one would expect to see variations in the definitions and use of treatment approaches based on the culture of individual drug courts in different localities (Ulmer, 1997).

Overview of Recommended Treatment Practices

Important objectives of this project included structuring the survey instrument and analyzing survey results to improve service delivery in the field and to encourage the adoption of best practices by drug courts. Review and examination of best practices and standards for drug courts were therefore conducted to provide a context for discussing the survey results. Survey results are also discussed in relation to the principles published in a recent National Institute on Drug Abuse (NIDA) monograph, as well as to the key components of drug courts. These documents are described below.

NIDA recently published a monograph titled *Principles of Drug Addiction Treatment: A Research-Based Guide* (National Institute on Drug Abuse, 1999). This guide succinctly summarizes current research-based findings related to effective drug treatment interventions and describes “several overarching principles that characterize the most effective drug abuse and addiction treatments and their implementation.” These principles are presented in full in appendix C and summarized in figure 1.

Although the NIDA principles focus on drug addiction treatment, they are also appropriate for the treatment of alcoholism. Throughout the NIDA report, references to substance abuse treatment include the treatment of alcohol and other drugs. While other sources (some of which are referenced in this report) also describe “best” treatment practices and set standards for the delivery of substance abuse treatment services, the



NIDA monograph serves as a point of reference in discussions of the results of the drug court treatment survey and for identifying ways to improve services for drug court participants.

The principles set forth in the NIDA monograph also apply to offender populations. In fact, much of the research cited by NIDA was conducted on offender populations. It is important to remember that treatment for offenders must be delivered within the supervision framework provided by the justice system. Effective drug courts integrate treatment services into the drug court process, thereby ensuring that supervision and services are applied in a sensible and coordinated fashion.

DCPO, in coordination with the National Association of Drug Court Professionals, has developed 10 key components that define drug courts (Office of Justice Programs, 1997). Many of these key components, and the performance standards that accompany them, relate to the quality and structure of treatment programming in drug courts (see figure 2).

Overall, issues of quality are more difficult to identify and quantify in comparison to the structural aspects of treatment delivery. Quality issues present a challenge to drug courts as they implement and improve their treatment components and as they strive to achieve good outcomes for drug court participants.

Several indicators, however, were included in the survey from which we can begin to assess the quality of treatment services in drug courts. These indicators relate to the qualifications and training of staff; the instruments and methods used in screening, assessing, and placing drug court clients into treatment; the reasons participants are discharged early from treatment; and the additional support that drug courts indicate they need.

Major Findings and Impressions

The survey results indicate that drug courts are striving to provide a comprehensive range of services to their clients and that most operate with dedicated services supplemented by other community services. Drug courts monitor participants through drug and alcohol testing, treatment, and case management, and they have developed an array of sanctions and interventions to promote compliance. Most drug courts require participants to remain in treatment for at least 1 year, and treatment primarily consists of group and individual counseling. A wide range of support services is also available to drug courts.

Drug courts primarily use substance abuse programming and staff who are certified, licensed, or otherwise clinically qualified. Some functions (e.g., screening and assessment) appear to be performed by professionals

Figure 1. NIDA Principles of Drug Addiction Treatment

1. No single treatment is appropriate for all individuals.
2. Treatment needs to be readily available.
3. Effective treatment attends to multiple needs of the individual, not just his or her drug use.
4. An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs.
5. Remaining in treatment for an adequate period is critical for treatment effectiveness.
6. Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction.
7. Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.
8. Addicted or drug-abusing individuals with coexisting mental disorders should have integrated treatment for both.
9. Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.
10. Treatment does not need to be voluntary to be effective.
11. Possible drug use during treatment must be monitored continuously.
12. Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases and counseling to help patients modify or change behaviors that place themselves or others at risk of infection.
13. Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.

Figure 2. Drug Court Key Components

1. Drug courts integrate alcohol and other drug treatment services with justice system case processing.
2. Using a nonadversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights.
3. Eligible participants are identified early and placed promptly in the drug court program.
4. Drug courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services.
5. Abstinence is monitored by frequent alcohol and other drug testing.
6. A coordinated strategy governs drug court responses to participant compliance.
7. Ongoing judicial interaction with each drug court participant is essential.
8. Monitoring and evaluation measure the achievement of program goals and gauge effectiveness.
9. Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations.
10. Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court effectiveness.

who may be operating outside their areas of expertise. In addition, while drug courts have established procedures to quickly assess and refer participants to treatment, objective and subjective criteria are sometimes used that are outside the parameters of acceptable professional standards.

Drug courts have relatively informal relationships with the providers they use, both those dedicated to the drug court and those in the larger community, and depend on programs that are supported through a variety of

funding mechanisms. As a result, drug courts are somewhat vulnerable to changes in policies and financing that occur in the mainstream treatment and mental health systems. While most drug courts track clients and can produce basic statistics, management information systems do not appear to be comprehensive or tied into larger justice or treatment data systems. For these and other reasons, drug courts may be at a disadvantage when trying to secure permanent and adequate funding.

The populations served by drug courts have changed significantly since drug courts started. Rather than diverting low-level offenders from further justice proceedings, most drug courts now target convicted offenders at postadjudication. In addition, many drug courts exclude participants with minimal substance involvement and focus on those whose substance abuse and related criminal activity may have public safety and other negative implications if not adequately addressed.

The objective structure and quality of substance abuse treatment and other programming is not enough to produce consistently good outcomes in drug court participant populations. Drug courts need counselors and administrators who are committed to their clients, have the courage to change and grow, make changes when existing strategies are not working, and turn negative client behaviors into personal challenges to improve their own skills and abilities to connect with and relate to clients. In addition, drug courts need the support of judicial, executive, and legislative agencies to thrive and continue to improve.

Survey Results

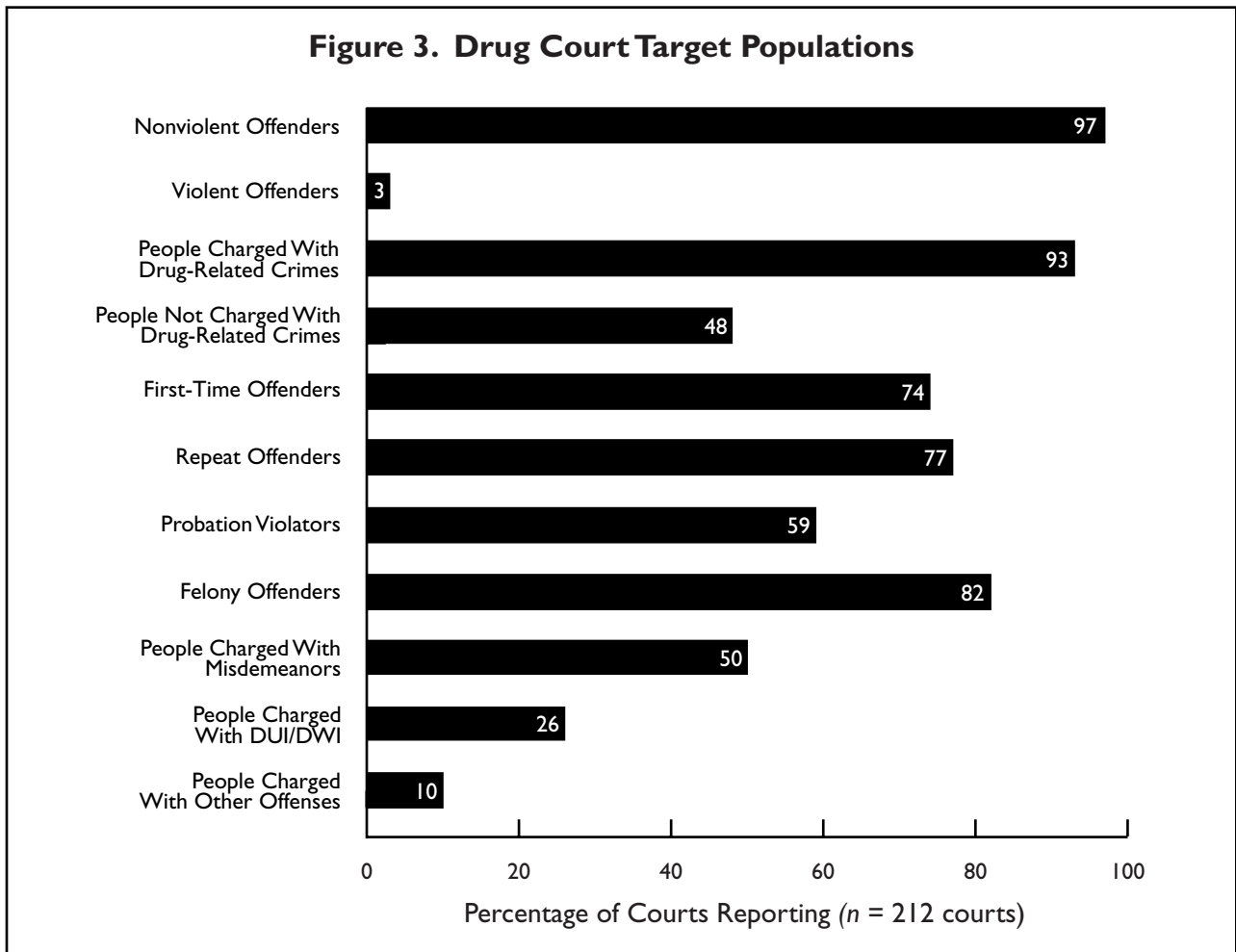
Drug courts exist in political, economic, and social contexts that affect how they can function and influence the resources at their disposal. Drug courts vary in size, capacity, and location, as well as in the characteristics of target populations. As expected, survey results show differences in the quantity and array of treatment services based on these variations.

Characteristics of Respondent Drug Courts

Seventy-one percent of respondent drug courts indicate they currently have a grant from DCPO. Most of these are single-jurisdiction implementation or enhancement grants. Thirty-nine percent of drug courts report being located in a rural setting. Thirty-three percent are in urban settings, and 25 percent report serving suburban areas. Many courts serve multiple types of areas; others do not. Ninety-seven courts describe themselves as urban only, 43 courts report serving rural areas only, and 17 courts describe themselves as suburban only. The rest are mixed, with most indicating that they serve both urban and suburban populations.

When the drug court movement began, most drug courts diverted first-time and low-level offenders into treatment in lieu of conviction. Over time, the focus of many drug courts changed to more serious offenders. This change is reflected in the survey results, with 43 percent of drug courts working with postadjudication populations, 22 percent working with diversionary populations, and 34 percent working with both pre- and postadjudication populations.

Drug courts report targeting a variety of populations for inclusion in their programs, as shown in figure 3. Of the 212 reporting drug courts in the study, nearly all (97 percent, $n=206$) report including nonviolent offenders. In contrast, very few (3 percent, $n=7$) report including violent offenders. (Drug courts that receive Federal funding from DCPO are prohibited from admitting offenders with current violent charges or with prior convictions of violent felony crimes.) Nearly all drug courts (93 percent, $n=197$) include offenders who are charged with drug-related crimes. An additional 48 percent ($n=101$) include offenders who are not charged with drug-related crimes. Repeat offenders (77 percent, $n=164$) are targeted by slightly more drug courts than first-time offenders (74 percent, $n=157$).



A little more than half (59 percent, $n=125$) of the drug courts report targeting probation violators. About four-fifths (82 percent, $n=173$) of the drug courts report targeting felony offenders, and half (50 percent, $n=106$) target misdemeanor offenders.

Size and capacity are two important factors in the ability to leverage resources and provide a continuum of care.³ More than a quarter (27 percent, $n=56$) of the drug courts have fewer than 50 participants in their program, about two-fifths (42 percent, $n=86$) have between 50 and 150 participants, and just less than a third (31 percent, $n=64$) have more than 150 participants in their program.

As for capacity, only 23 courts (10.9 percent) report having to limit their program to fewer than 50 participants. More than a third (38 percent, $n=74$) can serve between 50 and 150 participants, and a quarter can serve between 150 and 300 people. Very few (13.7 percent, $n=29$) drug courts can serve more than 300 participants.

More than half (55 percent, $n=97$) report being under their maximum capacity; the others (44 percent, $n=77$) report operating at or under capacity. Only two courts report being over capacity (both report having a maximum capacity of 150–199; one reports 200–299 clients, the other 300–399). During followup interviews, drug courts indicated that their capacity is limited by their eligibility criteria and the availability of treatment and court and judicial personnel.

Treatment Continuum of Care

NIDA Principle 1: No single treatment is appropriate for all individuals.

To meet the needs of drug court participants, a comprehensive continuum of treatment services is required. Drug court participants and others who need substance abuse treatment vary in the level and intensity of services required and in the type of programming or treatment approaches to which they best respond. In addition, treatment for participants needs to be available to coincide with the supervision that is required. In some instances, treatment needs to be provided in a secure setting, including jail or prison.

Treatment should be available to address the initial needs of participants and to provide additional support after primary treatment interventions are completed or if relapse occurs. Treatment also should be made available to accommodate participants who have employment, educational, or dependent care responsibilities. For drug court participants and other justice populations, programming should be designed for treatment-resistant clients.

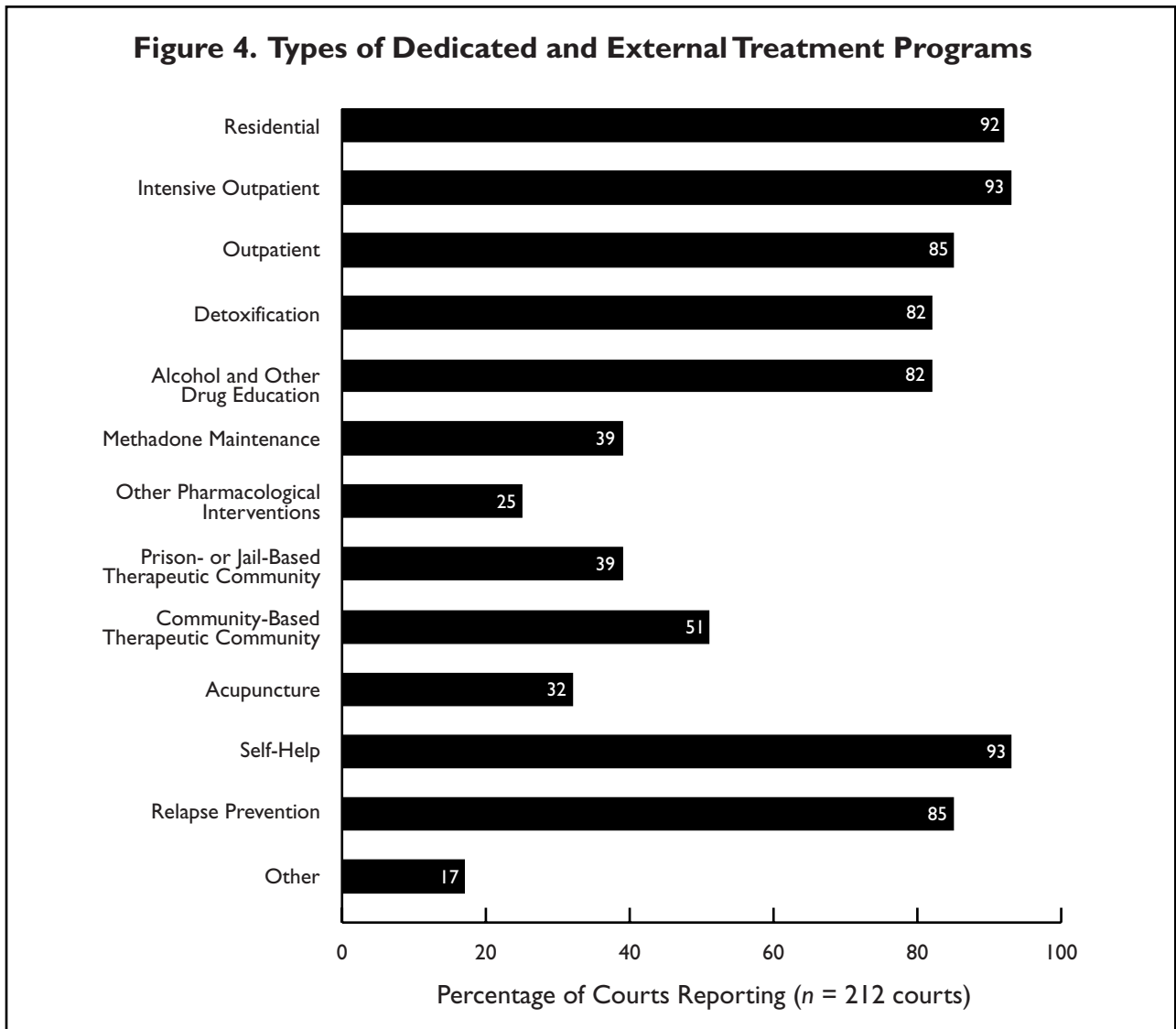
Drug Court Key Component 4: Drug courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services.

A description of the elements of a comprehensive care continuum is included in appendix F of the Drug Courts Program Office’s fiscal year 2000 application kit (U.S. Department of Justice, 2000). In addition, a number of CSAT Treatment Improvement Protocols (TIPs) describe and discuss the importance of establishing a comprehensive continuum of care.⁴

This section examines the question, Do drug courts have access to a comprehensive continuum of services to meet the needs of each individual participant?

Services Available to Drug Court Participants

As shown in figure 4, almost all drug courts have access to residential (92 percent, $n=195$), intensive outpatient (93 percent, $n=198$), outpatient (85 percent, $n=181$), and detoxification (82 percent, $n=174$) services. Almost all (93 percent, $n=196$) use self-help groups such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA), and others throughout the drug court program. About half (51 percent, $n=107$) report that community-based therapeutic community (TC) programs are available,⁵ and more than a third (39 percent, $n=83$) have access to TCs in prison or jails.



Relapse prevention programming is available in 85 percent of drug courts ($n=181$), and 82 percent ($n=174$) offer AOD education. Thirty-nine percent ($n=83$) of drug courts report being able to offer methadone maintenance to participants, and 25 percent ($n=52$) can provide other pharmacological interventions such as naltrexone. Thirty-two percent ($n=68$) of drug courts report that they can provide acupuncture to participants. In addition, almost two-thirds (64 percent, $n=135$) of all drug courts report that they can provide eight or more treatment interventions, suggesting that most have access to a broad continuum of services.

Differences by Drug Court Setting

Drug courts in urban (50 percent) or mixed (44 percent) settings are more likely than those in suburban (29 percent) or rural (14 percent) settings to have access to methadone maintenance programs.

Drug courts in suburban settings report having more access to prison- or jail-based TCs than courts in other settings and are more likely to have access to community-based TCs.

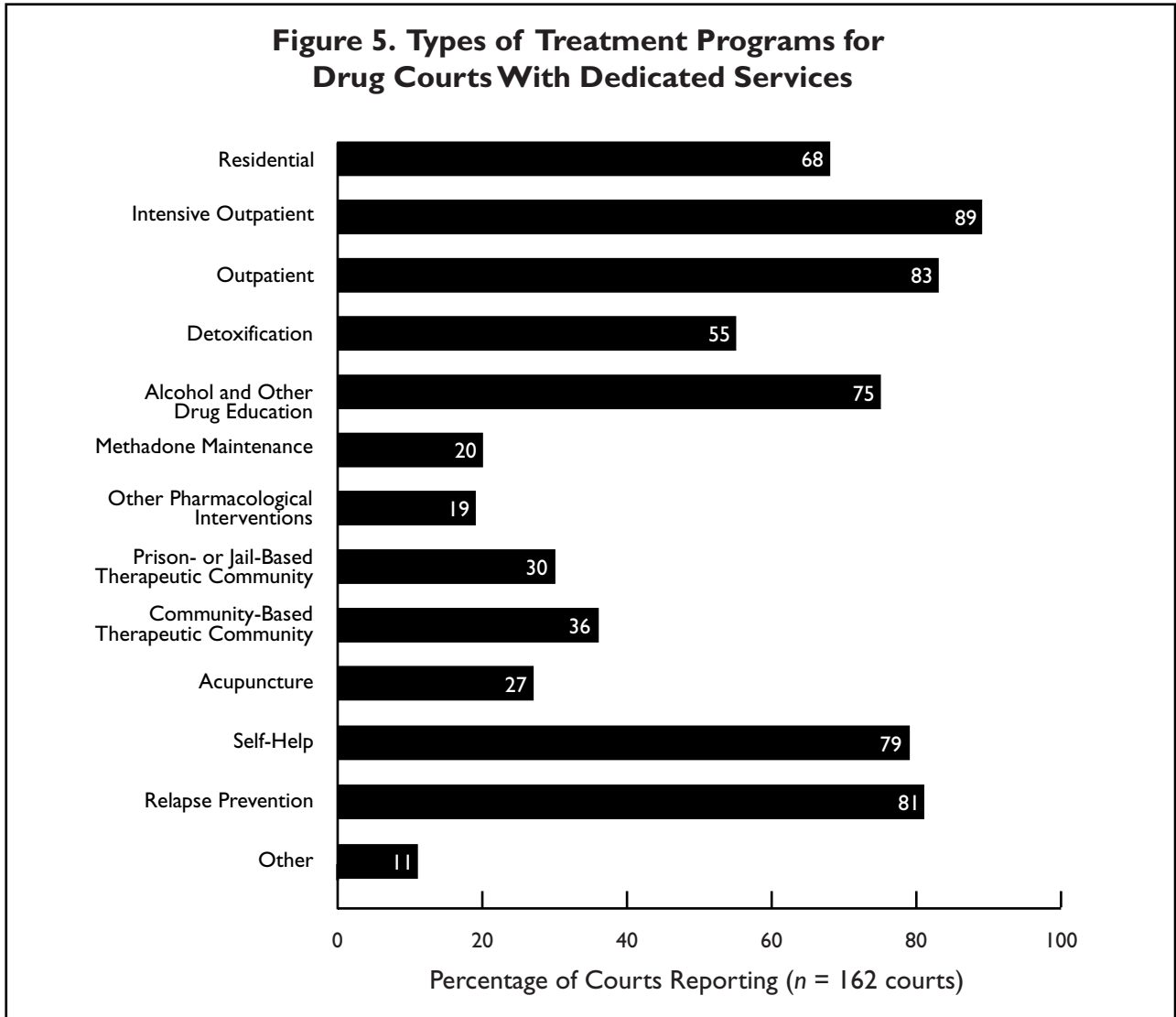
Differences by Caseload Size

Drug courts with large client caseloads (more than 150 participants) are more likely to be able to access methadone maintenance programs, other pharmacological interventions, and residential services than those with small caseloads.

Drug Court Performance Benchmark: Treatment is available in a number of settings, including detoxification, acute residential, day treatment, outpatient, and sober-living residences.

Drug Courts With Dedicated Services

Seventy-six percent of drug courts indicate that they have dedicated services or reserved slots for drug court participants.⁶ Of these, 40 percent report using one dedicated provider, and 16 percent report having four or more dedicated providers. Most drug courts with dedicated services report that dedicated providers can deliver residential (68 percent), intensive outpatient (89 percent), outpatient (83 percent), relapse prevention (81 percent), and AOD education (75 percent) services. In addition, 79 percent of courts with dedicated services include participation in self-help groups, and 55 percent can access detoxification services through their dedicated providers. Other services are available less frequently, as shown in figure 5.



More drug courts report access to acupuncture (27 percent) through dedicated providers than either methadone maintenance (20 percent) or other pharmacological interventions (19 percent). About a third report using TCs, either community based (36 percent) or prison/jail based (30 percent).

Less than a fifth (16 percent) of drug courts report having access to four or fewer interventions through dedicated providers, and nearly two-thirds (61 percent) report having access to between five and eight of these interventions.

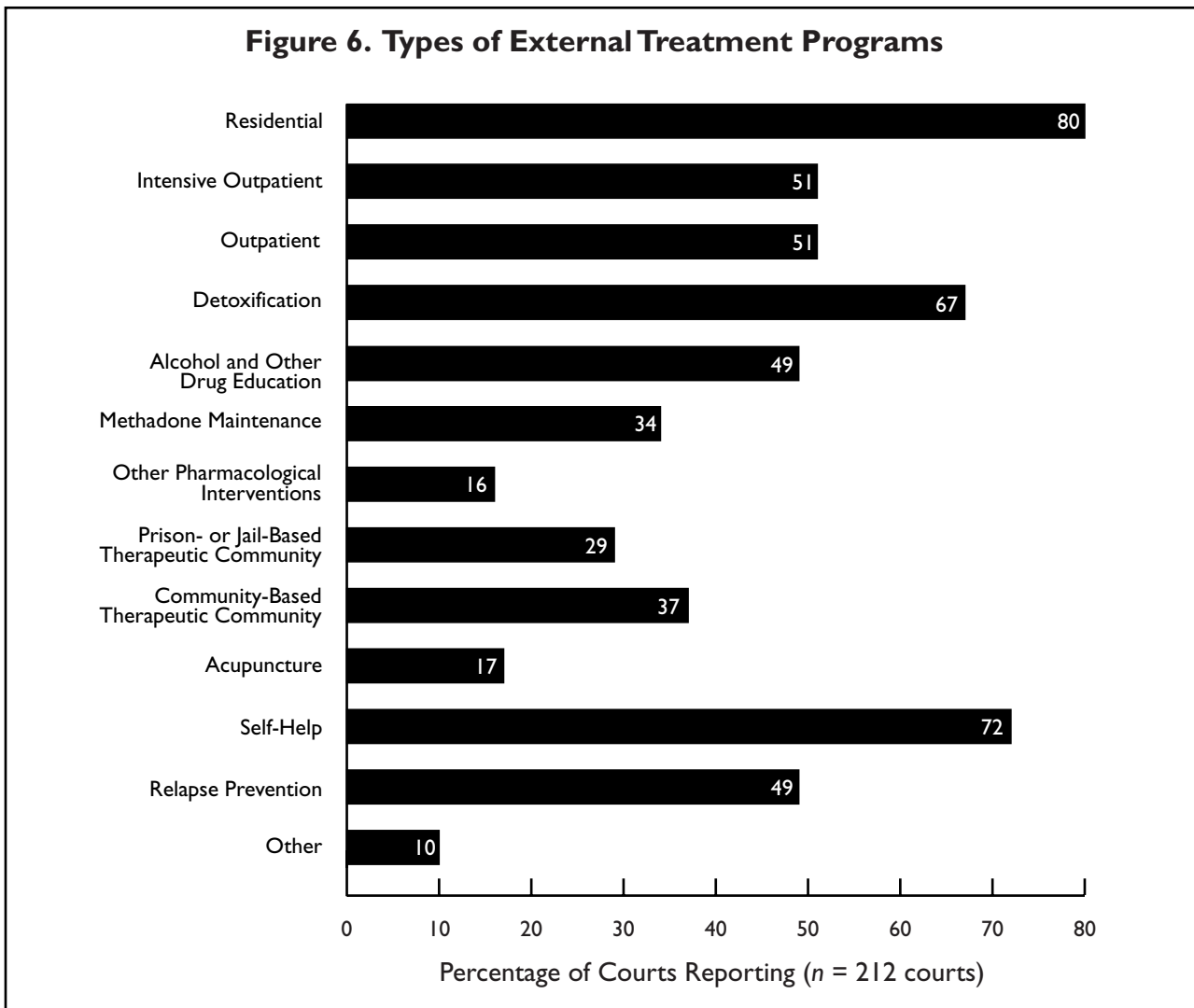
External Treatment Services

Drug courts also utilize services and programs that are not dedicated to the drug court but are available in the community. For the purposes of

this study, these providers are referred to as “external.” Twenty percent of drug courts indicate that they use external services only—that no services are dedicated to the drug court. Seventy-one percent ($n=130$) of drug courts in the study report that they use 4 or more programs that are not dedicated to the drug court.

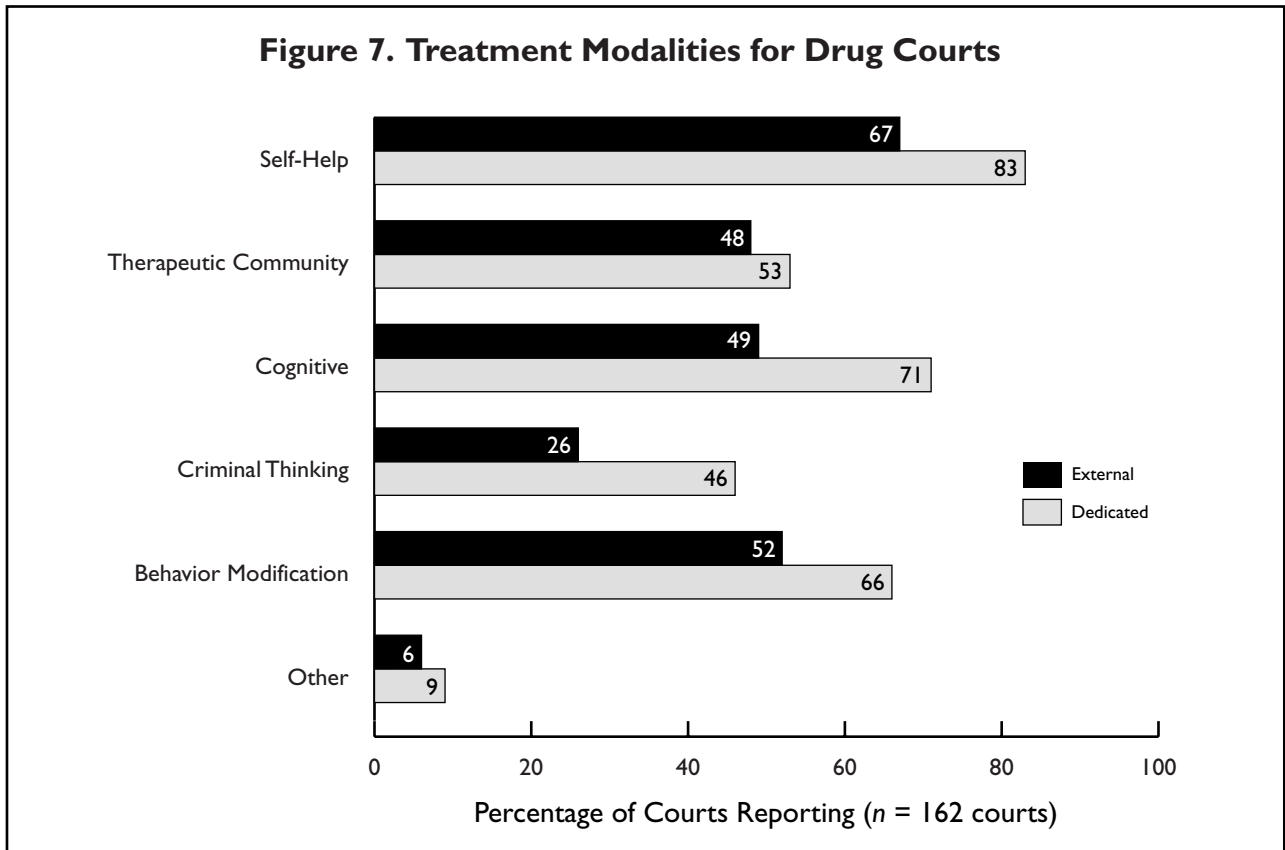
The types of services that drug courts can access through external providers are presented in figure 6. Two-fifths (40 percent, $n=85$) of drug courts report using 4 or fewer of these services, more than a third (37 percent, $n=78$) report using between 5 and 8 of these service types, and nearly a quarter (23 percent, $n=49$) report using more than 8 service types.

Drug courts are slightly more reliant on external programs to provide residential, detoxification, and methadone maintenance services.



Treatment Modalities

Both dedicated and external providers use a variety of modalities in their treatment approaches. Dedicated providers are more likely to use cognitive and behavioral approaches (71 percent and 66 percent, respectively) and to address criminal thinking (46 percent) than external providers. Figure 7 compares the types of modalities used by dedicated and external programs.



Program Certification, Licensing, and Accreditation

Ninety-eight percent of drug courts that have dedicated treatment programs report that the programs are licensed or certified by the State or local licensing authority, and 52 percent of drug courts that have dedicated treatment programs report that the programs are accredited by the Joint Commission on Accreditation of Health Care Organizations (JCAHO) or other accrediting bodies. An additional 25 percent of drug courts do not know or are not sure whether the programs dedicated to the drug court are accredited.

Ninety-nine percent of reporting drug courts indicate that the external programs they use for drug court participants are licensed or certified by State authorities. Thirty-one percent of respondent drug courts indicate that external treatment programs maintain some sort of outside accreditation. Fourteen percent indicate the external programs are not accredited. An additional 41 percent do not know whether the external programs they use are accredited.

Treatment Availability

NIDA Principle 2: Treatment needs to be readily available.

Motivation to participate in treatment and to change substance use patterns tends to fluctuate in individuals, depending on a variety of factors. Treatment needs to be readily available to capitalize on motivational opportunities—to be there when individuals are ready for it. Motivation is a state of mind that is driven by internal conditions as well as by external events and their impact on internal conditions. Motivating factors can include negative consequences, such as loss of freedom, loss of a job, loss of a relationship, or financial hardship. Motivation also can be enhanced by positive feedback, feelings of self-efficacy, relational connections, and development of insight. One of the precepts of drug court is to “capitalize on the trauma of arrest”—to make treatment services available when events that occur within the justice system (e.g., arrest, release from incarceration) provide the impetus for many offenders to seek treatment and change the behaviors associated with their drug use. It is often much more difficult to engage people in treatment if motivation is diminished by delays in accessing services.

Drug Court Key Component 3: Eligible participants are identified early and promptly placed in the drug court program.

This section addresses the question, Is treatment readily available in drug courts? The question is addressed by examining the methods that drug courts use to screen and assess participants, determine eligibility, and place participants in treatment services.

Screening

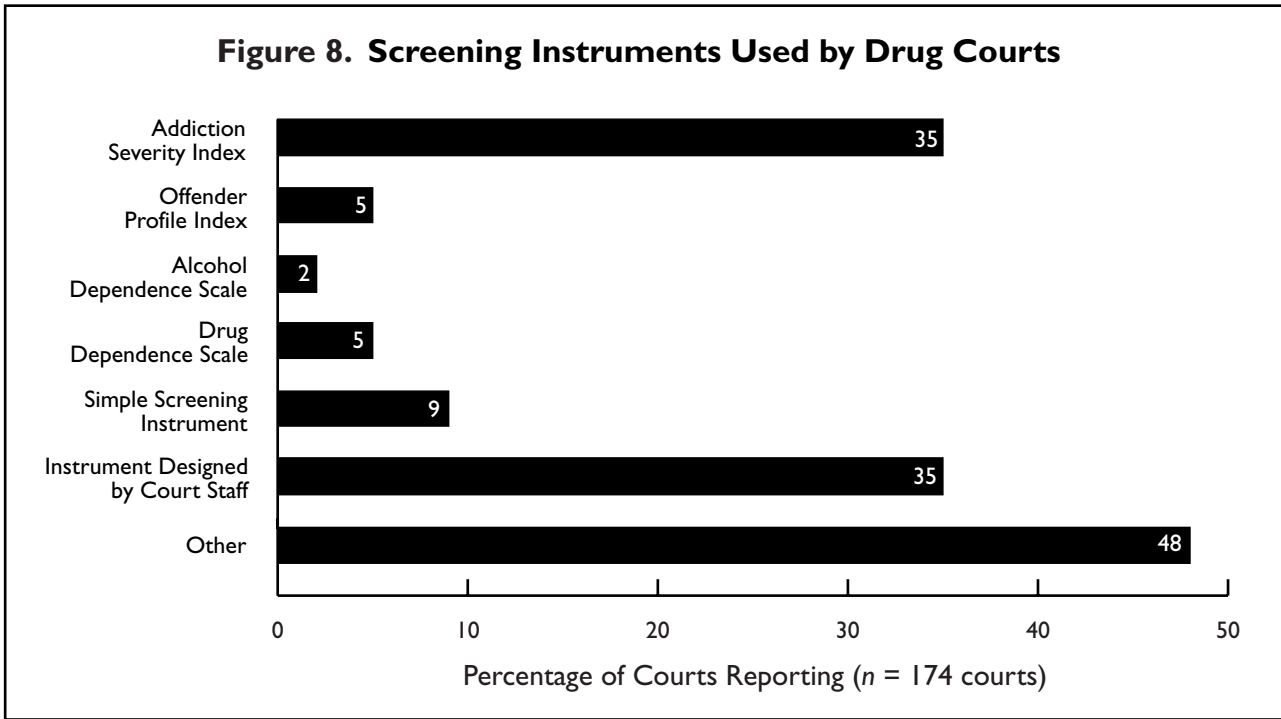
To place people in appropriate treatment environments and develop plans to provide additional support, comprehensive initial assessments or clinical screenings must be conducted. Clinical screening can be considered a “first pass” look at a potential participant. Clinical screening should be used to make broad decisions about potential eligibility and need for treatment.

The screening process generally involves face-to-face interviews combined with the use of a screening instrument designed to gather specific information in a structured format. Effective clinical screening also includes examination of collateral information, including information from the justice system, family members, and other people familiar with the client, and results of chemical testing and clinical observation. During screening interviews, clients may receive explanations about program requirements and sign confidentiality waivers and other required forms.⁷

Ninety-three percent of drug courts report that they conduct clinical screening for drug court participants to determine appropriateness and willingness for treatment, and 89 percent report conducting screening prior to program admission. Figure 8 shows the instruments used by drug courts that conduct clinical screening.

Effective screening processes include the use of a standardized clinical screening instrument that has been demonstrated to be reliable and valid, preferably with offender populations. For example, *Guideline for Drug Courts on Screening and Assessment* (Peters and Peyton, 1998) provides references to several screening instruments that have been validated for offender populations. Other scientifically validated screening instruments are referenced in the *Principles of Addiction Medicine*, second edition (Graham and Schultz, 1998), published by the American Society of Addiction Medicine (ASAM).

While drug courts may need to gather information that is not included in standardized instruments as part of their intake process, this information should be gathered separately, either before or after the instrument is administered. More than one-third (35 percent) of drug courts report they use a clinical screening instrument that was developed by court staff. It is important to note that ad hoc modifications of scientifically validated screening instruments, including reordering questions or inserting additional information, can render them invalid. In addition, it is difficult to compare drug courts if baseline client information is inaccurate or does not have the same meaning as information gathered with other instruments accepted to be valid and reliable.



The “other” category in figure 8 includes the Substance Abuse Simple Screening Instrument (SASSI) used by many of the drug courts surveyed.⁸ Other drug courts indicate they use probation risk instruments, including the Level of Supervision Inventory (LSI), screening tools developed or required in their local jurisdictions, or various individual tools or combinations of tools.

The timing of screening is also important. From initial identification of a defendant as potentially eligible for drug court:

- 15 percent of drug courts report conducting screening the same day.
- 15 percent report conducting screening within 1–2 days.
- 22 percent report conducting screening within 3–5 days.
- 47 percent report that initial screening takes a week or more to conduct.

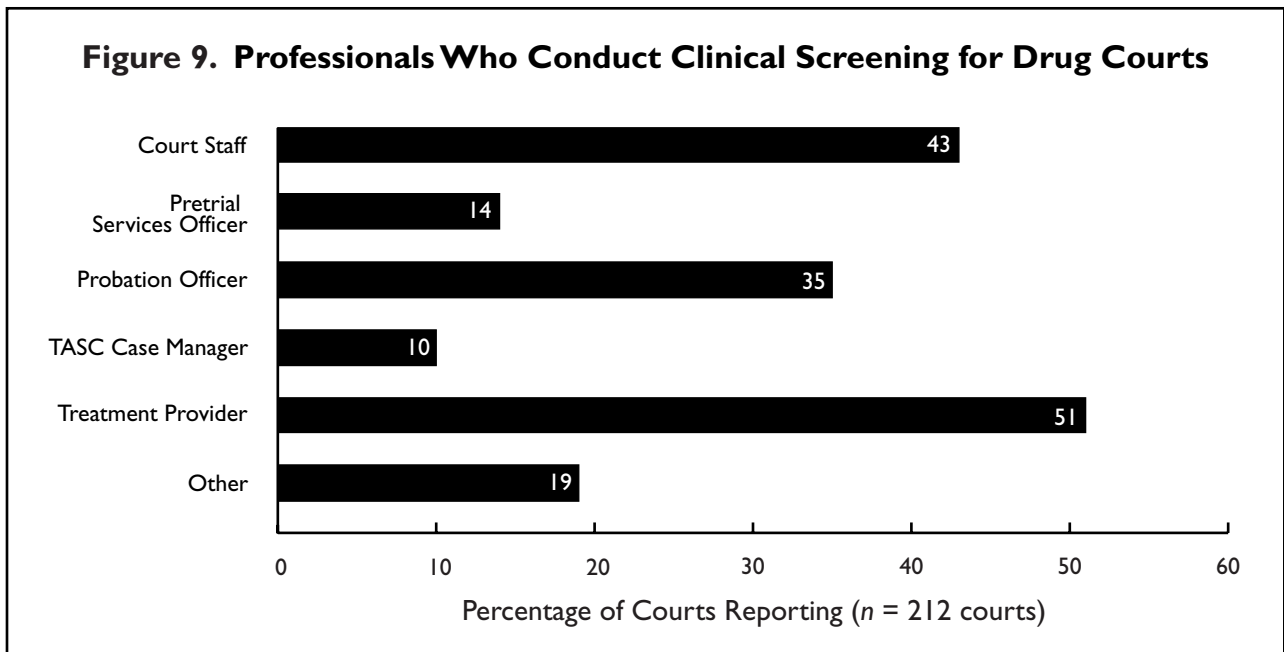
Fifty-nine percent of drug courts report conducting a drug screen as part of the screening process. Drug and alcohol test results are essential collateral information at the time of interview to obtain more accurate self-report information. Combined with an accurate criminal history, drug test results can give the interviewer information he or she needs to minimize denial or underreporting of substance involvement on the part of participants.

Screening in drug courts includes legal screening to determine whether participants are eligible for drug court based on legal criteria (e.g., current offense, criminal history) and a clinical screening to determine whether the defendant has a substance abuse disorder that requires a treatment intervention available through the drug court. Figure 9 shows drug court responses regarding who performs clinical screening.

Many clinical screening instruments are designed to be administered by trained nonclinicians. Training received by drug court screening staff is shown in figure 10.

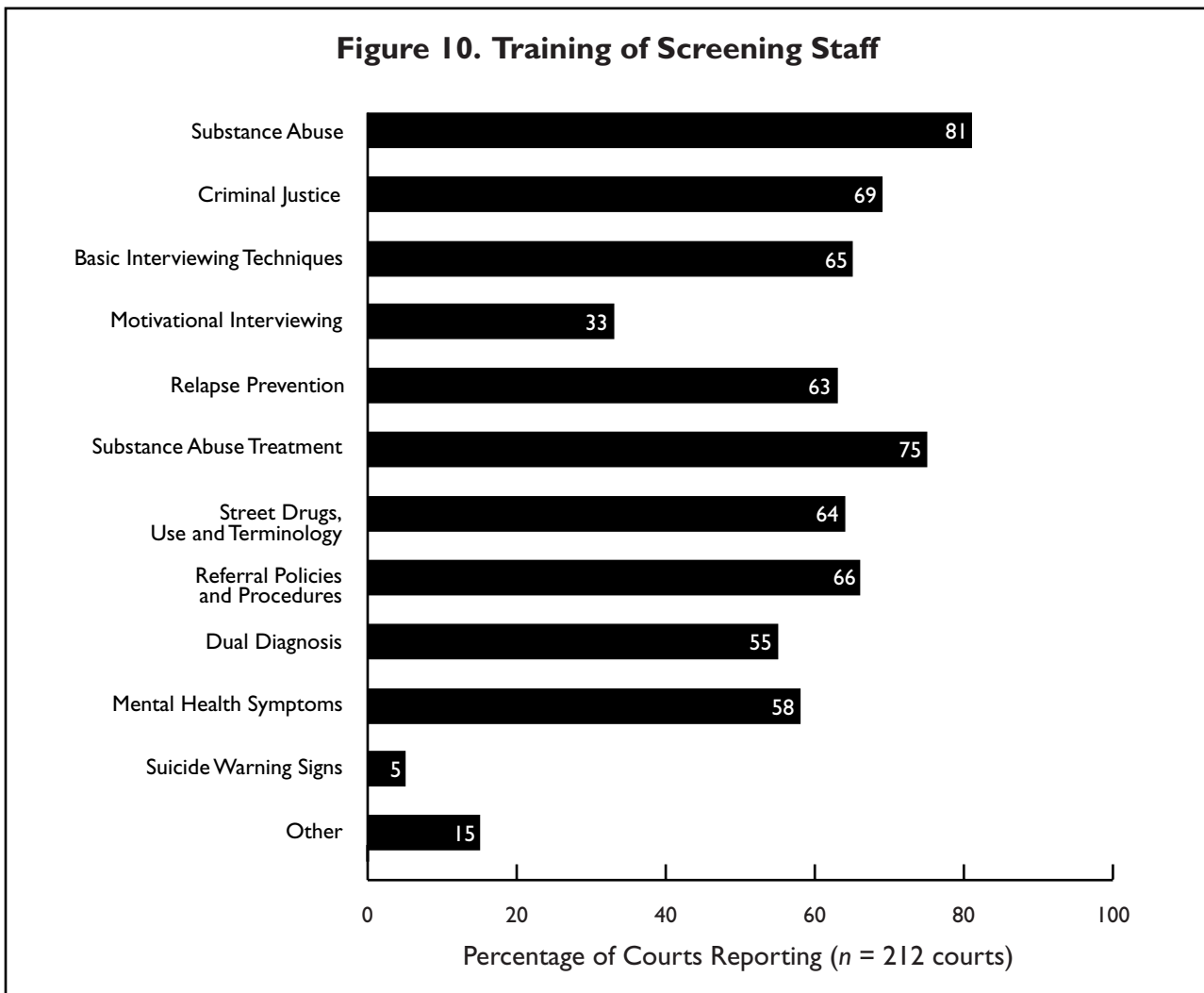
All staff who conduct clinical screening or are involved in the clinical processes of the drug court should, at minimum, receive training in the following:

- Substance use and abuse.
- Substance abuse treatment, including information on available treatment programming in the jurisdiction.
- Use of the specific screening instrument or instruments.
- The criminal justice system and specific criminal justice information relative to drug courts.
- Basic and motivational interviewing techniques.
- Street drugs and local terminology.



- Signs and symptoms of mental health problems.
- Risk factors for HIV/AIDS and other infectious diseases.

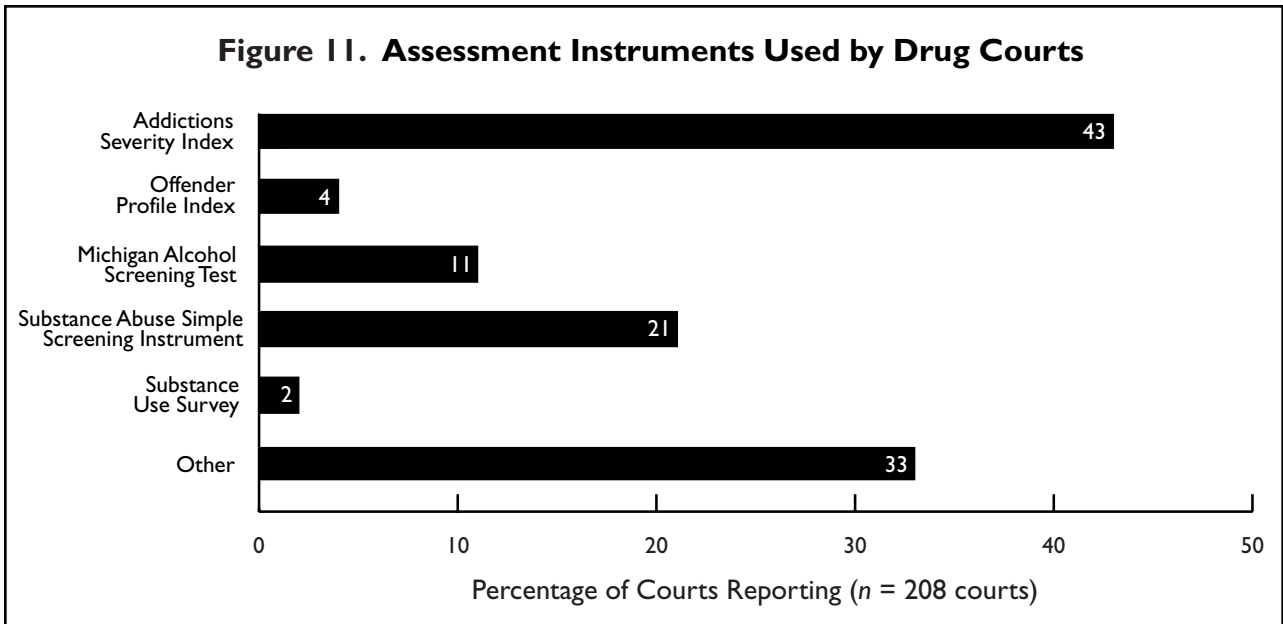
In addition, basic information regarding the policies and procedures of the drug court should be understood by screening staff so that they can answer participants' questions. Screening staff should be familiar with Federal confidentiality laws regarding substance abuse treatment and should be able to explain the release forms that may be required to enter the drug court.⁹



Assessment

Clinical assessments are designed to provide indepth information about a person's current and previous alcohol and drug use, as well as other domains, to make placement decisions and to develop a treatment plan. Unlike clinical screening, clinical assessments are designed to be

administered by social workers, physicians, nurses, or chemical dependency counselors who have received specialized training and supervised clinical experience. In addition, many State and local governments have minimum education and experience requirements that must be met to be licensed or certified to administer clinical assessments. Ninety-three percent of drug courts report that a clinical assessment is conducted for drug court participants. Figure 11 shows the percentage of courts using different types of instruments.



A large number of drug courts use widely accepted and scientifically validated clinical assessment instruments, with the majority using the Addictions Severity Index (ASI). Eleven percent of drug courts use the Michigan Alcohol Screening Test (MAST). In a recent examination of the effectiveness of eight clinical screening instruments with offender populations, MAST was identified as the least accurate, primarily because it was overly inclusive in identifying offenders as needing drug treatment (Peters et al., 2000). Four percent of courts report using the Offender Profile Index (OPI) as their assessment instrument. OPI was designed to provide broad information for “sorting” purposes and is not useful as a clinical assessment tool to diagnose and place participants in appropriate treatment services (Inciardi et al., 1993). Likewise, 21 percent of drug courts report using SASSI for clinical assessment, although it is a brief screening tool. Research has shown that the SASSI-2 was not as effective with offenders compared with other screening instruments and demonstrated reduced accuracy with African-Americans and those with higher education (Peters et al., 2000).

Of the drug courts reporting that clinical assessments are conducted for drug court participants:¹⁰

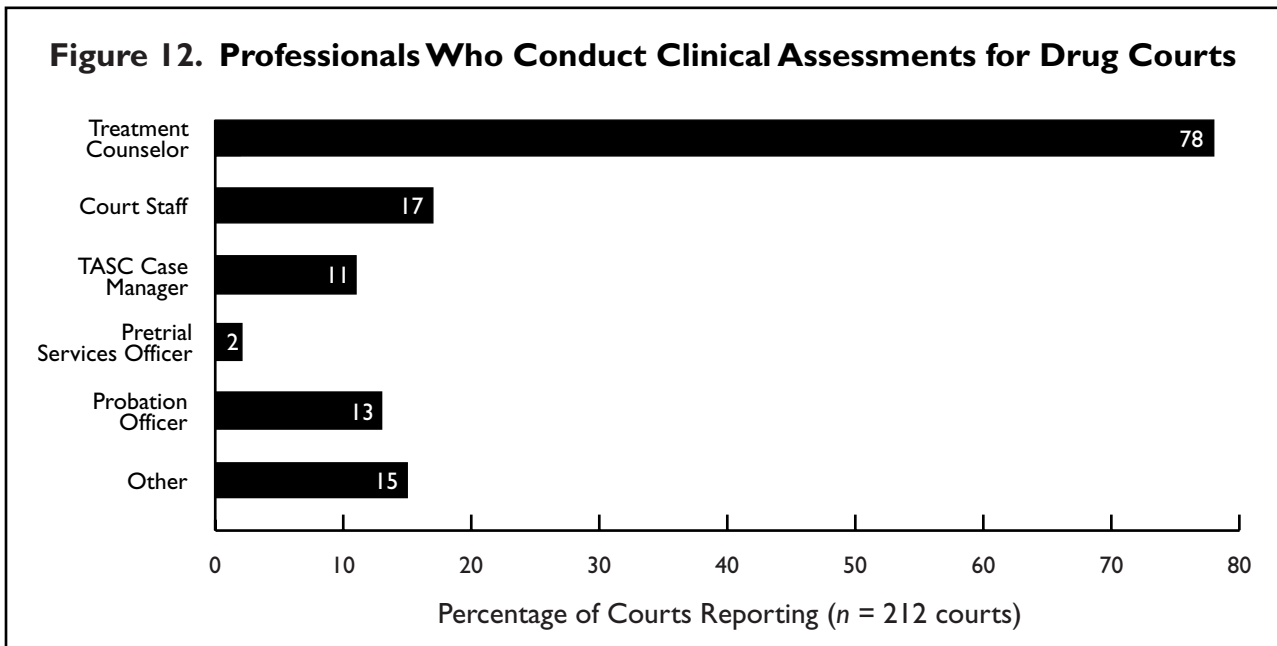
- 49 percent report that clinical assessments are conducted within 5 days after a defendant is identified as potentially eligible for drug court.
- 34 percent report that assessments are conducted within 1–2 weeks.
- 17 percent report that it takes longer than 2 weeks to have an assessment conducted.

Overall, the findings suggest that screening and assessment are conducted fairly rapidly in drug courts.

Sixty-two percent of drug courts report conducting a drug test as part of the assessment process. Again, results of drug and alcohol screening provide additional information to aid in the accuracy of self-reported assessment information.

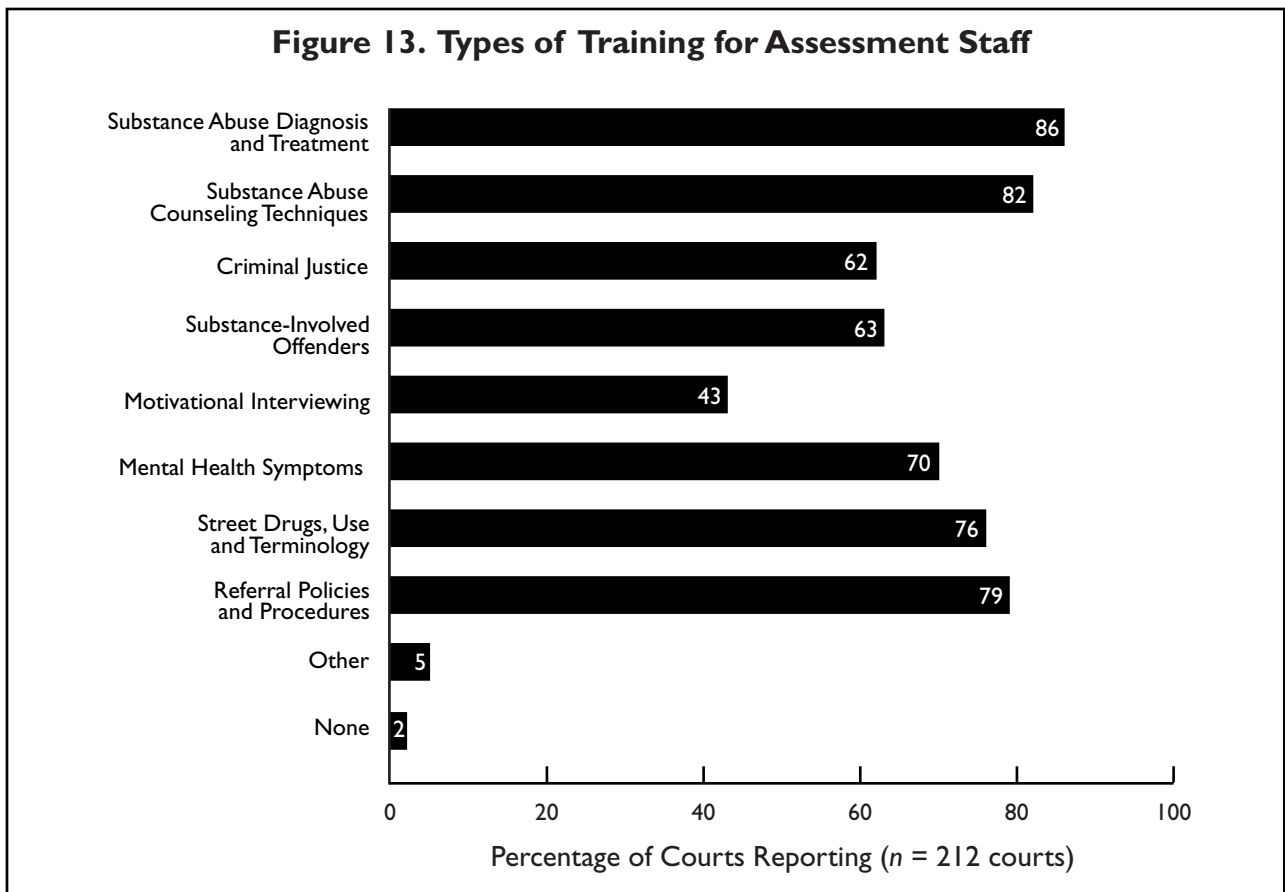
Seventy-eight percent of drug courts report that treatment providers conduct clinical assessments in drug courts. Assessments are also conducted by other staff, as shown in figure 12.

The majority of drug courts report that staff who conduct clinical assessments are licensed, certified, or work in licensed programs. However, 10 percent report that assessment staff meet court training requirements but are not otherwise credentialed, and 2 percent report that staff who conduct assessments have no formal credentials. According to the Center for Substance Abuse Treatment (1994b), assessors should be “qualified



human services professionals with demonstrated competence in AOD programs.” Ideally, persons who conduct clinical assessments, in addition to their individual qualifications, should work in a licensed or certified setting and receive ongoing clinical training and supervision. In the absence of other criteria, drug courts should follow guidelines for certification and credentialing established by their State or county substance abuse authorities (e.g., single State alcohol and other drug agencies). Issues related to certification and credentialing are becoming increasingly important with the proliferation of managed behavioral health care in the public sector. In many jurisdictions that have implemented managed care for clients (in general, Medicaid recipients), treatment authorization and payment are dependent on staff qualifications.

The types of training that assessment staff have received and the percentages of drug courts reporting are shown in figure 13.



In addition to training that relates to attainment of clinical qualifications, assessment staff should be trained in criminal justice issues, drug court policies and procedures, and counseling for substance-involved offenders. Clinical staff should also be adept at identifying signs and symptoms of

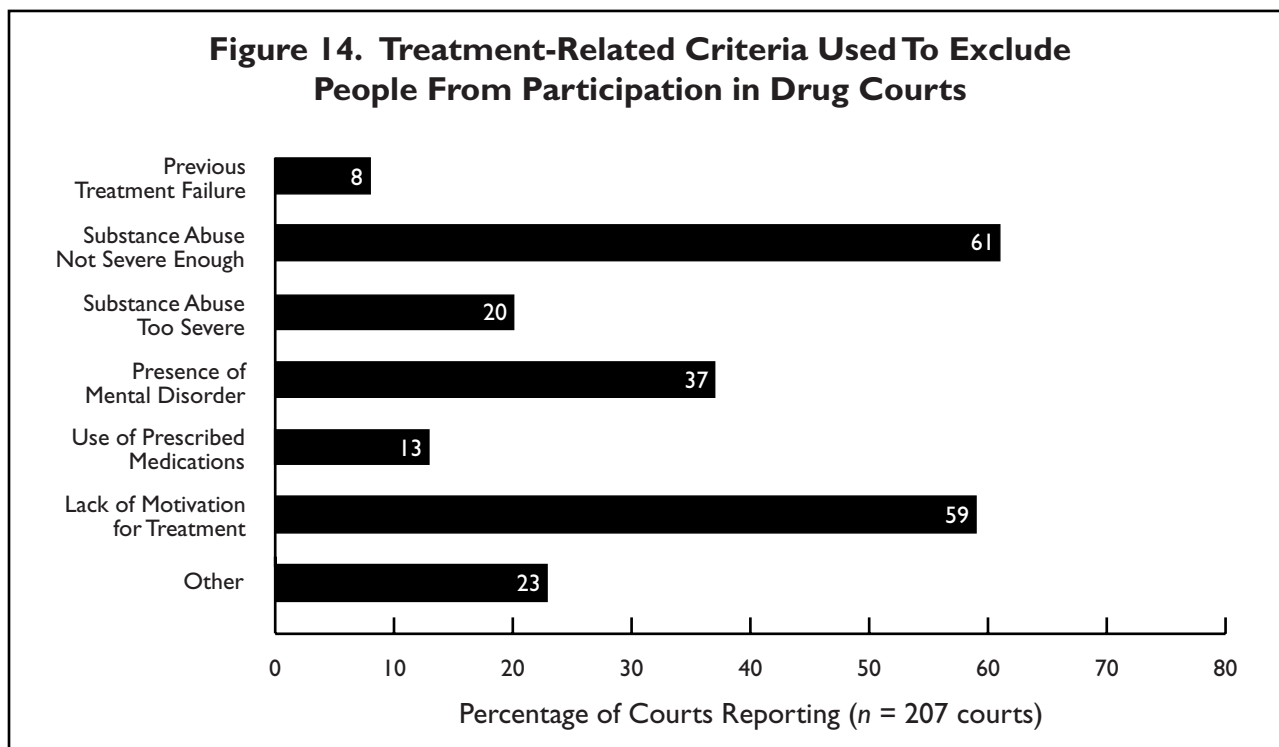
mental health disorders and risks and symptoms of HIV/AIDS and other communicable diseases. All staff who work with substance-involved offenders should also receive training in motivational enhancement techniques and relapse prevention, as well as training to comply with Federal confidentiality laws.

Eligibility Determination

Eighty-five percent of courts report that clinical criteria are used to determine eligibility for drug court. Forty percent indicate that eligibility decisions are made the same day that a clinical assessment is conducted, and 75 percent report that eligibility is determined within 5 days of assessment. It appears that once an assessment is conducted, eligibility is decided quickly.

Figure 14 shows the clinical criteria used to exclude people from drug court admission. Many drug courts (61 percent) report excluding people whose substance abuse disorder is not significant enough to warrant treatment interventions, suggesting that drug court services are being reserved for individuals who need the services.

Fifty-nine percent of drug courts indicate that lack of motivation for treatment is used as a criterion to exclude potential participants from drug court, although no drug courts report that they use this criterion exclusively. It is not known whether clients identified as having poor



motivation actually refuse to participate in drug court. Drug courts are designed to combine justice and treatment strategies to enhance motivation of offender clients. Unless an individual refuses to volunteer for the program, motivation, or lack thereof, is a poor screening criterion and probably should not be used to prohibit admission.

Research has clearly demonstrated that individuals who participate in treatment as a result of pressure from the justice system have outcomes as good as or better than “voluntary” treatment clients (Hubbard et al., 1989). Indeed, drug courts are founded on that premise and strive to integrate treatment and justice interventions to improve treatment retention and promote positive outcomes.

NIDA Principle 13: Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.

Only 8 percent of drug courts report that they exclude people from admission because of previous treatment failures. In addition, drug courts keep people in treatment for a lengthy period overall, and many participants are admitted to multiple programs during their drug court tenure. This survey does not show whether previous drug court failures are offered subsequent opportunities at drug court.

Decisions Related to Treatment Placement

The primary purpose of clinical assessment is to diagnose the problem or problems and thereby develop a treatment plan. One element of the treatment plan includes placement in a treatment program that is appropriate to the level of care and intensity of services needed by the client. Formal criteria have been established to aid in determining level of care and intensity of services. Many of these criteria are discussed in ASAM’s *Principles of Addiction Medicine*, second edition (Mee-Lee, 1998) and CSAT’s *The Role and Current Status of Patient Placement Criteria in the Treatment of Substance Use Disorders* (Center for Substance Abuse Treatment, 1995c).

Standardized patient placement criteria are being developed to do the following:

- Establish a common lexicon describing the dimensions of assessment and the components of continuum of care.
- Provide a common basis for study and continual improvement of the criteria and the services provided in response to the criteria.

- Alleviate the high cost of *undertreatment*, based on continued-stay criteria.
- Alleviate the high cost of *overtreatment* by ensuring that patients get only the treatment they need.
- Develop common definitions of levels of care, common standards of assessment, and common standards for continued stay and discharge for public and private programs (Center for Substance Abuse Treatment, 1995c).

Table 1 shows the criteria drug courts report using to place participants in treatment.

Table 1. Drug Courts Reporting Different Criteria To Determine Treatment Placement

Criterion Type	Percentage of Drug Courts
American Society of Addiction Medicine	34 (n = 73)
Other formal placement criteria	19 (n = 40)
Clinical judgment	74 (n = 156)
Other criteria	14 (n = 29)

Criteria developed by ASAM, known as ASAM-PPC-II, are perhaps the most widely accepted and widely studied patient placement criteria that exist. They consist of six problem areas, or dimensions, that are used to assign patients to four levels of care: (1) outpatient treatment, (2) intensive outpatient/partial hospitalization, (3) medically monitored intensive inpatient (generally referred to as “residential”), and (4) medically managed intensive inpatient or hospital-based care (Center for Substance Abuse Treatment, 1995c).

Seventy-four percent of drug courts report that clinical judgment is used to determine the level of care to which participants are assigned. Fifty-one percent report using clinical judgment exclusively. Clinical judgment should be used when assigning levels of care, but other objective criteria should also be used. In addition, the acceptance of managed behavioral health care will continue to create impetus for the development and use of standardized patient placement criteria.

Finney and Moos (1998) reviewed the literature on substance abuse treatment settings, amount, and duration, and they describe the following parameters for patient placement:

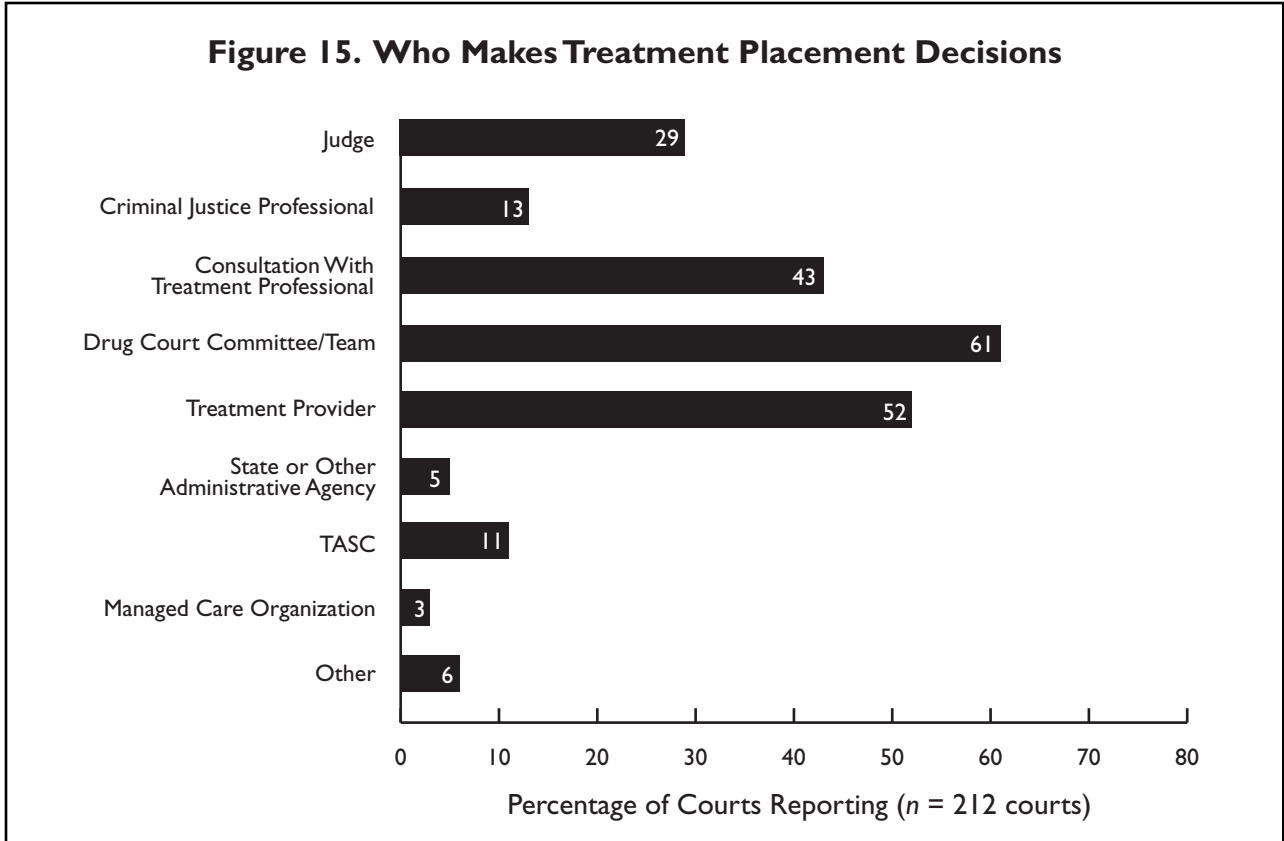
- Provide outpatient treatment for individuals who have sufficient social resources and no serious medical/psychiatric impairment.
- Use less costly, intensive outpatient treatment options for patients who have failed with brief interventions or for whom a more intensive intervention seems warranted but not in the structured environment of a residential setting.
- Retain residential options for patients with few social resources and those living in an environment that is a serious impediment to recovery.
- Reserve inpatient (hospital-based) treatment options for individuals with serious medical/psychiatric conditions.

These parameters may be useful to drug courts in the absence of or in conjunction with more formal patient placement criteria. Other factors, such as severity of drug use and prior treatment experiences, should also be considered in placement decisions.

In addition to the criteria used to make placement decisions, the study investigates who makes placement decisions. As shown in figure 15, the majority (61 percent) of drug courts use a team approach to make placement decisions, and, in a significant proportion (43 percent) of drug courts, justice professionals make placement decisions in consultation with treatment professionals. Treatment providers have significant input into placement decisions, with more than half (52 percent) of the courts indicating that providers make the decisions. Twenty-nine percent of courts report that the judge makes the placement decision, and 13 percent report that the decision is made by another criminal justice professional. Seventy-four percent of courts indicate that the court can override a clinical recommendation and require program admission.

The issues raised by survey results regarding placement decisions are complex. Whether treatment or justice personnel make placement decisions on their own, without input by the other party, cannot be determined from this survey. Results suggest, however, that decisions regarding placement are made collaboratively, with both clinical and justice points of view taken into consideration.

The reasons that judges override clinical recommendations and require program admission are also complex. Sometimes the judge has access to information that a provider may not have. Other times, the judge may

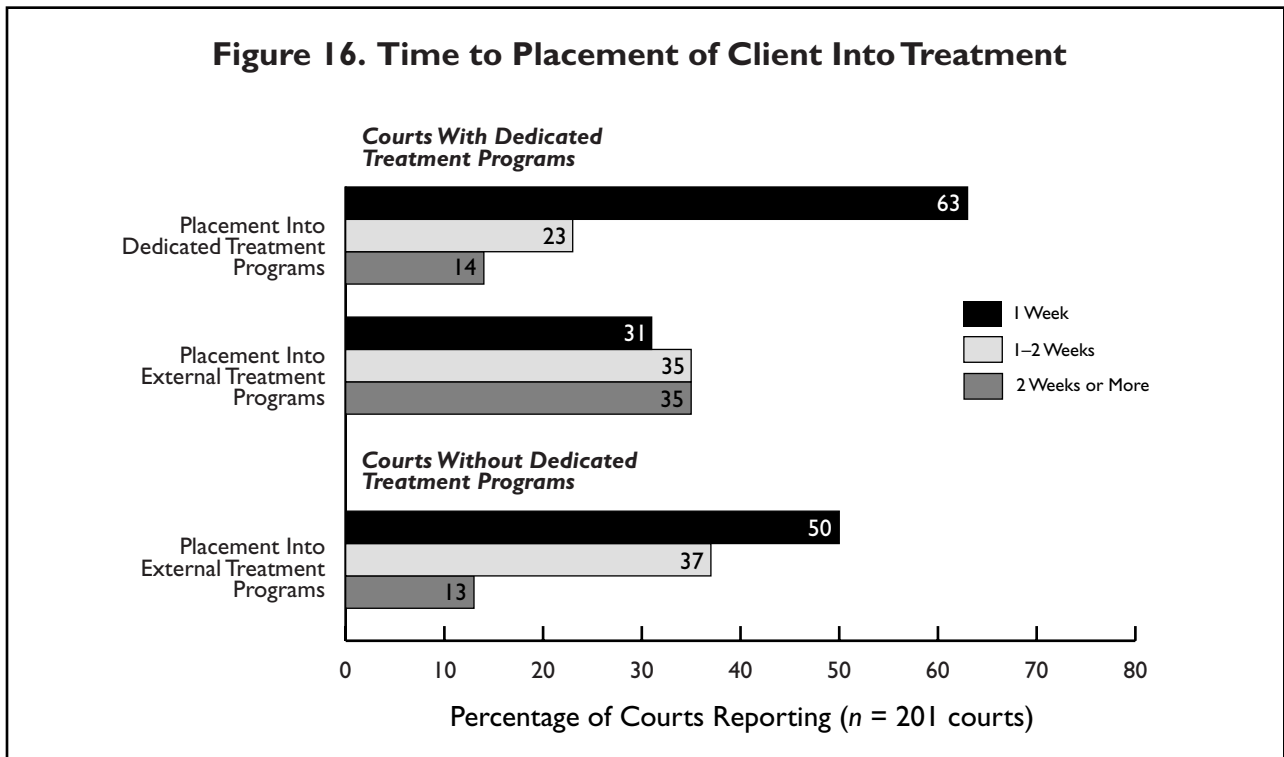


have limitations based on legal criteria (for instance, limited time left on a sentence) and may be unable to follow treatment recommendations. Judges may order certain types of treatment (particularly residential) because they are looking for additional supervision. In this case, providers can discuss other alternatives, such as halfway house placement, with judges at team meetings.

Some drug courts find that a few providers are reluctant to admit “challenging” clients. Program personnel are sometimes encouraged to expand their notions of acceptable clientele when a judge overrides a decision. On the other hand, most judges are not clinicians, and they should seek the input of clinicians when making treatment placement decisions (although they must make decisions that involve public safety). Providers must recognize that judges have ultimate authority over defendants/offenders and that they have ultimate responsibility for the drug court. Effective drug courts encourage collaboration, and exceptions to collaborative approaches are discussed by the drug court team.

Time to Treatment Admission

Sixty-three percent of drug courts report that treatment admission into programs dedicated to the drug court occurs within 1 week of eligibility determination. In 23 percent of drug courts, participants are admitted to



dedicated treatment 1–2 weeks after being determined eligible. Fourteen percent report that it takes longer than 2 weeks for treatment admission to dedicated programs.

Waiting periods for admission to external programs are longer than those for dedicated programs. Only 31 percent of clients are admitted within 5 days after eligibility is determined, although 66 percent are admitted within 2 weeks. Thirty-five percent of courts report that it takes longer than 2 weeks for treatment admission.

As shown in figure 16, courts that do not have dedicated treatment programs are able to access external services more quickly than drug courts that have dedicated programs and use external services. This may be because drug courts without dedicated providers communicate with external providers on a regular basis to ensure placement of their clients. Perhaps drug courts with dedicated services do not focus as much on developing relationships with external providers and consequently experience longer delays in placing participants. On the other hand, jurisdictions that can place participants into treatment services rapidly may have decided they do not need providers dedicated to the drug court because treatment is more readily available in their communities.

Twelve percent of courts that report having managed care in their jurisdictions indicate that one outcome has been an increase in waiting

times for treatment admission. Although drug courts overall report that participants access treatment relatively rapidly, their greatest and most common frustration regarding treatment is waiting for treatment, especially residential treatment.

Specialized and Support Services

Addiction to drugs or alcohol affects many aspects of a person's life. Addicts may have health problems, co-occurring mental health disorders or mental health symptoms, and social problems that extend to employment, interpersonal relationships, criminality, and beyond. Many drug court participants (and other addicts) are impoverished, and some may lack the skills needed to function effectively in society. Also, many substance-involved offenders have experienced physical and sexual abuse (as victims or as perpetrators), domestic violence, housing instability, and other problems that may significantly impede progress toward recovery if not addressed.

NIDA Principle 3: Effective treatment attends to multiple needs of the individual, not just his or her drug use.

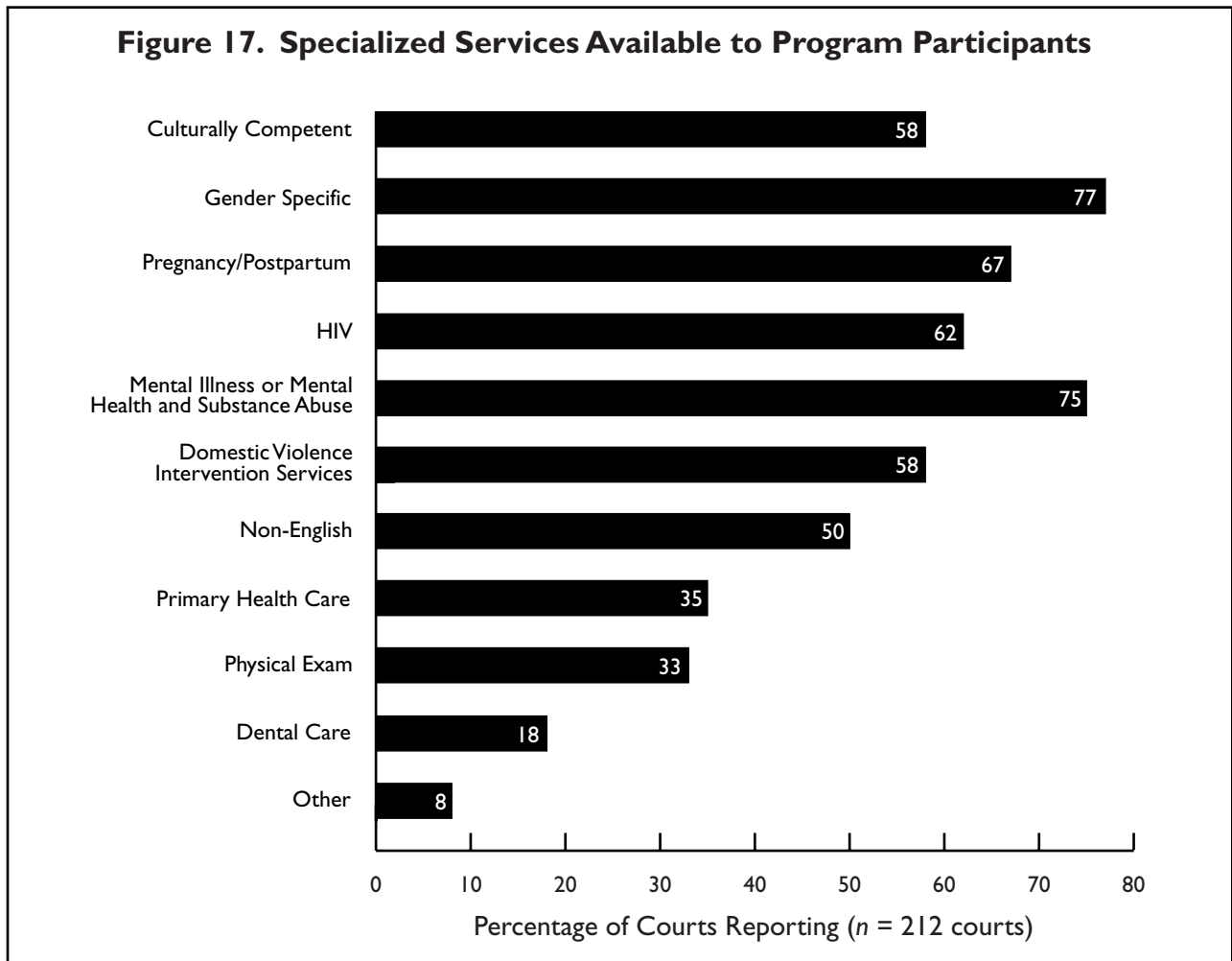
This section examines the services that are available to support participants and addresses the question, Are the services available to drug courts sufficient to meet the multiple needs of individuals?

Specialized Services

In addition to having access to various levels of services (e.g., residential and outpatient) and program approaches (e.g., self-help and criminal thinking), drug courts report that a substantial number of other services are available to participants.

Drug Court Key Component 4: Drug courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services.

Figure 17 lists services that drug courts indicate are available as part of their standard treatment regimen. A large percentage of drug courts report having access to a fairly wide range of specialized services, although the numbers of participants who receive these services are not known.



Fifty-eight percent of drug courts report that they provide culturally competent programming as part of their regular treatment regimen. Seventy-seven percent report providing gender-specific services. Providing services that are relevant to diverse populations is important in engaging and retaining clients in treatment and promoting recovery.

Although drug courts generally appear to have access to specialized services, a number of drug courts indicate they are frustrated by services that are inappropriate or have poor outcomes with women, the mentally ill, and people of different ethnic or racial groups. Followup interviews indicated a wide variation in how drug courts define “culturally competent,” ranging from “there is one Spanish-speaking counselor in one of the treatment programs” to “we only use providers that represent the culture of the community, that have staff that reflect the client population, and that address cultural issues in treatment.”

Support Services

Figure 18 lists services that drug courts report are available, either as part of the drug court program itself or in the community. According to survey results, drug courts have a wide range of support services that are accessible to participants.

Almost all drug courts report services for mentally ill clients (treatment, 91 percent; referral, 96 percent) and access to vocational training (86 percent) and educational remediation (92 percent). Clearly, these services are recognized as important to the success of drug court participants.

Drug Court Performance Benchmark: Services should be available to meet the treatment needs of each participant.

Challenges to Treatment

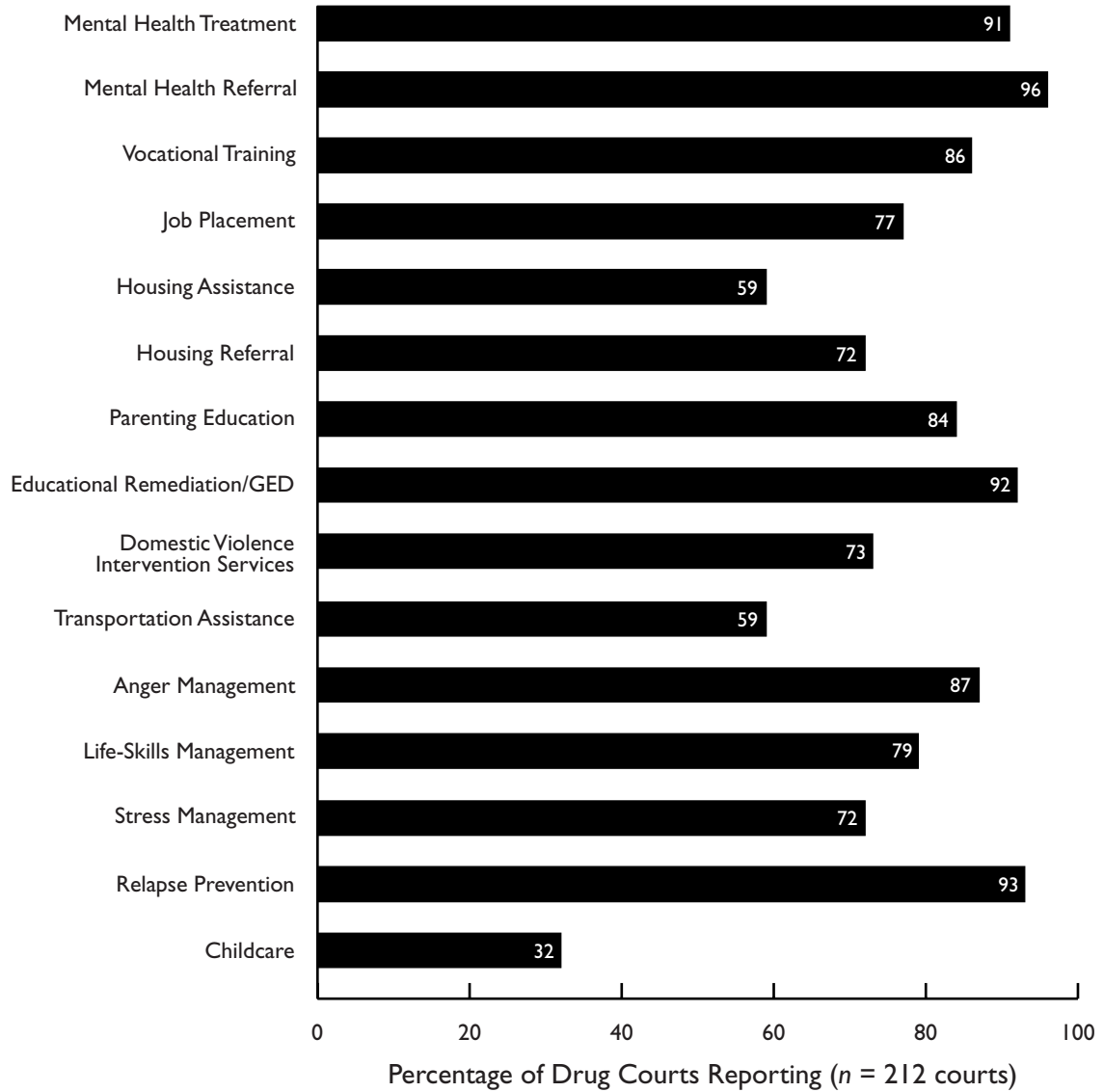
This section examines some common barriers to treatment and looks at the effectiveness of drug courts in reducing the barriers. A number of drug courts report that they use support services and specialized programs to address the needs of participants.

For clients to engage in treatment, physical and other barriers to treatment participation must be removed. Clients must have transportation or be transported, the delivery of treatment must not conflict with work or school schedules, and dependent care responsibilities must not be an obstacle to participation. In addition, conditions such as lack of housing or involvement in domestic violence can limit a participant's ability to attend treatment.

- 59 percent of drug courts indicate that they can provide housing assistance to clients.
- 59 percent of drug courts indicate that they can provide transportation assistance.
- 73 percent of drug courts indicate that they can provide domestic violence intervention services.
- 32 percent of drug courts indicate that they can provide childcare.

Other barriers to treatment are presented when programs do not or cannot provide services that are relevant to particular ethnic or racial groups.

Figure 18. Support Services Available to Program Participants



Treatment clients respond when they feel valued, respected, and understood and when they can relate to counseling staff and to their peer group in treatment.

At minimum, treatment programs should do the following:

- Recognize and value cultural differences and similarities.
- Understand and support the importance of cultural identity.
- Hire staff and retain mentors who reflect the client population.

- Review statistics to ensure that the client population is representative of community populations.
- Examine outcomes for racial/ethnic differences and adjust the program as needed.
- Identify strengths in the client and in the client’s environment.
- Create an office environment that is welcoming to all cultural groups.

Men and women also have unique needs and experiences that can best be addressed in gender-specific programming, or at least in same-sex treatment groups within coeducational programs (Blume, 1998). Seventy-seven percent of drug courts report that gender-specific and women-only programs are available. Sixty-seven percent have services for pregnant and postpartum women who participate in drug court. Women are likely to be primary caregivers of dependent children and are much more likely than men to be victims of sexual and/or physical abuse. Women are more likely than men to have co-occurring mental health problems, especially depression and posttraumatic stress disorder (Peters et al., 1997). Women are more likely than men to have health-related problems earlier in the course of their addiction, and they may have fewer financial resources and employment skills. The stigma associated with substance abuse is different for women than for men because of their social roles. As previously mentioned, only 32 percent of drug courts can provide childcare, which is likely to have a disproportionate impact on female clients.

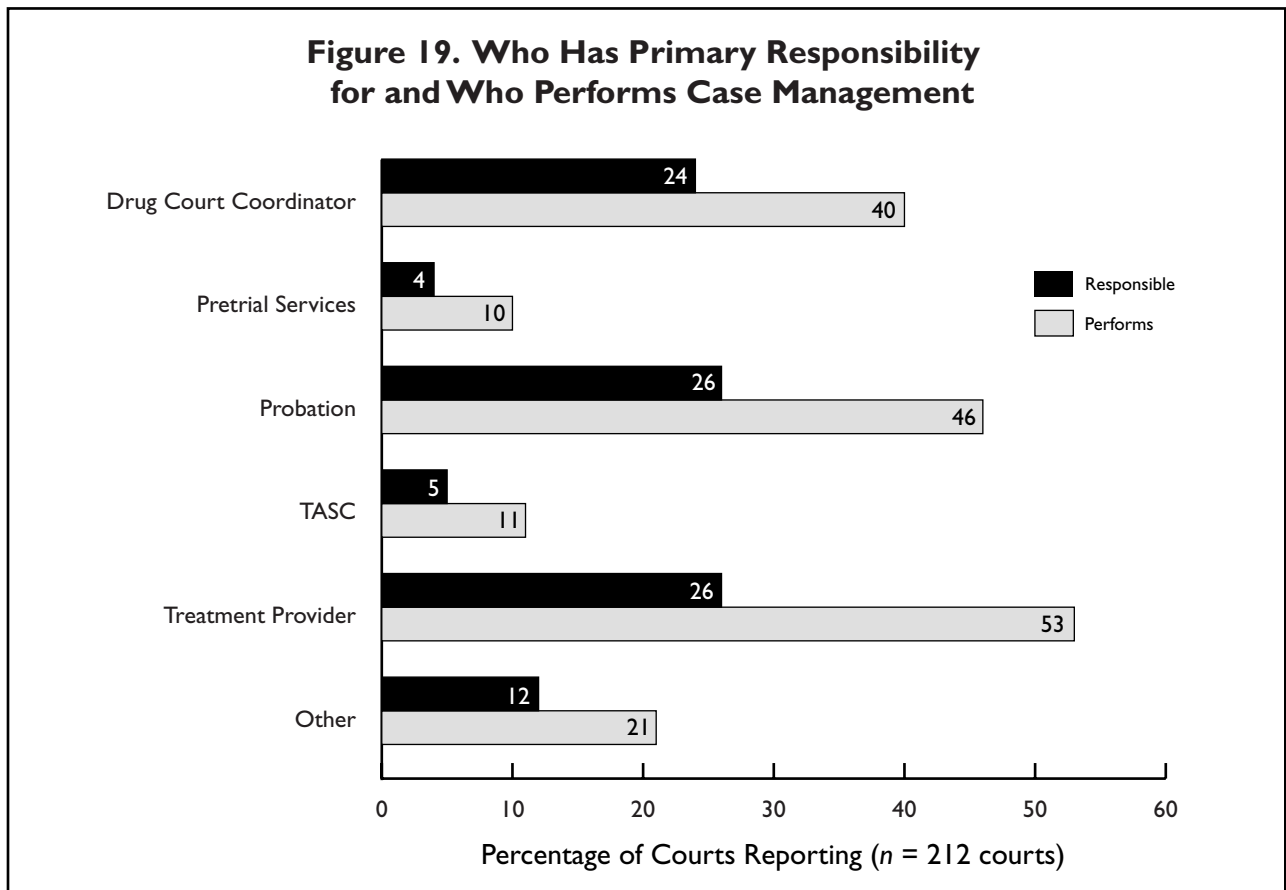
Case Management

NIDA Principle 4: An individual’s treatment and service plan must be assessed continually and modified as necessary to ensure that the plan meets the person’s changing needs.

One of the benchmarks of drug court is the ongoing monitoring and oversight of those participating in treatment and other services. This oversight is provided primarily through case management, a process designed to link participants with services, track progress, and promote continued involvement in treatment. Case management concepts evolved primarily from social work models (Center for Substance Abuse Treatment, 1998b) and have been adapted for populations with mental health issues and offender populations (Bureau of Justice Assistance, 1992).

Effective clinical case management is the glue that holds together all the services required to meet a client’s needs while supporting both justice and treatment. Case management ensures continuing assessment and linkage with the available continuum of care. Appropriately delivered, it is a clinical process that can overcome deficits in the treatment system and fill gaps in services. Effective case management is a core function that addresses treatment resistance and encourages engagement and retention in treatment. Clinical case management is essential for clients with complex needs that must be addressed by multiple agencies and programs that often have different missions, philosophies, and goals.

Case management is conducted by a variety of professionals in drug courts. Many drug courts use existing treatment or probation/pretrial staff to perform case management functions. This situation can be problematic if philosophical orientation or agency allegiance is too strong in the direction of either justice or treatment. Third-party case management, such as that provided by TASC programs, can overcome this dilemma. Case managers need to have the objectivity and independence to incorporate both justice and treatment priorities while supporting the client through requirements established by both systems.



The “other” category in figure 19 includes drug courts that primarily report case management responsibilities shared by two or more agencies or reliance on case managers who work specifically for the drug court.

Case managers in drug court perform a variety of functions, as depicted in figure 20, indicating that basic case management services in drug court provide a means for continuous assessment and monitoring of participant progress. Drug court participants report to case managers regularly, with 41 percent reporting to case managers weekly, as shown in figure 21.

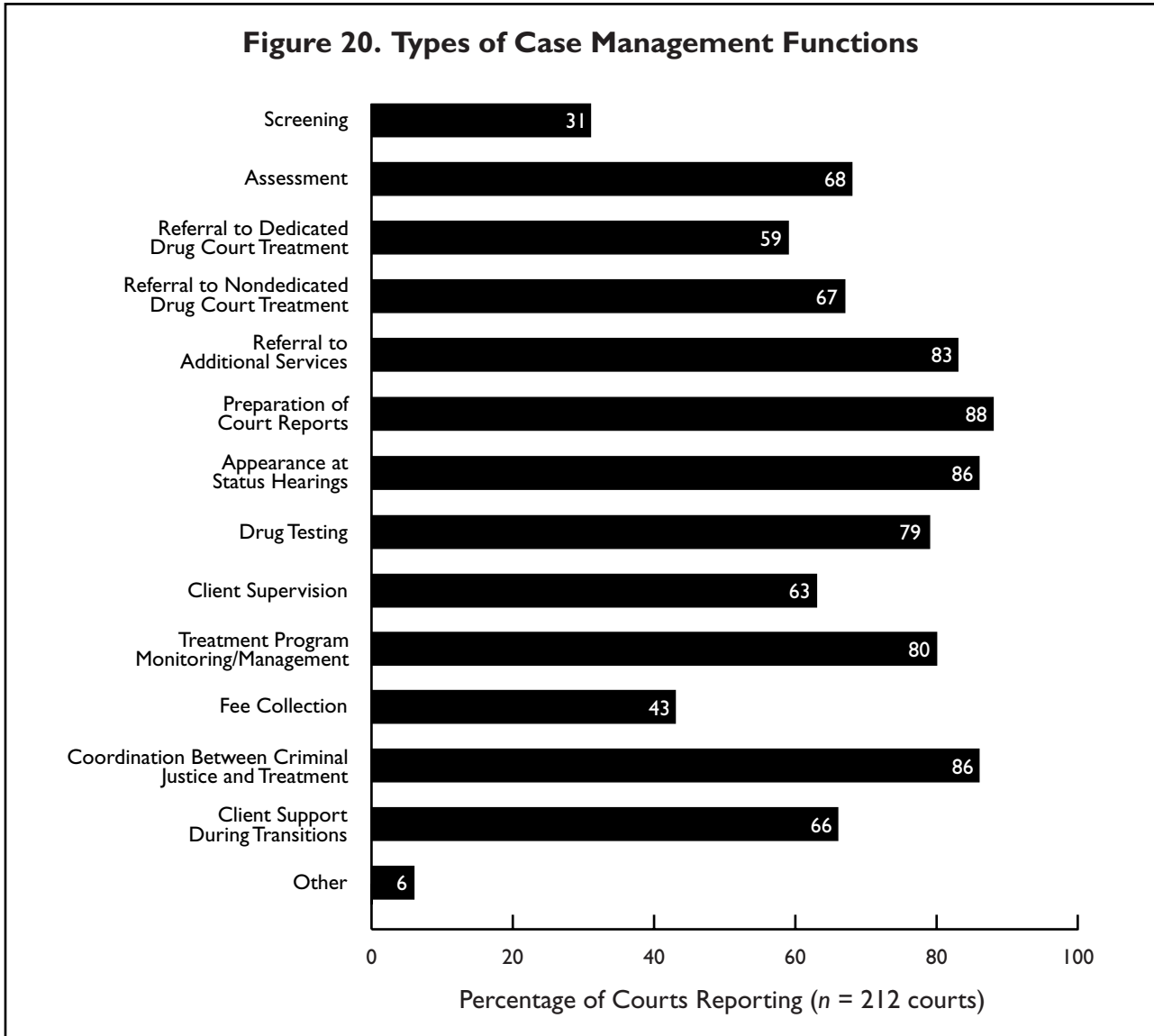
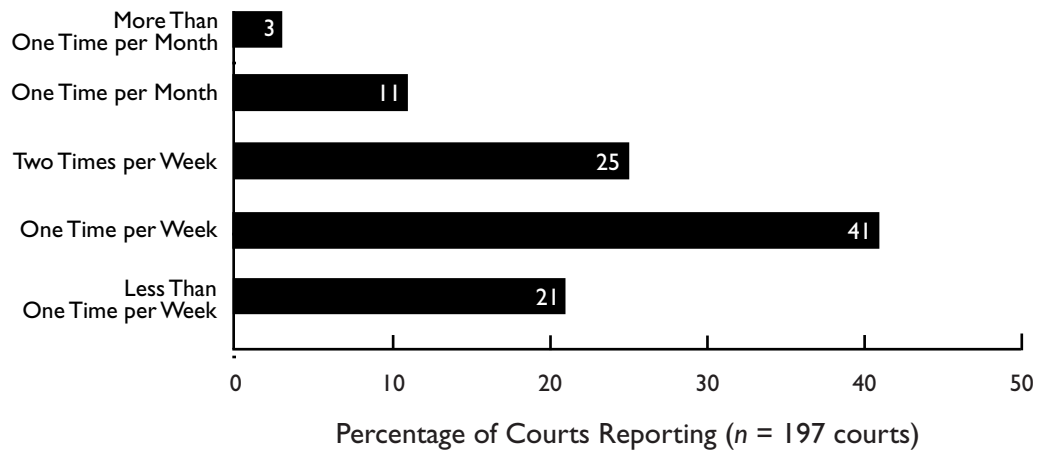


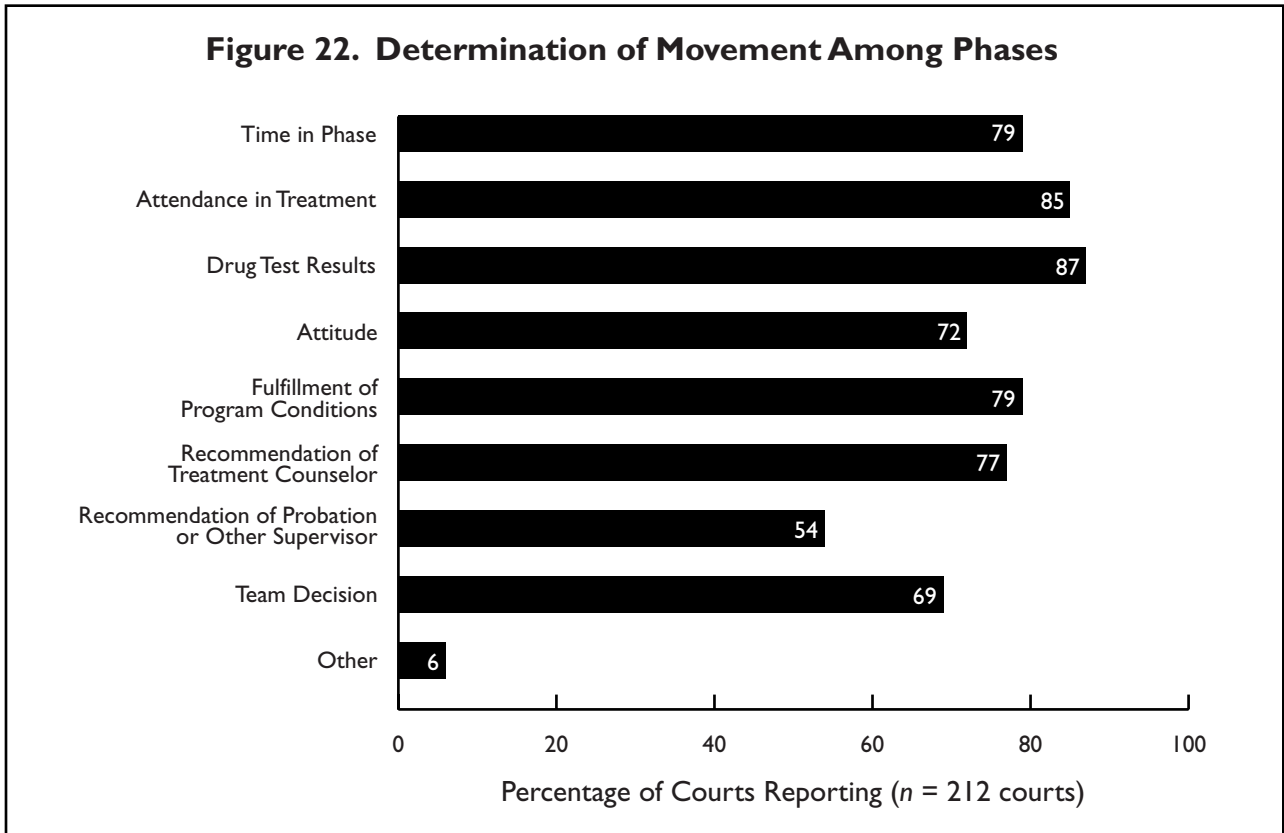
Figure 21. Frequency With Which Drug Court Participants Report to Case Manager



Case managers submit reports to the court regularly, with 35 percent of the courts receiving reports on a weekly basis. Case management reports inform the court about client progress across a number of domains:

- Treatment attendance (89 percent).
- Treatment progress (86 percent).
- Drug test results (89 percent).
- Compliance with probation or other criminal justice supervision (68 percent).
- School attendance (59 percent).
- Employment status (78 percent).
- Case manager recommendations (84 percent).

Drug Court Performance Benchmark: Clinical case management services are available to provide ongoing assessment of participant progress and needs, to coordinate referrals to services in addition to primary treatment, to provide structure and support for individuals who typically have difficulty using services even when they are available, and to ensure communication between the court and the various service providers.



Case managers provide comprehensive information to the court in their reports and offer options through recommendations. A number of courts report being frustrated, however, by late reports and poor communication by treatment providers.

Drug courts respond in a variety of ways to negative drug tests and other indicators of progress (or lack of progress). Drug court participants are moved between or among phases of treatment based on factors shown in figure 22.

Findings indicate that movement between or among phases is based on a variety of factors including, but not limited to, time in the program. Information provided in case management reports is used when making decisions to adjust the phase of treatment, and recommendations by treatment providers/case managers are major factors in making these decisions.

Time in Treatment

NIDA Principle 5: Remaining in treatment for an adequate period of time is critical for treatment effectiveness.

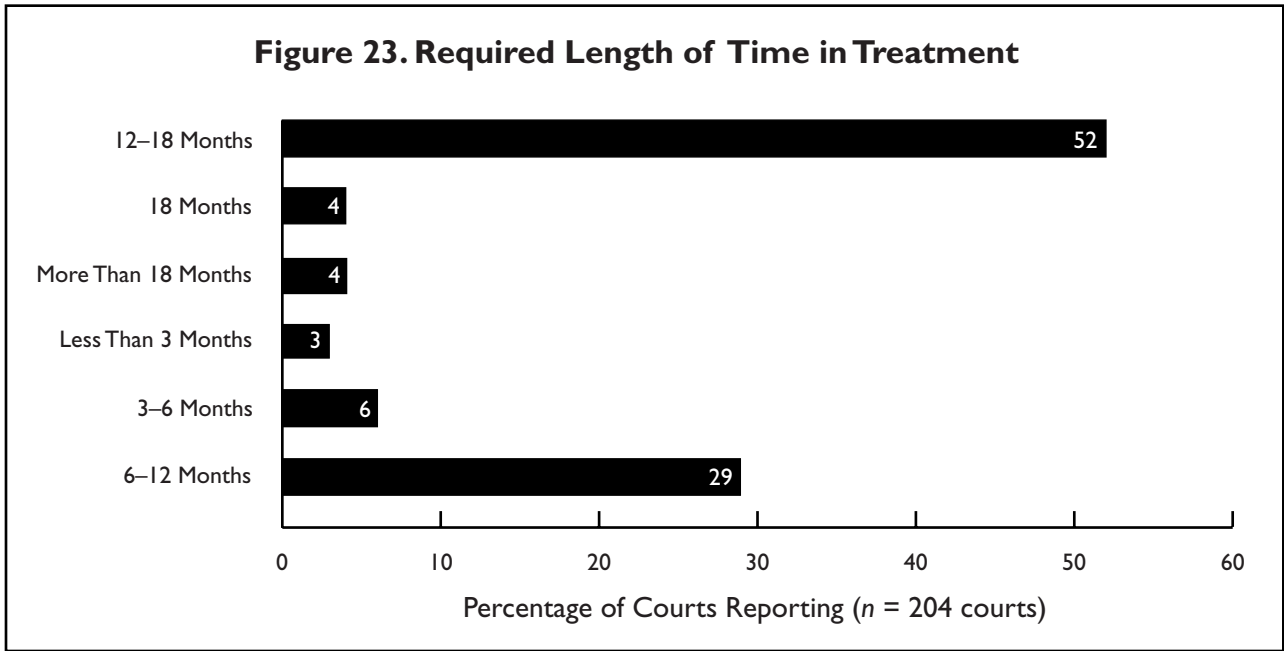
Research has clearly demonstrated that several variables lead to better treatment outcomes (McLellan and McKay, 1998): (1) longer stay in treatment; (2) individual counselors and more counseling sessions; (3) delivery of proper medications; (4) participation in behavioral reinforcement interventions; (5) participation in AA, NA, or Cocaine Anonymous following treatment; and (6) supplemental social services for adjunctive medical, psychiatric, and/or family problems.

Length of time in treatment has been shown to be the most salient factor related to successful treatment outcomes (Finney and Moos, 1998). Treatment provides an opportunity for substance abusers to learn about addiction, recognize the impact of drugs or alcohol on their lives, and adopt prosocial and drug-free behaviors.

This section examines how long drug court participants remain in treatment and the reasons they are discharged early. Slightly more than half (52 percent) of adult drug courts require participants to be in treatment for 12–18 months. Nearly a third (29 percent) require participants to attend treatment for 6–12 months. About 9 percent of drug courts require less than 6 months of treatment for participants. It appears that most drug court participants are required to stay in treatment long enough to reach a “significant improvement threshold” (National Institute on Drug Abuse, 1999, p. 3).

Treatment in most drug courts is structured in phases. In general, participants are detoxified and exposed to intensive treatment during the first phase, with subsequent phases devoted to maintenance and aftercare. So, while drug court participants are connected with treatment services throughout all or most of the drug court experience, active treatment generally occurs within the first 3–4 months, with treatment contacts becoming less frequent thereafter.

Nearly 80 percent of drug courts report that time in a phase of treatment is a factor in movement to another phase. Thus, most drug courts require a minimum time in treatment before considering reducing treatment participation requirements. Required length of time in treatment is shown in figure 23.



Reasons for Early Discharge

This survey does not ask about rates of graduation. Surveys by the Drug Court Clearinghouse indicate that in June 2000, retention rates in drug courts were about 67 percent (American University, 2000). Table 2 shows the percentage of drug courts reporting early discharge. Figure 24 shows why participants are discharged early.

A significant number of courts indicate that participants are discharged from treatment because they do not report initially, they are admitted to treatment but do not engage, they miss too many appointments (a clear sign of failure to engage), or they have a poor attitude or lack motivation.

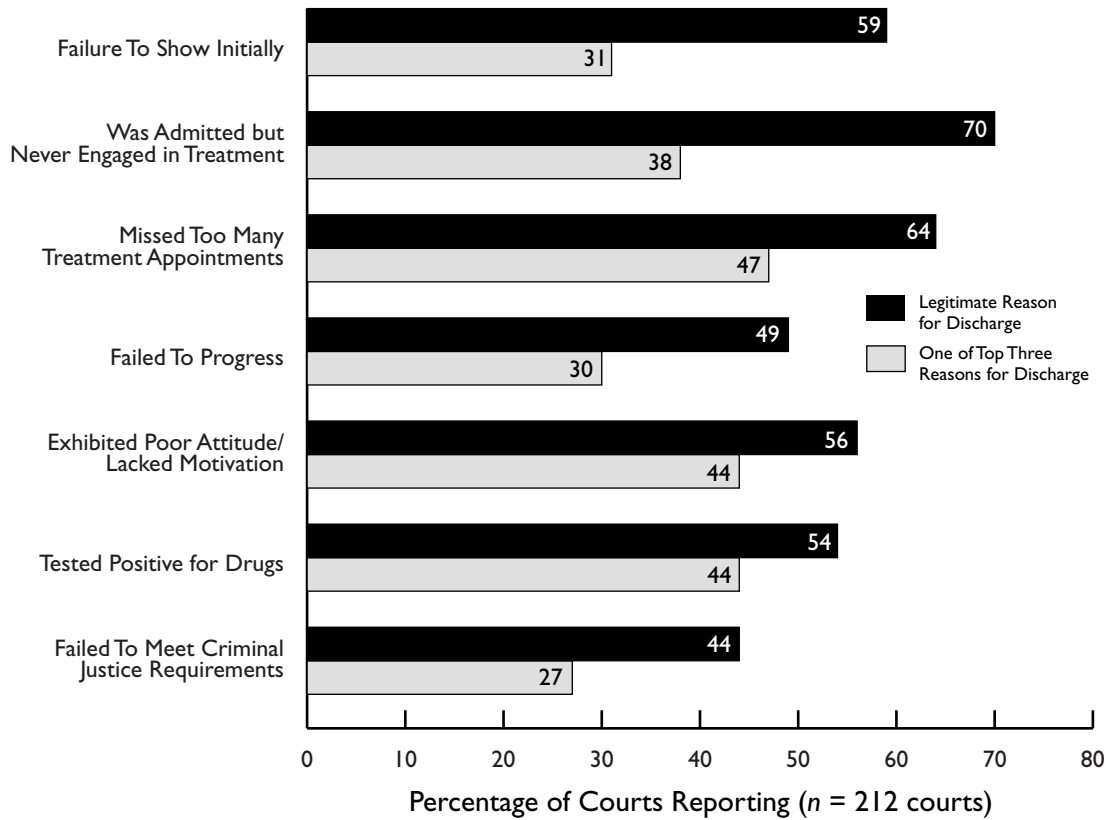
NIDA Principle 10: Treatment does not need to be voluntary to be effective.

These findings raise several points related to client engagement and retention that merit further discussion. Lack of motivation should never be the sole reason a potential participant is excluded from drug court, unless the lack of motivation means the participant refuses drug court. Instead, drug courts can develop activities to engage and motivate participants, as well as incentives for drug court participation.

Table 2. Drug Courts Reporting Early Discharge, by Proportion of Treatment Program Participants

Proportion of Program Participants (%)	Percentage of Drug Courts
Less than 5	48 (n = 78)
5–10	20 (n = 34)
11–24	23 (n = 38)
25–50	10 (n = 16)
Greater than 50	1 (n = 1)

Figure 24. Reasons For Early Discharge From Treatment



Encouragement through legal pressure and effective case management can also stimulate and enhance motivation to engage in treatment. Rather than using lack of motivation as a reason to discharge clients, drug courts and treatment programs can try other interventions to encourage participation. In some drug courts, the expectation of engagement is clear, and attendance in treatment is the norm.

Several instruments have been developed to identify motivation for treatment (Peters and Peyton, 1998). An assessment of motivation should be used to develop strategies to enhance motivation, not to disqualify someone from treatment. Specific clinical interventions designed to enhance motivation have also been developed. Known as motivational enhancement therapy (National Institute on Alcohol Abuse and Alcoholism, 1999), these techniques enable clinicians to reduce client defensiveness and encourage the development of personal insight and productive client-counselor relationships.

For staff who interact with drug court participants, especially during clinical screening, assessment, and counseling, drug courts can provide training and information on motivational interviewing and enhancement. In addition, case management techniques can promote improved engagement and retention of drug court participants.

Counseling and Counselor Qualifications

NIDA Principle 6: Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction.

Treatment clients have better outcomes when counseling is included as part of the treatment regimen. Research has shown that adjunctive therapies alone (e.g., pharmacological interventions or acupuncture) are not nearly as effective as counseling combined with these other, often essential services (Center for Substance Abuse Treatment, 1995a).

This section examines whether drug courts include counseling in their programming and addresses issues that relate to the quality of counseling provided. Almost all drug courts report that counseling is a primary part of their drug intervention services in both residential and outpatient settings.

Drug court programs rely heavily on participation in self-help groups such as AA and NA. As shown in figure 7, 67 percent ($n=142$) of

external programs and 83 percent ($n=135$) of dedicated programs use self-help as a treatment modality. Moreover, these services are combined with counseling services and continue as a major component of aftercare. Other programmatic interventions are offered in addition to more traditional counseling approaches.

Fifty-three percent ($n=86$) of drug courts with dedicated providers indicate that all counselors in these programs are licensed or certified as professional substance abuse counselors, and 44 percent ($n=71$) indicate that most counselors maintain professional certification. This is a typical occurrence in treatment programming as staff work to accrue education and experience required to obtain licensing and certification.

Twenty-seven percent of respondent drug courts report that all counselors in external programs are certified as professional substance abuse counselors, and an additional 44 percent report that most are certified. Fifteen percent of drug courts are unsure of the certification status of counselors in external programs.

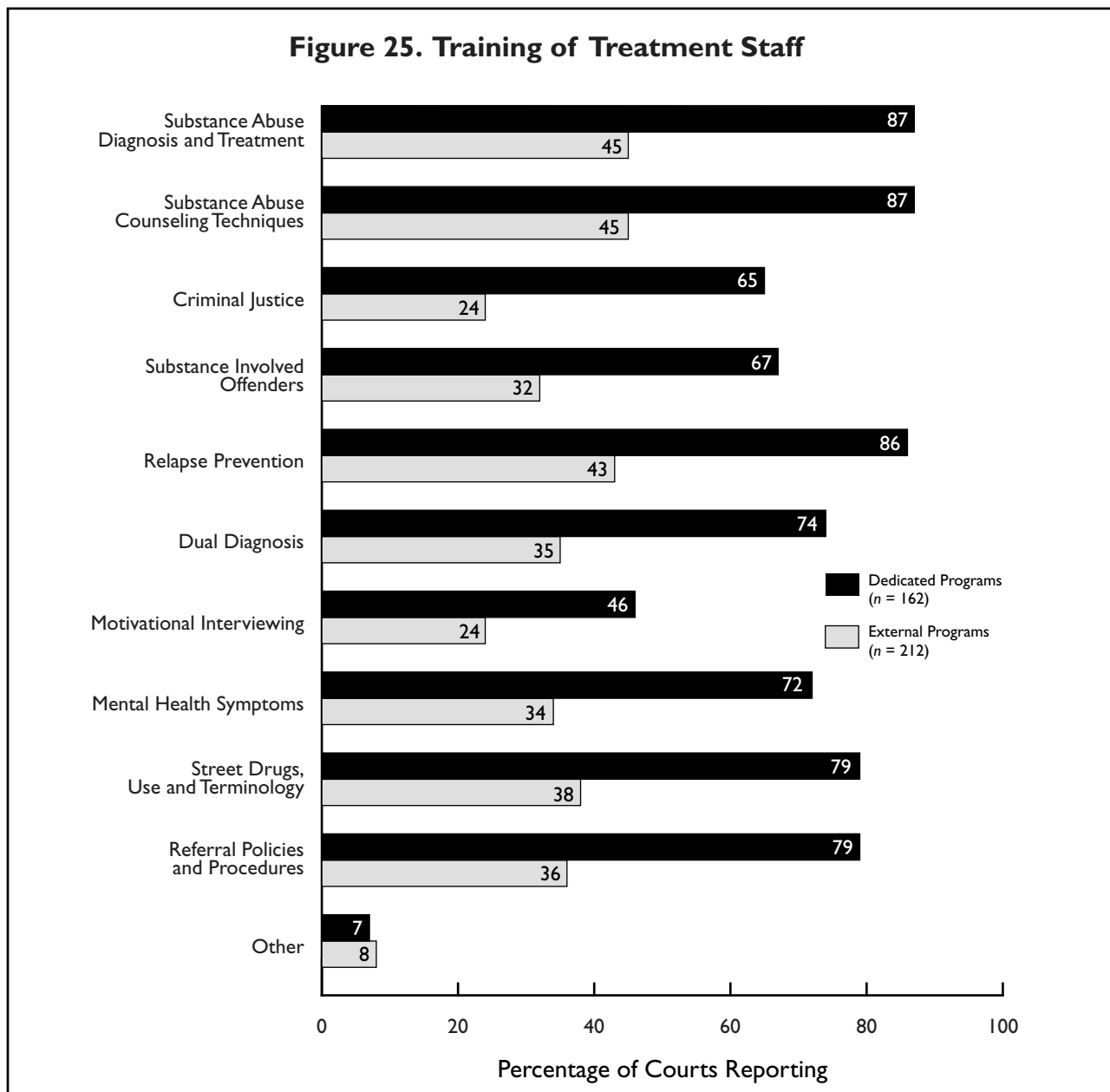
Drug courts report that specialized training is provided to counseling staff in dedicated and external substance abuse programs, as depicted in figure 25. Overall, results indicate that staff in dedicated programs receive a wide range of training to work more effectively with drug court populations. Counselors in external programs may not have access to critical information (for instance, information on the justice system) or may otherwise be unprepared to work effectively with drug court participants and other offender clients because they have less training in these areas. Drug courts that use external providers should offer training and information to assist these providers in delivering effective services to drug court participants. In addition, drug courts should work with single State AOD agencies to develop training and counselor certification requirements that relate to offender populations.

The findings demonstrate that most drug courts work with treatment programs that are licensed or certified and that most or all counselors are professionally certified to provide substance abuse services. Research has demonstrated that other factors are related to counselor effectiveness, including the following (McLellan and McKay, 1998):

- A client-centered approach that emphasizes reflective listening is more effective for problem drinkers than a directive, confrontational approach.
- Therapists' in-session interpersonal functioning is positively associated with greater effectiveness. Indicators of "interpersonal functioning" include
 - Ability to form a helping alliance.

- Accurate empathy.
- Genuineness, concreteness, and respect.

While requiring counselors to meet training and education requirements helps establish core competencies, identifying the kind of personal characteristics that effective counselors seem to exhibit is more difficult. However, some of these characteristics can be observed by watching the interaction of clients and staff in group treatment settings. Additional information on skills that counseling staff should possess is available in the CSAT publication on addiction counseling competencies (Center for Substance Abuse Treatment, 1998a).



Medications

NIDA Principle 7: Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.

Medications are often needed in conjunction with other forms of therapy to stabilize treatment clients, assist in detoxification, and help prevent relapse. In addition, clients with mental health disorders may need medication to control their symptoms. Opiate agonists, such as methadone, have proved effective in preventing relapses to heroin use, reducing crime associated with the use of illicit drugs, and improving the overall functioning of opiate addicts who cannot “get clean” (Effective medical treatment of opiate addiction, 1997). Opiate antagonists and substitutes, such as naltrexone and LAAM, have proved effective in preventing relapses into heroin use. These interventions are more effective when combined with more traditional counseling interventions; there is no “magic bullet.” Addiction is a biological, psychological, and social disorder, and all of these components must be addressed in successful treatment interventions.

This section addresses the question, Does drug court treatment include the appropriate use of medications? The survey reveals that 20 percent of drug courts report having methadone maintenance available through their dedicated providers, and 19 percent have access to other pharmacological interventions through dedicated services. In addition, 34 percent of drug courts can refer participants to methadone maintenance programs in the community, and 16 percent can refer participants to other pharmacological therapies.

This survey does not indicate the number of drug courts that have established policies (or preferences) precluding participants from methadone maintenance or other pharmacological interventions. Followup interviews suggest that many drug courts prohibit methadone maintenance but may allow participants to detoxify using methadone. More drug courts have access to acupuncture than to methadone and other pharmacological interventions. Given the research that supports the effectiveness of methadone and other pharmacological interventions (Effective medical treatment of opiate addiction, 1997), drug courts may want to examine their current practices regarding these services. While research related to acupuncture has also been positive, acupuncture is best used as an adjunctive therapy (Center for Substance Abuse Treatment, 1995a).



Philosophies regarding the use of prescription medication vary widely among treatment programs and among drug courts. Eleven percent of drug courts report that they exclude potential participants from admission to drug court because of use of prescribed medications. Followup interviews revealed that most drug courts have policies related to the use of prescription medications and will allow their use if there is an approved need.

Mental Health Issues

NIDA Principle 8: Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.

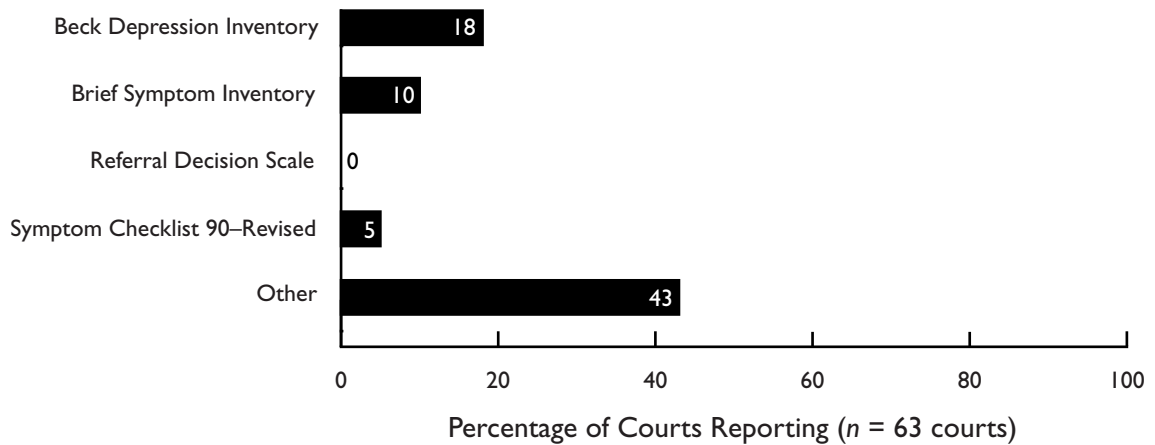
There is a high incidence of individuals with coexisting mental health and substance abuse disorders in the offender population. Studies indicate that 3 to 11 percent of jailed inmates have co-occurring disorders (Peters and Hills, 1993), and the National GAINS Center (1997) reports that 5 percent of arrestees in 1995 had both a substance abuse disorder and a coexisting mental illness. A 1990 study found that 26 percent of incarcerated substance users have a lifetime history of serious mental illness, including major depression, bipolar disorders, or schizophrenia (Cote and Hodgins, 1990). In addition, mental health problems, particularly depression and posttraumatic stress disorder, occur disproportionately among female offenders (Peters et al., 1997). Unless both disorders are addressed in treatment, it is unlikely that adequate progress will be made in either domain.

This section highlights the question, Do drug courts provide appropriate services for participants with mental health disorders? Sixty-one percent of drug courts report that they conduct a formal mental health screening as part of the assessment process. Eighty-three percent of those who do not conduct mental health screenings indicate that they can refer drug court participants for mental health assessments.

Sixty-seven percent of drug courts indicate that if participants are referred for mental health assessments, these assessments are conducted within 1–2 weeks. Fourteen percent indicate that it takes longer than 2 weeks for a mental health assessment to be done.

It is important to use scientifically validated instruments in screening for mental health history and symptoms to obtain accurate information that can be compared across drug courts. Nevertheless, few drug courts use a

Figure 26. Mental Health Clinical Screening Instruments Used by Drug Courts



scientifically validated instrument to screen for mental health problems. In addition, special training and professional qualifications are essential for diagnosing mental health issues. Figure 26 shows the instruments drug courts use to screen for mental health problems. Information regarding mental health screening instruments is contained in *Guideline for Drug Courts on Screening and Assessment* (Peters and Peyton, 1998), as well as ASAM's *Principles of Addiction Medicine* (Graham and Schultz, 1998).

A variety of responses were given in the “other” category. The most frequent response indicates that participants are referred to mental health professionals, and the instruments used are unknown to the drug court.

Seventy-five percent of drug courts report that services for persons who are mentally ill or have co-occurring mental health and substance abuse disorders are available as part of their standard treatment programming. More than 90 percent of drug courts can provide mental health treatment or referral to mental health services in support of participants.

Drug Court Performance Benchmark: Specialized services should be considered for participants with co-occurring AOD problems and mental health disorders.

Although drug courts report that mental health services are available in most jurisdictions, 37 percent report that the presence of a mental disorder is used to exclude people from admission to the drug court.

Followup interviews suggested that drug courts have varied experiences accessing mental health services for participants. In some jurisdictions, mental health services are readily available and integrated with substance abuse treatment services. In other jurisdictions, it is difficult for drug court participants to gain access to mental health services.¹¹ Responding drug courts indicate they are very concerned about mental health issues but may exclude the mentally ill because they cannot provide services for them.

Detoxification

NIDA Principle 9: Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use.

Medical detoxification is sometimes necessary for individuals who are addicted to certain types of drugs (particularly opiates, other narcotics, and alcohol) to safely and comfortably rid their systems of intoxicants. “Getting clean” is a necessary precursor to successfully engaging in the treatment process. Most drug court participants will likely be able to achieve this without medical intervention. However, it is only a first step, and abstinence alone does not necessarily lead to recovery. In fact, numerous inmates who were drug free while incarcerated go back to regular use as soon as they have the opportunity if they lack treatment intervention and support.

While NIDA principle 9 should be obvious, with the onset of managed care, some localities are experiencing an increase in clients being authorized for detoxification services only. In addition, new terminology for detoxification, notably “acute care,” is coming into usage as managed care organizations are increasing their reliance on detoxification services as a primary, singular intervention.

This section examines the questions, “Do drug courts have access to detoxification services?” and “Do drug courts use detoxification as the only treatment intervention?” Fifty-five percent of drug courts indicate that detoxification services are provided through their dedicated programs, and 67 percent report that they can access detoxification services through programs available in their communities. No drug courts report using detoxification as the only intervention for participants. Instead, drug courts report that they use detoxification as a precursor to participating in other drug court services.

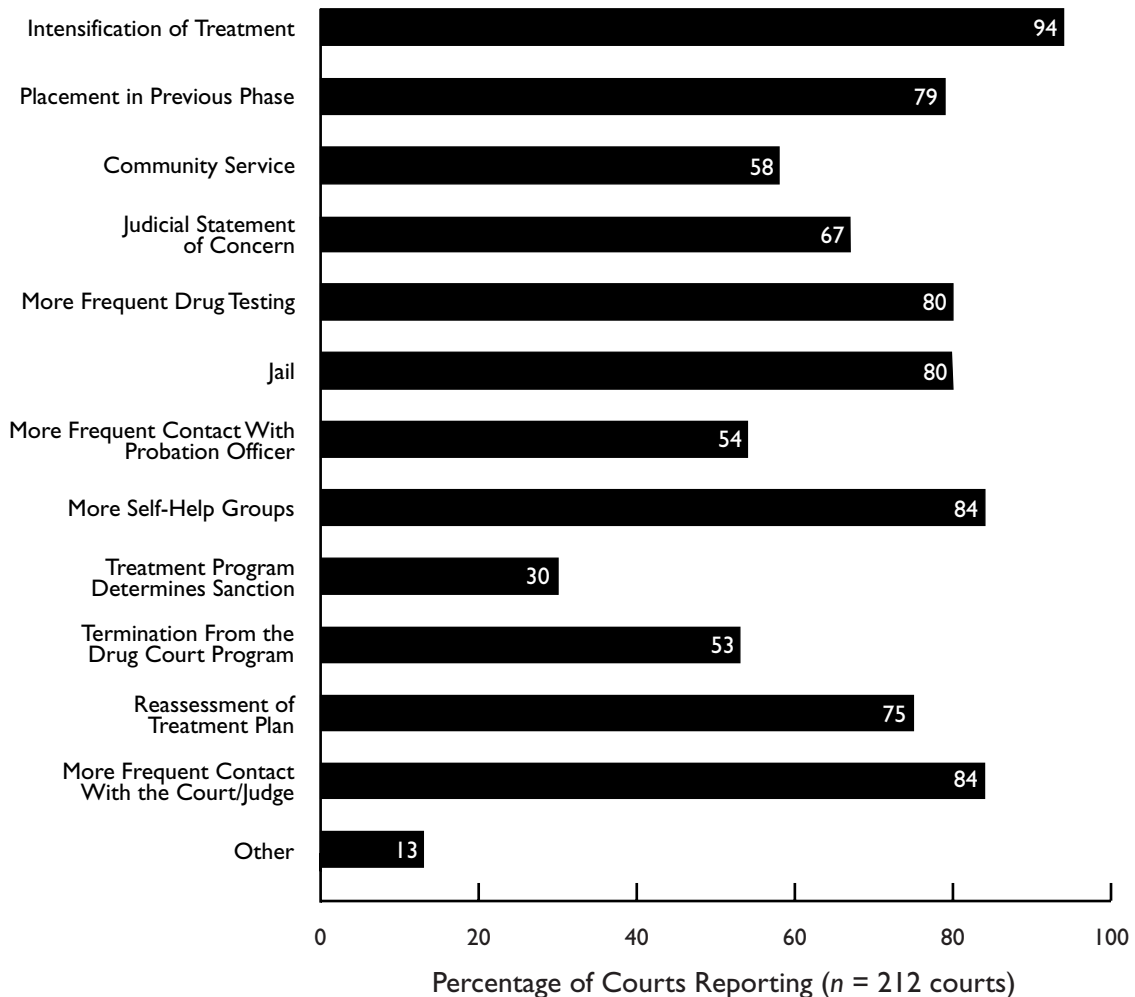
Testing for Alcohol and Other Drugs

NIDA Principle 11: Possible drug use during treatment must be monitored continuously.

Frequent testing for alcohol and other drugs is a key component of effective drug courts. AOD testing provides objective information regarding participants' progress and provides incentives for obtaining and maintaining abstinence.

This section answers the question, Do drug courts monitor participants for drug use during treatment? Drug courts actively monitor the drug use

Figure 27. Consequences of Positive Drug and Alcohol Tests

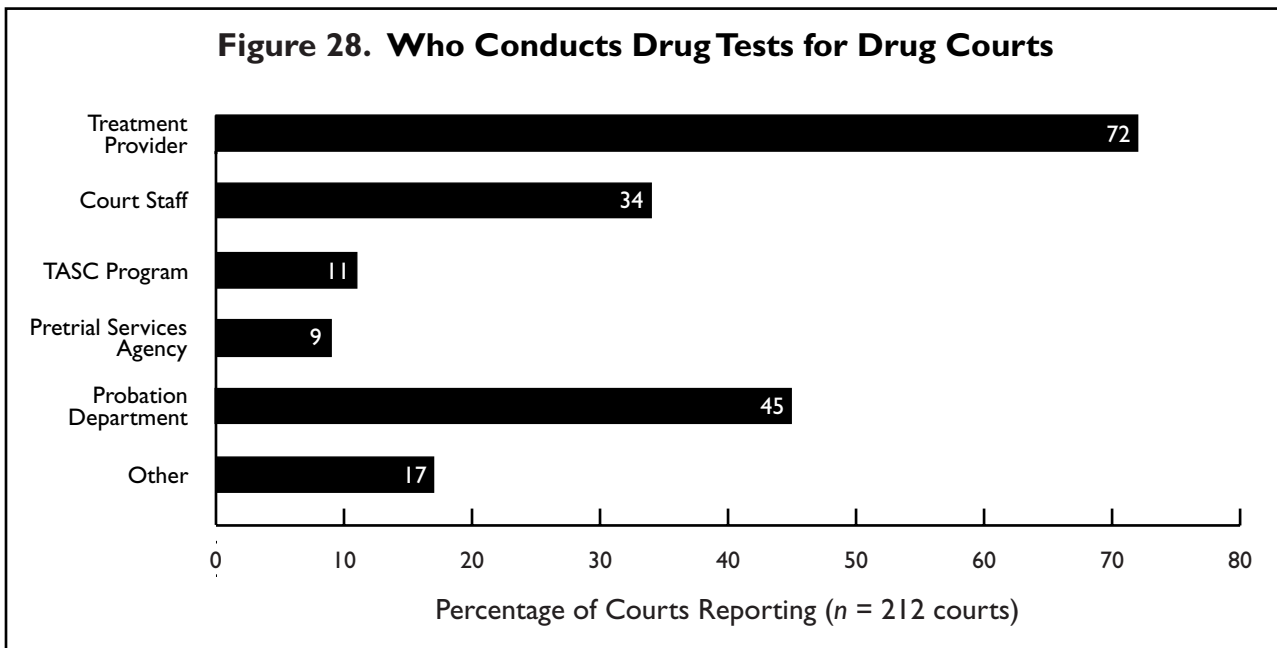


of participants through regular and random screening. Ninety-seven percent of drug courts conduct random drug screens on participants, and of those, 96 percent report that collection of specimens is observed. In addition, 85 percent of drug courts test participants for alcohol use.

A wide range of consequences are imposed for positive drug and alcohol tests. In addition to program termination, a variety of strategies are employed to impose sanctions for positive tests and encourage abstinence. These consequences are shown in figure 27.

Drug Court Key Component 5: Abstinence is monitored by frequent alcohol and other drug testing.

In addition, 53 percent of drug courts report that participants are discharged from treatment for positive drug tests. Although we would expect participants in the early stages of treatment to test positive and other participants to experience relapses, continued positive drug or alcohol tests should result in increases in treatment intensity and/or sanctions, as well as motivational enhancement efforts to improve responses. Results of drug and alcohol tests are also used to help make decisions to move participants through phases of treatment. Figure 28 shows the types of organizations that conduct drug testing for drug courts.



HIV/AIDS

NIDA Principle 12: Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases and counseling to help patients modify or change behaviors that place them or others at risk of infection.

Behavior associated with drug abuse is now the single most important factor in the spread of HIV infection in the United States (Holmberg, 1996). Confirmed cases in prisons more than tripled from 1991 to 1997, and the rate of AIDS infection in prison is at least five times the rate in the general population (Bureau of Justice Statistics, 1999a). Among jail inmates, those held for drug offenses are the most likely to be HIV positive, and female inmates have higher rates of HIV infection than male inmates (Bureau of Justice Statistics, 1997). Studies have shown that risk behaviors decrease when substance-involved persons participate in treatment (National Institute on Drug Abuse, 1995). Therefore, drug court participants must be screened for risk behaviors associated with HIV/AIDS and other infectious diseases, and services must be provided to reduce those risk behaviors. In addition, participants who test positive for HIV/AIDS or who have contracted other infectious diseases need appropriate counseling and medical care.

Sixty-two percent of drug courts indicate that they have access to services for persons who are HIV positive as part of their regular treatment regimen. Although the survey did not ask about screening for HIV and other infectious diseases, some of the assessment instruments used by drug courts (e.g., ASI) include an assessment of HIV risk factors (Center for Substance Abuse Treatment, 1993).

System Integration

Many drug courts have been started with an infusion of Federal funds, primarily through grants from DCPO or the Edward Byrne Memorial Formula Grant Program. As drug courts strive to obtain permanent funding, the importance of relationships with mainstream justice and treatment agencies, as well as with their own parent court and other administrative structures, has become more apparent. Some drug courts have ceased operating because they could not find permanent funding solutions and were unable to maintain treatment services. In addition, because many drug courts operate in relative isolation from mainstream



justice and treatment structures, they are vulnerable to changes that take place in these larger systems. For example, dramatic changes have taken place recently in the use of managed care for behavioral health (drug, alcohol, and mental health) services by State and local government entities.

Several questions in the survey were designed to determine the relationship between drug courts and the treatment community at large, the specific relationship that drug courts have with the providers they use, the impact of managed care on the operation of drug courts, and the extent to which drug courts are dependent on treatment services that they do not control or over which they have limited influence. Additional questions were designed to reveal the extent to which drug courts are collecting and evaluating data and the extent to which those data are integrated into larger administrative systems. Finally, questions were developed to identify costs associated with delivering treatment services in drug courts (although a cost-benefit analysis is outside the scope of this project, an examination of costs in relation to services provided and drug court target populations may be useful to drug courts that are seeking permanent funding). This section is designed to address some of these questions.

Relationship With Dedicated Services

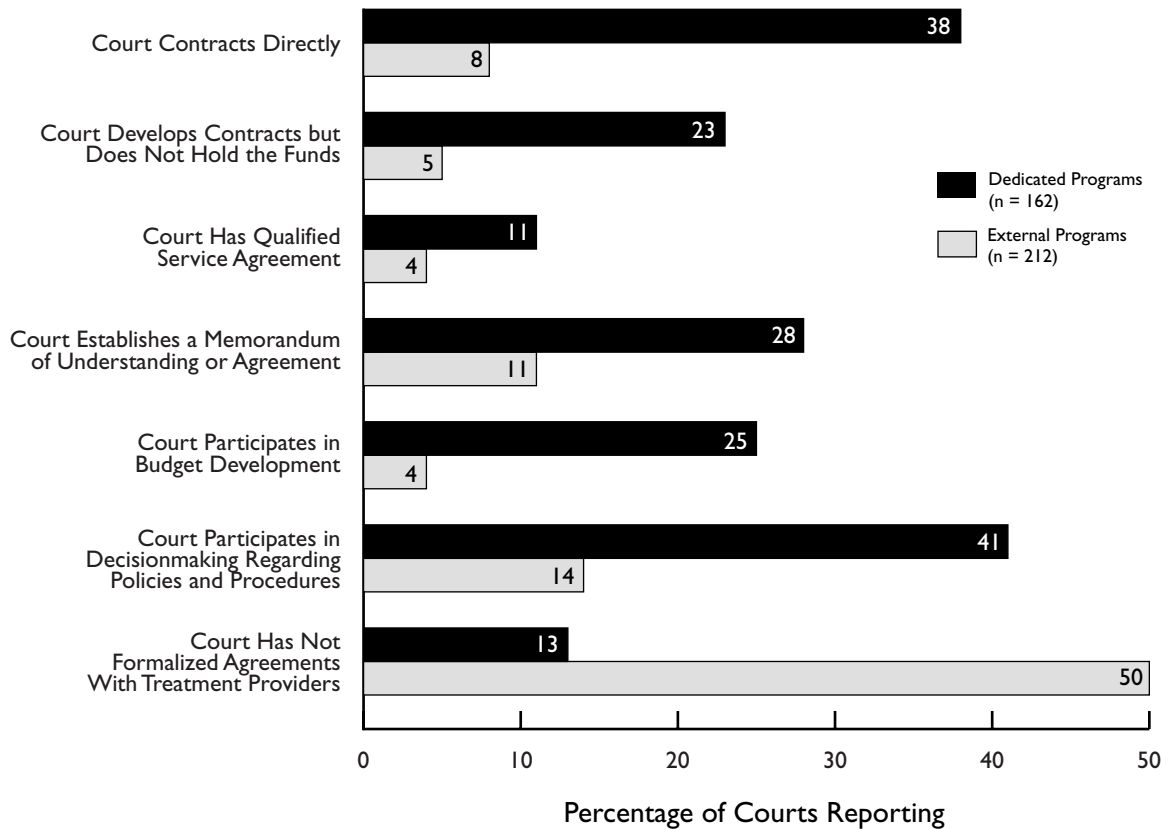
Although 76 percent of drug courts indicate that they have dedicated substance abuse service providers, only 38 percent report that they contract directly for these services. Eighteen percent of courts report that they participate in the development of contracts for services but do not hold the funds for these services. Twenty-eight percent report they have established a memorandum of understanding or agreement with their dedicated providers, either instead of or along with contracts for services, and 11 percent have established qualified service organization agreements (QSOAs).

Forty-one percent of drug courts report that they participate in making decisions regarding overall treatment policies and procedures, and 25 percent participate in budget development. Thirteen percent of drug courts report having no formal agreements with their dedicated treatment providers.

Relationship With External Programs

The relationships that drug courts have established with programs that are not part of the drug court structure are even less formal, with 50 percent of courts indicating they have no formalized agreements with these providers at all (figure 29). Many courts do not have the administrative infrastructure or ability to manage treatment contracts. In addition, in some jurisdictions, single State or local AOD authorities are the

Figure 29. Drug Court Relationships With Treatment Providers



authorized agencies to administer funding for community-based AOD programming. While corrections agencies may also fund treatment services, they fund only institutional services in many jurisdictions. Although there are good and legitimate reasons why drug courts may not contract directly for treatment services, not holding funds in formal contracts diminishes the courts’ ability to influence and manage treatment services, which may diminish the courts’ ability to receive permanent funding.

The development and maintenance of QSOAs and memorandums of agreement with providers or administrative agencies can help clarify roles, responsibilities, and intent and can have the additional benefit of solidifying cooperative and mutually supportive relationships. Drug courts should be encouraged to formalize their relationships with providers to this extent. In addition, these more formal relationships may enhance future funding prospects. Table 3 lists the sources of funding reported by programs dedicated to drug courts.

Twenty-two percent of drug courts indicate that they do not know or are unsure how their dedicated programs are funded. Treatment programs

generally receive funding from a variety of sources, and financing treatment services is changing and becoming increasingly complex. While it is not surprising that drug courts do not know how their dedicated providers are supported, it indicates the distance between drug courts and mainstream treatment, administrative, and funding entities and may indicate that drug courts lack influence on treatment funding decisions overall.

Managed Care

Forty-nine percent of drug courts indicate that managed care has been implemented for behavioral health services in their jurisdictions. Twenty-five percent indicate that managed care has not been implemented in their jurisdictions. An additional 18 percent of drug courts are not sure or do not know the status of managed care in their localities.

Some form of managed care has been or is being implemented in almost every State in the country. Managed care is a set of strategies that funding agencies (including State and local governments) are using to shift some of the financial risk to third-party entities—managed care organizations—that manage the financing and utilization of services for enrolled populations. In the public sector, enrolled populations are generally those eligible for Medicaid benefits. Managed care organizations control costs

Table 3. Funding Received by Treatment Providers

Source of Funding	Average Percentage of Funding
Federal grant	40
State funds	40
Local funds	31
Medicaid/managed care funds	11
Client fees	12
Court or other justice funds	12
State alcohol and other drug agency	25
Other funding source	15
Unsure or do not know how providers are funded	22

by controlling access to services, managing use of services, and establishing networks of providers that receive negotiated (and often discounted) rates for the services they provide. Some professionals are very concerned that managed care, as it is currently being implemented, will result in underserving substance-involved offender populations and shifting significant costs to the justice system.¹²

Drug courts report the following in regard to the impact of managed care:

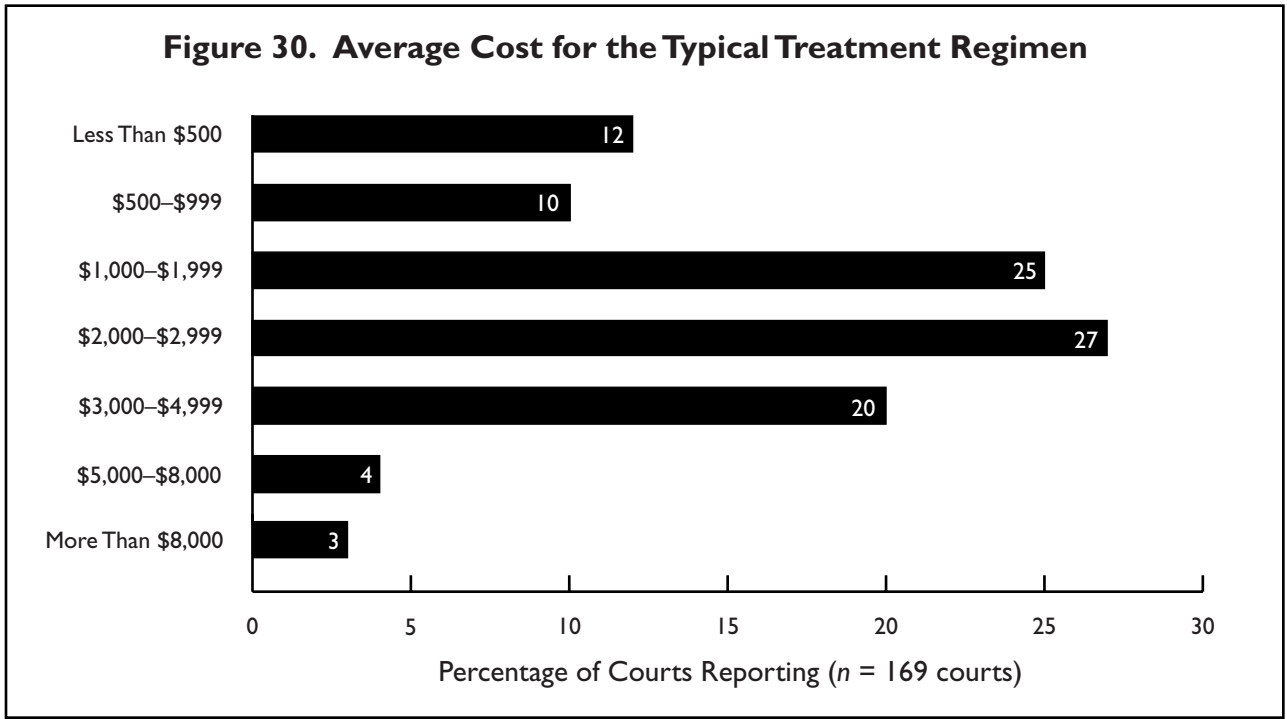
- 18 percent have implemented new policies and procedures for getting participants into programs.
- 9 percent are experiencing noticeable changes in staffing patterns and/or staff turnover.
- 12 percent are experiencing longer waiting lists.
- 21 percent report that less treatment is being authorized.
- 10 percent report that some programs are terminating.
- 20 percent have noticed no changes.

Drug courts need to work with single State AOD agency directors and others to make sure that drug court participants receive services of sufficient intensity and duration to result in long-term benefits under managed care systems. As shown in figure 30, 25 percent of drug courts report treatment costs of \$1,000–\$1,999 per participant, 27 percent report treatment costs of \$2,000–\$2,999, and 27 percent report higher costs for treatment services. Because this survey focuses on the courts rather than on participants, it does not indicate whether more expensive treatment is being provided to more heavily crime- and substance-involved participants. These costs are substantially lower than the cost of prison or jail beds.¹³

Management Information Systems

Drug courts need to report their success rates and justify their expenditures to funding sources. Sixty-four percent of drug courts report that they use a computerized data system that tracks client progress using criminal justice and treatment measures. Of these, 21 percent indicate that their management information system (MIS) is tied to the courts' data system. One measure of success for drug courts is their ability to reduce caseload pressures in the court overall. Tying drug court data to the main court data system can facilitate this comparison.

Twenty-four percent of drug courts with a computerized data system indicate that they use an MIS developed for drug courts. Of these,



- 24 percent developed their own MIS.
- 4 percent use the Brooklyn Drug Treatment Court MIS.
- 10 percent use the ACCESS-based system developed by Buffalo/Jacksonville drug courts.
- 2 percent use the system known as HATTS/HIDTA (High Intensity Drug Trafficking Area).
- 18 percent use other systems developed for stand-alone PC systems.

An additional 14 percent use MISs that were not developed for drug courts. Respondents that use a drug court MIS indicate that they can report the following:

- Success/failure rates (43 percent).
- Information related to client improvement (28 percent).
- Employment rates (36 percent).
- Information related to treatment retention (39 percent).
- Client demographics (49 percent).

Different agencies are responsible for the data systems utilized by drug courts, and not all drug court team members have access to drug court

data systems. Twenty-six percent of respondents indicate that the court is responsible for the data system; 11 percent report treatment agencies are responsible. Other responsible agencies include case management (11 percent), probation (12 percent), and pretrial services (2 percent).

Thirty-four percent of responding drug courts report that treatment providers can access the MIS. Forty-five percent report that their system is accessible by court staff and by the judge. Forty-four percent report that the system can be accessed by case managers.

Treatment providers or case managers maintain computerized records that track the following:

- Admissions (77 percent).
- Current status (72 percent).
- Discharges (76 percent).
- Graduations (72 percent).
- Rearrests (45 percent).

It appears that most drug courts have implemented computerized tracking systems that record basic client information, although most drug courts indicate that their systems primarily track demographic information. Few systems appear to be capable of providing operational and decision support to all members of the drug court team.

Survey results indicate that treatment providers and case management agencies keep computerized records of participants, but it appears that this information is not always linked to the drug court system. In addition, criminal justice information (e.g., rearrest rates) is not generally kept by treatment providers or case management agencies.

Drug courts are not highly automated, and most systems are not integrated into mainstream treatment or justice systems. Agencies involved in the operations of drug courts have limited access to data with which to monitor their activities and outcomes and to make program adjustments. Most drug courts appear to be using spreadsheets or other tracking mechanisms in stand-alone environments rather than fully automated systems that provide real-time information; support communication, decisionmaking, and operations; and link all team members. In addition, although 43 percent of drug courts indicate that they have conducted outcome evaluations,¹⁴ most drug courts appear to be unprepared to capture the information needed in a desirable format to assess ongoing program results.

Training and Technical Assistance Needs of Drug Courts

A section of the survey asks respondents to rank the improvements they would like to make in their service delivery component, as well as ways they would like to see treatment programs improve. As shown in figure 31, drug courts indicate a need to expand services, especially residential services, for participants. In addition, the need to improve participant engagement and retention rates and to improve services for special populations is widely recognized. As shown in figure 32, when asked about improvements that need to be made in current programs, drug courts indicate that treatment staff need to improve skills related to client engagement and retention and to improve cooperation and coordination with the justice system. Also, drug courts would like treatment providers to educate the justice system about treatment.

Responses to these questions, combined with an analysis of other survey results, indicate that drug courts could benefit from additional training and technical assistance. Specific training and technical assistance needs that were identified by drug courts are shown in figure 33.

Identification of these areas for targeted training and technical assistance reflects the major findings of this survey, with courts recognizing that they need additional support to engage and retain clients, cross-training to integrate justice and treatment and to improve drug court team functioning, and support to improve their MIS capabilities.

Drug Court Performance Benchmark: Interdisciplinary education is provided for every person involved in drug court operations to develop a shared understanding of the values, goals, and operating procedures of both the treatment and justice system components.

Figure 31. How Courts Rank Needed Improvements for Components of Treatment Service Delivery

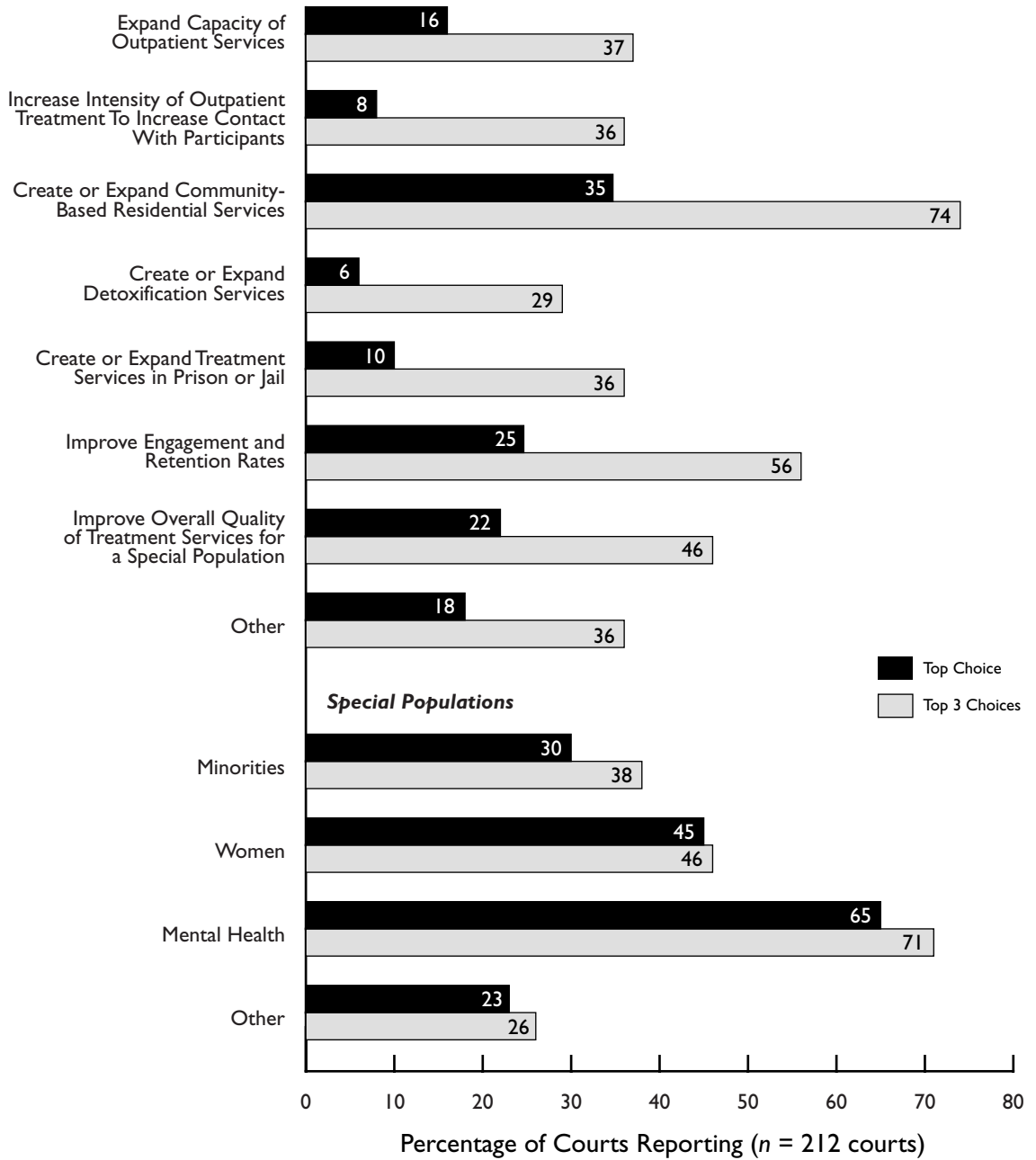


Figure 32. How Courts Rank Needed Improvements for Treatment Programs

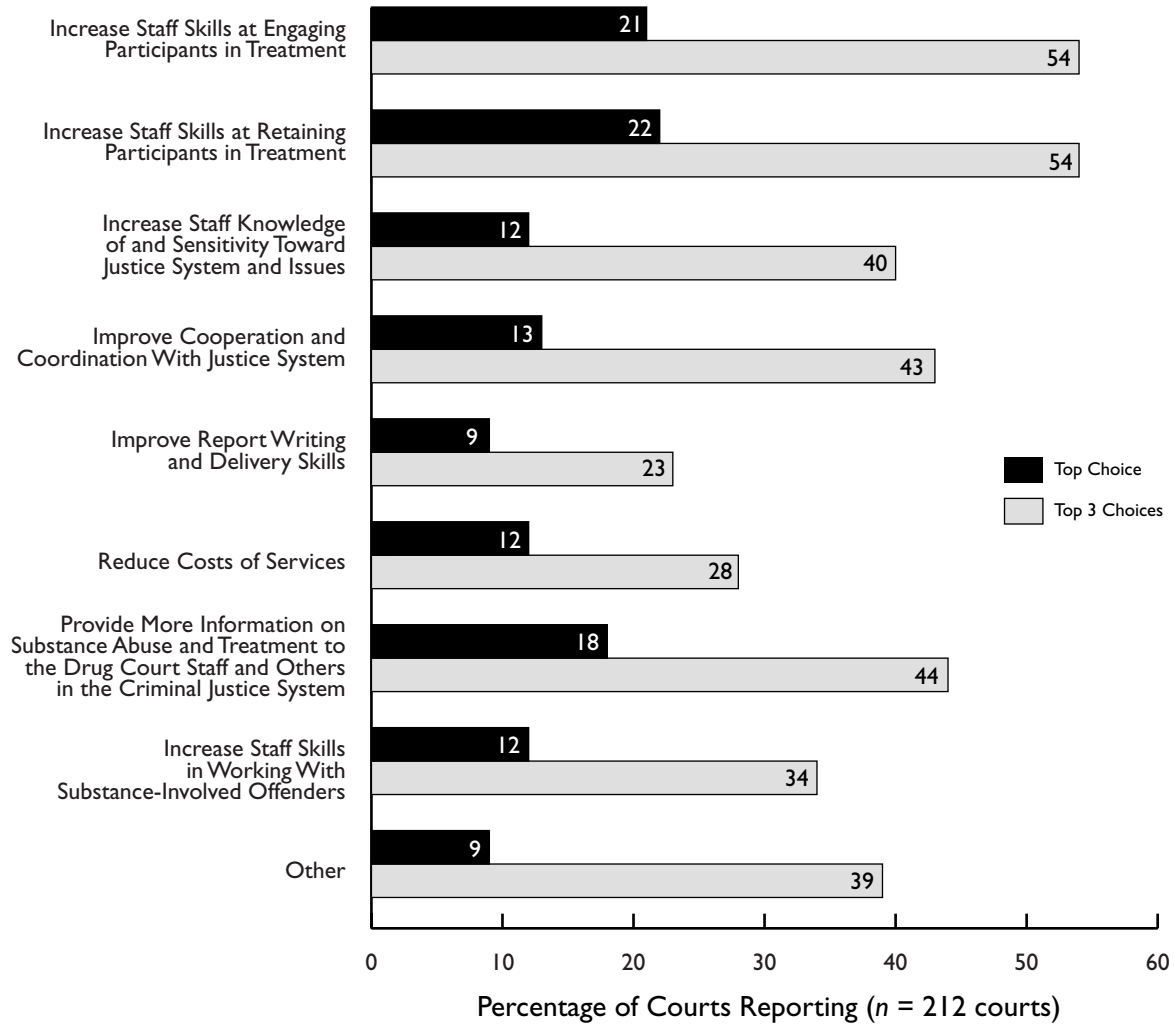
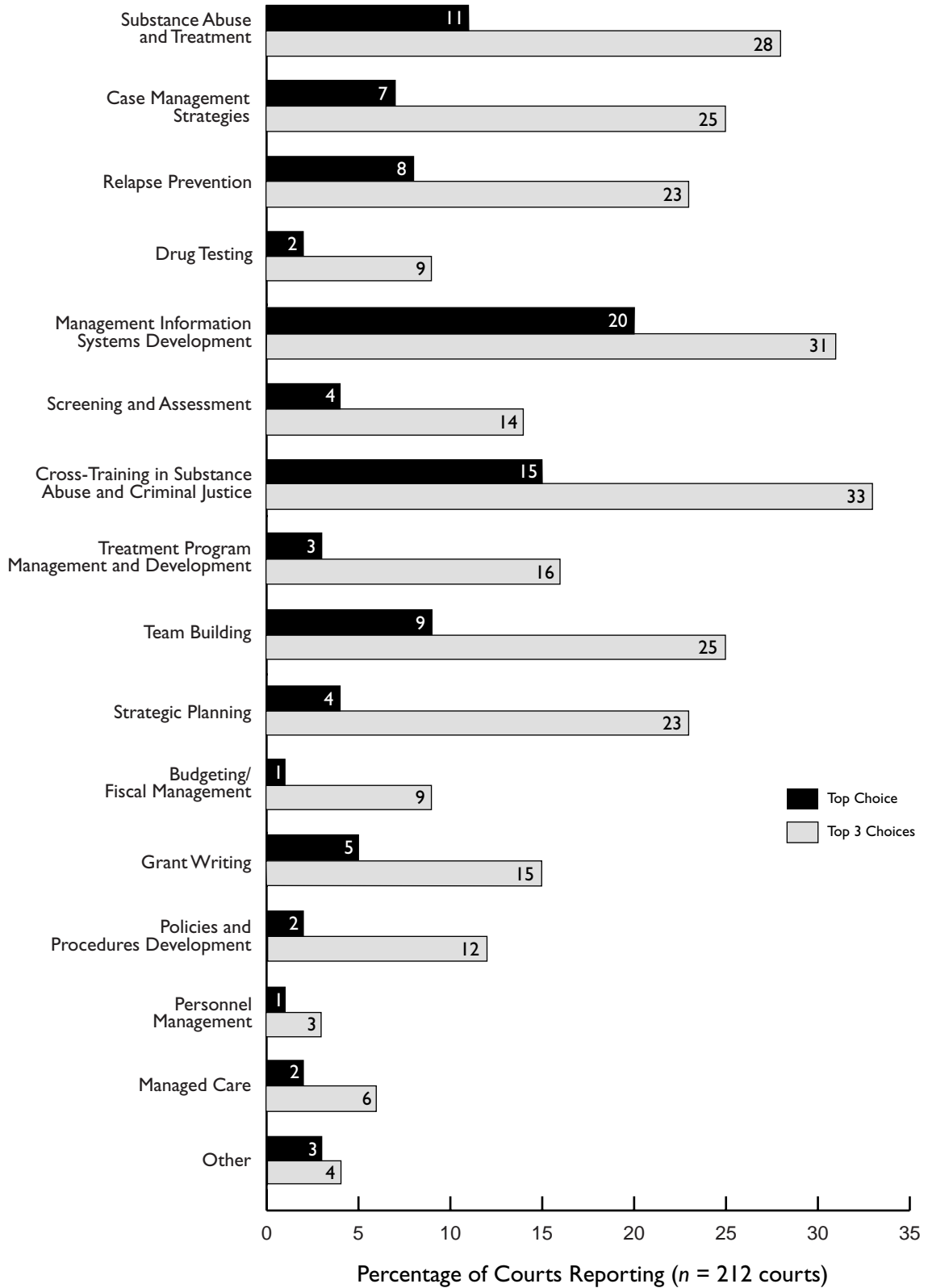


Figure 33. How Courts Rank Their Training or Technical Assistance Needs





Summary and Policy Implications

The results of this national survey indicate clearly that treatment services designed for and used by drug courts are delivered in accordance with scientifically established principles of treatment effectiveness. Overall, the structured drug court treatment is consistent with the principles established by NIDA, and it is delivered according to the drug court key components and the related performance benchmarks.

The majority of drug courts target adjudicated offenders. In addition, more than 60 percent of drug courts report excluding participants with minimal substance involvement, reserving drug court slots for participants whose substance abuse is severe enough to warrant significant interventions.

Overall, a broad continuum of primary treatment services is available to drug courts. Most drug courts report having access to residential and intensive and regular outpatient treatment, and almost all drug courts encourage or require participation in self-help activities, including Alcoholics Anonymous and Narcotics Anonymous. A significant proportion of drug courts report that they are able to provide culturally competent and gender-specific services as part of their regular treatment regimen. Although drug courts report access to these services, the survey does not show how many participants actually use them.

Drug courts recognize that multiple services are required to meet the needs of participants and report having access to a wide range of support services. However, access to medical care and dental care is lacking, and many drug courts cannot provide housing assistance, transportation, or child care. These practical problems present insurmountable obstacles for some participants.

Most drug courts report having dedicated services or slots for participants, as well as having access to services that are external to the drug court but available in the community. Drug courts generally report that dedicated and external providers meet State or local licensing requirements, and some are known to be accredited by bodies such as the Joint Commission on the Accreditation of Health Care Organizations. Providers that are dedicated to drug courts use cognitive behavioral approaches and address criminal thinking to a greater extent than do external providers. This suggests that dedicated providers are more likely than external service providers to use treatment strategies that address the specific criminal rehabilitation needs of offender populations.

Drug courts have informal relationships with both dedicated and external providers. Services are funded through a variety of mechanisms, with only a small number of drug courts holding funds and contracting for treatment services.


Screening and clinical assessments are routinely conducted in drug courts to identify the needs of participants. Processes for screening, assessing, and determining drug court eligibility work expeditiously, and most participants are able to enter treatment within 2 weeks after program admission. However, not all drug courts use screening or assessment instruments that have proved to be valid and reliable, and some do not appear to use appropriate clinically trained staff to conduct assessments. Likewise, objective, professionally accepted criteria and tools are not uniformly used to make treatment placement decisions. Standardized baseline information that is transferable across jurisdictions does not appear to be available for all drug courts.

Most drug courts require participants to be engaged in treatment services for at least 12 months and report using a phased approach whereby intensive treatment services are conducted for the first 3–4 months, followed by less intensive treatment and aftercare. Counseling interventions are a primary component of drug court treatment, and the majority of counselors in both dedicated and external programs meet State or local licensing and certification requirements. Counselors in dedicated programs receive more information and training on issues related to criminal justice populations than counselors in external programs.

A number of mechanisms are in place in drug courts, including drug and alcohol testing, case management, and regular status hearings that serve to assess client progress continually. In addition, drug courts have implemented a variety of responses, including sanctions and incentives, to modify treatment plans and encourage participant compliance. Case management services are provided by a wide range of justice and treatment professionals. Few drug courts report using objective, clinical case management; most rely primarily on existing treatment or justice staff for these services instead of objective, third-party entities (e.g., TASC).

Drug courts report having limited access to methadone and other pharmacological interventions, such as naltrexone. In addition, some drug courts appear to prohibit the use of prescribed medication.

There seems to be a wide recognition by drug courts that participants may suffer from mental disorders, including co-occurring substance abuse and mental health problems. Drug courts report having access to mental health services, but many drug courts also indicate they needed better access to these services. While screening staff appear to examine mental health issues as part of the screening process, very few drug



courts use clinically acceptable mental health screening tools or protocols, although they may refer participants to mental health professionals for additional assessment.

Detoxification services are available to more than half of respondent drug courts. Drug courts with access to detoxification services use them in conjunction with additional treatment interventions, not as primary treatment.

Drug courts are experiencing a variety of issues related to difficulties in engaging and retaining clients in treatment and with clients who are deemed “unmotivated.” Improvement in client engagement and retention is identified as a need, and as an urgent need for drug court training and technical assistance, along with cross-training between criminal justice agencies and treatment providers.

Drug courts do not currently have adequate MISs to track clients or to conduct outcome evaluations, nor is there a national system for tracking the successes or even survival of drug courts. Most drug courts use client reporting systems designed for stand-alone PCs, and data are not tied into larger justice or treatment MISs.

Several findings in this report point to areas in which treatment processes and services in drug courts can be improved. It is important to recognize, however, that some of the weaknesses identified in this report speak to general treatment systems as much as they do to drug court treatment specifically. In large part, drug courts are dependent on the service array, quality, and parameters of treatment delivery systems that exist in their own jurisdictions.

Policy Considerations

As the number of drug courts continues to grow, and as the process of integrating substance abuse treatment and criminal justice case processing continues to evolve, the drug court field is confronted with many challenges. Some of these challenges have been identified by this survey and raise issues that must be considered to establish policies consistent with the goal of dealing more effectively with the devastating impact of drugs and drug-related crime. Following are six policy considerations that have emerged as a result of the responses to this survey and a discussion of the implications of each proposed policy for drug courts.

Policy Consideration #1: Drug courts should establish and formalize more effective linkages with local service delivery systems and State and local alcohol and drug agencies.


Most drug courts do have **dedicated** services, generally outpatient, that are tied directly to the drug court program. In addition, all drug courts report using **external** services, services that are available in the mainstream treatment system, for some or all of their participants. Therefore, drug court treatment extends beyond the boundaries of the drug court program itself.

However, the relationship of drug courts to local treatment components does not appear to be well structured. Drug courts have relatively informal relationships with both dedicated and external service providers. Thirty-eight percent of drug courts contract directly for dedicated services, and 23 percent participate in contract development but do not hold funds. Forty-one percent participate in the development of policies and procedures related to treatment, but 13 percent have no formal agreements with their dedicated providers. Eleven percent of drug courts have established qualified service organization agreements with dedicated providers, and 28 percent have memorandums of understanding or other formal agreements in place with dedicated providers.

Fifty percent of drug courts have no formal relationships with external service delivery providers, and few participate in decisionmaking related to treatment policies and procedures. Survey results clearly indicate that all drug courts are dependent on accessing services through local treatment and other service delivery agencies but have not succeeded in formalizing these linkages. In addition, some drug courts are unable to provide a full continuum of services to participants either because the services do not exist in the community or because the drug court has difficulty accessing them.

Implications for drug courts:

Drug courts should focus on establishing linkages with various State and local service delivery agencies and should dedicate resources to formalize and manage these relationships. Treatment administrators, including State and county substance abuse authorities (e.g., single State alcohol and other drug agencies), often have responsibility for contracting with service providers and have considerable expertise designing and monitoring the delivery of treatment services. Collaboration with agencies that have the primary responsibility for funding and managing treatment services can help drug courts clarify their needs and goals, as well as augment current services. In addition, this collaboration can help emphasize why drug court participants should receive a high priority for receiving services. SSA directors and other high-level administrators can help drug courts design service systems and can provide support to drug courts in monitoring and managing treatment services. In addition, treatment administrators can help identify additional funding sources for treatment acquisition, can help



drug court participants access medical and behavioral health benefits, and may be able to provide needed education and training for drug court professionals.

TASC programs exist in many communities across the country, and some are integrated with drug courts. One of the hallmarks of TASC is the development and continual updating of written agreements between justice and treatment systems. Drug courts can receive assistance from TASC to develop qualified service organization agreements and memorandums of agreement or understanding to clarify roles, responsibilities, and relationships with both dedicated and external treatment providers, as well as other service providers. These agreements can serve as a basis for continual dialog and program improvements.

Finally, drug courts should advocate for the benefits of collaborative efforts between justice and treatment systems. Close collaboration substantially improves outcomes for participants in terms of reduced substance abuse and reduced criminal activity. Providers need to understand the benefits of working with drug court and other justice clients, including increased retention so that counselors can use their expertise and knowledge, support through justice leverage, increased client participation, and potentially increased revenues.

Policy Consideration #2: States and localities should explore the development of drug court treatment standards.

Although most drug courts require treatment providers and counselors to meet State and local licensing requirements as a minimum standard for providing services to drug court participants, they also recognize that State or local licensing standards may be inappropriate or insufficient to ensure the adequate provision of services for drug court participants or other offender clients. Cognitive behavioral and social learning models have been demonstrated to be effective in changing the behavior of offenders. Additionally, confronting criminal thinking patterns and teaching offenders problem-solving skills, socialization, prosocial values, and the restructuring of thoughts and actions have proved effective in reducing recidivism (Office of National Drug Control Policy, 2000). Drug courts have incorporated these methods into their programming to a greater extent than the mainstream treatment system.

Drug court treatment primarily consists of individual and group counseling. Outpatient drug court treatment may be supplemented by residential treatment when needed and by a number of additional requirements designed to hold participants accountable. These additional activities may include frequent alcohol and drug testing, reporting to case managers and/or probation officers, attending frequent court status hearings, and

participating in other services designed to improve skills and promote social competency and productivity. States and localities should consider establishing drug court treatment standards that recognize that these other activities are essential therapeutic components to achieve positive outcomes for drug court participants.

Drug courts should continue to work toward treatment standards even though the cost restraints of managed care may limit the range and availability of services. It is unlikely that the level and intensity of services required for drug court participants will be supported by managed care. Pressures to reduce treatment expenditures and manage costs associated with Medicaid are driving States to shorten lengths of stay in treatment and increasing the thresholds for admission to intensive treatment.

Implications for drug courts:

Providers, case managers, and substance abuse administrators should work together to deliver services that are most appropriate for drug court participants. Drug court professionals should stay abreast of the research findings related to effective treatment strategies for justice clients and make sure that policymakers and funders are aware of these findings.

As drug courts proliferate in States and in local jurisdictions, efforts should be made to develop criteria and standards to delineate the components of effective treatment for drug court participants and other offender clients. Traditional treatment criteria simply may not be adequate for treatment delivered in drug courts and other justice system venues.

Those who develop licensing and certification standards should be aware of the clinical techniques that have proved effective for offender clients and of the contribution that nonclinical services can make to positive outcomes. These strategies and techniques should be considered when licensing programs that work primarily with offender clients.

To ensure a full range of appropriate services for participants, drug courts often must supplement core treatment services (services eligible for reimbursement under managed care) with pretreatment, alcohol and other drug testing, case management, and continuing care activities. The St. Louis drug court has developed a comprehensive network of services using managed care principles and blending funds from treatment and justice (Alcoholism and Drug Abuse Weekly, 1999). This type of funding and service model may be of interest to other drug courts attempting to develop and fund a treatment network.



Policy Consideration #3: Drug court professionals and drug court treatment providers need skill-based training and technical assistance to improve engagement and retention of participants.

Responses to the survey across several topic areas indicate that drug courts are struggling with engaging and retaining participants in treatment. Fifty-nine percent of drug courts indicate that lack of motivation for treatment is used as a criterion to exclude people from drug court admission. Fifty-six percent report that participants are discharged early from treatment because they have a poor attitude or lack motivation. Other reasons for early discharge from treatment include failure to appear in court (59 percent), failure to engage in treatment (70 percent), and missing too many treatment appointments (64 percent). Drug court judges and coordinators ranked improving staff skills to engage and retain drug court participants in treatment as the most needed improvement in the court's treatment component.

Implications for drug courts:

Because drug courts can impose sanctions as leverage and provide incentives as encouragement, they can provide the structure to achieve positive results with treatment-resistant clients. Lack of motivation by drug-addicted offenders, short of participants' refusal to enter the program, should be seen as a challenge rather than a justification for excluding or discharging participants. Enhancing the skills of both justice and treatment practitioners may help reduce dropout and treatment discharge rates and improve outcomes.

In addition, a number of studies have shown that case management is effective in retaining clients in treatment. According to Marlatt et al. (1997), case management can also encourage entry into treatment and reduce the time treatment admission. Case management may be an effective adjunct to substance abuse treatment because (1) case management focuses on the whole individual and stresses comprehensive assessment, service planning, and service coordination to address multiple aspects of a client's life; and (2) a principal goal of case management is to keep clients engaged in treatment and moving toward recovery and independence (Center for Substance Abuse Treatment, 1998b). Studies of TASC case management programs have indicated that TASC clients remain in treatment longer than non-TASC clients, with better posttreatment success (Inciardi and McBride, 1991; Longshore et al., 1998; Hubbard et al., 1989; Hepburn, 1996).

When dealing with drug court participants or other justice clients, treatment providers must strengthen their skills regarding motivational counseling. Justice clients rarely come into treatment because they

want to be there. Treatment providers must be able to overcome client resistance and motivate clients to remain in treatment and achieve a drug-free lifestyle. Treatment providers and other drug court professionals also must be aware of new treatment technologies that may improve retention rates of the drug court population. For example, Project MATCH (National Institute on Alcohol Abuse and Alcoholism, 1999) indicates that new technologies like motivational enhancement therapy and other nonconfrontational approaches may work well with this population.

Influencing the delivery of treatment services via treatment network development also supports client engagement and retention. Treatment needs to be available to capitalize on motivational opportunities created by drug courts. In addition, culturally competent approaches, strength-based counseling, gender-specific programming, and more emphasis on wraparound services (job preparation, job placement, GED tutoring, childcare, domestic violence counseling, etc.) may all improve retention rates and outcomes for certain drug court populations.

Policy Consideration #4: Drug courts should improve the methods and protocols for screening, assessing, and placing participants in treatment.

Survey results indicate that drug courts routinely conduct screening and clinical assessments to identify the treatment and other service needs of participants and to determine eligibility. Drug courts report that screening, assessing, and determining drug court eligibility occur fairly quickly, with most participants entering treatment in less than 2 weeks from admission to the drug court program. However, not all drug courts use screening or assessment instruments that are proved to be reliable and valid. Additionally, some drug courts indicate that they do not use appropriately trained clinical staff to conduct assessments.

Objective, professionally accepted criteria and tools are not uniformly used by drug courts to make treatment placement decisions. Thirty-four percent of drug courts use ASAM–PPC–II. Seventy-four percent report that clinical judgment is used to determine the level of care to which participants are assigned, and 51 percent report using clinical judgment only.

Implications for drug courts:

Screening and assessment in drug courts should be structured to more closely adhere to methods and instruments that have been supported by research. Improvements in this area will also lead to greater transferability of information among and about drug courts. The survey reveals considerable inconsistencies among drug courts in terms of

screening and assessment instruments and levels of treatment services, indicating wide variation regarding the substance use severity of participants, as well as the methods for addressing substance abuse. Developing standard definitions and using standardized assessments and rational protocols for addressing substance use in drug courts will enable evaluators and policymakers to better assess the effectiveness of drug courts and suggest and provide support for program improvement. A number of publications by the Center for Substance Abuse Treatment describe appropriate screening and assessment instruments and methods (see TIPs 3, 7, and 11), and the Drug Courts Program Office published a *Guide for Drug Courts on Screening and Assessment* (Peters and Peyton, 1998). These documents provide guidance on conducting screening and assessment and provide information (and copies, in some cases) screening and assessment instruments that have proved effective and are available at low or no cost.

The Addictions Severity Index is the most widely used instrument for assessing substance abuse treatment and other needs of adults; it is in the public domain and, thus, free of charge. A number of screening instruments were examined by Peters et al. (2000) for their appropriateness with justice system populations. The Simple Screening Instrument (also in the public domain and free of charge) proved highly reliable for use with adult offenders.

The importance of consistent and appropriate participant placement criteria is described in Center for Substance Abuse Treatment TIP 13, *The Role and Current Status of Patient Placement Criteria in the Treatment of Substance Use Disorders*. In addition, ASAM-PPC-II is available from the American Society of Addiction Medicine and should be available through most State alcohol and other drug agencies.

Policy Consideration #5: Drug courts should implement effective management information systems to monitor program activity and improve operations.

The survey indicates that most drug courts do not have management information systems that are capable of tracking participants through all drug court processes or that are adequate to support outcome evaluations. Most drug courts use client tracking systems designed for microprocessors, and drug court data are not tied into larger justice or treatment management information systems. Although 43 percent of drug courts indicate that they have conducted outcome evaluations, most drug courts report that they are unable to obtain needed information in a format that would allow them to assess ongoing program results.

Implications for drug courts:


Drug courts need to have good management information systems in place to demonstrate program effectiveness, make ongoing operational improvements, and secure scarce resources. The technology exists to develop integrated data systems that can be used to support decisionmaking in drug courts and to support criminal justice and treatment systems and policymakers.

Drug courts should advocate for adequate budgets to cover the costs of automated management information systems, and funders and policymakers should be encouraged to support the development of good information systems for drug courts. Drug courts need the support of judicial, executive, and legislative organizational entities to thrive and continue to improve.

A number of drug court information systems have been developed with Federal support, and commercial products are available. The Buffalo/Jacksonville system is an ACCESS-based PC system. The New York City Treatment Drug Court system is tied to the State criminal justice system and provides client tracking, progress, and outcome information. The State of Delaware is implementing a drug court system that takes case information from the court's automated system and adds information from case managers and treatment providers through secure Internet connections. This system enables any number of agencies to partner with the drug court and makes client activities and status reports available to the court on a real-time basis. Information systems that have been developed in the public domain can be viewed at www.drugcourtech.org.

Policy Consideration #6: To achieve greater impact within the communities they serve, drug courts should strive to expand capacity and demonstrate that they are integral to the justice and substance abuse treatment systems.

Most drug courts work with relatively small populations. Approximately 75 percent of survey respondents report working with fewer than 150 participants. In addition, nearly all drug courts report being at or under their stated capacity. Factors related to capacity are complex and are usually tied to local or Federal restrictions on eligibility criteria, lack of treatment capacity, lack of personnel resources (including judicial time), and other issues. As a result of such challenges, drug courts often are not able to meet their capacity and consequently are having a limited impact on the problems that substance-involved offenders create in the overall justice system and in the community. Another complicating factor relating to drug court capacity is the lack of integration of the drug court approach into existing justice and substance abuse treatment systems. Even though



drug courts have expanded from serving less serious adult offenders to working with juveniles, adults charged with drug-related criminal and civil offenses, DUI offenders, and more serious offenders with more complex needs for services, full integration of the drug court approach is limited to a few jurisdictions. In San Bernardino, CA, Las Vegas, NV, Ft. Lauderdale, FL, Denver, CO, and Minneapolis, MN, the drug court approach is applied to all drug and drug-related cases. There are many challenges to meet to achieve acceptance of the drug court approach, stable funding, and integration of drug courts into the mainstream justice and substance abuse treatment systems.

Implications for drug courts:

Drug courts need to systematically examine all issues related to eligibility and capacity in an effort to determine whether and how these issues are preventing them from reaching as many potential participants as possible. Are the eligibility requirements too stringent, screening out more participants than are screened into the program? If the eligibility criteria are inclusive, are they being applied fairly? Is there a lack of treatment capacity in the community, and, if so, can the drug court partner with other community-based agencies and organizations to increase the availability and access to treatment and other collateral services? Is the drug court willing and/or able to commit the necessary resources—in funds and staff—to reach its full capacity or to expand its capacity?

Beyond accepting more participants into the drug court program, drug courts need to look at related issues such as the management and staffing necessary to support an expanded program. Since many drug courts operate with existing staff or have added only a single drug court coordinator or case manager, drug courts will likely need to support additional staff to manage the activities related to expanded populations. Working with larger populations may also require additional judicial staff, and some drug courts have addressed this issue by assigning court commissioners or other qualified persons to fulfill some traditional duties of drug court judges.

To gain acceptance and integration of the drug court approach into the mainstream justice and treatment systems, there must be continued concrete efforts to gain support within the justice system and the wider community. Drug courts need to look beyond the core drug court team (judge, prosecutor, treatment provider, defense counsel, coordinator) to other agencies and organizations that can be helpful in planning for and sustaining increased capacity and services. These might include local health and mental health departments, local social service agencies, State alcohol and other drug agencies, probation

departments, schools and colleges, local sheriff or police departments, local departments of corrections, community organizations, business leaders, media, and leaders in the faith community.

Efforts must be made to educate judges, justice system personnel, State and local policymakers, the media, and the general public so that there is a clear understanding of drug court concepts, operations, and successes. Similar outreach and education must be extended to substance abuse treatment providers, health officials, and others involved in substance abuse issues so that drug court treatment is seen as closely linked to overall efforts to reduce substance abuse within the community. Results of national and local evaluations must be shared widely, as they become available, to help demonstrate that drug courts are effective. In addition, drug courts can carefully track offender outcomes within their own programs.

To ensure that drug courts continue to follow best practices and produce the best outcomes, drug court professionals must maintain high professional standards by continuing to examine current practice and by developing more tools for continuing education.

Future Research Possibilities


The survey results identify a number of areas for future research, including the following:

- Examination of the actual use of available treatment services.
- Clarification and standardization of treatment and other terminology in drug courts.
- Analysis of the relationship between drug courts and the larger treatment and justice systems, with a focus on developing strategies for integrating drug courts into mainstream funding and decisionmaking cycles.

Conclusion

Drug courts represent a significant collaboration of the justice system, treatment systems, and other partners. This spirit of cooperation, which strengthens the effectiveness and options of all partners, would be even more beneficial if it were carried through to broader systems.

Drug courts can partner with treatment providers and administrators, TASC programs, and other offender management efforts to generate sufficient resources and support at the local, State, and national levels to



incorporate drug court activities into a larger strategy for managing substance-involved justice populations. This movement will provide the foundation for an effective, community-based strategy to reduce the drug use and criminal activity of the significant numbers of substance-involved offenders that are burdening our systems and our society.

Drug courts have demonstrated considerable success, and policymakers have been quick to respond to this success by replicating and supporting this model. However, results of this survey indicate that drug courts can be more successful and attain greater impact by continuing to improve operations and expand to larger and more significant populations. Attaining the full potential of drug courts will require continued partnerships and increased sophistication to develop optimal service delivery, funding mechanisms, and information management.

Notes

1. This treatment is generally on an outpatient basis. Drug courts that require some participants to complete residential treatment usually follow up by placing participants in the regular outpatient drug court treatment services regimen.
2. Our findings related to the structure of drug court treatment services (e.g., phased treatment) are consistent with findings presented in Cooper (1997). See American University (2000).
3. For the purposes of this study, size is measured as the number of participants in the program. Capacity is the number of participants that *can be served* by the drug court.
4. See especially TIP 17 (Center for Substance Abuse Treatment, 1995b) and TIP 12 (Center for Substance Abuse Treatment, 1994a).
5. Drug court definitions of “community-based TC” varied widely during followup interviews. Some drug courts define the term as a community-located program based on the model found in traditional institutional TC programming; others define it as sober living programs such as Oxford Houses. Some drug courts define residential services as TCs; others describe their entire program as a “therapeutic community.”
6. Followup interviews indicated that drug courts understand distinctions made between “dedicated” and “external” services in the survey instrument.
7. Additional information on screening and assessment in drug courts is available in Peters and Peyton (1998).
8. SASSI was inadvertently omitted as a choice in the survey instrument.
9. For an excellent discussion of Federal confidentiality laws and drug courts, see Office of Justice Programs (1999).
10. Not all drug courts conduct screening, so time to screening and time to assessment are not additive.
11. One jurisdiction reports that drug court clients do not meet eligibility requirements for mental health services, specifically, requirements of prior hospitalization. This jurisdiction also reports that when participants are admitted to mental health treatment, they are rapidly discharged by the program for lack of motivation or noncompliance.

12. A thorough discussion of managed care and its impact on justice populations is outside the scope of this document. For further information, see Peyton, Heaps, and Whitney (in press); Morrissey (1996); and Chalk (1997).

13. In 1997, the average annual cost of incarceration in State prisons and jails was approximately \$20,000 per person. See Camp and Camp (1999).

14. An analysis of evaluations is outside the scope of this project. However, many drug court evaluations are on file with the Drug Court Clearinghouse and Technical Assistance Project at American University.

Appendix A

National TASC Treatment Accountability for Safer Communities

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Drug Court Treatment Services Inventory

U.S. Department of Justice, Office of Justice Programs
Drug Courts Program Office
September 1999

Thank you for taking the time to complete this survey. The results of the survey will be used in a variety of ways to support the drug court field. First, the results will help us delineate the types of treatment services currently being delivered to drug court participants, as well as the services that appear to be lacking for this population. Second, survey results will be used to develop training and technical assistance that can be made available to improve service delivery to drug courts. In addition, we hope to provide assistance to existing and emerging drug treatment courts to support, improve, and manage substance abuse and other treatment services. Finally, these survey results will assist us in modifying training that is provided by the Drug Courts Program Office.

The issues related to providing treatment for drug court participants are complex. As such, some questions or sections of this survey require additional explanation or instructions. *These special instructions are in bold, italic print.* Careful reading of them will facilitate answering questions easily and correctly.

This survey is intended to be completed by the one person best able to describe how treatment operates in the drug court. While respondents may wish, and are encouraged, to get needed information from treatment providers, we are interested in knowing about treatment from the court's perspective.

Thank you very much for your cooperation and assistance.

Part I: Jurisdiction

Judge Court clerk

1. Court of Jurisdiction:

2a. Drug Court Judge:

2b. Court Coordinator/Administrator:

3. Address:

Street Address or Post Office Box

-

City

State

Zip Code

4. Telephone: () - Fax: () -

E-mail:

5. When did your drug court become operational? / /
MM DD YY

6. Name and title of person completing survey:

Name (first, middle, last)

Title

7a. Do you currently have a grant from the Drug Courts Program Office?

- Yes
- No
- Unsure/Don't know

7b. If Yes, what type of grant is it?

- Single Jurisdiction Implementation
- Single Jurisdiction Enhancement
- Multi-jurisdiction Implementation
- Multi-jurisdictional Enhancement
- Unsure/Don't know

8. Is your drug court in a rural, urban, or suburban setting? (Mark all that apply.)

- Rural Urban Suburban

9. In general, what is the drug court target population? (Mark all that apply.)

- Nonviolent offenders
- Violent offenders (past or present)
- Offenders charged with drug related crimes
- Offenders charged with non-drug related crimes
- First time offenders
- Repeat offenders
- Probation violators
- Felony offenders
- Misdemeanor
- DUI/DWI
- Other (please describe):

10. What is the structure of your drug court?
 Diversion Post-adjudication Both
11. How many participants are currently in your drug court program?
 < 40 200-299
 40-49 300-399
 50-99 400-500
 100-149 > 500
 150-199 Unsure/Don't know

12. What is the maximum capacity of your drug court program?
 < 40 400-500
 40-49 > 500
 50-99 Unsure/Don't know
 100-149 Other (please specify):
 150-199
 200-299
 300-399

Part II: Eligibility Determination

This section of the survey is designed to identify the types of populations that participate in drug courts; to determine the treatment or clinical criteria that drug courts use to make eligibility decisions; and to assess how drug courts classify and assign participants to treatment.

A. Clinical Screening

1. Are clinical screening activities conducted for drug court participants? (*Clinical screening is a brief evaluation designed to determine appropriateness and willingness for treatment.*)
 Yes No Unsure/Don't know

If you answered No to this question, go to Section B - Clinical Assessment.

2. Is screening conducted prior to admission of an offender into the drug court program?
 Yes No Unsure/Don't know
3. What screening instrument is used? (Mark all that apply.)
 Addiction Severity Index (ASI), Drug Use Section
 Offender Profile Index (OPI)
 Alcohol Dependence Scale (ADS)
 Drug Dependence Scale (DDS)
 Simple Screening Instrument (SSI)
 Instrument designed by court staff
 Unsure/Don't know
 Other (please describe):

- 4a. Is a drug urine test conducted as part of the screening process?
 Yes
 No
 Unsure/Don't know

- 4b. If Yes, is the collection of the specimen observed?
 Yes
 No
 Unsure/Don't know

5. Who conducts screening for the drug court? (Mark all that apply.)
 Court staff
 Pretrial services agency
 Probation department
 TASC program
 Treatment provider
 Unsure/Don't know
 Other (please explain):

6. What training has been provided to screening staff?
(Mark all that apply.)

- Substance abuse
- Criminal justice
- Basic interviewing techniques
- Motivational interviewing
- Substance abuse treatment
- Relapse prevention
- Other (please explain):
- Dual diagnosis
- Mental health symptoms
- Suicide warning signs
- Street drugs, use & terminology
- Referral policies and procedures
- Unsure/Don't know

Drug courts vary in the time it takes from initial arrest to entry into the drug court. We are interested to know how long it takes for some things to occur from the time a defendant is identified as potentially eligible for drug court.

7. What is the average length of time from initial identification of a defendant as potentially eligible for drug court to completion of clinical screening? In other words, how long does it take to decide a defendant has a substance abuse disorder that qualifies him or her for drug court participation?

- Same day
- 1-2 days
- 3-5 days
- 1-2 weeks
- > 2 weeks
- Unsure/Don't know

B. Clinical Assessment

Clinical assessments are designed to diagnose substance abuse and other disorders, develop individualized treatment plans, and make treatment placement decisions. They are generally conducted by substance abuse counselors, psychologists, social workers, and other professionals who have received specialized training. A clinical assessment will often include a structured interview using a questionnaire designed to assist in diagnosis and placement decisions, collection of additional information (such as arrest records), and clinical observation.

Clinical assessments are much more in-depth than clinical screening discussed in the previous section.

1. Are clinical assessments conducted for drug court participants?

- Yes
- No
- Unsure/Don't know

If you answered No or Unsure to this question, go to Question 3a.

2. What primary assessment instrument is used?

- Addiction Severity Index (ASI)
- Offender Profile Index (OPI)
- Michigan Alcohol Screening Test (MAST)
- SASSI
- Substance Use Survey (SUS)
- Unsure/Don't know
- Other (please describe):

3a. Do you conduct formal mental health screening?

- Yes
- No
- Unsure/Don't know

If you answered No or Unsure to this question, go to Question 3c.

3b. What instrument do you use?

- Beck Depression Inventory (BDI)
- Brief Symptom Inventory (BSI)
- Referral Decision Scale (RDS)
- Symptom Checklist 90-Revised (SCL-90R)
- Unsure/Don't know
- Other (please describe):

3c. If you don't conduct mental health screening, can drug court participants be referred for a mental health evaluation?

- Yes No Unsure/Don't know

3d. If participants are assessed for mental health issues, are the assessments conducted in a timely fashion, within 1-2 weeks of identification as eligible for the drug court?

- Yes No Unsure/Don't know

3e. Who pays for mental health assessments? (Mark all that apply.)

- Client
- Court
- Public funds through the Mental Health Agency
- Medicaid/Medicare
- Private insurance/HMO
- Unsure/Don't know
- Other (please describe):

4a. Is a drug urine test conducted as part of the assessment process?

- Yes No Unsure/Don't know

4b. If Yes, is the collection of the specimen observed?

- Yes No Unsure/Don't know

5. Who conducts clinical assessments? (Mark all that apply.)

- Court staff
- Pretrial services agency
- Probation department
- TASC program
- Treatment provider
- Unsure/Don't know
- Other (please explain):

6. What credentials do clinical assessment staff possess? (Mark all that apply.)

- Substance abuse counselor certification
- Work in programs that are licensed
- Licensed clinical social worker
- Licensed psychologist
- Registered nurse/clinical nurse specialist
- Physician/psychiatrist
- Meet court training requirements but no credentials
- No credentials
- Unsure/Don't know
- Other (please describe):

7. What training has been provided to assessment staff? (Mark all that apply.)

- Substance abuse diagnosis and treatment
- Substance abuse counseling techniques
- Criminal justice
- Substance involved offenders
- Motivational interviewing
- Mental health symptoms
- Street drugs, use and terminology
- Referral policies and procedures
- None
- Unsure/Don't know
- Other (please explain):

8. What is the average length of time from initial identification of a defendant as potentially eligible for drug court to completion of assessment?

- Same day 1 - 2 weeks
- 1 - 2 days 2 - 3 weeks
- 3 - 5 days > 3 weeks
- Unsure/Don't know

C. Eligibility

1. Are clinical criteria (need for substance abuse treatment) included as criteria to enter the drug court?
In other words, does the court consider the presence and/or intensity of a substance abuse disorder when making drug court admission decisions?
 Yes No Unsure/Don't know
2. What treatment-related criteria are used to exclude people from participation in drug court?
(Please mark all that apply.)
 Previous treatment failure
 Substance abuse disorder not present or severe enough for treatment
 Substance abuse disorder too severe for available services to address
 Presence of mental disorder
 Use of prescribed medications
 Lack of motivation for treatment
 Unsure/Don't know
 Other (please describe):
3. What is the time frame from assessment to determination of clinical eligibility (appropriateness for treatment admission)?
 Same day
 1 - 2 days
 3 - 5 days
 1 - 2 weeks
 > 2 weeks
 Unsure/Don't know

D. Treatment Placement

1. What criteria are used to determine treatment placement? (Mark all that apply.)
 American Society of Addiction Medicine (ASAM)
 Other formal placement criteria (please identify):

 Clinical judgment
 Unsure/Don't know
 Other (please describe):
2. Who makes the treatment placement decision? (Mark all that apply.)
 Judge
 Other criminal justice professional
 Judge or other criminal justice professional in consultation with treatment professional
 Drug court committee/team
 Treatment provider
 State or other administrative agency (please describe):

 TASC
 Managed Care Organization
 Unsure/Don't know
 Other (please describe):
3. Can the court override the treatment placement decision?
 Yes, the court can override the clinical recommendation and require program admission
 No
 Not applicable

Part III: Treatment Services

This section of the survey is intended to determine how drug court managers define their treatment programming needs, how they configure services that are controlled by the court, how they utilize services that are available in the larger system, and how they select and evaluate providers.

A. Available Services

These questions are meant to elicit information about primary substance abuse treatment services. Questions about support services (job training, education, etc.) appear in Part V. Please limit your responses to only primary substance abuse treatment services.

1. Do you have access to dedicated services or reserved slots for drug court participants? Are these slots/services specifically earmarked to serve the drug court?
 - Yes
 - No
 - Unsure/Don't know
2. How many of these programs are funded to provide services specifically for drug court?
 - One
 - Two
 - Three
 - Four or more
 - Unsure/Don't know

If you answered Yes to Question 1 above, please answer the remaining questions in Section 1 before answering questions in Section 2. If you answered No to Question 1 above, please go directly to Section 2.

Section 1: Dedicated Treatment Programs

1. How many substance abuse treatment programs have dedicated slots for the drug court?
 - One
 - Two
 - Three
 - Four or more
 - Unsure/Don't know

2. What substance abuse treatment services are currently available to drug court participants through these dedicated drug court providers? (Mark all that apply.)
 - Residential
 - Intensive outpatient
 - Outpatient
 - Detoxification
 - Education
 - Methadone maintenance
 - Other pharmacological (e.g. Naltrexone)
 - Prison or jail based therapeutic community
 - Community based therapeutic community
 - Other (please describe):
 - Acupuncture
 - Self-help (AA/NA, etc.)
 - Relapse prevention
 - None
 - Unsure/Don't know

3. Please mark the choice below that describes the relationship the drug court has established with dedicated treatment providers. (Mark all that apply.)
 - The Court contracts for services directly.
 - The Court participates in the development of contracts but doesn't hold the funds.
 - The Court has a Qualified Service Agreement.
 - The Court has established a Memorandum of Understanding or a Memorandum of Agreement.
 - The Court participates in budget development.
 - The Court participates in decision making regarding overall treatment policies and procedures.
 - The Court has not formalized the agreement.
 - Unsure/Don't know

4. What is the ratio of counselors to clients in your dedicated programs?

Unsure/Don't know

	# of Counselors		/	# of Clients	
Intensive outpatient	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>
Outpatient	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>
Aftercare group	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>
Substance abuse education	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>
Residential	<input type="text"/>	<input type="text"/>	/	<input type="text"/>	<input type="text"/>

5. Do the substance abuse treatment programs dedicated to the drug court meet state or local licensing and/or certification requirements?

- Yes
- No
- Unsure/Don't know

6. Are the substance abuse treatment programs dedicated to the drug court accredited by JCAHO (Joint Commission on Accreditation of Hospital Organizations) or other body?

- Yes
- No
- Unsure/Don't know

7. Are counselors at the dedicated drug court treatment programs licensed, certified or accredited by the state or county as professional substance abuse counselors?

- Yes, all
- Yes, most
- No
- Unsure/Don't know
- There is no certification process for counselors in my locale.

8. Approximately what percentage of the clients in your dedicated treatment programs are drug court participants?

- 100%
- 75%
- 50%
- 25%
- 10% or less
- Unsure/Don't know

9. What training has been provided to counseling staff in programs dedicated to the drug court? (Mark all that apply.)

- Substance abuse diagnosis & treatment
- Substance abuse counseling techniques
- Criminal justice
- Substance involved offenders
- Relapse prevention
- Dual diagnosis
- Motivational interviewing
- Mental health symptoms
- Street drugs, use and terminology
- Referral policies and procedures
- Unsure/Don't know
- Other (please explain):

10. Treatment programs are often funded through many sources. Please indicate the percentage of funds received by programs dedicated to the drug court, by source. Estimate if necessary.

Unsure/Don't know

%	Funding Source
<input type="text"/>	Federal grant
<input type="text"/>	State funds (including block grant funds)
<input type="text"/>	Local funds
<input type="text"/>	Medicaid/managed care funds
<input type="text"/>	Client fees
<input type="text"/>	Court or other justice funds
<input type="text"/>	State AOD agency
<input type="text"/>	Other (please describe):

11. What is the average time from eligibility determination to admission into dedicated treatment program(s)?

- Same day
- 1 - 2 days
- 3 - 5 days
- 1 - 2 weeks
- 2 - 4 weeks
- > a month
- Unsure/Don't know

12. What treatment modalities are used by the dedicated program(s)? (Mark all that apply.)

- Self-help (AA/NA, etc.)
- Therapeutic community
- Cognitive
- Other (please describe):
- Criminal thinking
- Behavior modification
- Unsure/Don't know

Section 2: External Treatment Services

Please complete this section if you ever use treatment services for drug court participants that are not dedicated to the drug court. For the purposes of this survey, we refer to these services as external services.

1. How many external (not dedicated to the drug court) substance abuse treatment programs are used by the drug court? In other words, how many programs external to the drug court do you use for drug court participants?

- One
- Two
- Unsure/Don't know
- Three
- Four or more

2. What substance abuse treatment services are currently available to drug court participants through these external drug court providers? (Mark all that apply.)

- Residential
- Intensive outpatient
- Outpatient
- Detoxification
- Methadone maintenance
- Other pharmacological (e.g. Naltrexone)
- Prison or jail based therapeutic community
- Community based therapeutic community
- Other (please describe):
- Acupuncture
- Self-help (AA/NA, etc.)
- Relapse prevention
- Education
- Unsure/Don't know

3. Please mark the choice below that describes the relationship the drug court has established with non-dedicated treatment providers. (Mark all that apply.)

- The Court contracts for services directly.
- The Court participates in the development of contracts but doesn't hold the funds.
- The Court has a Qualified Service Agreement.
- The Court has established a Memorandum of Understanding or a Memorandum of Agreement.
- The Court participates in budget development.
- The Court participates in decision making regarding overall treatment policies and procedures.
- The Court has not formalized the agreement.
- Unsure/Don't know

4. What is the ratio of counselors to clients in these external programs?

- Unsure/Don't know

	# of Counselors	/	# of Clients
Intensive outpatient	<input type="text"/>	/	<input type="text"/>
Outpatient	<input type="text"/>	/	<input type="text"/>
Aftercare group	<input type="text"/>	/	<input type="text"/>
Substance abuse education	<input type="text"/>	/	<input type="text"/>
Residential	<input type="text"/>	/	<input type="text"/>

5. Do the external drug court treatment programs used by the drug court meet state or local licensing and/or certification requirements?

- Yes
- No
- Unsure/Don't know

6. Are the external drug court treatment programs used by the drug court accredited by JCAHO (Joint Commission on Accreditation of Hospital Organizations) or other body?

- Yes
- No
- Unsure/Don't know

7. Are counselors at the external drug court treatment programs licensed, certified or accredited by the state or county as professional substance abuse counselors?

- Yes, all
- Yes, most
- There is no certification process for counselors in my locale.
- No
- Unsure/Don't know

8. Approximately what percentage of drug court participants are served exclusively by programs that are not dedicated to the drug court?

- 100%
- 75%
- 50%
- 25%
- 10% or less
- Unsure/Don't know

9. What training has been provided to counseling staff at the non-dedicated programs? (Mark all that apply.)

- Substance abuse diagnosis and treatment
- Substance abuse counseling techniques
- Criminal justice
- Substance involved offenders
- Relapse prevention
- Dual diagnosis
- Motivational interviewing
- Mental health symptoms
- Street drugs, use and terminology
- Referral policies and procedures
- Unsure/Don't know
- Other (please explain):

Managed behavioral health care, whereby the funding and management of substance abuse and mental health services are handled by Managed Care Organizations, primarily for persons eligible for Medicaid, has been implemented in some fashion by many states and counties.

10a. Has managed behavioral health care been implemented in your locale?

- Yes
- No
- Unsure/Don't know

10b. If Yes, how has the drug court been affected? (Mark all that apply.)

- New policies and procedures for getting participants into treatment programs
- Noticeable changes in staffing patterns/staff turnover at programs
- Longer waiting lists
- Less treatment authorized
- Some program closings
- No effect
- Unsure/Don't know
- Other (please explain):

11. What is the average time from eligibility determination to admission to external programs? In other words, how long is the waiting list or time to admission?

- Same day
- 1 - 2 days
- 3 - 5 days
- 1 - 2 weeks
- 2 - 4 weeks
- 1 - 2 months
- 2 - 4 months
- > 4 months
- Unsure/Don't know

12. What treatment modalities are used in the external program(s)? (Mark all that apply.)

- Self-help (AA/NA, etc.)
- Therapeutic community
- Cognitive
- Other (please describe):
- Criminal thinking
- Behavior modification
- Unsure/Don't know

B. Program Components and Requirements

Most drug courts have designed a standard treatment regimen, although there may be many exceptions to how individual participants move through treatment services. Please answer the questions in this section in relation to your standard treatment regimen.

1. How long are participants required to attend treatment overall?

- < 3 months
- 3 - 6 months
- 6 - 12 months
- 12 - 18 months
- 18 months
- > 18 months
- Unsure/Don't know

2. Are the following services available for drug court participants? (Mark all that apply.)

- Culturally competent programming
- Gender-specific/Women-only programming
- Services for pregnant/post-partum women
- Services for persons who are HIV positive
- Services for persons who are mentally ill or have co-occurring mental health and substance abuse disorders
- Services for victims or perpetrators of domestic violence
- Services for non-English speaking participants
- Primary health care services
- Physical examination
- Other (please explain):
- Dental care
- Unsure/Don't know

3. Please describe the way a typical client progresses through the treatment continuum. (Example: Participant attends intensive outpatient treatment for 3 months, followed by 4 months of twice per week outpatient counseling, followed by 2 months of once per week relapse prevention group.) Unsure/Don't know

4a. Is the program structured in phases?

- Yes
- No
- Unsure/Don't know

If you answered No or Unsure to this question, go to Question 5.

4b. Briefly describe the program phases, giving the number and length of each phase in the chart below.

Phase number	Length (wks)	Brief description
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>	<input type="text"/>

4c. Briefly describe the objective of each program phase in the chart below.

Phase number	Objective
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>
<input type="text"/>	<input type="text"/>

4d. How is movement between/among phases determined? (Mark all that apply.)

- Time in phase
- Drug test results
- Fulfillment of program conditions (e.g. employment)
- Recommendation of treatment counselor
- Recommendation of probation or other supervision/case mgr
- Team decision
- Other (please describe):
- Attendance in treatment
- Attitude
- Unsure/Don't know

5. What is the average cost for the typical treatment regimen for drug court participants?

- < \$500
- \$500 - \$999
- \$1000 - \$1999
- \$2000 - \$2999
- \$3000 - \$49999
- \$5000 - \$8000
- > \$8000
- Unsure/Don't know

6. Is random drug testing conducted?
 Yes No Unsure/Don't know

7. Who conducts drug testing for the drug court?
(Mark all that apply.)
 Treatment provider Pretrial services agency
 Court staff Probation department
 TASC program Unsure/Don't know
 Other (please explain):

8. How frequently is drug testing conducted?
 Unsure/Don't know

Phase I*

Phase II

Phase III

Phase IV

**If your program is not structured in phases, indicate frequency of drug testing by length of time in program, if appropriate. Use the following space to add descriptive information if needed.*

9. Are participants tested for alcohol use?
 Yes No Unsure/Don't know

10. Is collection of drug test specimens supervised?
(Are urines observed?)
 Yes No Unsure/Don't know

11. What are the consequences of positive drug/alcohol tests?
(Mark all that apply.)
 Intensification of treatment Judicial statement of concern
 Movement to a previous phase More frequent drug testing
 Community service Jail
 More frequent contact with probation officer
 More self-help groups (AA/NA etc.)
 Treatment program determines sanction
 Termination from the drug court program
 Reassessment of treatment plan
 More frequent contact with the court/judge
 Unsure/Don't know
 Other (please describe):

In some drug courts, participants may be discharged from treatment by the treatment provider, yet still be an active drug court participant (while waiting for admission to a different program, for instance). The following questions are designed to measure the reasons for discharge from the treatment component of drug court -- we are interested in knowing treatment-related reasons for discharge.

12a. What are the reasons participants are discharged early -- or "therapeutically discharged" -- from treatment?
(Mark all that apply.)
 Failure to show initially
 Was admitted, but never engaged in treatment
 Missed too many treatment appointments
 Failed to progress
 Exhibited poor attitude/lacked motivation
 Positive drug tests
 Failed to meet criminal justice requirements and was terminated from treatment
 Unsure/Don't know
 Other (please describe):

12b. Please identify the *top three reasons* participants are discharged early from treatment by entering 1, 2, and 3 in the box to the right of the reasons listed below:

- Failure to show initially Unsure/Don't know
- Was admitted, but never engaged in treatment
- Missed too many appointments
- Failed to progress
- Exhibited poor attitude/lacked motivation
- Positive drug tests
- Failed to meet criminal justice requirements and was terminated from treatment
- Other (please describe):

13. What percentage of participants are discharged early from treatment by the treatment program?
(Please estimate if unknown.)

- < 5% 25% - 50%
- 5% - 10% > 50%
- 11% - 24% Unsure/Don't know

14. What treatment or treatment-related interventions seem to be particularly effective with the drug court participants?

- Unsure/Don't know

15. What is the court's greatest frustration or concern about treatment programming?

- Unsure/Don't know

Part IV: Case Management

This section is designed to identify the various methods and agencies used by drug courts to provide case management for participants.

1a. Who performs client case management for drug court participants? (Mark all that apply.)

- Drug court coordinator
- Pretrial services
- Probation
- TASC
- Treatment provider
- Unsure/Don't know
- Other (please define):

1b. Who has primary case management responsibility?

- Drug court coordinator
- Pretrial services
- Probation
- TASC
- Treatment provider
- Unsure/Don't know
- Other (please define):

2. Which of the following functions does case management entail? (Mark all that apply.)
- Screening
 - Assessment
 - Referral to dedicated drug court treatment
 - Referral to non-dedicated drug court treatment
 - Referral to additional services (e.g. parenting, vocational training, etc.)
 - Preparation of court reports
 - Appearance at status hearings
 - Drug testing
 - Client supervision (in lieu of probation or pretrial supervision)
 - Treatment program monitoring/management
 - Fee collection
 - Coordinate between criminal justice and treatment
 - Client support during transitions (e.g. from jail to community)
 - Unsure/Don't know
 - Other (please describe):

3. What training has been provided to case managers? (Mark all that apply.)

- Substance abuse diagnosis and treatment
- Substance abuse counseling techniques
- Criminal justice
- Substance involved offenders
- Relapse prevention
- Dual diagnosis
- Motivational interviewing
- Mental health symptoms
- Street drugs, use and terminology
- Referral policies and procedures
- Unsure/Don't know
- Other (please explain):

4. What is the average caseload per case manager?

- Unsure/Don't know

5. How often do drug court participants report to the case manager?

- < once per week
 - 1x per week
 - 2x per week
 - 1x per month
 - > 1x per month
 - Unsure/Don't know
- Other (please describe):

6. How often are court reports prepared by case managers?

- < once per week
- 1x per week
- 2x per week
- 1x per month
- > 1x per month
- Unsure/Don't know
- Other (please describe):

7. What do case management reports include? (Mark all that apply.)

- Treatment attendance
- Treatment progress
- Drug test results
- Compliance with probation or other criminal justice supervision
- School attendance
- Employment status
- Case manager recommendations
- Unsure/Don't know
- Other (please describe):

Part V: Support Services

Drug court participants often require services in addition to substance abuse treatment. In fact, these support services can contribute significantly to participants' progress toward recovery and reintegration into the community as fully productive members of society.

This section is designed to ascertain whether support services are available to drug court participants.

1a. Please indicate the availability to drug court participants of the support services listed below. Unsure/Don't know

<u>Support Service</u>	<u>Available</u>	<u>Not available</u>
01. Mental health treatment	<input type="radio"/>	<input type="radio"/>
02. Mental health referral	<input type="radio"/>	<input type="radio"/>
03. Vocational training	<input type="radio"/>	<input type="radio"/>
04. Job placement	<input type="radio"/>	<input type="radio"/>
05. Housing assistance	<input type="radio"/>	<input type="radio"/>
06. Housing referral	<input type="radio"/>	<input type="radio"/>
07. Parenting education	<input type="radio"/>	<input type="radio"/>
08. Educational remediation/GED	<input type="radio"/>	<input type="radio"/>
09. Domestic violence intervention svcs	<input type="radio"/>	<input type="radio"/>
10. Transportation assistance	<input type="radio"/>	<input type="radio"/>
11. Anger management	<input type="radio"/>	<input type="radio"/>
12. Life skills management	<input type="radio"/>	<input type="radio"/>
13. Stress management	<input type="radio"/>	<input type="radio"/>
14. Relapse prevention	<input type="radio"/>	<input type="radio"/>
15. Childcare	<input type="radio"/>	<input type="radio"/>

1b. Please describe any additional support services available to drug court participants:

Unsure/Don't know

1c. Please describe any support services not available to drug court participants that you believe are essential to their success:

Unsure/Don't know

2. Using numbers from the list of support services above, please rank the top 10 support services essential to success of drug court participants. Enter the number of the support service in the blocks below.

Unsure/Don't know

1st	2nd	3rd	4th	5th	6th	7th	8th	9th	10th

3. How have you funded these support services? (Mark all that apply.)

- Publicly funded services
(State, county or other government funding)
- Drug court funds
- Client fees
- Medicaid or other federal dollars
- Funded by Department of Corrections
- Unsure/Don't know
- Other (please explain):

4. Are participants required to attend AA/NA or other self-help support groups?

- Yes, during entire drug court experience No
- Yes, but only as aftercare Unsure/Don't know

5. Are participants required to show proof of attending AA/NA or other support meetings?

- Yes No Unsure/Don't know

6. Has the drug court established formal relationships with agencies that provide support services (e.g. memoranda of understanding, service agreement, etc.)?

- Yes No Unsure/Don't know

Part VI: Management Information Systems (MIS)/Evaluation

In order to make program improvements, track outcomes, and monitor the impact of policy changes, drug courts need access to information. In addition, a good information system can support communications and effective operations among the many agencies involved in drug court.

This section is designed to describe information systems that drug courts currently use, and to determine information systems needs that exist.

1a. Does the drug court have a computerized data system that tracks client progress using both criminal justice and treatment measures?

- Yes No Unsure/Don't know

*If you answered **No** or **Unsure** to this question, please go to **Question 3a**.*

1b. Is the system tied to the court's data system?

- Yes Unsure/Don't know
 No

1c. What agency has primary responsibility for this data system?

- Court
 Treatment
 Case management
 Probation
 Pretrial services
 Unsure/Don't know
 Other (please describe):

1d. Who has access to this data system?
(Mark all that apply.)

- Treatment provider
 Court staff
 Case managers
 Judge
 Unsure/Don't know
 Other (please describe):

2a. Do you use an MIS developed for drug courts?

- Yes, we developed our own Unsure/Don't know
 Yes: No
 Brooklyn Drug Treatment Court MIS *If you answered*
 Buffalo/Jackson ACCESS MIS *No to this*
 HATTS/HIDTA *question, please*
 Other (please describe): *go to Question 3.*

2b. Can the MIS generate statistical reports related to:

	<u>Yes</u>	<u>No</u>	<u>Unsure/Don't know</u>
success/failure rates?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
client improvement?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
employment rates?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
treatment retention?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
demographics?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3a. Do drug court treatment providers or case managers keep computerized records of participants':

	<u>Yes</u>	<u>No</u>	<u>Unsure/Don't know</u>
admissions?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
current status?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
discharges?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
graduations?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>
rearrests?	<input type="radio"/>	<input type="radio"/>	<input type="radio"/>

3b. This information is provided by:
(Mark all that apply)

- treatment providers.
 case managers. Unsure/Don't know
 court staff.

4. Has an evaluation of drug court outcomes been conducted?

- Yes No Unsure/Don't know

Part VII: Training/Technical Assistance

Drug courts are innovative, and are constantly striving for self-improvement to achieve better outcomes for participants and to maintain effective communication and working relationships among partners. The Drug Courts Program Office and National TASC are committed to helping drug courts achieve their self-improvement goals.

This section is designed to identify the training and technical assistance needs of drug courts in the area of developing and managing treatment and case management services.

1. If you were able, what improvements would the drug court make in its treatment services delivery component?

Please rank (1 through 8) in priority order:

- Expand capacity of outpatient services
- Increase intensity of outpatient treatment to increase contact with participants
- Create or expand community-based residential services (not in jail)
- Create or expand detoxification services
- Create or expand treatment services in prison or jail
- Improve engagement and retention rates of participants in treatment
- Improve overall quality of treatment services for:
 - minorities.
 - women.
 - mental health needs.
 - other special populations.

Other (please describe):

Unsure/Don't know

2. In what ways would the court like to see the treatment program improve?

Please rank (1 through 9) in priority order:

- Increase staff skills at engaging participants in treatment
- Increase staff skills at retaining participants in treatment
- Increase staff's knowledge of and sensitivity toward justice system and issues
- Improve cooperation and coordination with justice system
- Improve report writing/delivery skill
- Reduce costs of services
- Provide more information on substance abuse and treatment to the drug court staff and others in the criminal justice system
- Increase staff skills in working with substance involved offenders
- Other (please describe):

Unsure/Don't know

3. If offered, what types of training or technical assistance could benefit your drug court/drug court team?

Please rank (1 through 16) in priority order:

Enter a 0 if the specific assistance is not needed.

Substance abuse and treatment

Teambuilding

Case management strategies

Strategic planning

Relapse prevention

Budgeting/fiscal management

Drug testing

Grant writing

Management information systems development

Policies and procedures development

Screening and assessment

Personnel management

Cross training in substance abuse and criminal justice

Managed care

Treatment program management and development

Unsure/Don't know

Other (please describe):

END OF QUESTIONNAIRE

Comments on the Survey:

**Thank you very much for taking the time to complete this survey.
Your input is very valuable to us.**

Please return by October 15th in the enclosed pre-addressed envelope to:

**The College of William and Mary
Policy Studies Resource Laboratories
Morton Hall, Room 305
Williamsburg, VA 23187**

If you have questions or need additional information, please contact:

**Irene Gainer
National TASC
1911 N. Fort Myer Drive, Suite 900
Arlington, VA 22209**

**Phone: 703-522-7212
Fax: 703-741-7698**

Additional comments on Drug Court Treatment Services:

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Instrument Formatting and Data Entry performed by Policy Studies Resource Laboratories at
The College of William and Mary in Virginia.**

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The College of William and Mary in Virginia.***

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Appendix B

National TASC
Treatment Accountability for Safer Communities

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**Drug Court Treatment Services Follow-up
Questionnaire**

U.S. Department of Justice, Office of Justice Programs
Drug Courts Program Office
March, 2000

Name of Drug Court: _____

Name of Person Being Interviewed: _____

Survey Number: _____

Name of Person Filled out Survey: _____

Name of Interviewer: _____ Date: _____

I. I'd like to ask you some general questions about how you filled in the questionnaire.

A. 1. If you did not know the answer to a question, what did you do?

Probe: Left it Blank

Probe: Guessed or Estimated

Probe: Researched the question– looked it up in my files.

Probe: Asked someone for help.

Follow-up probe: Who did you ask for help on the survey?

2. Was there anything on the survey that you did not understand?

B. *We asked about dedicated and non-dedicated, or external, treatment services. We explained that a dedicated treatment program was one that had services or slots specifically for drug court participants. External services were defined as those programs that did not have special slots for drug court participants, but who would admit drug court participants.*

1. Did the distinction between dedicated and external programs make sense to you?
2. Could you give me some examples of dedicated treatment programs?
3. Could you give me some examples of external treatment programs?

C. *We need to have more information on how your treatment services are funded.*

1. Does your drug court grant support treatment services?
2. Do you have ready access to treatment services because of this funding?
3. What will happen to your ability to get treatment when your federal funding stops?

D. *Many courts noted that they were below their maximum client capacity.*

1. Do you think the court's capacity to handle clients is higher than the capacity of treatment services in your area to handle clients? In other words, is your ability to admit clients restricted because treatment is not available?

2. Is it easy to find treatment for clients?

Yes _____ No _____

Why or why not?

II. Results of the survey indicated that drug courts have access to a wide array of services, and that waiting times to access these services was relatively short. We would like to further clarify this finding by asking a few additional questions about treatment utilization.

A. 92% of drug courts indicated they had access to residential services.

1. Does this surprise you?

Yes _____ No _____

Why or why not?

2. Does your court have access to residential services?

Yes _____ No _____ if no, go to section II B, below.

3. What percentage of your drug court population is admitted to residential services?

A. Is this an estimate?

B. Do you formally keep track of the proportion of drug offenders who are admitted to residential services?

4. Describe these residential services in terms of type of residential program and average length of stay.

5. What is the average wait for admission to residential services?

B. 93% of drug courts indicated they had access to intensive outpatient services.

1. Does your court have access to intensive outpatient services?

Yes _____ No _____ if no, go to section II C, below.

2. What percentage of your drug court population is admitted to intensive outpatient services?

Probe: Is this an estimate?

Probe: Do you formally keep track of the proportion of drug offenders who are admitted to intensive outpatient services?

3. Describe these intensive outpatient services in terms of components and frequency of treatment/counseling sessions.

4. What is the average wait for admission to intensive outpatient services?

C. *51% of drug courts report that community based therapeutic communities are available.*

1. Does your court offer such programming?

Yes _____ No _____ if no, go to section II D, below.

2. Describe this programming and the proportion of participants that access it.

D. *Over 90% of drug courts report that mental health treatment services are available.*

1. Does your court offer such programming?

Yes _____ No _____ if no, go to section II E, below.

2. What proportion of your drug court population utilizes mental health services?

3. Describe mental health services that are available.

4. What is the average wait to access mental health services?

5. Describe any problems you have accessing these services.

E. *A number of courts reported having access to methadone maintenance or other pharmacological interventions such as Naltrexone.*

1. Does your court offer such programming?

Yes _____ No _____ if no, answer 1.a. and go Section II F, below

a. If no, does your drug court have a policy prohibiting the use of methadone or other pharmacological interventions?

2. What proportion of your drug court population is admitted for methadone maintenance or naltrexone therapy?

3. Do you have a policy regarding the use of prescription drugs?

Yes _____ No _____

a. If yes, describe.

F. *58% of drug courts report that culturally competent programming is available.*

1. Does your court offer such programming?

Yes _____ No _____ if no, go to Section II G, below

2. Describe this programming and the proportion of participants that access it.

G. *77% of drug courts report that gender-specific programming is available.*

1. Does your court offer such programming?

Yes _____ No _____ (if no, conclude interview)

2. Describe this programming and the proportion of participants that access it.



Thank you for taking the time to assist us with this survey. This information will help us clarify some of our findings. The report is scheduled to be available in June at the Drug Court Conference.

Appendix C: NIDA Principles of Drug Addiction Treatment

Reproduced from *Principles of Drug Addiction Treatment: A Research-Based Guide*. National Institute on Drug Abuse, 1999. NIH Publication No. 99-4180.

No single treatment is appropriate for all individuals. Matching treatment settings, interventions, and services to each individual's particular problems and needs is critical to his or her ultimate success in returning to productive functioning in the family, workplace, and society.

Treatment needs to be readily available. Because individuals who are addicted to drugs may be uncertain about entering treatment, taking advantage of opportunities when they are ready for treatment is crucial. Potential treatment applicants can be lost if treatment is not immediately available or is not readily accessible.

Effective treatment attends to multiple needs of the individual, not just his or her drug use. To be effective, treatment must address the individual's drug use and any associated medical, psychological, social, vocational, and legal problems.

An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs. A patient may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, a patient at times may require medication, other medical services, family therapy, parenting instruction, vocational rehabilitation, and social and legal services. It is critical that the treatment approach be appropriate to the individual's age, gender, ethnicity, and culture.

Remaining in treatment for an adequate period of time is critical for treatment effectiveness. The appropriate duration for an individual depends on his or her problems and needs. Research indicates that for most patients, the threshold of significant improvement is reached at about 3 months in treatment. After this threshold is reached, additional treatment can produce further progress toward recovery. Because people often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment.

Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction. In therapy, patients address issues of motivation, build skills to resist drug use, replace drug-using activities with constructive and rewarding nondrug-using activities, and improve problem-solving abilities. Behavioral therapy also facilitates interpersonal relationships and the individual's ability to function in the family and community.

Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies. Methadone and LAAM are very effective in helping individuals addicted to heroin or other opiates stabilize their lives and reduce their illicit drug use. Naltrexone is also an effective medication for some opiate addicts and some patients with co-occurring alcohol dependence. For persons addicted to nicotine, a nicotine replacement product or an oral medication can be an effective component of treatment. For patients with mental disorders, both behavioral treatments and medications can be critically important.


Addicted or drug-abusing individuals with coexisting mental disorders should have both disorders treated in an integrated way.

Because addictive disorders and mental disorders often occur in the same individual, patients presenting for either condition should be assessed and treated for the co-occurrence of the other type of disorder.

Medical detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug use. Medical detoxification safely manages the acute physical symptoms of withdrawal associated with stopping drug use. While detoxification alone is rarely sufficient to help addicts achieve long-term abstinence, for some individuals it is a strongly indicated precursor to effective drug addiction treatment.

Treatment does not need to be voluntary to be effective. Strong motivation can facilitate the treatment process. Sanctions or enticements in the family, employment setting, or criminal justice system can increase significantly both treatment entry and retention rates and the success of drug treatment interventions.

Possible drug use during treatment must be monitored continuously. Lapses to drug use can occur during treatment. The objective monitoring of a patient's drug and alcohol use during treatment, such as through urinalysis or other tests, can help the patient withstand urges to use drugs. Such monitoring also can provide early evidence of drug use so that the individual's treatment plan can be adjusted. Feedback to patients who test positive for illicit drug use is an important element of monitoring.



Treatment programs should provide assessment for HIV/AIDS, hepatitis B and C, tuberculosis, and other infectious diseases and counseling to help patients modify or change behaviors that place them or others at risk of infection. Counseling can help patients avoid high-risk behavior. Counseling also can help people who are already infected manage their illness.

Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment. As with other chronic illnesses, relapses into drug use can occur during or after successful treatment episodes. Addicted individuals may require prolonged treatment and multiple episodes of treatment to achieve long-term abstinence and fully restored functioning. Participation in self-help support programs during and following treatment often is helpful in maintaining abstinence.

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