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Quality Improvement For Drug Courts:

Evidence-Based Practices

National Drug Court Institute

Monograph Series 9

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Quality Improvement for Drug Courts:
Evidence-Based Practices

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April 2008

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Quality Improvement for Drug Courts: *Evidence-Based Practices*

Prepared by the National Drug Court Institute, the education, research, and scholarship affiliate of the National Association of Drug Court Professionals.

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INTRODUCTION

Currently 22.6 million Americans abuse or are dependent on alcohol and/or illicit drugs (SAMHSA, 2007). In 2005, more than 20,000 clean, sober, and law-abiding participants graduated from drug courts across the country (Huddleston, Marlowe, & Casebolt, 2008).

In the grand scheme of things, and given the total number of people in the criminal justice system with a drug abuse problem, the need to bring drug courts to scale is of great importance. The research is clear that drug court graduates reoffend considerably less than others in and out of the criminal justice system who have drug problems (Belenko, 2001; Government Accountability Office, 2005).

Given all the research and the associated literature reviews on drug courts, there can be little doubt that drug courts are effective, but can they be more effective? The answer will always be "yes," as we continue to innovate and learn more about what works and what does not. As we bring drug courts to scale in terms of capacity and geography, are we also bringing drug courts to scale in terms of quality? Are we using *all* the research that is currently available to keep people in the drug court process and improve our graduation rates? Probably not.

That is why the National Drug Court Institute and a cadre of the world's best researchers developed *Quality Improvement for Drug Courts: Evidence-Based Practices*.

We are now approaching 3,000 drug courts and other problem-solving courts in the United States. Some state Supreme Courts or Administrative Offices of the Courts have gone to their legislatures with budget recommendations that provide for a drug court in every judicial district in the states. The literature supports this level of effort.

The Ten Key Components are the guidelines for the drug court movement. The drug court community is indebted to the group that developed that document for the direction and standard it set for us. However, for many drug courts in the country, it is time to ensure fidelity to the model by ensuring that evidence-based practices are implemented. This monograph will serve as the catalyst for teams to insist upon a higher standard of drug court operations. Each chapter of this monograph provides research that can guide drug courts in their efforts to increase retention and graduation rates of participants that agree to go through the drug court process. Our hope is that a drug court that implements evidence-based practices like those recommended in this monograph could increase its graduation rate by as much as 10%.

This is an important work not only for treatment workers, but for judges, prosecutors, defense attorneys, probation officers, drug court administrators, and other drug court team members. We hope that this monograph will be a cornerstone document in the drug court movement.

HOW TO USE THIS DOCUMENT

The National Drug Court Institute is committed to improving drug court operations by equipping the field with best practices that are evidence-based. The present document is intended to be used by the drug court team to help improve treatment practices. The document aims to provide a "what works" approach based upon the science with recommendations to assist courts in implementation of best practices to improve overall program operations. The guidance in this document is intended for interpretation at the local and state levels in a manner that allows teams to consider their resource limitations and diverse population needs.

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The chapters in this document are organized into four main areas: introduction, narrative, recommendations, and resources. In each chapter, the researchers' recommendations are presented in order of importance. Each chapter also provides an extensive list of resources which will allow the teams to further review the concepts.

This monograph presents a general overview of the research on effectively treating the drug court client. It also elucidates the kinds of issues that a drug court administrator and supervisor should consider in developing Request for Proposals for treatment services and identifying additional resources to better serve drug court participants. Every member of the drug court team should read this document. Each member plays a vital role in ensuring that the needs of drug court participants are addressed. Focusing on quality improvement in order to better engage, retain, and graduate more clients in the drug court process requires understanding and utilizing the evidence and research. This document can provide that focus.

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DRUG COURT SCREENING

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INTRODUCTION

Not only do drug court judges decide who is eligible to be admitted into their court, they also make referral decisions about the most appropriate set of services. Should offenders who have any history of illegal substance use and criminal activity be admitted, or should admission be restricted to those who currently are addicted and pose the greatest threat to public safety? Is referral or placement to a regular outpatient drug treatment program sufficient, or is a more extensive and intensive level of care more appropriate because of greater needs and problem severity?

While the potential effectiveness of the drug court model has been well documented, completion rates for many remain unacceptably low, ranging from 27% to 66% in selected adult drug court programs (Government Accountability Office, 2005). These rates are not surprising, however, because poorly informed, subjective decisions often are being made that lead to inappropriate candidates being admitted into a drug court program. Unwarranted placements typically result in failures to engage and noncompletions, wasting valuable resources that would have been better allocated to more suitable candidates.

One of the key ingredients in achieving favorable outcomes is the use of objective, evidence-based screening and assessment instruments to inform the decision-making process. When used along with collateral data (such as urine test results and arrest records), information gathered from brief screens and lengthier clinical assessments can be used to maximize court resources through optimal client selection and identification of problems needing specialized interventions (Miller & Shutt, 2001). Furthermore, these tools can be used to help define a treatment plan and monitor client progress throughout treatment and the related drug court process (Simpson, 2004). The benefits from this approach are clear; research has shown that individuals with multiple problems have better outcomes when an integrated screening and assessment protocol is used to assess need and assist in referral decisions (Kofoed, Dania, Walsh, & Atkinson, 1986).

At the most basic level, screening determines ***eligibility*** and typically takes place soon after arrest. Assessment determines ***suitability*** for specific types and intensity of services, and it routinely occurs after the offender is admitted into the drug court program.

Despite these benefits, many drug court programs have yet to adopt the use of standardized instruments for screening and assessment (Cooper, 1997; Peyton & Gossweiler, 2001). While recognizing the value of such an approach, some courts simply do not know what steps to take toward achieving this goal. This chapter, therefore, focuses on providing practical guidance in the selection and use of standardized *screening* instruments.

NARRATIVE

While "screening" and "assessment" are often used interchangeably, they have distinctly different functions within the drug court process. At the most basic level, screening determines ***eligibility*** and typically takes place soon after arrest. Assessment determines ***suitability*** for specific types and intensity of services, and it routinely occurs after the offender is admitted into the drug court program. The assessment process provides a more detailed, in-depth, and dynamic picture of client problems and helps to specify appropriate types and levels of services. For a detailed

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discussion regarding drug court assessments, see Peters and Peyton (1998) and Center for Substance Abuse Treatment (CSAT) Treatment Improvement Protocols (TIPs) 7, 11, and 44 (CSAT, 1994a, 1994b, 2005).

Screening for drug court eligibility primarily involves two components: 1) the review of legal requirements (e.g., residency requirements, no violent or sex offenses, etc.), and 2) clinical appropriateness of the individual being considered for admission. While the legal requirements may be straightforward, determining clinical status is dependent on the selection and use of screening instruments which may or may not be as clearly well defined. Given the myriad screening instruments available today, what should be considered when selecting screening instruments for use in drug courts?

What Should Drug Courts Screen For?

The simple answer is to identify the type of information that is needed to determine clinical eligibility and to *select only those instruments that will screen for established clinical inclusion criteria*.

First and foremost, it is essential that individuals be screened for ***drug use severity***, most often defined as alcohol or drug "dependence." Research has clearly demonstrated that intensive treatment services should be reserved for individuals with the most severe drug use problems (Knight, Simpson, & Hiller, 1999; Simpson, 2002). Providing intensive services to those with less severe problems is not only a waste of valuable resources (particularly since these individuals tend to do as well with less intensive intervention), but may actually make their drug use problem worse (Andrews, Bonta, & Hoge, 1990). As Peters et al. (2000) concluded in their landmark study of alcohol and drug use screening instruments within correctional settings, there are several good instruments that accurately identify offenders who are drug-dependent. These screens include the Alcohol Dependence Scale/Addiction Severity Index Drug Use section (McLellan et al., 1992; Ross, Gavin, & Sinner, 1990; Skinner & Horn, 1984), the Simple Screening Instrument (Center for Substance Abuse Treatment, 1994), and the TCU Drug Screen II (Knight, Simpson, & Hiller, 2002). They are all relatively brief, have good psychometric properties, and, with the exception of the ADS, are available for free.

Second, drug courts should screen for ***major mental health problems***, including suicidal ideation. Quickly identifying the potential existence of mental health disorders enables the drug court judge to assess the appropriateness of available treatment services and the need for subsequent clinical assessment to determine diagnostic classifications. Left undiagnosed and untreated, drug court participants with mental health disorders are likely to experience severe difficulty in functioning effectively in the drug court program and in the community. In some cases, individuals with certain types of mental health disorders may be more appropriate for other types of services or courts, such as a Mental Health Court. For a more in-depth discussion on this topic and recommendations regarding screening instruments worth considering, see Chapter 6 on co-occurring disorders.

Third, although drug use severity and major mental health problems are the primary clinical factors to consider when determining drug court admission, some courts also may want to

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consider the individual's ***motivation for treatment***. Legal pressures play an important role as external motivators for offenders to enter and stay in treatment (Knight, Hiller, Broome, & Simpson, 2000); however, clients who are internally motivated for treatment are the ones who are more likely to engage in the treatment process (e.g., attend sessions, develop rapport, and report satisfaction) and have better long-term outcomes (Simpson & Joe, 2004). Prospective drug court participants who do not recognize that they have a drug use problem, do not want help, or simply believe they are not ready for treatment may require motivational enhancement services (e.g., Motivational Interviewing) before being mainstreamed into the drug court process. The Treatment Needs/Motivation scales found within the TCU Criminal Justice Client Evaluation of Self and Treatment (CJ CEST) is one example of a freely available, evidence-based tool that can be used effectively to assess an offender's readiness for the drug court (Garner, Knight, Flynn, Morey & Simpson, in press). Other free screening instruments for motivation worth considering include the Circumstances, Motivation, and Readiness (CMR) scales (De Leon, 1993) and the URICA (Prochaska & DiClimente, 1983).

Fourth, drug courts may want to consider an offender's **criminal thinking patterns** when making placement decisions. With a primary goal of targeting the "highest risk" offenders for admission into the program, the court typically determines criminal risk by examining the type of offense that was committed and the offender's criminal history. This information can be supplemented through the use of a screening tool that captures common criminal thinking errors. The TCU Criminal Thinking Scales (Knight, Garner, Simpson, Morey, & Flynn, 2006) is a free instrument that examines entitlement, justification, power orientation, cold heartedness, criminal rationalization, and personal irresponsibility. Drug dependent individuals who score high on these scales "think like a criminal" and pose a threat to public safety. They clearly are a good candidate for intensive drug court interventions designed to address both drug use and criminality.

Factors to Consider When Selecting Screening Instruments

In addition to decisions about information needed from the screening process, other factors should be considered when selecting a screening instrument.

1. *Only select instruments that actually will be* ***used in the decision-making process***.
Regrettably, the screening process often results in the collection of information that is filed away, never to be seen or used again. In these situations, instead of gathering information to inform decision-making, the information collection process becomes the goal (e.g., fulfilling auditing requirements). Therefore, it is essential that programs maintain vigilance and collect only the information that is needed to determine drug court eligibility, and they ensure the information actually gets used in the decision-making process (Knight et al., 2002). While an argument might be made to administer a more comprehensive set of screening instruments, the extra time and effort needed to collect excessive data will be overly burdensome (and costly) if this information is not used in the decision-making process.

2. *Choose screens that can be* ***easily administered and scored, as well as provide clinically meaningful results based on comparisons with normative data***. Pursuant to the third Key Component (National Association of Drug Court Professionals, 1997), eligible participants

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should be identified early and promptly placed in the drug court program. Given that the initial appearance before the judge should occur very soon after arrest, screening needs to be conducted in a timely manner if it is to be used in the decision-making process. For this to occur, screens need to be easily administered, quickly scored, and provide a summary of results for use in determining drug court eligibility. Optically-scanned and computerized screens are becoming more readily available and make this process much easier than the traditional paper-and-pencil administration and hand-scoring methods. Additionally, normative data[1] based on results from a large pool of offenders should be available so that clinically meaningful comparisons can be made (e.g., a potential drug court participant's initial score on "motivation for treatment" falls within the lower 10% and is an ideal candidate to receive motivational enhancement services).

3. *Select instruments that have* ***good overall classification accuracy*** and psychometric properties, particularly ***reliability and validity.***

Ultimately, the ideal screening instrument is one that is highly accurate (e.g., its classification is nearly identical to one obtained from a clinical "gold standard" assessment); however, no screening instrument is 100% accurate. For example, some drug use screening instruments tend to classify individuals as being drug dependent when they are not; others tend to classify individuals as not being drug dependent when they have the disorder. In statistical terminology, these elements of accuracy are referred to as "sensitivity" and "specificity." Sensitivity is the probability that the screen result is positive and correctly classifies a dependent individual as positive when the disorder is present. Specificity is the probability that the screen result is negative and correctly classifies a nondependent person as negative when the disorder is absent. Thus, a screener with perfect sensitivity and specificity would correctly classify 100% of drug court admissions as being either dependent or nondependent. Unfortunately, as noted above, this ideal has yet to be obtained. Therefore, part of the decision in selecting a screening instrument comes down to whether it is better to err on the side of referring a client to services they do not need (i.e., imperfect specificity) or on the side of failing to refer a client to the services they do need (i.e., imperfect sensitivity). While at first glance the former option may seem the "safe way to go," filling service slots with offenders who do not need them can result in lack of service availability for those that need them. Another aspect to consider is whether the instrument is reliable and valid. That is, do clients respond consistently to the screen (i.e., reliability), particularly across different gender and race/ethnic groups, and does the screen measure what it claims to measure (e.g., validity). For a detailed discussion on this topic, see Knight, Simpson, & Hiller (2002).

4. *Consider the* ***length of time it takes to administer***.
According to Peters and Peyton (1998), the screening process is usually completed within a half hour, therefore the amount of time an instrument takes to administer must be considered when selecting screening instruments. When multiple screens are to be used, the issue of length becomes even more critical. Trying to administer too many instruments within a limited amount of time likely will result in staff and clients feeling rushed and result in unreliable data.

[1] Norms are just like par on a golf course. To be at all informative, an individual's score must be compared to an average person's score (par) as well as to below-average people's scores (bogey) and to above-average people's scores (birdie).

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5. *Screens **need to be affordable**.*
The costs of using certain instruments can add up quickly, both financially and in required staff resources. Consider using instruments that are free and quickly administered, such as those available from TCU.

6. *Review **staff qualifications and training requirements** for administration.*
Many popular screens have fairly stringent restrictions on who is qualified to administer the instrument (e.g., a licensed psychologist). Some require intensive initial and ongoing training to remain qualified. For most correctional programs, these requirements simply cannot be met; in situations where there is frequent staff turnover, training demands may be insurmountable. The screening process needs to be able to be provided by existing staff, such as those who work in pretrial services, probation, Treatment Alternatives for Safe Communities (TASC) agencies, or treatment programs. However, individuals who administer screens should have or be trained on basic interviewing skills, such as not being argumentative and being able to identify self-reported responses that are inconsistent with court records, are important abilities and requisites for successful screening practices.

RECOMMENDATIONS

In conclusion, drug courts should screen for offender drug use severity and major mental health problems. In addition, supplemental screens for treatment motivation and "criminal thinking patterns" may be appropriate if they are relevant to the overall plan of available services. Ultimately, however, the key to an efficient and effective screening process is based on the careful consideration of the following factors: 1) how the information will be used; 2) ease of administration, scoring, and clinical interpretation; 3) classification accuracy, reliability, and validity; 4) time required to administer; 5) affordability, and 6) staff qualifications and training requirements.

While the screening process is important, it is important to remember that collecting data is different from actually using data! When used correctly, appropriate screening instruments serve as an essential means to an end, providing judges with critical information needed in making admission decisions that ultimately maximize the effectiveness of drug court protocols and practices. It is important to note, however, that self-report screens are only part of the process. Equally important is the collection of collateral information, such as drug test results, in determining whether an individual is appropriate for a drug court program.

RESOURCES

- Alcohol Dependence Scale: www.camh.net
- Addiction Severity Index Drug Use section: www.tresearch.org
- Circumstances, Motivation, and Readiness (CMR) scales: www.ndri.org
- CSAT TIPs 7, 11, and 44: www.treatment.org/Externals/tips.html
- *Guide for Drug Courts on Screening and Assessment*: www.ncjrs.gov/pdffiles1/bja/171143.pdf

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- Texas Christian University, Institute of Behavioral Research: www.ibr.tcu.edu
  - TCU Drug Screen II
  - TCU Criminal Justice Client Evaluation of Self and Treatment (CJ CEST)
- Simple Screening Instrument: ncadi.samhsa.gov
- URICA: www.uri.edu/research/cprc/

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EVALUATING THE EFFECTIVENESS OF ADDICTION TREATMENT:

What Should a Drug Court Team Look for in a Referral Site?

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INTRODUCTION

This review discusses the concepts behind, the clinical goals of, the current structure of, and outcome findings from contemporary addiction treatments. The paper draws on published, randomized controlled trials in peer-reviewed research journals (an indication of scientific rigor) since 1980.

The paper is presented in two parts. Part I discusses the fundamental issues in addiction treatment, its structure, and the basis for what might be called reasonable criteria for effectiveness with drug court-referred participants. Part II summarizes those components of treatment that have shown significant evidence of being effective, especially with court referred participants.

NARRATIVE

PART I - What is "effective treatment" and how can you tell?

What are appropriate goals of addiction treatment?

Many parts of the criminal justice system—and particularly drug courts—refer substance users from their caseloads to community substance abuse treatments as a means of dealing with the "addiction-related" criminal problems. These referrals typically have three rehabilitative goals for the participant that are also relevant to the public health and safety goals of society:

1. *Elimination or reduction of alcohol and other drug use.* This is the foremost goal of all substance abuse treatments.

2. *Improved health and function.* Improvements in the medical health and social function of substance abusing participants are clearly important from a societal perspective, but in addition, improvements in these areas are also related to prevention of relapse to substance abuse.

3. *Reduction in public health and public safety threats.* The commission of personal and property crimes for the purpose of obtaining drugs and the dangerous use of automobiles or equipment under the influence of alcohol are examples of major threats to public safety.

These three goals form the basis for reasonable expectations regarding the "effectiveness of addiction treatment" as it pertains to the drug court situation. Thus, in the review that follows we have used these three outcome domains as the basis for an evaluation of the effectiveness of substance abuse treatment programs and treatment components.

Are These Expectations Reasonable?

Though in many ways, these expectations on the part of drug abuse treatment are sensible, they are difficult to fulfill given the often chronic and complex nature of the substance use related problems presented by drug-involved offenders sent from drug courts. Nonetheless, a review of the now over 1,000 controlled experimental evaluations of drug abuse treatments shows that many components of treatment can reliably produce lasting (six months or longer) changes in one or more of the evaluation domains that are so pertinent to Drug Court function (Hubbard et al., 1989; McLellan et al., 1994; Miller & Hester, 1986).

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What is the Standard of Evidence?

As in the courtroom, the research field has levels of evidence with the strongest and most reliable being the randomized controlled trial (RCT). These kinds of experimental studies are a requirement of the Food and Drug Administration, which will not review any new medication or medical device unless there are at least two RCTs by independent, impartial investigators showing significantly better results from the new intervention than from placebo or "treatment as usual" on a relevant outcome indicator. This is a rigorous standard of evidence but one that seems particularly appropriate for the present review given the significant public health and public safety issues at stake in drug court-referred treatment interventions. Thus in the text that follows, the only medications, therapies, and interventions considered are those that have shown positive results in at least two experimental trials.

What is Treatment?

Addiction treatment is typically provided in specialty "treatment programs." These programs may be residential, offering 30 to 60 days of 8 to 10 hour days of rehabilitative care; or may be community centered, outpatient programs that offer 2 to 5 hours of rehabilitative care for 2 to 5 days per week over a 30 to 120 day period.

Regardless of setting or duration, these programs are actually the combination of various therapeutic ingredients or components designed to first overcome denial and to promote recognition and acceptance on the part of the participants that the have a significant addiction problem that they are capable of addressing. Concurrent with this effort, the program attempts to promote acceptance of and preparation for total abstinence from alcohol and other drugs of abuse, which is historically and empirically the best method of assuring sustained rehabilitation. A third clinical goal is assessment of so-called "addiction related" health and social problems that may have led to or resulted from the substance use, but that will have to be addressed if sustained rehabilitation is to be achieved. Finally, responsible clinical programs know that no finite amount of addiction treatment, regardless of the type or intensity or content, is likely to cure addiction. Thus, responsible clinical programs attempt to prepare participants for the inevitable temptations and triggers for return to drug use that they will face following formal care. This final goal is typically achieved by attempting to engage a participant into continuing mutual support for necessary life changes that is offered by Alcoholics Anonymous (AA) or Narcotics Anonymous (NA).

Better programs also prepare the participant's family and friends to help in this process by providing continuing support and monitoring and make attempts to stay in touch with the participant through monthly telephone calls for up to a year following discharge.

How Can This Review Help in the Evaluation of Local Programs?

As should be clear, the program is the basic unit of addiction treatment delivery, but this review cannot provide an evaluation of individual programs. The quality and effectiveness of a program is substantially driven by its personnel, policies, practices, resources, and of course its treatment

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components. Unfortunately, most of these aspects of programmatic care are idiosyncratic and subject to continuous change.

The current review does provide a review and summary evaluation of the important treatment components that have shown evidence of effectiveness. Thus the capacity of a local program to provide "evidence-based treatment components" offers one important, but imperfect, indication of that program's quality and potential effectiveness.

Drug courts are thus strongly advised to visit and inspect potential program referral sites regularly. A visual inspection of the physical facility and discussions with clinical staff may be informed by questions regarding the types and variety of "evidence based components" provided, but the visit will provide a much more thorough indication of true quality and effectiveness.

Part II – What is "Evidence-Based" Treatment?

Principles of Effective Treatment

One way to define effective treatment is to borrow from the scientific principles described in the National Institute on Drug Abuse publication entitled *Principles of Drug Addiction Treatment: A Research-Based Guide*. Examples of these principles of effective care derived from scientific studies include:

- No single treatment is appropriate for all individuals.
- Effective treatment attends to multiple needs of the individual, not just drug use.
- Remaining in treatment for an adequate period of time is critical for treatment effectiveness.
- Counseling (individual and/or group) and other behavioral therapies are critical components of effective treatment for addiction.
- Medications are an important element of treatment for many patients.

Regular visits by the drug court team to personally inspect the care provided in local programs are a handy and sensible method to get a sense of the quality of treatment provided by programs used as referral sources.

Evidence-Based Components of Treatment

Another quick method for getting a sense of the adequacy of potential treatment providers is asking about the nature of the components or ingredients that comprise the treatment regimen at the program. The components or ingredients of treatment, regardless of setting or duration, may be divided into three types: medications, therapies, and services. Here we present a summary discussion of the specific components within each type that have demonstrated effectiveness by the criteria described above.

Medications

Medications have developed remarkably over the past five years to the point that a "good treatment program" should have the capacity to assess for and provide medications (see chapter 4). There are now effective medications for the treatment of opiate, alcohol, and nicotine

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dependence. Medications for cocaine and marijuana addiction are nearing the marketplace, but are not yet available. There are presently no proven or promising medications for methamphetamine dependence.

An important additional consideration is that at least 50% of any addicted population concurrently experiences significant psychiatric problems such as depression, anxiety, and phobia where the first line treatment of choice is a medication. Psychotropic medications work equally well among addicted participants as they do among those not addicted. Again, "good treatment programs" will have the capacity for professional psychiatric assessment and appropriate medication.

Medications prescribed for reducing alcohol and drug abuse problems may have one or more of several actions including prevention of withdrawal, reduction of postwithdrawal cravings, reducing or completely blocking the pleasurable effects of substances of abuse, and finally punishing re-use of addictive substances by inducing an unpleasant physical effect. Importantly, no medication works with all drugs of abuse, no medication has all the therapeutic effects described, and very few medications work well for even a majority of the population. Reasons for this likely involve specific interactions with genetic qualities of individual metabolism. With this important caution, the following medications have been shown to be effective in the treatment of the designated addiction problems and are currently available for prescription:

Medications have developed remarkably over the past five years to the point that a "good treatment program" should have the capacity to assess for and provide medications for their addicted patients.

- Alcohol - Disulfiram (Antabuse), Naltrexone (Revia or sustained release Vivitrol), Acamprosate (Campral)
- Opiates - Methadone, Buprenorphine (Subutex, Suboxone), Naltrexone (Trexan)
- Cocaine - Disulfiram (Antabuse)

Treatment Interventions

There are specific behavioral treatment interventions that also have developed a strong evidence base over the past 5 to 7 years. All the examples cited below have supporting training programs to assure they are applied with fidelity and potency. You will note that many are referred to as "therapies." There is a difference between "counseling" and "therapy." Individual counseling is an important component of addiction treatment and it may be delivered by a range of professionals, even those with little formal training. Counseling focuses upon advice and suggestions for concrete, real world problems in the here and now, such as strategies for how to avoid drug-using friends, how to apply for a job and what to say about an addiction problem, where to obtain drug-free housing, referrals for services and to AA meetings, etc.

Importantly, drug counseling has been shown to be very effective when offered in individual, one-on-one situations. *Group counseling alone has not been shown to be effective* and yet group

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counseling is a staple of most addiction programs. Programs that offer only group counseling without any individual counseling should be considered carefully prior to referral.

Therapy should only be delivered by an individual who has had specialized training (but not necessarily a specific degree). Therapies focus on interpersonal and intrapersonal problems with moods, impulse, and relationships. Most evidence-based therapies help participants acquire specific skills rather than just insights or problem recognition. Many can teach useful skills such as relapse prevention, decisional balance, parenting skills, relationship skills, etc., within 24 weekly sessions or less. No therapist can perform all therapies and not all participants are attracted to or respond equally to all therapies. Thus a "good treatment program" should have several therapists trained to proficiency in different evidence-based therapies as well as the capacity to provide individual counseling. What follows are those therapies that have been shown to be effective in the treatment of alcohol, cocaine and opiate addiction problems and that have developed training manuals to assure proficiency.

Group counseling has not been shown to be effective and yet group counseling is a staple of most addiction programs.

Programs that offer ***only*** group counseling and ***not*** individual counseling should be considered carefully prior to referral.

- Motivational interviewing and motivational enhancement therapy
- Voucher-based reinforcement of drug-free urines
- Cognitive behavioral therapy
- Community reinforcement and family training
- Multisystemic family therapy
- Behavioral couples therapy
- 12-step facilitation therapy

Health and Social Services

Virtually all addicted individuals have one or more concurrent medical, psychiatric, employment, family, and social problems. These problems can seriously complicate the delivery of and benefits from addiction treatment. Thus, "good treatment programs" will have the ability to assess a broad range of potentially complicating health and social problems of their participants and to provide necessary services either on-site or through referral to cooperating community agencies.

Critical Service Needs

Among the most important "addiction related problems"—those that have been shown to affect treatment outcomes—are employment, housing, and psychiatric illness. Thus, these may be among the most critical adjunctive services for addicted populations, although child care, parenting skills training, and services for violence and abuse are particularly important for women participants.

Clinical Case Management

While the on-site availability of health and social services is optimal, in fact very few community treatment programs, especially outpatient programs, have the personnel and administrative infrastructure necessary to provide even the most critical support services. Because of this, many

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programs have hired and trained clinical case managers whose job it is to assess the needs of the addicted participants and to provide active referral (actually taking a participant, not just calling on their behalf) to appropriate and willing community agencies to assure service linkage. Case management also involves postreferral follow-up to assure compliance with the service delivery plan of the referral agency and in some cases active interventions to prevent or detect early relapses (see chapter 3).

RECOMMENDATIONS

The evidence-based findings summarized here indicate that better outcomes are found in programs that have the capacity to provide or access

a. *individual* drug counseling in addition to group counseling;

b. proper medications (anti-addiction medications and medications for adjunctive psychiatric conditions);

c. supplemental social services for medical, psychiatric, and family problems; and

d. active engagement into 12-step programs or other continuing care regimen following treatment.

Perhaps the most important conclusion to be drawn from this chapter is that, like all other areas of healthcare, addiction treatment also has evidence-based practices derived from the same evaluation designs and methods also used to evaluate pharmacological, educational or medical interventions. Secondly, based on these evaluation methods and standards of evidence, there are several components of addiction treatment that have proven effectiveness, not only in reducing target substance use behaviors, but also in achieving the broader goals of rehabilitation (Hubbard et al., 1989; Institute of Medicine, 1995, 1998; McLellan et al., 1994; McLellan, O'Brien, Lewis, & Kleber, 2000; Miller & Hester, 1986).

At the same time, not all treatments are effective by any standard, and some treatment types and treatment programs are better than others (McLellan et al., 2000). Like the famous adage about politics, all addiction treatment "is local." The ability of a local program to provide many of the evidence-based clinical practices presented here is one good but imperfect indication of true effectiveness of an individual program.

There is no substitute for regular personal inspection and discussion about treatment components (evidence-based practices) with treatment programs that serve as major referral sites for drug court participants. In addition, it is important that drug court judges and case managers monitor attendance of participants at scheduled appointments with community agencies if they are to get the benefits from that referral.

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RELAPSE PREVENTION THERAPY WITH SUBSTANCE-ABUSING OFFENDERS

An Overview with Recommendations for Drug Courts

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INTRODUCTION

Longitudinal studies have repeatedly demonstrated that substance abuse treatment (particularly for 90 days or more) is associated with major reductions in substance use, problems, and costs to society (French et al., 2000, 2002a, 2002b; Hser et al., 2001a; Hoffman, Grella, & Anglin, 2001b; Hubbard et al., 1989; Salome et al., 2003; Sells, 1974; Simpson, Joe, & Roway-Szal, 1997a; Simpson et al., 1997b; Simpson, Joe & Brown, 1997c; Simpson, Joe, Fletcher, Hubbard, & Anglin, 1999). However, postdischarge relapse and eventual readmission are also the norm (Godley, Godley, Dennis, Funk, & Passetti, 2002; Lash, Petersen, O'Connor, & Lehmann, 2001; McKay et al., 1997, 1998). Substance abuse is increasingly seen as similar in course and outcome to chronic health problems such as diabetes, hypertension, and asthma (Donovan 1998; O'Brien & McLellan, 1996). Although the risk for relapse is greatest during the first 3 to 6 months following initiation of abstinence (Hunt, Barnett, & Branch, 1971), recovering substance abusers are still at relatively high risk for 2 years (Moos, Finney, & Cronkite, 1990) and as some risk even after that (Vaillant et al., 1983). In spite of this evidence of chronicity and multiple episodes of care, most substance abuse treatment continues to be characterized as relatively self-encapsulated, serial episodes of acute treatment with postdischarge aftercare typicallty limited to passive referrals to self-help groups (Dennis, Perl, Huebner, & McLellan, 2000; Godley et al., 2002; McLellan et al., 2000; White, 1996; Etheridge, Hubbard, Anderson, Craddock, & Flynn, 1997).

Concern about these issues has led to new approaches modeled after treatment of other chronic disorders with similar rates of relapse, readmission, and co-occurring problems that complicate treatment. Clients should be urged to participate in some form of lower intensity continuing care, also known as "step-down" care or aftercare, after their initial phase of higher intensity treatment has ended (American Society of Addiction Medicine, 1996; Brownell et al., 1986; Rawson et al., 1991; Washton, 1989). The primary goals of this phase of treatment are to maintain the gains that have been achieved in the initial phase of care and prevent relapses, thereby reducing the likelihood that additional episodes of intensive care will be required. Continuing care is also thought to be important in the treatment of other medical disorders. For example, diabetic, hypertensive, or asthmatic patients are encouraged to comply with medication regimens, attend regular follow-up appointments, and maintain changes in diet and lifestyle to sustain the improvements from their initial phases of care.

NARRATIVE

Addictive Behaviors and Relapse Prevention Therapy

Relapse Prevention Therapy (RPT) is a cognitive-behavioral approach to the treatment of addictive behaviors that specifically focuses on the nature of the relapse process and suggests coping strategies useful in maintaining behavior change initiated during drug treatment or while incarcerated in an institution (Marlatt & Donovan, 2005; Parks, Marlatt, & Anderson, 2003). RPT is based on the idea that engaging in addictive behaviors helps people "feel good" (enhanced pleasure) or to "feel better" (self-medication of physical or emotional pain) as long as the intoxicating effects of the drug last.

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RPT views addictive behaviors from a *biopsychosocial* point of view. *Biologically*, psychoactive chemicals affect brain function and narrow a person's ability to experience pleasure other than from a drug high. *Psychologically*, addictive behaviors result in distorted thinking including denial and rationalization as well as preoccupation with acquiring and using drugs. Finally, *socially*, addictive behaviors can cause interpersonal conflicts with family, friends, fellow workers, and association with those who use and sell drugs can result in criminal activity. Over time, the cycle of drug highs and drug withdrawal leads to tolerance, dependency, and numerous drug-related harms such as physical disease, financial losses, relationship problems, and conflict with the law. Unfortunately, a person's alcohol or drug habit not only becomes their main source of pleasure and relief from pain, but also their characteristic means of coping with life in general.

A Cognitive-Behavioral Model of the Relapse Process

RPT is based on a Cognitive-Behavioral Model of Relapse Prevention developed by Alan Marlatt and his colleagues designed to help substance-abusing clients 1) prevent relapse by coping more effectively with high-risk scenarios and 2) manage relapse by coping with lapses before they escalate into a full-blown relapse (Marlatt & Donovan, 2005). Relapse Prevention Therapy begins by assessing a client's unique risk factors, which increase his or her vulnerability to relapse. In RPT, these high-risk scenarios are defined as any internal state or external circumstance in which it is difficult for a client to avoid using alcohol or other drugs. Three of the most common high-risk scenarios are social pressure, negative emotions, and interpersonal conflict.

Biologically, psychoactive chemicals affect brain function and narrow a person's ability to experience pleasure other than from a drug high.

Psychologically, addictive behaviors result in distorted thinking including denial and rationalization as well as preoccupation with acquiring and using drugs.

Socially, addictive behaviors can cause interpersonal conflicts with family, friends and fellow workers and association with those who use and sell drugs can result in criminal activity.

When faced with a high-risk scenario, a client's ability to use effective coping strategies to respond successfully to risky people, places, thoughts, feelings, or things reduces the probability of a lapse and allows the client to prevent a relapse from developing by never allowing it to start (See "Relapse Prevention" path on Figure 1). Ineffective coping decreases a client's motivation and self-efficacy. The client may begin to think there is no use trying to resist temptation and that he or she is just not able to cope with the high-risk scenarios without using drugs (low self-efficacy). Getting drunk or high begins to sound good as positive outcome expectancies for substance use start to grow and reasons not to use fall prey to denial and rationalization (See lower path of Figure 1).

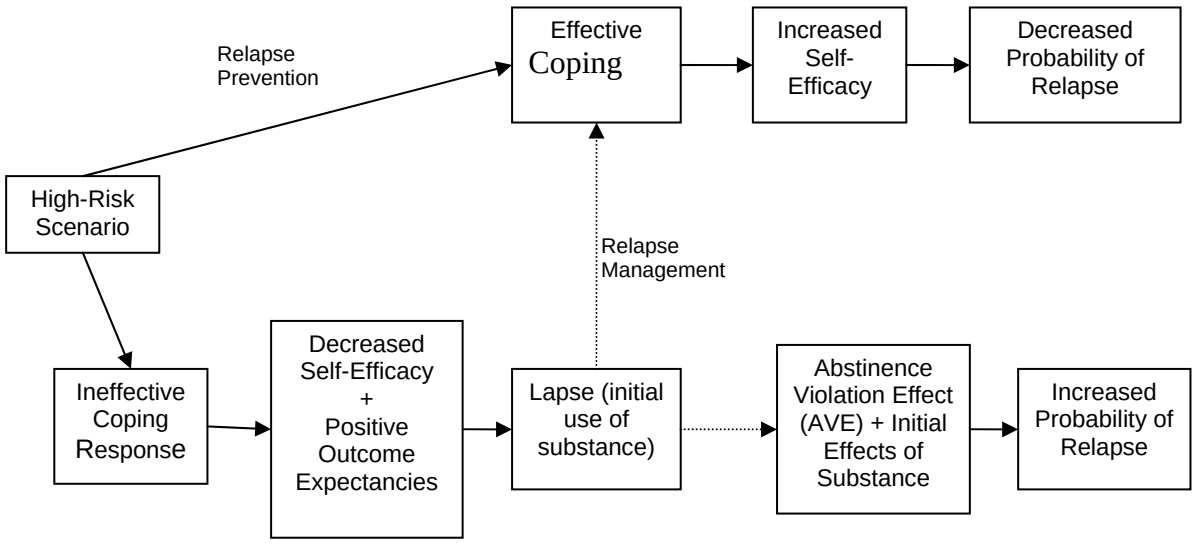
Failure to cope with high-risk scenarios combined with a belief that alcohol or drug use will fix the problem may result in a lapse or a single instance or episode of use that may or may not lead to relapse. Whether a lapse becomes a relapse depends on the person's emotional and cognitive reactions following the use of a substance. The Abstinence Violation Effect (AVE) consisting of black and white (dichotomous) thinking (e.g. "What's the use, I may as well continue since I'm

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dirty anyway.") and attributing the cause of the lapse to personal flaws (e.g. "I guess I'm just a hopeless drunk and might as well admit it.") will increase the likelihood that a person will go on using after a slip (see lower path of Figure 1). However, relapse management, including damage control measures, which allow the individual to quit early and escape the high-risk scenarios, is always another option and may lead to a prolapse and getting back on track.

The RPT model views a lapse as a Fork in the Road, one path leading to full-blown relapse and the other path leading to Relapse Management through damage control and a return to abstinence with a recommitment to sobriety and recovery (See "Relapse Management" line on Figure 1). This analysis of the crisis created by a lapse is consistent with the view of the maintenance stage of habit change as a time when mistakes are expected and can be overcome with renewed effort. As the old adage goes, "We can learn much from our mistakes." Seen in this way, a lapse is a crisis involving both the danger of full-blown relapse but also the opportunity for learning to avoid a future relapse. In drug court clients, a lapse may also involve criminal conduct or harm to victims and therefore may need to be managed from both therapeutic and correctional perspectives involving various types of sanctions. Lapse should be assessed and debriefed by both treatment and drug court personnel and then responded to in a way that balances sanctions and increased treatment.

Figure 1. A Cognitive-Behavioral Model of Relapse: Immediate Determinants



Relapse Set-Ups

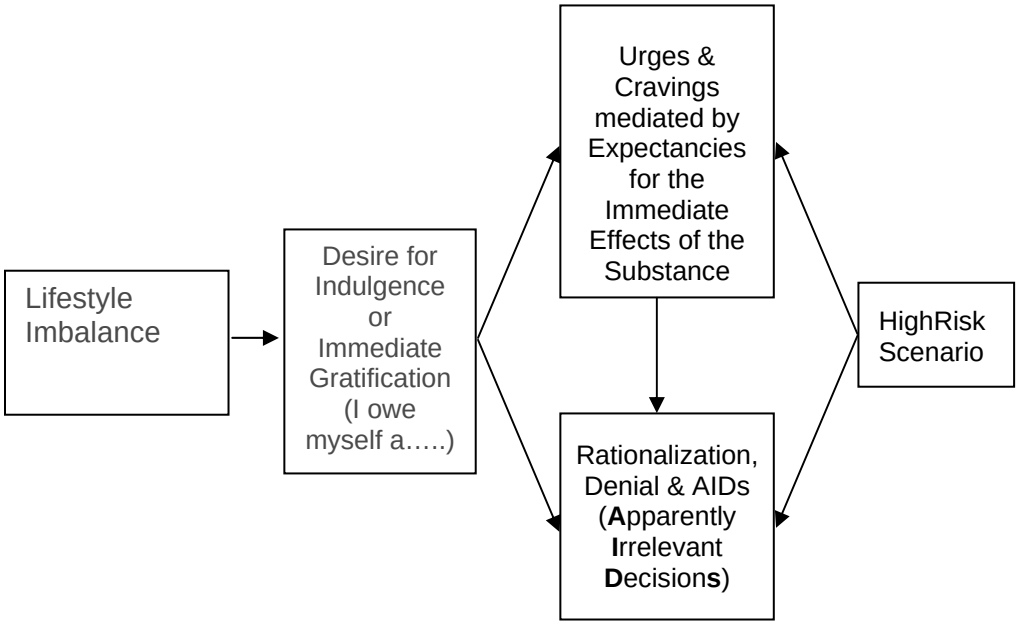
In many, perhaps even most, of the relapse episodes we have studied in our research or worked with in offender supervision or clinical practice, the first lapse a client experiences is preceded by internal states or external circumstances the client was not expecting and/or was generally unprepared to cope with effectively. Often, clients report finding themselves in rapidly escalating high-risk scenarios with which they could not deal effectively and so reverted to their familiar

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habit of substance use. When we later debrief and analyze a lapse or relapse episode with the client, the lapse or subsequent relapse often appears to be the last link in a chain of events that preceded the client's exposure to the high-risk scenario itself, beginning with an unbalanced lifestyle leading to a desire for indulgence and craving that were transformed by distorted thinking into decisions that led to exposure to that particular high-risk scenario where a lapse or relapse eventually occurred (See Figure 2). It seems as if, perhaps unknowingly, even paradoxically, some clients set themselves up for relapse and, when in drug court, set themselves up for criminal recidivism too.

Cognitive distortions such as denial and rationalization make it easier to set up one's own relapse episode without having to take personal responsibility. Not only can a client deny having held any intent to resume alcohol or other drug use, but that client can also minimize or discount the severity of the long-range negative consequences of personal choices and actions. The process of relapse is often begun by a number of covert antecedents that through a chain of events and Apparently Irrelevant Decisions (AIDs) lead a client toward a high-risk scenario. When cognitive distortions mask true intent, clients can deny any responsibility following a relapse or recidivism event, saying, "This is not what I expected or wanted to happen and it really isn't my fault."

Figure 2. Relapse Set-Ups: Covert Antecedents of Relapse Scenarios



Evidence Supporting the Efficacy of Relapse Prevention Therapy

Carroll (1996) conducted a review of the efficacy of Relapse Prevention Therapy as a substance abuse treatment. Incorporating studies of RPT for smoking, alcohol, marijuana, and cocaine

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addiction, Carroll concluded that RPT was more effective than no-treatment control groups and equally effective as other active treatments. Based on the qualitative results from Carroll, Irvin and colleagues conducted a meta-analysis on the efficacy of RPT techniques in the improvement of substance abuse and psychosocial outcomes (Irvin, Bowers, Dunn, & Wang, 1999). Overall treatment effects demonstrated that RPT was a successful intervention for reducing substance use and improving psychosocial adjustment. RPT was equally effective across different treatment modalities, including individual, group, and marital treatment delivery.

Marlatt's cognitive-behavioral model of relapse prevention has also been used as the foundation for several empirically supported correctional programs for substance abusing offenders typically delivered in jails, in prisons and in the community (Pelissier et al., 2000; Peters, Kearns, Murrin, Dolente, & May, 1993; Porporino, Robinson, Millson & Weekes, 2002). A recent meta-analytic review of the use of RPT in correctional programs reported that when RPT components are added to an offender change program, the rehabilitation program has a greater impact on reducing recidivism. More RP components associated with greater efficacy (Dowden, Antonowicz & Andrews, 2003).

Relapse Prevention Therapy in Special Populations

When applying Relapse Prevention Therapy with offenders in treatment for substance abuse problems, intervention techniques may need to be adapted for special populations and their unique needs and learning styles. Special populations include both young and elderly offenders, women in treatment (also women with children at-risk for brain damage due to alcohol or other drug exposure), offenders with co-occurring mental health and addiction problems, different ethnic groups (e.g., Native Americans, African Americans, Hispanics), and those with multiple addictive behavior problems (e.g., drug use and gambling).

One drug court special population that clearly requires specially adapted techniques of Relapse Prevention Therapy is individuals who have been exposed to alcohol in utero. Fetal Alcohol Spectrum Disorder (FASD) is the prevailing term describing all birth defects associated with this exposure. The organic brain damage associated with FASD causes a range of serious cognitive and behavioral problems. The incidence/prevalence of FASD is approximately 1 in 100 births (Sampson et al, 1997). This disability is seen with fair frequency in drug court. Streissguth and colleagues (1996, 2004) found in their study for the Centers for Disease Control that 30% of adolescents and adults with FASD have drug or alcohol abuse problems.

The value to drug court of identifying those defendants who may be cognitively disabled, is to provide the most effective approach to achieve and maintain abstinence. These individuals generally have average or borderline I.Q. scores but have far more difficulty in managing their lives than those with the same I.Q. who are not brain damaged. In King County Drug Court (Washington State), court personnel are using a referral check sheet to identify those who may be disabled by prenatal alcohol exposure. This check sheet can be found in the Legal Issues section of the Fetal Alcohol and Drug Unit Web site: http://depts.washington.edu/fadu/legalissues/

Some elements of traditional Relapse Prevention Therapy are unlikely to be effective for individuals with FASD, although the disability caused by FASD varies significantly. Individuals with this

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disability often will lack the degree of self-awareness and maturity needed to understand why particular scenarios entail a high risk of triggering a relapse or to be able to master an abstract and complex coping strategy. Several alternative approaches seem more effective for preventing relapse by individuals with FASD.

Treatment should include identifying the scenarios likely to pose a high risk of relapse and offer simple, concrete corresponding rules (e.g. "Don't go to the Dew Drop Inn or hang out with Danny Drug Dealer") that are taught to clients through repetition. Written copies of those rules, limited in number and in easily understood language, may be useful. Regarding both rules and role-playing, repetition and continuing reinforcement is key. Since those with FASD generally respond well to the authority of the court, the judge can play a significant role in providing ongoing positive reinforcement of Relapse Prevention goals.

RECOMMENDATIONS

In order to encourage the utilization of research-based best practices in the area of Relapse Prevention Therapy (RPT) the following recommendations including many useful suggestions by Kushner (2007) are offered:

1. Drug courts should *recognize the chronic, relapsing nature of substance use disorders*. Evidence from both community-based and correctional drug treatment programs strongly suggests that drug courts should institute long-term continuity of care including structured aftercare services for as long as the court's mandate permits to more effectively reduce relapse and recidivism.

2. Drug courts should *model case management and treatment services after strategies utilized in long-term care for other chronic diseases* such as diabetes, asthma, and cancer *including periodic post-discharge monitoring, reintervention as needed, and long-term recovery management*. This approach is consistent with evidence that suggests stable recovery from substance use disorders is likely to involve multiple treatment episodes over a protracted period of time.

3. Drug courts should *urge treatment providers to use principles of evidence-based RPT in their services at all levels care* including early intervention, outpatient treatment, intensive outpatient treatment, day treatment, and residential care.

4. Drug courts should *encourage treatment providers to tailor their RPT services to address the needs of special subpopulations of participants* including young and elderly offenders, women, offenders with co-occurring disorders, offenders with cognitive disabilities and those from different ethnic groups. In addition, all drug court personnel should receive training to enhance their effectiveness in working therapeutically with these special populations.

5. Drug courts should *encourage treatment providers to offer integrated RPT services to participants with co-occurring substance use and mental disorders* since the research evidence shows that an integrated approach is more effective than parallel or sequential treatment that fragments service delivery.

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6. Drug courts should *require systematic, comprehensive and formalized Relapse Prevention Plans* (*RPP*) to assist drug court participants to remain abstinent from drugs. RPPs are an essential component to effective RPT. Early identification of problems through monitoring of the RPP will allow the drug court team to intervene in a timely and appropriate way and should improve long-term outcomes.

7. Drug courts should *ensure that the judge, case managers, the participant, and the entire drug court team continually monitor the effectiveness of the RPP* that is currently in place. When there is evidence of problems in maintaining sobriety or complying with the RPP, the drug court team should require participants to make changes in the RPP including a return to treatment or an increase in the level of care of an ongoing treatment.

8. Drug courts should *ensure that RPPs should contain, at a minimum, the following components:*

    - Identifying and managing relapse warning signs,
    - Understanding the "cues" that trigger craving and managing craving and urges,
    - Identifying, disputing and replacing patterns of thinking that increase relapse risk,
    - Anticipating high-risk relapse scenarios and developing effective coping skills,
    - Identifying and learning to manage negative emotional states,
    - Identifying and coping with social pressure to use,
    - Learning ‘damage control’ to interrupt lapses early in the process and return to treatment,
    - Improving interpersonal relationships and developing a recovery support system,
    - Developing employment and financial management skills, and
    - Creating a more balanced lifestyle.

9. Drug courts should *provide legislative, administrative, and funding bodies with information and supporting statistics to demonstrate the value of increased financial support for aftercare services* including Relapse Prevention Therapy, breath testing for alcohol, urinanalysis for the presence of drugs, contingency management to encourage abstinence from drugs, post-discharge monitoring, reintervention as needed, and ongoing, long-term recovery management.

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MEDICATION-ASSISTED TREATMENT FOR PARTICIPANTS IN DRUG COURT PROGRAMS

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INTRODUCTION

Modern research has demonstrated that the brain plays a major role in the etiology and persistence of substance use disorders. Comorbid psychiatric conditions such as attention deficit hyperactivity disorder (ADHD), depression, posttraumatic stress disorder (PTSD), and schizophrenia are major risk factors for becoming addicted to drugs. Appropriate medications for treating these conditions are essential for the successful treatment of the comorbid substance abuse disorder. In the same way, medications for the treatment of certain substance abuse disorders are of importance if the comorbid psychiatric disorder is to be brought under control. In addition genetic predispositions for alcoholism are well established and recent research has shown that genetics may also play a major role in other forms of addiction. Thus, substance abuse/dependence is best viewed as a chronic relapsing brain disorder requiring comprehensive treatment of the individual if rehabilitation is to be successful. Such comprehensive treatment includes behavioral interventions such as motivational incentives as well as counseling or some type of formal psychotherapy. In addition, for alcoholism and opioid dependence, as will be reviewed in this chapter, medications have clearly been shown in randomized placebo controlled clinical trials to further improve the outcome of treatment. The National Institute on Drug Abuse (NIDA) has an active program working on the discovery of medications for the treatment of other forms of substance abuse and dependence. Thus, effective new medications for the treatment of methamphetamine and cocaine addiction, for example, may be developed in the near future and should be considered for integration into drug court programs as soon as they are approved by the FDA for this indication. It should be noted that although there are claims made concerning the effectiveness of certain medications (or combinations of medications) for the treatment of methamphetamine and cocaine addiction, there is presently no acceptable evidence base for these claims and none of these medications are approved by the FDA for these indications. Drug court programs should consult with SAMHSA/HHS and NIDA/NIH if they are considering the adoption of new medications as part of their treatment to determine whether there is sufficient research evidence to justify inclusion.

NARRATIVE

Medications for the Treatment of Withdrawal Signs and Symptoms

In most programs the first stage of treatment is *detoxification,* where the drug of abuse (e.g. heroin, cocaine, alcohol) is removed from the body by metabolism and is not replaced by continued drug taking. The patient thus becomes drug-free. This procedure is often conducted in the hospital depending on the type of drug or drugs involved. Withdrawal can be uncomfortable (opioids) and in some cases life threatening (alcohol, barbiturates). The symptoms tend to be the opposite of the initial effects of the drug. Heroin, for example, causes pupillary constriction and constipation. In withdrawal, there is pupillary dilation and a hyperactive gut or diarrhea. Alcohol depresses many brain functions, and during withdrawal brain hyperactivity can lead to prolonged convulsions that can be fatal if not treated (O'Brien, 2006).

Medications can be used to ease the discomfort of withdrawal and prevent life-threatening events. Thus, we have medications for barbiturate and alcohol withdrawal (benzodiazepines) and

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opioid withdrawal (clonidine, lofexidine, buprenorphine and methadone) that are given in decreasing doses over a period of days while the body adapts to being without the drug of abuse. Usually withdrawal from stimulants, such as cocaine or methamphetamine, does not require treatment with medications unless the patient is severely depressed.

Medications are very effective in preventing or relieving the signs and symptoms of withdrawal but this is only the first stage of treatment. It is essential that detoxification be followed by appropriate counseling, psychotherapy, and other rehabilitative interventions if relapse is to be avoided.

Medications for Preventing Relapse

In addition to the behavioral and psychotherapeutic interventions mentioned above, there are also medications for certain substance abuse problems that are useful in preventing relapse and should be employed for maximizing long term positive treatment outcomes. For instance, disulfiram is a medication that has been used for many years to prevent relapse to alcohol use. It interferes with the metabolism of alcohol, slowing it at the acetaldehyde stage that produces extremely toxic aversive effects. These toxic effects can be life threatening if the individual has consumed enough alcohol. Although this treatment has been found to be effective, most people refuse or stop taking the medication (Fuller et al., 1986). Thus, disulfiram's usefulness is limited because of lack of adherence as well as its potential toxicity if alcohol is used. Recently the opioid antagonist, naltrexone, has been shown to be effective in preventing relapse to alcohol abuse/dependence. Individuals treated with naltrexone have been shown to have significantly fewer days of drinking and fewer drinks on any occasion than those given placebo. In particular, naltrexone prevents a lapse in abstinence from becoming a relapse to alcohol dependence (Garbutt et al., 2005). Acamprosate (Campral) is another medication used to treat alcohol abuse and alcoholism. It has been shown in controlled clinical trials to maintain higher rates of abstinence than placebo for periods up to one year (Lesch et al., 2001).

Medications are very effective in preventing or relieving the signs and symptoms of withdrawal ***but this is only the first stage of treatment***. It is essential that detoxification be followed by appropriate counseling, psychotherapy and other rehabilitative interventions if relapse is to be avoided.

Although naltrexone is used to treat alcoholism, naltrexone is actually an opioid antagonist that can prevent relapse to heroin and other opioids by literally preventing these drugs from having their usual effect, i.e., they block opioid receptors in the brain for periods up to 48 to 72 hours. Unfortunately, the vast majority of patients previously dependent upon opioids stop taking naltrexone and relapse to drug use. Those who are highly motivated to remain drug free, however, have been effectively maintained on opioid antagonists. It has been found particularly useful for two groups of people. One group is the highly motivated, so-called, "white collar addicts", such as physicians, nurses, pharmacists, and other professionals (O'Brien, Woody, & McLellan, 1986). Physicians who have to work with opioids on a regular basis find that having an antagonist in their body prevents them from even feeling tempted to use opioids. The second group that has been found to respond very well to opioid antagonists are those with a past history of heroin addiction who are being released from prison on parole. If the individual suffered from

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heroin addiction prior to going to prison, there is a high probability that they will relapse soon after they are released. Naltrexone has been found to be useful in this population to prevent such relapse (Cornish, et al., 1997; O'Brien & Cornish, 2006). It is important to note that to avoid precipitating an intense withdrawal syndrome, initiating treatment with naltrexone should not begin for at least five days after the cessation of use of short-acting opioids (heroin) or longer for long-acting opioids such as methadone. To insure that the individual is no longer physically dependent upon an opioid, it is recommended that a challenge dose of naloxone (Narcan), a short-acting opioid antagonist, be given. If the individual shows no signs of withdrawal to this challenge, treatment with a low dose of naltrexone can begin. If the individual does not experience any adverse effects to the low dose of naltrexone, the dose can be increased to a full therapeutic dose (Center for Substance Abuse Treatment [CSAT], 2005). Ideally, individuals who have been incarcerated and drug free for some period of time could be initiated onto naltrexone prior to the time they leave prison, thus insuring that they cannot relapse to opioid dependence before entering outpatient treatment.

One study involved randomly assigning federal parolees to either naltrexone (Revia®) or treatment as usual. Within six months, 57% of the control group was reincarcerated. The group randomized to naltrexone had only a 27% reincarceration rate (Cornish et al., 1997). Recently naltrexone has become available as a depot preparation that is effective for 30 days after a single injection (Vivitrol®). A study in progress in Philadelphia is using this depot preparation in parolees with encouraging results so far. The parolees report that the antagonist prevents them from getting high if they inject heroin, and because they only have to come back once a month for an injection, there is good adherence to the treatment program. Participation in the Philadelphia study has been completely voluntary; parolees are offered treatment with naltrexone, but there is no coercion. It has been proposed, however, that treatment with depot naltrexone be made available as an option in plea bargaining. Those pleading guilty to nonviolent, drug-related crimes might be presented with a choice of depot naltrexone or a prison term, thus increasing the likelihood of rehabilitation and saving public funds currently supporting overcrowded prisons (Bonnie, 2006; Caplan, 2006).

Pharmacotherapy for Opioid Addiction

Since the 1970's methadone has been used for the long-term treatment of opioid dependent individuals. Randomized controlled clinical trials as well as analysis of national treatment data has shown that methadone treatment as part of a comprehensive rehabilitation program, decreases illegal opioid use, normalizes the endocrine and immune system, decreases the spread of blood-borne diseases such as AIDS and hepatitis, decreases criminal activities, and increases prosocial activities. It must be emphasized that methadone is not a cure for opioid addiction, but it improves retention and facilitates involvement with rehabilitation services. Because for many opioid addiction is a chronic relapsing disease state, lifelong treatment with methadone may be indicated (Kreek, 1992). Unlike treatment with naltrexone, it is not necessary for patients who are dependent upon opioids to be detoxified prior to the initiation of methadone. There are, however, federal regulations governing the dosages that can be used in the initiation of treatment with methadone. These are described in TIP 43 put out by SAMHSA/CSAT (2005). The general principle is to first make certain that the individual is not intoxicated with illegal drugs and then to start treatment with a low dose (30 mg), escalating slowly over the next week until the

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individual shows no signs of withdrawal. The maintenance dose of methadone is adjusted by the prescribing physician to achieve abstinence from illegal opioids while avoiding deleterious side effects. It should be noted that large individual differences in the rate of metabolism of methadone exist, and some individuals require much larger doses of methadone to remain drug free and functional. Regulations that arbitrarily set limits on maximum daily methadone dosage are not in the best interest of the patient.

In 2003 buprenorphine was introduced for the treatment of opioid dependence. Since the passage of the Drug Abuse Treatment Act of 2000, physicians who have received a waiver from the Secretary of Health and Human Services (HHS) can prescribe any Schedule III, IV or V medication that has been approved by the FDA for the treatment of opioid addiction. Currently, the only medication meeting this requirement is buprenorphine. There are two buprenorphine preparations for the treatment of opioid addiction, both of which are taken sublingually: Suboxone®, which is buprenorphine combined with the opioid antagonist naloxone in a 4 to 1 ratio, and Subutex® (buprenorphine alone). Suboxone® is the formulation primarily used in the United States for the treatment of opioid addiction. The naloxone in Suboxone® is not well absorbed when the medication is taken as directed sublingually. If, however, Suboxone® is administered intravenously by someone dependent on heroin or other strong opioid analgesics, the naloxone will precipitate a very intense withdrawal syndrome. Thus, the addition of naloxone decreases the likelihood of the diversion of Suboxone® into the drug-using subculture. It should be noted, however, that the addition of naloxone does not prevent the intravenous abuse of Suboxone® by individuals who are not physically dependent on strong opioids (Fudala et al., 2003).

Buprenorphine has very high affinity for the sites in the brain (mu receptors) where opioids exert their addictive actions and it only leaves these receptors slowly. Once it occupies these receptors, it produces an opioid effect but with a much lower ceiling than drugs such as heroin, oxycodone, or methadone. The effects are sufficient, however, to satisfy the body's needs for an opioid in most opioid-addicted individuals. This ceiling on buprenorphine's effects, particularly on respiration, makes the drug much safer. It also means that individuals maintained on buprenorphine have a lesser level of physical dependence and can be tapered off of the drug more easily than with the stronger opioids. Importantly, because of the high affinity and slow disassociation of buprenorphine for the opioid receptor, it can block the effects of other opioids such heroin. This has led to some referring to buprenorphine as a mixed agonist/antagonist. Because of these properties, it is important to initiate treatment with buprenorphine only after the opioid dependent person begins to show signs of withdrawal. Administration of buprenorphine shortly after an individual has taken heroin or other strong opioids may precipitate withdrawal signs and symptoms. On the other hand, if the individual is in withdrawal, buprenorphine's limited opioid effects will produce some withdrawal relief. If this occurs, a second dose may be given. Initiation of treatment with buprenorphine is described in TIP 43 (CSAT, 2005).

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Community Model
Buprenorphine Maintenance in a Small Community

The program in Lewistown, Pennsylvania illustrates an ideal interaction between local community leaders, the medical profession, and law enforcement. In 1998, several key leaders in the community and concerned residents came together to talk about the rise in heroin abuse. Out of this discussion, the Mifflin County Heroin Task Group was established. It was clear to all that treatment for opioid/heroin addiction was sorely lacking. However, they knew that a new medication for opioid addiction, buprenorphine, was under consideration by the FDA and began educating the community on the possible use of this new medication. When the FDA approved buprenorphine for outpatient use in October 2002, Mr. Ray Dodson, the Executive Director of Juniata Valley Tri-County Drug and Alcohol Abuse Commission, provided information, education, and personal contact to primary care physicians across eight counties. In addition, he organized the certification course for prescribing buprenorphine to be held locally, and invited not only physicians, but also pharmacists, drug and alcohol counselors, and other service providers. The Mifflin County Commissioners' office, as well as the District Attorney's office, sponsored the training financially, allowing all participants to attend at a very nominal fee. The training occurred in June 2003.

The program saw its first patients in September 2003 and has been filled to capacity ever since. Of key importance is t a clinical psychologist who serves as the coordinator of the program and who maintains close contact with all of the patients during the initiation of treatment and is available when problems arise. This position could as well be handled by a social worker with training in the use of buprenorphine. This program has been a model for buprenorphine treatment that has received the endorsement of the Center for Substance Abuse Treatment (CSAT) of the Substance Abuse and Mental Health Services Administration (SAMHSA).

In addition, the New York University Graduate School of Public Service undertook a study of buprenorphine services across the country, and recommended to the New York Department of Health that it adopt the "Lewistown Model" for implementation in New York City (*NYU Capstone Report, 2004*). The close cooperation of the criminal justice system, community leaders, and physicians at a local hospital has made this program possible in a small, semirural community. It should serve as a model for other communities that have drug courts but limited resources for providing drug abuse treatment services.

Currently there are over 7000 physicians who have received the special training and waivers from HHS to prescribe buprenorphine for the treatment of opioid dependence. This means that smaller communities that do not have methadone maintenance programs can use local community physicians to provide the medication.

Currently a pilot study using Suboxone® for the treatment of individuals with an opioid addiction problem who have been referred by the county drug court is being conducted in Wayne County, Michigan (Rhodes, Majeda, Smith, & Schuster, 2006). The drug court participants are offenders with a minimum of three nonviolent felony offenses. Participants are required to remain in treatment for 1 year, with the medication phase lasting a maximum of 9 months. Immediately upon intake, participants undergo an orientation as well as thorough psychosocial

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and psychiatric assessments. Those patients with current psychiatric diagnoses (36%) are evaluated and undergo treatment by the clinic psychiatrist. All drug court participants attend one hour of individual therapy weekly and one hour of group therapy weekly. During the initial phase of treatment, all participants also attend an additional six sessions of psycho-educational group therapy. Participants provide weekly urine samples for drug testing. Eight participants have completed the medication phase of this program and six have remained drug free as determined by weekly drug testing. Thirteen other participants are still maintained on Suboxone®and most are abstinent from any illegal drug use. This pilot study strongly suggests that short term maintenance on Suboxone® in combination with counseling and other rehabilitation interventions is an effective means of treating drug court referred individuals with a long history of opioid addiction.

Faced with the multiple options for treating opioid addiction, it is important that drug court programs recognize, as is the case in all of medicine, that choice of treatment is dictated by a number of variables. If individuals are repeat offenders with multiple treatment attempts, these should be reviewed with the idea of trying a new approach. Thus, individuals who have previously been assigned to Twelve Step Drug Free programs and failed to achieve any long-term abstinence should definitely be candidates for treatment with a medication. It is our opinion that the first medication to be utilized is naltrexone. If naltrexone is taken as prescribed, it is virtually impossible for the participant to relapse to opioid abuse/dependence. Unfortunately, even in the best of programs some individuals stop taking naltrexone and relapse to opioid abuse. Such individuals should be considered for Suboxone (buprenorphine + naloxone) therapy. If the participants are successful in achieving abstinence form opioids and other drugs of abuse, Suboxone treatment should be continued while the individual is engaged in other forms of therapy and rehabilitation. Subsequently, participants may be able to be successfully tapered off of Suboxone and, in an ideal setting, would be transferred to depot naltrexone for a period of at least three months. During this critical transition period, naltrexone will prevent relapse even if the participant attempts to use an illegal opioid. Recent research has shown the feasibility of this sequential treatment with medications (Comer et al., 2006).

Individuals who have been physically dependent upon opioids for a long period of time at high doses may require treatment with the full opioid agonist methadone. Thus, we are recommending that drug court programs be flexible enough to allow physicians to use all the available medications that have been shown to be useful in the treatment of opioid addiction. Choices should be based upon the patient's history of drug taking and prior treatment successes or failures. Just as there is no single pathway to addiction, there is no single pathway to abstinence and programs must be flexible enough to deal with individual differences as well as different needs at different points in the recovery process.

RECOMMENDATIONS

1. Drug court teams should become educated about medications for treatment, and a determination made as to what is currently available in the community and what could be made available to improve treatment outcomes and drug court successes.

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2. Drug court programs should adopt the use of medications as part of a comprehensive treatment program for the initiation of abstinence and the prevention of relapse for individuals with a history of alcohol or opioid dependence.

3. Consideration should be given to using plea bargaining agreements to motivate individuals who have a history of alcohol dependence to initiate and remain on naltrexone, acamprosate, or disulfiram for a minimum period of 1 year.

4. Consideration should be given to using plea bargaining agreements to motivate individuals who have a history of opioid dependence to initiate and remain on naltrexone for a minimum period of 1 year.

5. Consideration should be given to the use of buprenorphine for individuals who are opioid dependent.

6. For individuals with a history of opioid dependence who have been unsuccessfully treated with naltrexone and/or buprenorphine, treatment with methadone should be an option.

RESOURCES

It is well established by research and years of clinical experience that medications are an important part of the treatment of alcoholism and opioid addiction. Medications such as methadone, buprenorphine, and naltrexone have been shown to clearly improve treatment outcomes for opioid-addicted individuals over detoxification followed by counseling and rehabilitative services alone. Similarly, naltrexone, acamprosate, and disulfiram have been shown to improve the outcome of treatment for alcohol dependence. Drug court judges should be made aware of these data that clearly show the increased effectiveness of treatment and rehabilitation programs for the treatment of alcoholism and opioid addiction when medications are properly utilized. The data fully justify the conclusion that medications should be considered as an integral part of any drug court treatment program. Given these data, to deny drug court participants the option of receiving medications for their treatment is in our opinion unethical. The cost-effectiveness of the use of medications in preventing reincarceration more than offsets the additional costs of providing medications. Efforts must be made to convince state and federal policy makers that the use of medications for the treatment of substance abuse disorders is not only humane but cost-effective as well.

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CULTURAL COMPETENCY IN DRUG COURT TREATMENT

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INTRODUCTION

When making any drug treatment court or problem solving court operational, teams aspire to incorporate the Ten Key Components into their courts' protocols. Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court program effectiveness. This requires an understanding of the participant's culture and the capacity of the provider in order to make the best possible treatment match. CSAT's Technical Assistance Publication (TAP) 21 states that "Clients' experiences of culture predate and influence their interaction with substance abuse treatment professionals" (2006, p.162). In order to forge the therapeutic relationship, which would enhance the likelihood of a positive outcome, teams must encourage culturally competent treatment services. Drug court brings together diverse professional cultures with different missions, objectives, goals, skill sets, and subcultures. The treatment community contains diverse subcultures: therapeutic community, residential, out patient, methadone, mental health, public health, etc. The criminal justice community also contains diverse subcultures and disciplines: judicial, district attorney, defender, probation, police, corrections, parole, etc. The blending of these distinctly different cultures to accomplish an agreed upon goal demands a certain level of competency.

Cultural competency has been defined as a set of congruent behaviors, attitudes, and policies that come together as a system or agency and enable that system or agency in cross-cultural situations. The word culture is used because it implies the pattern of human thoughts, customs, beliefs, values, and institutions of a racial, ethnic, religious, or social group. The word competence is chosen because it implies having a capacity to function effectively (Cross, Barzon, Dennis, & Isaacs, 1989).

This blending and matching can be accomplished through organizational needs assessments, regularly scheduled community and provider forums, alumni groups, cross disciplinary training, research partnerships, and codesigned evaluations to determine what works on whom. By matching the participant with the most appropriate individualized treatment, the court increases the likelihood of a positive outcome.

This positive outcome will require a fair amount of behavior change. Participants are engaged in risky behavior, and drug court practitioners would like to move them along the continuum to exhibit less. This will require holistic needs assessments. These assessments must include cultural information in order to ascertain what culture the participant identifies with, yielding the best possible treatment match. The diverse participant pool exhibits cultural diversity by race, ethnicity, gender (see chapter 7), age, class, education, neighborhood, drug of choice, route of ingestion, literacy, and other attributes.

As no two drug courts are alike either professionally or in the participant mix, practitioners should assess all participants to determine how their culture impacts on beliefs/behaviors that might inhibit them from successful completion. These would include some of the following:

Child Rearing- Most cultures assign either the women, grandparents, aunts/uncles, men, or extended family the task of rearing the children. Assessment must ascertain what childcare

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resources are available to the client. When childcare resources are provided, women graduate at a higher rate then the men.

Mental Health- For many cultures this is a taboo topic. For others it is discussed openly. Know where the participant stands on this issue before making a referral.

Sexual Roles- Know what roles the culture has assigned by gender pertaining to employment, money management, disclosure, decision making, and education.

Adult Care-taking- Ascertain if the participant is the designated adult caretaker.

Discipline- Drug court professionals would want to know what forms of discipline are culturally acceptable. We may need to advise participants of what forms are not allowable in this country.

Treatment- Individuals from some cultures may be resistant to chemotherapy and surgery. We may need to set up the referral to lower resistance.

Punctuality- Throughout the program, the concept of being on time must be stressed. Many cultures operate in time.

Marriage- Many cultures sanction arranged marriages. This practice can run against the law in the United States.

Death & Dying- Many cultures practice ancestor worship. Speaking to the ancestors may occur more than once per year and conflict with program protocols.

Government- Many individuals come from countries where they fear government. They are then very fearful of government when they are here, especially post-9/11. This limits disclosure and may cause confusion about legal terms. Further, when you give money to the court in this country we call it bail. In another country it might be considered a bribe.

Family Authority Figures- Many cultures respect elders. If your participant comes from such a culture you may want to make a connection to the family elder to assist in getting the individual through the program.

Hospitality- Many cultures have strict rules on who can be allowed in the home. Check before making a home visit to lower resistance.

This list comprises some of the human behaviors about which culture impacts and shapes beliefs. Other behaviors that might bear further assessment are living arrangements, dress, domestic violence, and traditional medications. The very nature of the list tells us that we cannot see culture, we must ask questions. The drug court team must designate the most appropriate persons to gather this information. For many courts this might point to a treatment professional whose skill set would include interviewing skills. The results of this interview should be consulted whenever the case or treatment plan is going to be adjusted.

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NARRATIVE

As we are gathering information about the client in our needs assessment in an effort to make a more customized case plan, we should also assess the organizational cultural competency of our providers. We may discover that 80% of all the declared gay participants who were referred to a provider for housing services did not graduate. Or that the participant's culture emphasizes the importance of family authority figures who could be an ally in their recovery. Or the court can mandate that all participants must attend AA meetings. A 21-year-old participant may not be able to connect with the message when the individuals giving the message are over 50 and from an alternative drug culture.

To assist drug court teams in assessing the cultural competency of themselves and their providers, following is a cultural competency needs assessment instrument designed to start identifying strengths and areas that require improvement. What must be kept in mind is that all drug courts are both similar and dissimilar at the same time. All drug courts have is participant and provider diversity; the mix is different court to court. For some courts certain questions are not relevant. For example the court may only have one provider available, thus eliminating professional diversity. However, all the participants are not alike. If we are attempting to effect behavior change, then the more descriptive information we have the better.

Cultural competency is a process that is on-going, constantly needing fine tuning. It's not one and done. It must become institutionalized.

Lastly, cultural competency is a process that is ongoing, constantly needing fine tuning. It is not "one and done". It must become institutionalized.

Drug Court Cultural Needs Assessment

- Has the court done formal needs assessment during past the 3 years pertaining to the minority/ethnic population it serves?
- Are the collected data compared with comparable data from the population at large?
- Are the collected data compared with comparable data from the jail population?
- Are the collected data used in the annual Criminal Justice Statistics or the Department of Corrections offender characteristic report?
- Are the collected data used for self-evaluation?
- Are the collected data used for criminal justice, correctional, or institutional planning?

Training Needs Assessment

- Has the court required any training to enhance the cultural competence of its professional staff during the past 3 years?
- Have TASC evaluators, probation officers, court officers, criminal case management staff or drug court team members been trained in cultural competency during the past 3 years?
- Have the treatment providers (all staff) received training to enhance the cultural competency of its professional and support staff during the past 3 years?

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Staffing Patterns

- What percent of the drug court team reflects the composition of the minority population served?
- What percent of the staff is bilingual or multilingual?
- What percent of staff is trained in cultural awareness?
- What percent of minorities are represented on the drug court steering committee and/or planning committee?
- What percent of minorities are represented on any advisory board?
- What percent of minorities are represented at the judicial and/or administrative level?

Prior Performance Patterns

- Are there linkages with minority organizations, churches, and other institutions in the community that serve the same group?
- Are contract awards given to ethnic/racial service providers for issues specifically related to the minority or special needs population? If the answer is no, why?
- Does the drug court mission statement provide for culturally competent services and training?
- Does the court adjust holidays to accommodate cultural/religious diversity?
- Does the target population evaluate the court performance? What is the target population's perception of court effectiveness?
- Is the court located in the community it serves, or does it have a satellite facility where the target population reports?
- Do service hours reflect client accessibility?
- Is cultural sensitivity considered in treatment matching?
- Does the treatment environment reflect the culture of the target population?
- Does the court distribute materials in languages that its target population understands? Are court-approved interpreters available to the drug court team and treatment providers?
- Have the drug court researchers or evaluator included in their research design (in addition to race and ethnicity) questions drafted to elicit cultural practices and /or idiosyncrasies?
- Has the drug court researcher analyzed treatment outcomes based on race, ethnicity, and gender?
- Does the court seek to improve relations between and among culturally based organizations throughout the larger community?

RECOMMENDATIONS

1. Assess your court and providers for cultural competency strengths and weaknesses.
2. Where possible, conduct community and provider forums, alumni groups, and cross-disciplinary training.
3. Where possible foster research partnerships and codesigned evaluations.
4. Designate individuals to identify participant culture.

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RESOURCES

Chapter 4 of the Center for Substance Abuse Treatment's Treatment Improvement Protocol (TIP) 46, *Substance Abuse: Administrative Issues in Outpatient Treatment,* (2006a) includes resources for program assessment and cultural competency training.

Chapter 10 of TIP 47, *Substance Abuse: Clinical Issues in Intensive Outpatient Treatment,*(2006b) addresses the clinical implications of culturally competent treatment and includes:

- An introduction to current research supporting the need for individualized treatment that is sensitive to culture,
- Principles in the delivery of culturally competent treatment services, and
- Topics of special concern, including foreign-born clients, women from other cultures, and religious considerations.

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CO-OCCURING DISORDERS

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INTRODUCTION

As drug courts have rapidly expanded across the U.S., there has been an increasing recognition of the need to provide specialized approaches for persons with co-occurring mental health and substance abuse problems (Peters & Osher, 2004). From 10% to15% of offenders have mental disorders (National GAINS Center, 2004; Teplin, 1996, 1997), and approximately three quarters have a diagnosable lifetime substance abuse or dependence disorder (Bureau of Justice Statistics, 2006; Peters, Greenbaum, Edens, Carter, & Ortiz, 1998), rates that far exceed those of the general population (Robins & Regier, 1991). An estimated one third of drug court participants have co-occurring disorders (Center for Court Innovation, 2001).

The presence of co-occurring disorders increases the risk for arrest (Monahan et al., 2001, 2005), and once arrested, persons with co-occurring disorders are more likely to be incarcerated and to remain in jail significantly longer than other offenders (Bureau of Justice Assistance, 2006; Peters, Sherman, & Osher, 2008). Offenders with co-occurring disorders also tend to cycle rapidly between the criminal justice system and other social service systems. These persons often have difficulty obtaining employment, are often homeless, lack transportation and significant financial or social supports, and are not easily placed in traditional residential or other intensive treatment services (Chandler, Peters, Field, & Juliano-Bult, 2004; Osher, 2006a; Peters & Bekman, in press). Offenders with co-occurring disorders have not fared well in traditional substance abuse or mental health services, and require specialized treatment and supervision approaches (Peters & Hills, 1997; Sacks et al., 2004; Sacks & Ries, 2005).

Offenders with co-occurring disorders are characterized by significant diversity in their symptoms, functional abilities, and in their response to treatment (Mueser et al., 2003). Many drug court participants who have less severe symptoms of mental disorders (e.g., mild anxiety or depression) may not require immediate or specialized interventions such as integrated dual diagnosis treatment. For example, many drug court participants have one or more elements of personality disorders, characterized by longstanding impairment in interpersonal relationships. Although personality disorders do not typically require urgent or focused interventions, they certainly affect the quality of participation in drug courts, and should be considered in developing treatment plans, in crafting effective sanctions, and in other areas of service delivery.

The mental disorders that have the most profound impact on functioning in drug courts are the bipolar, major depressive, and psychotic disorders. Drug court participants who have these disorders are often difficult to engage in treatment, have high dropout rates in traditional treatment settings, and may require immediate involvement in more intensive services such as psychiatric consultation and medication monitoring, ongoing mental health counseling, and specialized co-occurring disorders treatment groups.

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treatment groups. Several types of cognitive and behavioral impairment and other unique features related to co-occurring mental disorders should be considered in screening, assessing, treating, and supervising drug court participants. These include the following:

- Poor judgment;
- Difficulties in recognizing consequences of behavior;
- Difficulties in understanding, remembering, and integrating information;
- Short attention span and difficulties in concentration;
- Low motivation for treatment;
- Poor response to confrontation and stressful situations;
- Disorganization in major life activities;
- Impaired social functioning; and
- The interactive nature of the disorders in affecting symptoms and relapse.

NARRATIVE

Identification, Screening, and Assessment

Due to individual differences in the level of impairment and abilities to participate effectively in treatment and other programmatic requirements, not all persons with co-occurring disorders are good candidates for drug courts. However, drug courts should not restrict admission on the basis of co-occurring disorders, and instead should consider the extent to which the disorders lead to functional impairment that may detract from meaningful participation (Peters & Osher, 2004). Drug courts should also examine resources that are available (e.g., staff with mental health training, existing or potential partnerships with mental health agencies, specialized community treatment programs) to accommodate persons who have mental disorders of differing levels of severity. Many persons with co-occurring disorders have successfully graduated from drug courts, and drug courts are often uniquely suited to implement a multidisciplinary team approach that has proven effective in working with this population. Although it is sometimes difficult to anticipate the effects of co-occurring disorders on drug court participation, several key areas that tend to affect drug court outcomes include:

- The severity of cognitive impairment related to attention, concentration, memory, abstract thinking, and planning ability.
- The severity of mental health symptoms related to major depression, suicidal behavior, hallucinations, delusions, paranoia, and anxiety; and the degree of stabilization on psychiatric medications.
- Ability to interact with treatment staff, judges, and community supervision staff; to participate in group treatment sessions; and to handle stress.
- Presence of complicating personality disorders, such as antisocial or borderline personality disorders.

Screening and assessment for co-occurring disorders in drug courts should include an integrated approach that examines key mental health and substance abuse indicators, the interaction of both disorders, program eligibility criteria, and motivation and readiness for treatment (Peters, Bartoi, & Sherman, 2008). Mental and substance use disorders often have overlapping sets of symptoms

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(e.g., anxiety, depression, paranoia, sleep disturbance), making it difficult to determine whether ongoing mental health services are needed by drug court participants. In general, acute and serious mental health symptoms (e.g., suicidal behavior) should be addressed immediately, although assessment, diagnoses, and treatment recommendations should be reexamined following 10 to14 days of sustained abstinence to determine if these symptoms were related to substance abuse.

Mental and substance use disorders often have overlapping sets of symptoms, making it difficult to determine whether ongoing mental health services are needed by drug court participants.

In general, acute and serious mental health symptoms should be addressed immediately, although assessment, diagnoses, and treatment recommendations should be reexamined following 10-14 days of sustained abstinence to determine if these symptoms were related to substance abuse.

Screening and assessment approaches for mental and substance use disorders are also described in several Treatment Improvement Protocols (TIPs) developed by the Center for Substance Abuse Treatment (CSAT, 1994a, 1994b, 1994c, 1999, 2005a, 2005b). A wide range of screening instruments are available to identify mental and substance use disorders, and several specialized co-occurring disorders screens have also been recently developed. These instruments require little or no training to administer and score. Additional screening should be provided in drug courts for trauma/abuse and for motivation and readiness for treatment, if time is available. Assessment of co-occurring disorders in drug courts should provide detailed coverage of mental health, substance abuse, and related psychosocial issues. Specialized training is required for administration and scoring of assessment instruments. For example, use of psychological assessment instruments generally requires graduate training related to assessment approaches and other test and measurement issues. Effective screening and assessment instruments for use in drug courts are described in the recommendations section to follow.

Evidence-Based Practices

Several key principles of care have been identified that reflect evidence-based practices for offenders who have co-occurring disorders (Peters & Hills, 1997; Peters & Osher, 2004). These principles can be used to guide the design and implementation of services for drug court participants who have co-occurring disorders. Key principles include the following:

- *Co-occurring disorders should be expected* among a significant number of drug court participants. Screening, assessment, treatment planning, supervision, and drug court team training activities should be configured to accommodate this assumption (Minkoff, 2001; Osher, 2006b).

- *Treatment, supervision, and management of drug court participants should provide an integrated approach* to address both mental and substance use disorders. This blended approach should be incorporated in the content, format, staffing, location, and anticipated outcomes of services related to co-occurring disorders. For example, Integrated Dual Disorder Treatment (IDDT) approaches include interventions to address both disorders by staff who have experience and training in mental health and substance abuse areas (Osher, 2006a).

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- *Treatment, supervision, sanctions, and incentives should be individually tailored* to accommodate drug court participants' immediate needs, strengths, areas of impairment, motivation, and learning styles. Staged interventions should be crafted to effectively match drug court participants to services according to their individual needs.

- *Drug court interventions should address the need for long-term involvement in treatment and recovery services that address both disorders*. Interventions are based on the need for self-management of lifelong disorders and periodic checkups by treatment professionals, similar to approaches used for diabetes, heart disease, and other chronic health disorders. Relevant drug court interventions include reentry planning, relapse prevention, aftercare and alumni groups, supervised recovery-oriented housing, case management and crisis services, and reassessment services.

Adapting Drug Courts for Co-Occurring Disorders

Given the significant number of participants who have co-occurring disorders, all drug courts should develop the capacity to modify program services accordingly. Several of these modifications do not require extensive resources or significant restructuring of program services. A number of modifications for co-occurring disorders in drug courts are described in a recent monograph (Peters & Osher, 2004), and a checklist is available (see Appendix) to assist drug courts in designing and implementing these modifications. Key modifications for co-occurring disorders that should be provided in drug courts are also described in the recommendations section to follow.

Several treatment-based court programs have recently been developed for co-occurring disorders (Broner et al., 2003; Peters & Osher, 2004; Redlich et al., 2006; Sage, Judkins, & O'Keefe, 2004). These include specialized court dockets for persons who have co-occurring disorders, and drug courts and mental health courts that include structural components or "tracks" for participants who have co-occurring disorders. Key features of these programs include case management services with 24-hour crisis response capability, treatment groups that focus on providing coping skills for both mental health and substance abuse problems, staff who are cross-trained in co-occurring disorders, and involvement in specialized peer support/self-help groups such as "Double Trouble". Preliminary findings from evaluation of specialized court-based treatment programs for co-occurring disorders indicate the potential for reductions in hospitalization and recidivism, and for overall cost savings (Sage, Judkins, & O'Keefe, 2004). Additional research is needed to identify court-based models for addressing co-occurring disorders, to examine outcomes associated with these models, and to isolate key components that contribute to positive outcomes.

RECOMMENDATIONS

1. *Drug courts should strive to be inclusive of persons with mental disorders*, as reflected in mission statements, eligibility criteria, and program descriptions.

2. Screening and assessment in drug courts should address both mental and substance use disorders.

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3. The following combination of evidence-based instruments is recommended for *screening* of co-occurring disorders in drug courts (Peters, Bartoi, & Sherman, 2008):

A. Either the Global Appraisal of Individual Needs (GAIN-SS) **or** the Mental Health Screening Form-III (MHSF-III) to address mental health symptoms,

and

B. Either the Simple Screening Instrument (SSI), the Texas Christian University Drug Screen–II (TCUDS-II), **or** a combination of the Alcohol Dependence Scale (ADS) **and** the Addiction Severity Index (ASI) – Drug Use section to address substance abuse symptoms.

4. The following combination of evidence-based instruments is recommended for *assessment* of co-occurring disorders in drug courts (Peters, Bartoi, & Sherman, 2008):

A. Either the Psychiatric Research Interview for Substance and Mental Disorders (PRISM),

or

A. A combination of either the Minnesota Multiphasic Personality Inventory-2 (MMPI-2) the Millon Clinical Multiaxial Inventory-III (MCMI-III), or the Personality Assessment Inventory (PAI) to examine mental disorders,

And

The Addiction Severity Index (ASI) to examine substance use disorders.

5. *Key modifications for co-occurring disorders* that should be made within all drug courts include the following:

- Psychiatric consultation and medication monitoring should be available to all drug court participants.
- Education regarding mental and substance use disorders should be provided to all drug court participants.
- Liaison should be provided with community mental health agencies and practitioners, and with emergency, transitional, and permanent housing providers. Drug courts should consider routinely involving mental health staff in team meetings and treatment planning activities.
- Graduated sanctions and incentives should be flexibly applied to consider the effects of mental disorders on sanctionable behaviors and difficulties in achieving sustained

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abstinence, and to encourage small positive changes in behavior and ongoing involvement in mental health services.

- Drug courts should coordinate with residential treatment providers and jail mental health services to insure that drug court participants who are sanctioned to residential treatment or to jail have access to medications that were previously received, and are engaged in other services to prevent destabilization of mental health symptoms.

- Judicial hearings should focus on mental health issues, including adherence to medication and other mental health treatment requirements.

- Specially trained case managers with dedicated assignments and reduced caseloads should be provided whenever possible to assist drug court participants who have co-occurring disorders.

- Clinical services should be adapted to provide shorter group treatment sessions; greater use of modeling, feedback, and rehearsal; (Bellack, 2006; Peters & Hills, 1997; Sacks & Ries, 2005), and to include skills development activities that are focused on both mental and substance use disorders.

- Timelines for movement through drug court program phases and for graduation should be more flexible and should allow for longer periods of treatment, court monitoring, and supervision.

RESOURCES

The *Co-Occurring Center for Excellence (COCE*) was established in 2003 by the Substance Abuse and Mental Health Services Administration (SAMHSA) and serves as a national resource in the area of co-occurring mental health and substance use disorders. The COCE Center has developed overview paper and technical reports, provides technical assistance and training, hosts a web site, convenes meetings and conferences, and has developed performance measures for federal grantees working in the area of co-occurring disorders. You can contact the COCE Center by phone: (301) 951-3369, by email: coce@samhsa.hhs.gov, or at their web site: coce.samhsa.gov/.

The *National GAINS Center in the Justice System* has operated since 1995 through federal support and provides a national resource for the collection and dissemination of information about effective practices for persons with co-occurring disorders who are in contact with the justice system. The National GAINS Center has developed a wide range of resource materials which are available on its web site, provides training and technical assistance, convenes meetings and conferences, and actively collaborates with public and private organizations to address needs for planning and coordination. The National GAINS Center also operates the Technical Assistance and Policy Analysis (TAPA) Center for Jail Diversion. You can contact the National GAINS Center by phone: (800) 311-4246 (TAPA Center: (866) 518-8272), by email: Gains@prainc.com, or at their web site: gainscenter.samhsa.gov/html/about.

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A monograph entitled *Co-Occurring Disorders and Specialty Courts* (Peters & Osher, 2004) was developed for NADCP/NDCI and the National GAINS Center. This source document provides drug court staff with an overview of persons with co-occurring disorders, and describes best practices related to treatment, supervision, and management of co-occurring disorders in drug courts. This monograph is available by contacting the National GAINS Center (see information above), or at http://gainscenter.samhsa.gov/pdfs/courts/CoOccurringSpecialty04.pdf.

Several useful *Treatment Improvement Protocols (TIPs)* have been developed by the Center for Substance Abuse Treatment (CSAT) that describe effective practices related to offenders who have co-occurring disorders. Copies of TIPS may be obtained free of charge from the National Clearinghouse for Alcohol and Drug Information (NCADI) by phone at (800) 729-6686 or electronically at www.ncadi.samhsa.gov. Useful TIPs related to co-occurring disorders in drug courts include TIP 42, *Substance Abuse Treatment for Persons with Co-Occurring Disorders* (2005a), and TIP 44, *Substance Abuse Treatment for Adults in the Criminal Justice System* (2005b).

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GENDER-RESPONSIVE DRUG TREATMENT SERVICES FOR WOMEN:

A Summary of Current Research and Recommendations for Drug Court Programs

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INTRODUCTION

In the past 20 years, new funding and policy initiatives have increased the availability of substance abuse treatment services developed specifically for women, thus enabling researchers and evaluators to study gender-specific treatment processes and outcomes (Blumenthal, 1998; Greenfield, et al., 2007). Traditionally, men have been more likely than women to access substance abuse treatment through the criminal justice system; however, women substance abusers are increasingly entering into the criminal justice system and consequently being referred to treatment under court supervision (Grella & Greenwell, 2004). Drug courts can build upon this body of research on the treatment needs, processes, and outcomes of women in order to improve the likelihood of successful treatment and drug court outcomes.

NARRATIVE

Profile of Women Offenders with Substance Abuse Problems

Women offenders typically have complex treatment/service needs given their multiple problems and the barriers they often face to obtaining needed services (Alemagno, 2001; Freudenberg, Wilets, Greene, & Richie, 1998). Women offenders often present to treatment with co-occurring substance abuse and mental health problems, limited employment skills and work history, and repeated prior interactions with the criminal justice system (Greenfield & Snell, 1999; Grella & Greenwell, in press; Messina, Burdon, & Pendergast, 2003; Owen & Bloom, 1995; Teplin, Abram, & McClelland, 1996). Considerable research has shown that most women offenders with substance abuse problems have been exposed to abuse, trauma, or violence as children and/or as adults (Browne, Miller, & Maguin, 1999; Green, Miranda, Daroowalla, & Siddique, 2005; Greene, Haney, & Hurtado, 2000; Grella, Stein, & Greenwell, 2005; Zlotnick, 1997). Many, if not most, women substance abusers who enter into the criminal justice system have been separated from their children, either through informal arrangements with other family members or because their children have been put into foster care by the child welfare system (Bogart, Stevens, Hill, & Estrada, 2005; Grella & Greenwell, 2006; Goldberg, Lex, Mello, Mendelson, & Bower, 1996). Many women substance abusers have physical health problems that stem from the consequences of substance abuse and associated unhealthy and risky behaviors, which are further compounded by their lack of access to or utilization of health care services (Messina & Grella, 2006; Staton, Leukefeld, & Logan, 2001). Moreover, women offenders tend to have more severe family and social problems; have higher rates of co-occurring mental disorders, particularly mood and anxiety disorders; and are less likely to have viable work skills or employment history, as compared with males (Langan & Pelissier, 2001; Pelissier & Jones, 2005; Sacks, 2004: Weitzel et al., 2007). Hence, in recent years there has been increasing attention to designing treatment interventions that address the clinical and service needs of women offenders, as distinct from their male counterparts.

Characteristics of Gender-Responsive Treatment Programs

Specialized substance abuse treatment services and programs for women generally focus on the psychosocial profile of substance-abusing women and their need for comprehensive services, particularly in regard to pregnancy and parenting, physical and mental health problems,

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employment and housing, and history of trauma and victimization. Moreover, substance abuse treatment for women usually employs "empowerment" and supportive approaches to treatment, rather than confrontational approaches that were originally developed for male clients(Brown, Sanchez, Zweben, & Aly, 1996; Hodgins, el-Guebaly, & Addington, 1997; Strauss & Falkin, 2000). Some research suggests that women may be more responsive to treatment within women-only treatment facilities or groups, because they feel less intimidated or concerned about being stigmatized in such settings, because of a desire to obtain services specific to their needs (e.g., for pregnancy or parenting), or because they seek shelter from intimate partner violence (Dahlgren & Willander, 1989; Green, 2006; Jessup, Humphreys, Brindis, & Lee, 2003). These emergent treatment approaches have been characterized as "gender-sensitive" or "gender-responsive" (Bloom, Owen, & Covington, 2003; Luthar & Walsh, 1995). Yet, according to national survey data, fewer than half of the substance abuse treatment programs in the U.S. that accept women clients offer services or groups specifically for female clients (Substance Abuse and Mental Health Services Administration [SAMHSA], 2006).

A growing literature has examined the characteristics of those substance abuse treatment programs that do provide services for women. These programs typically provide a wider range of services designed to meet women's specific treatment needs (Grella, Polinsky, Hser, & Perry, 1999; Uziel-Miller & Lyons, 2000). Some studies have shown that women who receive treatment in specialized treatment programs generally have more severe problems, greater needs, and fewer resources compared with women in mixed-gender programs (Copeland, Hall, Didcott, & Buiggs, 1993; Reed & Leibson, 1981). Yet, despite their more severe problem profile, several studies have shown that women treated in women-only programs are more likely to complete treatment compared with women who receive treatment in mixed-gender treatment programs (Grella, 1999; Niv & Hser, 2007). Similarly, in a study using a national treatment sample, pregnant and parenting women who were treated in residential programs in which there were higher proportions of other such women had longer stays in treatment; longer stays, in turn, were positively associated with higher rates of posttreatment abstinence (Grella, Joshi, & Hser, 2000).

Research suggests that ***women may be more responsive to treatment within women-only treatment facilities or groups***, because they feel less intimidated or concerned about being stigmatized in such settings, because of a desire to obtain services specific to their needs, or because they seek shelter from intimate partner violence. These emergent treatment approaches have been characterized as "gender-sensitive" or "gender-responsive."

Outcomes of Gender-Responsive Treatment Programs

Research on gender-responsive treatment has shown that substance abuse treatment services that address women's needs have promising results. Several studies have demonstrated that women have higher rates of treatment completion and better outcomes when residential treatment programs have live-in accommodations for children (Hughes, Coletti, Neri, & Urmann, 1995; Stevens & Patton, 1998; Szuster, Rich, Chung, & Bisconer, 1996; Wobie, Eyler, Conlon, Clarke, & Behnke, 1997); when outpatient treatment includes the provision of family therapy (Zlotnick, Franchino, St Claire, Cox, & St John, 1996), individual counseling (Volpicelli, Markman,

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Monterosso, Filing, & O'Brien, 2000), and family services (Wingfield & Klempner, 2000); and when treatment includes comprehensive supportive services, such as case management, pregnancy-related services, parenting training/classes, childcare, vocational training, and aftercare (Brindis, Berkowitz, Clayson, & Lamb, 1997; Camp & Finkelstein, 1997; Howell, Heiser, & Harrington, 1999; Lanehart, Clark, Bollings, Haradon, & Scrivner, 1996; Strantz & Welch, 1995; Weisdorf, Parran, Graham, & Snyder, 1999). In addition, studies have shown that women in substance abuse treatment who receive more health and social services report better outcomes and greater satisfaction with treatment (Sanders, Trinh, & Sherman, 1998), particularly when services are matched with the patients' needs (Marsh, D'Aunno, & Smith, 2000; Smith & Marsh, 2002). A review of 38 studies showed that the following treatment elements were associated with better outcomes among women: child care, prenatal care, women-only admissions, supplemental services and workshops on women-focused topics, mental health services, and comprehensive programming (Ashley, Marsden, & Brady, 2003). Among these elements, the provision of child care appears to be one of the most important factors in increasing the retention of women in treatment (Brady & Ashley, 2005). Overall, the accumulated research findings demonstrate the benefits of substance abuse treatment services that are specifically designed to meet women's needs and support the use of gender-specific or gender-responsive treatment services (Orwin, Francisco, & Bernichon, 2001).

Evidence-Based Treatment Approaches for Women Substance Abusers

In the past few years, a greater emphasis has been placed on incorporating treatment approaches that have received empirical support from scientific research on treatment effectiveness and outcomes. Several treatment approaches have emerged as the primary evidence-based treatment practices within the field of addictions treatment. These include: relapse prevention, motivational interventions, contingency management, and trauma-informed interventions. These treatment approaches have either been modified, or have the potential to be, in order to address the specific treatment needs of women. These are briefly described below.

Relapse Prevention

Relapse prevention approaches focus on teaching clients to recognize "cues" or "triggers" for substance use and strategies for avoiding relapse in those situations. Research has shown that different factors are associated with relapse to substance use following treatment for men and women. For males, these include living alone, positive affect, and social pressures, whereas for females, relapse has been associated with not living with one's children, being depressed, having a stressful marriage, and being pressured to use by their sexual partners (Rubin, Stout, & Longabaugh, 1996; Saunders, Baily, Phillips, & Allsop, 1993; Walitzer & Dearing, 2006; Zywiak, et al., 2006).

Motivational Interventions

Motivational interventions use therapeutic strategies to increase the individual's awareness of their substance abuse problems and to engage their commitment to behavior change. This approach can build upon the issues that are central to motivating women to address their substance abuse problems, particularly related to their identity, self-esteem, health, and relationships with children, other family members, and friends. Yet few studies have actually

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looked at gender differences in motivational approaches (Vasilaki, Hosier, & cox, 2006). In one example, a brief motivational intervention was used to address alcohol use among pregnant women in primary health care settings; information on the health effects of alcohol use during pregnancy was provided, with the aim of motivating women based on their desire to protect the health of their child (Handmaker, Miller, & Manicke, 1999).

Contingency Management

Contingency management approaches employ a schedule of rewards to strengthen the practice of desired behaviors (e.g., abstinence). These rewards may be small gifts, cash, or vouchers, which can be accumulated based on the duration of abstinence attained, as well as reversed upon a relapse. These approaches have been successfully used in smoking reduction programs for pregnant women who are in treatment for drug abuse (Donatelle, et al., 2004). One creative approach to contingency management utilized a community outreach program that solicited donations of personal hygiene or household items from local merchants and businesses that were then used to stock an on-site "store" from which women could choose their "prizes" upon attaining certain thresholds of abstinence (Amass & Kamien, 2004).

Trauma-Informed Interventions

Several interventions have been developed to incorporate treatment for prior trauma exposure within the context of substance abuse treatment; these treatment approaches are referred to as "trauma informed" (McHugo, et al., 2005). Examples of these approaches include: *Seeking Safety*, which integrates cognitive behavioral strategies with group psychotherapy to address both PTSD and substance abuse disorders (Najavits, 2002); *Beyond Trauma*, a curriculum that was developed specifically for women offenders and employs "relational theory" to build upon the importance of relationships in women's emotional wellbeing (Covington, 2003); and the *Trauma Recovery and Empowerment Model*, which uses group therapy to promote recovery skills and social functioning (Fallot & Harris, 2002).

RECOMMENDATIONS

Based on the accumulated clinical and treatment outcome research on treatment for women with substance abuse problems, there are several recommendations for treatment of women within a drug court context. These include:

1. Drug courts should *refer women to treatment programs that are either focused exclusively on women clients or that provide services specifically tailored for women's needs*. Of primary importance is referring women with young children to residential programs that have certified child care programs and bed capacity for their children, or to outpatient programs that have access to child care programming while the mother is in treatment. It is essential that programs provide a supportive and safe environment for women and their children, in which women can address the issues that uniquely impact their recovery.

2. Because of the generally high prevalence of co-occurring mental and substance abuse disorders among women offenders, drug courts should *make sure that mental health screening and assessment occurs for all women and, when indicated, that mental health treatment is integrated with addiction treatment*. Provision of integrated treatment at a single

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site is preferable, including individual and group counseling, access to medications with medication management, and psychosocial support groups. Optimal programs include those in which staff have been specifically trained in "best practices" for treating individuals with co-occurring disorders.

3. Because of the high rates of trauma exposure among this population, drug courts should *ensure that treatment programs screen women for their history of trauma and the ongoing effects of exposure to trauma, violence, and victimization,* including posttraumatic stress disorder. Integrated treatment approaches should be used to address these issues within the context of substance abuse treatment. Use of empirically supported trauma-focused treatment approaches enhances the likelihood that these approaches will be effective.

4. Because of the generally low levels of work skills and employment history among women offenders, drug courts should *assure that treatment programs provide services that address their need for education and employment skills*. These can include screening and assessment of need for literacy education; pre-vocational services; preparation for job search (including resume development, computer literacy, interview preparation); and job referrals.

5. Because of the high likelihood that women offenders will enter drug court with parenting-related issues, drug courts should *ensure that parenting-related needs are assessed, and, if appropriate that treatment is coordinated with child welfare services*. These can include case conferencing with social workers, family reunification services, parenting education and skills training, and supervised visitation with children living with other caretakers.

6. Drug courts should *refer women to treatment programs that screen for health problems commonly found among female substance abusers*, including infectious diseases (HIV, HCV, other sexually transmitted diseases), untreated chronic health problems (e.g., hypertension, diabetes), and reproductive-related problems or needs.

7. Whenever possible, drug courts should *utilize treatment programs that incorporate evidence-based treatment approaches*, such as those covered in this monograph (i.e., case management, cognitive behavioral therapies, relapse prevention, pharmacotherapy, contingency management), and that these approaches are modified, as appropriate, to increase their relevance and application to women's specific treatment needs.

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CASE MANAGEMENT AND DRUG COURTS

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INTRODUCTION

Over the past decade, interest in case management in the substance abuse field has grown as practitioners and researchers have begun to view substance abuse as a multifaceted problem rather than a single phenomenon (Ridgely, 1994). Case management has the potential to address the multiple needs of substance abuse clients and to individualize treatment approaches to meet the needs of a specific client (Cellini, 2003; Mehr, 2001; Siegal, Rapp, Fisher, Cole, & Wagner, 1993; Sullivan, Wolk, & Hartmann, 1992). Case management also offers the possibility of coordinating the care of individuals who have needs that cannot be met by a single agency.

Several reports have been published on drug court programs and evaluations of drug court effectiveness (Cooper, 1995; Prendergast & Maugh, 1995), yet a review of the research literature could not identify a program description or evaluation of case management in a drug court setting. Although drug courts primarily focus on substance use, the courts do acknowledge that their participants may have complex biopsychosocial needs. Thus, case management may be appropriate for clients in drug courts and may enhance service utilization and improve outcomes. The purpose of this chapter is to describe how case management can be integrated with drug court programs.

NARRATIVE

What is Case Management?

Case management is the coordination of care and services in order to help people better meet their needs and attain specific goals.

In studies on the effectiveness of case management with substance abusers, case management has been linked to improved retention in substance abuse treatment, greater use of primary care and other medical services, and fewer employment problems.

Case management is the coordination of care and services in order to help people better meet their needs and attain specific goals. In studies on the effectiveness of case management with substance abusers, case management has been linked to improved retention in substance abuse treatment (Laken & Ager, 1996; Mejta, Bokos, Mickenberg, Maslar, & Senay, 1997; Rapp, Siegal, Li, & Saha, 1998; Siegal, Rapp, Li, Saha, & Kirk, 1997), greater use of primary care and other medical services (Knowlton et al., 2001; McCoy, Dodds, Rivers, & McCoy, 1992; Schlenger, Kroutil, & Roland, 1992), and fewer employment problems (McLellan et al 2003; Siegal et al., 1996). Case management has been shown to improve family functioning (Loudenburg & Leonardson, 2003; McLellan et al 2003; (Sharlin & Shamai, 1995) and reduce substance use among parents, which also reduces associated individual and family risk factors brought into the home by the substance abuser (Kerson, 1990; Lanehart, Clark, Dratochvil, Rollings, & Fidora, 1994).

Despite the broad application of case management to various problems and populations, operational definitions of case management are often nebulous. Case management models are usually described by the methods employed or by the philosophy behind the model. Ross (1980) distinguishes case management models based on levels of comprehensiveness: minimal, coordinated (i.e., brokerage), and comprehensive. *Minimal models* of case management involve minimal supervision and referral. *Brokerage models* of case management attempt to match

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resources to client needs, and are characterized by more office-based work, telephone contact, and higher caseloads, with the process of the brokerage case management system being to assess, refer, and follow-up (i.e., evaluate). *Comprehensive models* of case management (e.g., Iowa Case Management; Hall et al., 1999) are characterized by greater intensity of services, including therapeutic services and lower caseloads.

Studies show that comprehensive case management is an effective intervention with substance abusers (Kutchins & Kirk, 1997; Rapp, Kelliher, Fisher, & Hall, 1994; Sullivan et al., 1992). Despite the dominance of brokerage case management in the field, few studies have focused on the brokerage form of case management (Ridgely, 1994) and even fewer studies have compared the brokerage form of case management with comprehensive case management. Of three studies located, researchers found the comprehensive form of case management produced better outcomes compared to brokerage models (Bond, Miller, Krumweid, & Ward, 1988; Morse et al., 1997; Wolff et al., 1997).

Case management has already been recommended for use with incarcerated offenders by the National Institute on Drug Abuse in their research based guide, *Principles of Drug Abuse Treatment for Criminal Justice Populations* (National Institutes of Health, 2006) which recognizes that drug abusers often have other problems ranging from mental and physical health, family and couples counseling, parenting, and educational or vocational. Currently, Prendergast & Cartier (2004) are evaluating the impact of Transitional Case Management (based on the Iowa Case Management model; Hall et al., 1999) with incarcerated drug abusers who are returning to the community. Thus far, case managers of Transitional Case Management report that integration into the community is possible, but that working with multiple providers and systems is very difficult (M. Prendergast, personal communication, December 16, 2006).

Dimensions of Case Management

Case management comes in several different forms that may be adapted to the needs of the client and the culture of the specific drug court. In order to understand case management programs in relation to the needs of drug courts, the unique characteristics of case management programs need to be identified and compared (Hall et al. 2002). Similarities and differences can be examined using the eleven continuous dimensions described by Ridgely & Willenbring (1992) and expanded to 12 dimensions (adding *Type of Service*) by Hall et al.. In Table 1, three models of case management are compared across the 12 dimensions of case management, including a Low Intensity model (e.g., brokerage), a High Intensity model (e.g., PACT), and the Iowa Case Management (ICM) model, which is a comprehensive case management using a strengths-based orientation.

PACT is a high intensity case management model that has been used extensively with chronically mentally ill clients who have histories of high medical service utilization. This model utilizes a multidisciplinary treatment team to maintain supervision over a client's treatment needs. The PACT model tends to require the most effort within each case management dimension, reflecting the intensity of the services provided. The *Brokerage model* is a low intensity model of case management that provides much less service and coordination compared with PACT. The ultimate low intensity model is the care management model often used by insurers to manage

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costs. In comparison, the *ICM model* takes a middle ground in most of these dimensions and reflects a more limited intensity (compared to PACT) and the lack of cost containment strategy (no financial authority). In addition, the ICM approach provides direct counseling with clients, refers clients to other needed services in the community, maintains contacts with community agencies, and is consumer oriented.

In any case, those drug courts considering implementing case management or revising their current model should work through each of these dimensions to determine the kind of system needed. Each dimension can be asked as a question in order to make a decision. For example, for *duration*, the planning team could ask, "For how many weeks or months (or even years), do we want to provide case management services?" Or, for *type of service*, the team could ask, "What types of services should our case managers provide?" Or for *case manager authority*, the team could ask, "How much authority can and should our case managers have?" Obviously, this last question will be very relevant to drug courts who are considering using independent, human services case managers versus parole officers to provide case management services.

Case Manager Functions

A case manager typically takes on six important functions in the case management process—assessment, planning, linking, monitoring, advocacy, and education—that translate well into the drug court system (Johnson & Rubin, 1983). In the drug court system, the case management team should begin *assessment* (the initial and ongoing evaluation of a client's needs, wants, strengths, and resources) when determining whether or not the potential participant will be a good fit for the drug court process. Assessments should be comprehensive and address mental health, physical health, trauma history, personal and environmental resources, substance use and abuse, legal problems, risk factors, personal and social supports, educational and vocational areas. If possible (and with the participant's permission), assessments should also include collateral information (e.g., friends and family, employers).

If all members of the team (including the participant) decide to proceed with the drug court process, the *planning* process will begin. Based on the information from the assessment and in collaboration with the participant and other team members, the participant and case manager devise a formal care plan that describes realistic and measurable goals, including a specific step-by-step, task-oriented plan to meet each goal. The formal *care plan* will identify who is responsible for each of the tasks within the plan, how the task will be accomplished, who to consult when confronted with barriers, and a timeline for both the step-by-step tasks and the overall goals. The care plan document should be signed by all members of the case management team and the plan should be reviewed and revised regularly to identify barriers and to celebrate successes as each task is accomplished.

Another important responsibility of the drug court case manager is *linking* the participant to needed resources as identified in the plan. For example, a case manager in a drug court will provide linking to the probation officer, judge, and attorneys, but also to other resources, such as housing, job skill development, physical healthcare, mental health treatment, and family counseling. Therefore, a case manager must be willing and able to assist with the needs of the participant outside of the area of substance abuse treatment. In this way a case manager provides

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a single point of contact between the participant and other agencies and services (Siegel, 1998). Because the needs of the participant change over time, assessment, planning, and linking should be an ongoing process.

Table 1. Comparison of Case Management Models by Dimension

Dimension	**Low Intensity** (brokerage)	**Iowa Case Management**	**High Intensity** (PACT)
Duration	Time limited	Up to 1 year	Indefinite
Intensity: frequency of contact	Infrequent (quarterly contact)	Mixed (weekly to monthly)	Frequent (daily contact)
Caseload: staff ratio	High (1:75)	Mid range (1:15 intense services; 1:30 minimal services)	Low (1:10)
Focus of service	Narrow; exclusive	Broadly defined	Broad; inclusive
Type of service	Management of services provided by others	Primarily manage services provided by others	Provides all services
Availability	Office hours	Work days and evenings	24 hours
Site of case management	Office only	Mixed (office & community)	In vivo
Consumer (client) direction	Professionally directed	Client-directed goal setting, planning, and attainment	Consumer directed
Advocacy /Gatekeeper	Gatekeeper for system (finds alternatives to requested services)	Advocates for client	Advocates for client (to gain access to services)
Case manager training	On-the-job training	Master's degree in social work or other helping profession	Advanced professional degree
Case management authority	No authority, persuasion only	No authority, persuasion only	Broad authority, administrative control
Case management team structure	Primary case manager with individual caseload	Individual case loads/ team supervision	Full team mode: All case managers share all clients

References: Ridgely & Willenbring (1992), and Hall, et al. (2000)

A case manager's function also includes the *monitoring* of these linkages. Through monitoring, a case manager makes sure that the participant is able to access the needed resources without encumbrances and that the services provided by the resources are perceived as helpful by the participant. If through monitoring the case manager and participant decide that an intended

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service is not working, the case management team can return to the planning and linking functions to find a different service that will help the participant (Monchick, Scheyett, and Pfeifer, 2006). Monitoring linkages is *not* associated with monitoring participant outcomes in a "trail-em, nail-em" type approach (Clear, 2005, p. 176). In fact, to remain a trusted resource for the participant, the case manager should be exempt from any "tattling" or sanction-provoking activities.

In some circumstances *advocacy* may be necessary. For example, if a participant is being denied services he or she is eligible for a case manager may have to use their skills to advocate for the participant to ensure the participant can access the needed service (Monchick, Scheyett, and Pfeifer, 2006). In other cases, the case manager may have to advocate for the participant in drug court or even within the case management team. In these instances, advocacy may require the case manager to be an *educator* (formal and informal) to provide information to his or her team members about issues or problems. In addition to these specific functions of a case manager, case managers should be flexible, familiar with the community, participant oriented, and strengths based. On the whole, the case manager must be able and willing to work with others as part of the team and support the participant as he or she moves through the recovery process.

Thus, case management is well suited for drug courts, and provision of case management services is becoming an accepted practice at various locales in the drug court system. The purpose of the next section is to describe some of the challenges of integrating high quality case management practices within drug court programs.

The Challenge of Integrating Case Management in Drug Courts

With a highly collaborative multidisciplinary team, attention must be paid to the division of responsibilities and duties of the team members. Without this attention, drug courts may encounter a potentially crippling blow to their implied mission of helping persons stop abusing alcohol and drugs and related criminal activities.

Many problems can arise from mismatching individual team member duties in order to meet goals. In fact, conflicting dual roles may serve only to isolate the participant from the team and deny him or her access to the full spectrum of resources from within the team. For example, if a team member is expected to assume dual or conflicting roles, such as the counselor role *and* the court informant of substance use violations, then one of these roles will be lost (i.e, the latter will invalidate the former by inhibiting the development of trust between the team member and participant). Parole officers who are expected to take on the case manager role will also encounter this same problem, to the detriment of the case manager-participant relationship. Thus, with the exception of reporting suspicion of child or elder neglect or abuse and duty to warn, the responsibilities of the case manager should not include reporting parole violations to the court so that the case manager can build a working relationship with the participant based on openness and trust. Instead, reports of parole violations should be the responsibility of the parole officer assigned to the participant or another team member who is designated for this responsibility. To avoid conflicting roles, the case manager should take care to align the tasks of the team members within their respective purviews.

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Conclusion

Case management is a multidimensional service enhancement system that could be integrated with almost any drug court system. Case managers assist participants to identify personal needs, develop goals, link participants to needed services, and followup with these participants to evaluate service utilization and effectiveness. Even though the integration of case management with drug court systems appears to have potential, future research should evaluate the actual implementation of various case management models at various locations. Only then will data be available to help understand the costs and benefits and whether or not to use case management in these settings.

RECOMMENDATIONS

1. Drug court systems should *choose a case management model appropriate to their needs and services*. The dimensions of case management can be used to assist with this decision.

2. *Case managers should have formal training* in the case management model and the duties and functions of a case manager.

3. Case management involvement should *begin with assessment of a potential participant* for the drug court system.

4. To avoid conflicting roles, *the case manager should take care to align the tasks of the team members within their respective purviews*.

5. With the exception of reporting suspicion of child or elder neglect or abuse and duty to warn, *the responsibilities of the case manager should not include reporting parole violations to the court*.

6. The integration of various models of case management within drug court systems should include formal, rigorous, and ongoing *evaluation of the implementation process and participant outcomes*.

RESOURCES

The National Drug Court Institute published the monograph *Drug Court Case Management: Role, Function, and Utility* in 2006. It is available by contacting NDCI, or can be accessed from the publications page of NDCI's website.

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LINKING DRUG COURT PARTICIPANTS TO NEEDED SERVICES:

Background, Strategy, and Recommendations

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INTRODUCTION

Within the *Defining Drug Courts: The Key Components* document (NADCP, 1997), the fourth key component of an effective drug court involves providing "access to a continuum of alcohol, drug, and other related treatment and rehabilitation services." Key aspects to providing this access to drug court participants outlined under this component include initial assessment, responsive ongoing case management, matching participant needs to appropriate specialized and comprehensive services, assuring services are accessible and affordable to participants, and monitoring the quality and accountability of treatment agencies serving drug court participants. With this component as a foundation, drug courts have the potential to provide a bridge between the legal system and needed health services (Wenzel, Longshore, Turner, & Ridgely, 2001).

Unfortunately, realizing the potential benefits of drug courts linking participants to needed services has proven difficult (Bull, 2005; Wenzel, Turner, & Ridgely, 2004). Wenzel, Turner, and Ridgely (2004) explored the nature of the collaborative relationships between drug courts and service providers. They found that although social service provider-drug court "linkage" relationships were perceived to be strong or moderately strong, services other than drug or alcohol treatment were only intermittently provided through the drug courts. They also identified numerous barriers that stood in the way of better collaboration with providers of other types of services including funding limitations and staffing problems. Notably, case studies of drug court participants interacting with the judge in court reveal that participant reference to and report of everyday hassles and barriers corresponds to actual outcome in drug court, and that participants are most likely to reference problems with social services, employment, education, and the legal system (Wolf & Colyer, 2001).

It is important to note that referral of drug court participants to drug and alcohol treatment facilities will not insure that participants' other varied psychosocial needs will be addressed. There has been recognition of a gap between what is known to be *effective clinical practice* as judged from the scientific literature, and what is *common practice in "real world" conditions* (Lamb, Greenlick, & McCarty, 1998). While there has been significant progress in the development of new medications, therapies, interventions, and procedures over the past decade, they have largely remained *undelivered* in community treatment programs; as will be discussed in this chapter, this gap can include effective case management and client referral.

To insure that participants access needed services, drug court administrators must be aware of the significant economic, political, technological, and practical issues faced in the drug treatment community. For example, in our own work we contacted 127 treatment programs that were randomly selected for participation in another national study. Twenty percent did not even have voicemail, 90% had no access to physician services, 75% had no psychologist OR social worker (McLellan, et al., 2003a & 2003b). These indications of the degradation of the national addiction treatment infrastructure pose real challenges for the transfer of "scientifically supported" interventions and it is clear that *applied research* is required to develop new methods of enhancing information dissemination, and innovation diffusion for proven interventions (Backer & David, 1995).

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NARRATIVE

Perhaps the first opportunity for linking services with participant problems is during the participant assessment and planning meetings. Accurate client assessment, which fosters the ability of case managers and treatment providers to meet their clients' needs, may be one of the most important yet underemphasized elements of contemporary addiction treatment. The clinical logic behind this assessment and service planning process is direct, and quite applicable to the drug court model. If problems of participants are accurately and comprehensively assessed, they may feel "heard" by their case manager, potentially leading to the development of rapport and a helping alliance (Barber et al., 1999, 2001; Luborsky et al., 1996; Luborsky, Crits-Cristoph, McLellan, & Woody, 1986). If this problem assessment and recognition process leads to a jointly determined and feasible action plan for addressing the identified problems, there is the potential for the case manager/treatment provider to be perceived as helpful and for the client to have confidence in the court intervention process.

Furthermore, if in addition to problem assessment and recognition, the case manager offers available, accessible and potentially effective services for the identified problems, there is the potential for relief from those problems and with it, increased optimism about and confidence in the process as well as increased likelihood of continued participation (retention) (Azrin, 1976; Higgins et al., 1994, 1995; Meyers & Smith, 1995). There is ample clinical conceptual justification for the premise that the initial problem assessment/service planning phase is important for engaging clients in the process of self-care and for initiating the still poorly understood sequence of efforts to enhance problem recognition, provide problem relief, build client confidence, and increase the likelihood of continued treatment participation.

Effective service planning begins with adequate and detailed assessment. It is important that drug court participants be assessed in numerous domains for the case manager to collaborate with them on services to address to current life problems. Numerous instruments exist that can be combined for this purpose; alternatively, treatment planners can use a multidomain assessment tool such as the Addiction Severity Index (ASI). The ASI is a research-derived problem assessment interview that allows for comprehensive measurement of client's problems at the time of treatment admission. The ASI interview produces reliable and valid measures of the nature and severity of clients' problems (Mc Lellan et al., 1992a; McLellan, Luborsky, O'Brien, & Woody, 1980; McLellan, et al., 1985). Research has shown it can be used effectively as the basis for providing tailored, appropriate treatment services and that clients who receive services for their identified problems are more likely to remain in treatment and have better during-treatment and posttreatment outcomes (Hser et al.,1999; Kosten, Rounsaville & Kleber, 1986; McLellan, Alterman, Cacciola, Metzger, & O'Brien, 1993b; McLellan et al., 1997). Because two decades of research findings show that problem assessment and service planning with the ASI can be reliably, validly, and usefully applied by researchers and clinicians across a wide range of client populations and treatment settings, the ASI has been widely adopted by across the United States and abroad.

Effective service planning begins with ***adequate and detailed assessment.*** It is important that drug court participants be assessed in numerous domains for the case manager to collaborate with them on services to address to current life problems.

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Despite the broad use of the ASI, survey research has shown that the instrument is often used because it has been mandated by state, county, or program administrators, not because it is valued for its utility by the staff who are asked to use it (Crevecoeur, Finnerty & Rawson, 2002; McLellan, et al., 2003a, 2003b). This finding is important, because the crux of providing effective assessment-treatment service linkages rests on the commitment of case managers to sensitively assess participant needs and refer them to accessible services. Unfortunately, a recent survey of a nationally representative sample of treatment programs indicated that most personnel in those treatment programs considered the problem assessment/service planning phase of treatment to be merely "paperwork" with no inherent clinical value (McLellan, et al., 2003a, 2003b). Most substance-dependent individuals have multiple, serious problems compromising their ability to engage in and benefit from addiction treatment, and most programs are rarely able to provide the types of services needed for those problems. Our 20 years of experience suggests that case manager frustration is exacerbated by the facts that the process of finding appropriate services is inherently difficult and time consuming, that most case managers or addiction counselors are not trained to do this type of activity, and that they do not have time to do it.

In efforts to improve the breadth and fit of services offered to drug court participants, it is important to secure the commitment of case managers to appropriately assess and individually tailor referrals to outside agencies. Securing this commitment is facilitated by focusing training on this crucial phase of drug court intervention, and empowering case managers with tools that greatly ease the burden of finding the appropriate referrals. In an effort to make this process more streamlined we developed a computer-assisted resource guide designed to help locate services for participants right in their community (Gurel, Carise, Kendig, & McLellan, 2005). Midsized to large communities often already have compilations detailing free and/or low cost services available within the local community which address physical and mental health, relationship, housing, parenting, employment, and legal problems. The United Way is a leader in producing these compilations (often titled "First Call for Help"). However, many times, these books go unused, perhaps because they are unwieldy as well as temporally and physically removed from the assessment process.

To demonstrate the importance of service planning and referral, we used the United Way's database to create an easy to use electronic format that would make finding appropriate referrals convenient. We developed the linking software, referred to as the Computer Assisted System for Patient Assessment and Referral (CASPAR), and a brief training on linking appropriate, accessible services within the community to the problems presented by client's based on their ASI assessment interviews. We trained 33 counselors from 9 community-based substance abuse treatment programs to use the ASI and then randomly assigned half of the sample to receive an additional 2-hour training session in the CASPAR system.

To assess the effects of the CASPAR training on outcomes, we collected treatment plans on five clients from each participating counselor and contacted those clients at 2 weeks and 4 weeks after admission to determine what services they had received. We also tracked attendance and retention in services. Full results of that study are reported elsewhere (Carise, Gurel, McLellan, Dugosh, & Kendig, 2005); they will be briefly summarized here. Seventy-one percent of

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counselors made at least one referral using the CASPAR system in the 10 months following the training. Three counselors used the CASPAR with all of their clients, and 7 counselors used the CASPAR with more than half their clients. More than 50% of these clients received referrals from the CASPAR system. Those referred received a total of 69 "wrap-around" services from the CASPAR system. Psychological services accounted for the largest number of referrals (35%, n=24), employment services accounted for 26% of referrals (n=18). Family/social services accounted for 22% (n=14) of service referrals, whereas medical accounted for only 13% (n= 9), and legal services accounted for 5% (n=4).

When we compared the CASPAR-trained counselors to the comparison counselors, we found that clients whose counselors were CASPAR-trained had treatment plans that were better matched to their intake ASI assessment in every one of the seven problem areas covered by the ASI (medical, employments, drug, alcohol, legal, family, psychiatric). Furthermore, at the 2-week point in treatment, the services *received* by clients in the CASPAR-trained group were significantly more likely to be "matched" in 5 of the 7 problem areas (medical, employment, drug, alcohol, and psychiatric). In the other two areas (family and legal problems), there were no significant between-groups differences. Services reported in the second two weeks of treatment continued to remain better matched ($p<.05$ or less) to the client's needs in 4 of the 7 problem areas (employment, drug, alcohol, and psychiatric), but not in the other 3 areas (medical, family and legal problems). We also examined session attendance as verified in chart records and by our research assistants' observations. Clients of CASPAR-trained counselors averaged 65 total sessions, comprised of 53 group and 12 individual sessions. Clients from the comparison counselors averaged 34 total sessions, comprised of 27 group and 7 individual sessions. Analysis of variance showed significant differences in total sessions ($F=14.64$, $df=1, 128$, $p<.000$) in group session attendance ($F=10.29$, $df=1, 128$, $p<.002$); and in individual sessions ($F=4.31$, $df=1, 128$, $p<.04$). Program completion rates were higher in the CASPAR-trained group (53%) than in the comparison group (24%).

We also hypothesized better relationship formation between EA clients and counselors and better client satisfaction. We collected this data using the helping alliance questionnaire (Luborsky, 1976) and the 8-item Atkinson patient satisfaction scale (Attkisson & Zwick, 1982) at the end of the 4th week of treatment. Contrary to our hypothesis, we found no between-groups differences in either helping alliance or patient satisfaction measures. Both scores in both groups were above average, indicating generally high reported rates of overall rapport and satisfaction. However, surprisingly, we did find that CASPAR-trained counselors remained in their jobs longer than comparison counselors; when assessed six months later, we found that (80%) of CASPAR-trained counselors remained in their jobs, as compared to (40%) of comparison-trained counselors.

RECOMMENDATIONS

Based on the above background and the importance of client needs assessment and service referrals, we have compiled the following recommendations for use of a CASPAR system in drug court settings.

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1. Drug court administrators must *recognize the importance of emphasizing accurate assessment of participants' needs across multiple domains coupled with making targeted referrals* to meet needs in a manner accessible to the participant.

2. In practice, case manager and participant follow through depends on "buy-in" from case managers regarding the importance of the assessment and referral process. Administrators must *emphasize this phase of drug court intervention in staff training and in providing the necessary tools for staff to confidently and efficiently perform these activities*. Such tools include a comprehensive, sensitive baseline assessment of needs using instruments that can be administered efficiently, as well as referral information in a convenient format that is easily searched and comprehensive in scope.

3. Successful referral of participants is facilitated by administrators and case managers *cultivating relationships with referral agencies*. Specifically, case managers should know key contact persons at the main agencies they regularly refer to, and should get feedback from those contact persons about participant effort. Feedback should also be elicited from drug court participants about the quality of services they receive from various agencies.

4. It is important that the drug court team *make the judge, as the leader of the staffing of the docket, aware of referrals made and appointments given to clients*. This will allow the judge to monitor client follow through on recommendations and to reward compliance or address failures to comply from the bench.

5. Case managers must *take steps to assure that referrals made are truly accessible to participants relative to their financial and transportation options*. Furthermore, case managers should consider any cognitive impairment that participants may face in negotiating referrals. Successful referrals are more likely to be made by breaking referrals into small, concrete steps and managing participant expectations about what they will receive.

6. Case managers must *follow up with referrals* and may need to troubleshoot any problems to help participants confidently follow through with referrals. The judge can provide continued monitoring and provide a level of accountability to ensure that this process is followed.

7. As highlighted in chapter 7, female participants may face special needs that are not addressed in treatment facilities where the overwhelming majority of clients' are male. *Finding "wraparound" services that fill these need gaps* is especially crucial in contributing to retention and graduation of female participants.

8. It should be noted that, in addition to treatment attendance and urine results, simply accessing the service is another concrete outcome. The insights on sanctions provided in chapter 11 could be applied to assure that participants access services.

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RESOURCES

We have received numerous requests from various organizations and treatment systems for help in creating a CASPAR referral system and resource guide. To avoid redundant work, we always encourage inquirers to check into the referral resources that may already be available in their communities. Numerous communities are beginning to invest in telephone and internet-based 311 and 211 systems that provide many of the referrals available in the CASPAR system. Furthermore, several communities have online databases that list volunteer and low-cost services that may serve as the beginning of a searchable resource guide.

What is 2-1-1? www.211.org
List of organizations using United Way 2-1-1: www.211.org/documents/Endorsements.pdf
Find your local United Way: national.unitedway.org/myuw/
Find you local 2-1-1 call-in center: www.211.org/status.html

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MOTIVATIONAL INCENTIVES IN DRUG COURTS

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INTRODUCTION

Positive reinforcement methods have recently received a great deal of attention because of their ability to promote sustained behavior change while emphasizing a more supportive and celebratory approach to treatment and other interventions with substance abusers. Further, positive reinforcement approaches have received a considerable amount of empirical support. The empirical support is reviewed below, followed by recommendations on how positive reinforcement can be integrated into drug courts with the potential to further boost effectiveness of the court programs.

NARRATIVE

Positive Reinforcement in Drug Abuse Treatment

> "In over ten years as the presiding Judge of the Philadelphia Treatment Court I can state without reservation that **incentives are a classic example that positive reinforcement does work**. Certificates, gifts, applause and judicial recognition are eagerly sought by the participants. For them, it is a sign of accomplishment and also recognition by others, especially the Court for their achievement and success."
>
> -Judge Louis J. Prezenza

The principle of positive reinforcement has been effectively incorporated in drug abuse treatment in order to counter the ever-present lure of potent drug reinforcers that underlies relapse. Frequently, the benefits of abstinence, such as better health and a more productive lifestyle, appear abstract and distant to the drug abuser, with an unclear and difficult pathway interposed to achieve these benefits. The point of motivational incentive programs is to bring the benefits of abstinence forward in time by providing tangible and immediate rewards. The original intervention that provided competing reinforcers during drug abuse treatment was developed by Steve Higgins and consisted of a voucher system in which points could be earned each time a drug (cocaine) negative urine was submitted. The points had monetary value and could be used to purchase retail goods (e.g. clothing, sports equipment) and services (e.g. rent or bill payments) with clinic staff making the purchases. This system was very effective (Lussier, Heil, Mongeon, Badger, & Higgins, 2006; Stitzer & Petry, 2006), but also costly and labor intensive. A variation on the theme was developed by Nancy Petry, who used the principle of intermittent reinforcement to lower costs. In Petry's prize-based or "Fishbowl" system, patients could draw a slip from a bowl each time they submitted a drug-free urine, with the chance of winning prizes that were kept and displayed on-site. However, the likelihood of drawing a winning slip, particularly one of substantial value, was relatively low, thus reducing and controlling cost.

Both voucher and prize-based reinforcement systems targeting drug abstinence have been repeatedly shown to be efficacious interventions in controlled research studies conducted in drug treatment programs. These procedures have promoted sustained abstinence with stimulant abusers enrolled in psychosocial counseling programs, stimulant abusers enrolled in methadone maintenance treatment and with treatment-seeking abusers of a variety of other drugs including opiates and marijuana (Lussier et al.., 2006; Stitzer & Petry, 2006). Recently, the effectiveness of low-cost, prize-based motivational incentives has been demonstrated in two large multisite

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clinical trials conducted within the National Drug Abuse Treatment Clinical Trials Network. One study showed that ongoing stimulant use could be suppressed among methadone maintenance patients offered the chance to win up to $400 worth of prizes for submitting drug-free urines during a 3-month intervention (Peirce et al., 2006). A second study showed significant improvement in treatment retention and longer durations of abstinence among stimulant abusers enrolled in psychosocial counseling programs who had the opportunity to participate in the same prize-based abstinence incentive program (Petry et al., 2005).

Although much of the work on positive incentives has focused on reinforcing abstinence from drugs, it is abundantly clear that this same approach can be used to improve other discrete and observable target behaviors that are important for recovery. Thus, for example, several studies have shown improved attendance at treatment sessions when incentives are available for that behavior (e.g. Sigmon & Stitzer, 2005), while other studies have explored the utility of incentives for motivating adherence to treatment goals (e.g. Petry et al., 2006).

Application of Positive Reinforcement in Drug Court Systems

The principles of positive reinforcement can readily be translated for use within the drug court system in order to promote desired behavior of clients while at the same time fostering a more positive and celebratory atmosphere within the system. It should be noted at the outset that little research has been conducted to date that specifically tests the effectiveness of adding positive incentives delivered in the courtroom at status hearings. Further, the research that has been conducted suggests that it may be difficult to see a benefit when positive incentives are added in a context where powerful sanctions are concurrently operating. Nevertheless, preliminary data from one study has suggested that courtroom-based incentives may improve outcome particularly for individuals with a more extensive criminal history (Marlowe et al., 2005).

Three things would be needed to implement a positive reinforcement intervention: 1) definition of the behavior(s) to be targeted, 2) identification of effective reinforcers to employ, and 3) development of an implementation plan that ensures immediate, reliable, and consistent application of the intervention.

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3) development of an implementation plan that ensures immediate, reliable and consistent application of the intervention.

Selecting Target Behaviors

The ideal target behavior is one that can be readily observed and tracked and that needs improvement (i.e., participants may have trouble with adherence to this behavior). Possibilities include any of the typical drug court requirements: keeping regular status hearing dates in front of the judge, probation officer, case manager and treatment provider, giving urines on demand, attending self-help meetings and remaining abstinent. The key principle in selecting target behaviors is that they represent an outcome that needs to be improved. If participants are all reliably performing the desired behavior, then it is an ineffective use of resources to offer incentives. Thus because participant

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characteristics will differ in every jurisdiction, it would be very useful to have data on performance of prior participants in the particular drug court involved before selecting target behaviors. It is likely, for example, that drug abstinence will be a critical and appropriate target behavior in most courts, while the need to deliver incentives for keeping appointments may vary across treatment, probation, case management, and courtroom settings.

Selecting Reinforcers to Use

Reinforcers selected will depend on resources available within the particular jurisdiction. The principle is that more is better. That is, research has shown that more valuable (higher magnitude) rewards are more effective for promoting sustained behavior change than less valuable rewards (Lussier et al., 2006). This is why tangible prizes or vouchers may be more powerful than verbal praise and social support alone. Tangible prizes (e.g. entertainment or transportation passes) can also be a way to help support lifestyle changes of clients. While high magnitude rewards are best, low cost rewards may nevertheless be effective incentives, particularly for individuals in poor economic circumstances. Thus, small prizes such as cups, hats, and t-shirts may be used effectively in drug courts.

It is important to remember that in general, the reinforcing value of any item is not intrinsic to the item, but depends on views of the recipient. Thus, it is always a good idea to ask the clients what they would like to work for. Alternatively, gift vouchers to local retail stores provide a way to take this variability into account since they can be traded in for individually selected desirable items. Giving cash is generally not a good idea since it can too easily be used to purchase unhealthy substances including alcohol, cigarettes, and illicit drugs.

Escalating schedules

Research has shown that use of an escalating reinforcement schedule is the most effective way to promote sustained behavior change (Stitzer & Petry, 2006). In an escalating schedule, either the cash value of vouchers or the number of prize draws awarded increases systematically with successively longer periods of good performance and resets to an original low value if the client slips up (e.g. misses a scheduled appointment or provides a drug positive urine). Thus, it is important to consider the use of escalating schedules of reinforcement in designing a positive incentive program.

Implementation Plan: Where and When Should Incentives Be Delivered?

Drug court is a multifaceted intervention built on cooperation between the judge, the probation officer, the prosecutor, the defense, the treatment provider, and the case manager, with each participant serving a unique and important role. Ideally, positive incentive interventions would be offered throughout the system by multiple members of the team, with due consideration given to what behaviors should be targeted for reinforcement in each setting.

Incentives in the Courtroom: Praise from the Judge

The drug court judge is a powerful authority figure whose words and decisions play a central role in each client's progress and outcome. It is important for judges to use positive reinforcement when interacting with clients. Failures of compliance or appearance of unwanted behaviors can and should be met with appropriate sanctions. However, it is incumbent upon the judge to also

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deliver praise for any successes and accomplishments, however small these may be. Judges should make sure that documentation of client progress includes positive as well as negative behaviors so that they can make an appropriate response. Praise should be delivered routinely at every hearing, not just at certain transition or graduation points. Verbal praise is a powerful intervention, especially for disenfranchised individuals who may have experienced little success or praise in their lives. Further, by delivering praise in the status hearings, judges will act as a model for other members of the team, each of which should also be looking for opportunities to deliver praise in their own interactions with clients.

Community Model

Tangible Awards and Prizes in Maricopa County

Dear Drug Court Participant:

The Drug Court Team is pleased to inform you that we will be starting a new incentive program in court. Each time you come to court you will have an opportunity to participate, if you have met the requirements. When you come to court, you will be able to make draws for prizes based on your recent attendance and urine sample results. Specifically, regular attendance and drug negative samples will be rewarded. There are three categories of incentives: small, medium and large. All draws will result in a win!!! Below is a list of the types of incentives that will be available. There may be times that a certain gift card is not available, so please have a second choice in mind.

SMALL ($10 value): Coldstone Creamery, Dairy Queen, Dunkin Donuts, Jack-in-the-Box, McDonalds, Starbucks, and Subway.

MEDIUM ($50.00 value)**:** AMC Theatres, Harkins, Pizza Hut, Home Depot, Bath & Body Works, Old Navy, Sears, Kohl's, Cracker Barrel, Foot Locker, Best Buy, and Barnes and Noble.

LARGE ($200.00 value): The winner of a large gets some input on this prize. What do you need and/or want? Examples: tires, oil changes, haircuts, clothes, shoes. This prize will not be awarded in court and will require a little extra time to allow for your specific need and time to get the incentive.

Sobriety and treatment attendance are an important part of this program. We want to acknowledge your hard work and encourage you to keep it up. These behaviors will ultimately lead to the best incentive of all- GRADUATION!

Incentives in the Courtroom: Tangible Awards and Prizes

Some judges have started to offer prize drawings in the courtroom as a way to acknowledge positive behaviors of participants. While the research currently is inconclusive as to whether this can impact outcomes in the context of powerful sanctions that judges impose for undesired behavior, it has been noted that the infusion of positive incentives can change the atmosphere in the courtroom to one that is more celebratory and uplifting.

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Incentives in Drug Treatment, Probation, and Case Management Settings

In an ideal world, positive incentives would be infused throughout the drug court system. This is because effectiveness is likely to be maximized if incentives are delivered immediately for desired behavior in the setting where the behavior occurs, rather than delivered occasionally in the courtroom after long periods of good performance has been observed. Success of the drug court participant will depend on regular reporting to a treatment program, probation officer, and possibly a case manage as well. It will also depend on consistent delivery of drug negative urines that may be collected in any of these settings. Status hearings in front of the judge are less frequent and no direct observation of drug use occurs in this setting. As previously discussed, most of the evidence for efficacy of incentive interventions comes from the drug treatment setting, where frequent reporting and frequent urinalysis testing is usually required. Thus, in the ideal situation, positive incentives in the form of vouchers or prize drawings would occur both in the treatment program and at each meeting with the probation officer or case manager, with attendance and drug negative urines as the most likely targets for these interventions (See Chapter 8 for a more detailed discussion of opportunities to deliver positive incentives in these settings).

Other Implementation Considerations

In developing an implementation plan, a balance must be struck between feasibility and known principles of effectiveness. For example, an escalating system of prize draws is known to be more effective for sustained behavior change, but it is also more difficult to implement. Staff responsibilities always need to be clear. In a voucher system, for example, someone must keep client accounts up-to-date, while in a system that involves dispensing prizes, someone must keep prize stocks refreshed and varied so that they remain attractive to clients. As with any multifaceted system, everyone who has contact with the client should be aware of the contingencies and the client's progress to avoid misunderstanding or manipulation. Finally, it is important, if possible, to build in evaluation to learn what works and what aspects of the program need further refinement. For example, process evaluation could be used to learn whether clients value the prizes being offered and whether interventions are being implemented with good consistency, while outcome evaluations may be useful to learn which behaviors are more or less resistant to change with incentives.

In summary, positive incentive approaches have proven efficacy and effectiveness for promoting sustained behavior change in drug abuse populations. The principles of positive reinforcement interventions are clear and methods can be tailored for application in drug court programs with the potential to enhance outcomes. However, consideration will need to be given as to where, when, and for what the incentives should be offered in order to optimize their effectiveness in the drug court system.

RECOMMENDATIONS

1. *Positive reinforcement should be incorporated into all levels of the drug court program.*

2. *Reports to the judge should highlight success and accomplishments of participants.*

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3. *The judge should deliver praise for accomplishments at all status hearings.*

4. In courts with more resources, *tangible incentives (vouchers, gift cards, or prizes) should be incorporated* into the system at drug treatment, probation, case management and courtroom levels to reinforce regular attendance and drug abstinence in each of these settings.

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APPLICATION OF SANCTIONS

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INTRODUCTION

Generally speaking, rewarding desired behavior is more effective and efficient than punishing undesired behavior for improving client outcomes. As will be discussed, sanctions may bring with them a host of negative side effects and their influence tends to be fleeting once control over the client has ended. Nevertheless, some behaviors cannot be permitted to recur and must be squelched quickly in the interests of public safety. Drug court personnel and the public at large need to be confident that drug-abusing offenders, who may only be out on the street because of a diversionary or probationary opportunity, are not continuing to engage in risky activities. When administered correctly and in combination with adequate treatment and incentives for sobriety, sanctions can be effective at reducing substance use and crime. This chapter briefly reviews the research evidence concerning the essential parameters for designing and implementing effective sanction programs in drug courts.

NARRATIVE

Specificity

Ambiguity undermines the effects of sanctions. If clients do not have advance notice about the specific behaviors that may trigger a sanction and the types of sanctions that can be imposed, they will be apt to view the imposition of sanctions as unfair. This is unlikely to improve their behavior and may lead some clients to sabotage their own treatment goals. Moreover, it leaves room for after-the-fact misinterpretation or reinterpretation of the rules, which may give clients "wriggle room" to avoid a deserved sanction.

Clients should be clearly informed in advance about the ***specific behaviors*** that constitute infractions. Vague terms such as "irresponsible behavior" or "immaturity" are open to differing interpretations and should be avoided. Infractions should be defined concretely, such as drug-positive urines, unexcused absences from treatment, or failures to appear in court. It is also important to specify up front that, barring unusual circumstances, urine tests or retests are the ***final*** word on the question of whether new drug use has occurred.

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Because sanctions may need to be individualized in many instances, it may not be feasible to inform clients in advance about the precise sanctions that will be imposed for specific behaviors. However, clients do have a right to know the permissible range of sanctions that can be imposed for specified conduct. For example, sanctions for drug use might range from a verbal reprimand or writing assignment for the first few instances to residential treatment following multiple instances. Sanctions for criminal recidivism might range up to jail detention or termination after only a single instance. This information should be memorialized in a written

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manual that clients can refer to and that can be consulted to resolve disputes concerning the rules of the program.

Certainty

The more certain it is that clients will receive sanctions for infractions the less likely it is they will repeat those infractions. It is essential, therefore, to closely monitor clients' treatment attendance, substance use and criminal activity on a continuous basis to ensure that infractions are detected and elicit an appropriate consequence. Case managers should regularly document and report on all unexcused absences from treatment. Urine specimens should be collected no less frequently than weekly, and ideally twice-weekly. Urine collection must also be random and unexpected. If clients can anticipate on which days they will be urine tested, they can simply adjust their usage accordingly to avoid detection. This will reduce the certainty of detection and thus reduce the efficacy of the program.

The frequency of urine testing should be the *last* supervisory burden that is lifted. Only after clients have demonstrated an extended interval of continuous sobriety, when other requirements such as treatment sessions and status reviews have been lifted, can one be confident that abstinence may endure following graduation. Given the chronic course of addiction, continuous sobriety would be roughly 4 to 6 months in a noncontrolled environment; i.e., not counting time in residential treatment, recovery housing or jail where drug use is more difficult to engage in.

Second Chances

Giving a client a second chance before administering a sanction reduces the certainty that sanctions will be applied, which in turn reduces their efficacy. It may be appropriate, however, to withhold a sanction as a reward for subsequently correcting a mistake. For example, assume a client uses drugs but then feels bad about it, spontaneously reports the drug use to his or her counselor, and voluntarily seeks treatment to avoid a continued relapse. In this instance, being truthful and voluntarily seeking treatment may be seen as canceling out the impending sanction. Importantly, this should not be confused with clients simply acknowledging their transgressions after they have already been caught. Second chances must be earned through concrete actions reflecting demonstrable attainment of treatment goals.

For clients who do not act on their own volition to correct a transgression, this same principle (called "negative reinforcement") may be applied prospectively and incrementally. For example, following an infraction a court might order a 5-day jail sanction or 5 days of community service, but suspend execution of the sanction pending subsequent improvements in the client's conduct. The client might then earn progressive reductions in the length and severity of the sanction for each week he or she remained abstinent and complied with treatment. Failure to comply would result in imposition of the full sanction plus any additional sanctions for new infractions.

Immediacy

Unfortunately, the effects of sanctions begin to degrade within only hours or days after an infraction has occurred. Clients' performance must therefore be evaluated frequently and

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sanctions applied quickly where indicated. Drug court team members should be in regular contact with each other by phone or e-mail to permit a quick consensus to be reached about infractions and to permit sanctions to be imposed by the staff person in the most expedient position to do so. For those sanctions that can be imposed by clinicians or case managers (e.g., more frequent urine collection or treatment sessions), waiting several days or weeks for a court hearing may unnecessarily delay imposition. For those sanctions requiring the authority of a judge (e.g., fines or jail time), status hearings may need to be held more frequently or procedures may be required to rapidly schedule noncompliance hearings when indicated. Research reveals that high-risk clients who have more severe drug-use histories or antisocial predispositions may require status hearings to be held on a bi-weekly basis.

Magnitude

Sanctions tend to be least effective at the lowest and highest magnitudes and most effective within the moderate range. Weak sanctions may precipitate "habituation," in which clients become accustomed to punishment and thus less responsive to it. Severe sanctions may precipitate anger or despondency, which can interfere with the therapeutic relationship. A drug court's success will depend largely on its ability to apply a creative range of intermediate sanctions that can be ratcheted upward or downward in response to clients' behaviors. The sanctions should be delivered on an escalating or graduated gradient, in which the magnitude of the sanction increases progressively in response to each successive infraction.

Therapeutic Responses vs. Punitive Sanctions

There is considerable controversy about whether drug courts should increase treatment requirements as a "sanction" for misbehavior. Doing so could inadvertently give the impression that treatment is aversive and thus interfere with the therapeutic alliance.

Many drug courts distinguish between applying ***punitive*** sanctions for ***noncompliance*** with program requirements, and applying ***remedial or therapeutic*** responses to ***insufficient progress in treatment***.

For this reason, many drug courts distinguish between applying punitive sanctions for noncompliance with program requirements, and applying remedial or therapeutic responses to insufficient progress in treatment. For instance, a client might receive a verbal reprimand, community service or a few days in jail for failing to show up for counseling sessions or failing to deliver urine specimens when directed. On the other hand, if a client is compliant with counseling but continues to use drugs due to the severity of his or her addiction, then arguably the problem lies not with the client but with the care plan. Under such circumstances, the appropriate response would be to adjust the treatment regimen. For example, the client might be required to attend more frequent counseling sessions, receive a different type of treatment (e.g., medication) or be transferred to a more intensive modality of care (e.g., residential treatment).

Importantly, the decision about whether and how to adapt a client's care plan should be made by an appropriately trained treatment professional in consultation with other members of the drug court team. It would not be appropriate for a non-clinically trained criminal justice professional

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to increase a client's treatment requirements as a punishment for misbehavior without a well-articulated therapeutic rationale.

Shaping Behavior

Placing excessive demands on clients can overwhelm them and cause them to give up. It is necessary, therefore, to distinguish between proximal (or short term) goals and distal (or long term) goals and apply sanctions accordingly. This process is called "shaping." Proximal behaviors are those that (1) clients are readily capable of engaging in and (2) are necessary for longer-term objectives to be attained. Examples may include attendance at counseling sessions or provision of urine specimens. Distal behaviors are those that (1) are ultimately desired, but (2) may take time to accomplish. Examples may include earning a GED or obtaining gainful employment. Early in treatment, higher-magnitude sanctions should be imposed for proximal behaviors and lower-magnitude sanctions should be imposed for distal behaviors. For example, clients might receive a verbal reprimand or writing assignment for failing to look for a job, but might receive community service or a brief period of jail detention for failing to show up for counseling sessions or not providing urine specimens. Over time, the emphasis should shift to distal goals and higher-magnitude sanctions should be applied for avoiding work as well.

For clients who are *addicted* to or *dependent* on drugs or alcohol—i.e., they suffer from severe cravings or withdrawal symptoms when they stop using the substance—abstinence should be conceptualized as a distal goal. Substance use is compulsive for these individuals and they may be expected to require time and perhaps multiple relapses before achieving abstinence. Imposing high-magnitude sanctions for drug use early in treatment would be unlikely to improve their conduct and would be likely to drive them from the program. This would have the paradoxical effect of making the most drug-dependent individuals ill-fated for drug court. In contrast, for those clients who merely abuse or misuse drugs, abstinence should be conceptualized as a proximal goal. For these individuals, higher-magnitude sanctions should be applied from the outset to rapidly squelch drug use.

Fairness

Clients are most likely to respond well to a sanction if they feel they (1) had a fair opportunity to voice their side of the story, (2) were treated in an equivalent manner to similar people in similar circumstances, and (3) were accorded respect and dignity throughout the process. When these factors are absent, behavior fails to improve and clients may sabotage their own treatment goals.

Clients should always be given a chance to explain events from their perspective. This does not mean that their story should be taken at face value or that they should necessarily receive the outcome they desire. The important thing is that they feel they were listened to. In addition, it is essential to be on guard for inadvertent biases that can creep into the process of administering sanctions. If staff members have difficulty articulating why one client is being handled differently from others, then perhaps inadvertent partiality is at work and the team should reconsider its response. Most importantly, it is never appropriate to be condescending or discourteous. Even the most severe sanctions should be delivered in a dispassionate manner with no suggestion that the team enjoys meting out punishment.

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Positive Reinforcement

When administered properly, sanctions can reduce crime and drug use over the short term while clients are in the program. However, these effects should not be expected to endure after the coercive control of the program has been lifted unless the clients receive alternative rewards in their natural social environments that maintain their abstinence over time. For instance, clients who find a job, develop hobbies, or improve their family relationships are more likely to be rewarded (e.g., by receiving praise, social prestige or wages) for prosocial behaviors and punished (e.g., by being ostracized from peers or fired from their job) for drug-related behaviors. Clients who simply return to their previous routines and habitats will find themselves back in an environment that rewards drug use at the expense of pro-social achievements. To maintain treatment effects over time, it is essential for drug courts not merely to punish crime and drug use, but also to reward productive activities that are themselves incompatible with crime and drug use, such as gainful employment, education and healthy recreation. Only then can the effects of drug courts be expected to make lasting contributions to the well-being of clients, their families and their communities.

RECOMMENDATIONS

1. *Lay the Ground Rules in Advance.* Infractions should be concretely defined and the permissible range of sanctions that can be imposed for certain types of infractions should be clearly specified. This information should be memorialized in a written program manual.

2. *Monitor Clients Closely.* Treatment attendance, substance use and criminal activity should be carefully monitored on a continuous basis to ensure infractions are reliably detected and responded to. The frequency of urine testing should be the last supervisory burden that is lifted, only after clients have achieved several months of consecutive abstinence in a noncontrolled setting.

3. *Second Chances Should be Earned.* Sanctions should only be withheld if clients have engaged in concrete actions intended to correct transgressions.

4. *Respond to Infractions Promptly.* Clients' performance must be evaluated frequently and sanctions applied quickly where indicated. Delays greater than two weeks can substantially reduce the efficacy of sanctions, especially for individuals with more serious drug problems or criminal backgrounds.

5. *Use Moderate Sanctions.* Sanctions tend to be least effective at the lowest and highest magnitudes and most effective in the moderate range. It is best to have available a range of intermediate sanctions that can be ratcheted upward or downward in response to clients' behaviors.

6. *Punish Misbehavior But Treat Dysfunction.* Administer punitive sanctions for willful noncompliance with program requirements, but apply remedial or therapeutic responses to insufficient progress in treatment.

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7. *First Things First.* During the early phases of treatment, shape clients' behavior by applying higher-magnitude sanctions for failing to satisfy short-term proximal goals, and lower-magnitude sanctions for failing to satisfy long-term distal goals.

8. *Be Fair.* Give clients a chance to explain their side of the story, pay careful attention to issues of equal protection, and always treat clients with respect and dignity.

9. *Do Not Rely on Sanctions Alone.* The effects of sanctions are unlikely to endure after graduation unless clients also receive positive rewards for engaging in prosocial behaviors that will continue to compete against drug use and crime on into the future.

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APPENDIX

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Checklist for Designing Problem-Solving Courts to Address Co-Occurring Disorders

Directions

The following checklist is intended as a guide for problem-solving courts in developing services and community resources to meet the unique needs of participants with co-occurring mental health and substance abuse disorders.

I. Core Program Modifications				
Activity	***Goal***	***Proposed Modifications***	***Time Frame***	***Individual Responsible***
✓**Court Commitment**	Explicit statements of inclusiveness of persons with co-occurring disorders should be developed within mission statements and/or program descriptions.			
✓**Blended Screening and Assessment**	Routine screening and assessment address both mental health and substance abuse disorders			
✓ **Court Monitoring**	Conditions, frequency of hearings, staff assignments, and program intensity reflect the presence of a co-occurring mental disorder.			
✓**Education about Co-Occurring Disorders**	All participants receive education about the nature and treatment of co-occurring disorders			
✓**Medication Monitoring**	Ongoing psychiatric consultation and assessment is provided to monitor medication needs, use and side effects			

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I. Core Program Modifications				
Activity	***Goal***	***Proposed Modifications***	***Time Frame***	***Individual Responsible***
✓**Graduated Sanctions**	Consider the effects of mental health disorders in developing and applying flexible sanctions			
✓**Liaison with Community Treatment Services**	Coordinate treatment planning, referral and monitoring with community mental health services, including integrated treatment for co-occurring mental health and substance use disorders			
✓**Liaison with Emergency, Transitional and Permanent Housing Providers**	Ensure access to safe and stable housing with established linkages to community treatment services			
✓**Court Hearings and Judicial Monitoring**	Adjust court hearings and monitoring to address mental health needs of participants			

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II. Program Enhancements (e.g. co-occurring disorders groups, program tracks, additional counseling, specialized case management services outreach procedures, reduced caseloads etc.)			
Activity	***Proposed Modifications***	***Time Frame***	***Individual Responsible***
✓Proposed Enhancement:			
✓Proposed Enhancement:			
✓Proposed Enhancement:			
✓Proposed Enhancement:			
✓Proposed Enhancement:			

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III. Developing Community Resources				
Community Resource	***What Partners Need to be Engaged***	***Key Services or Activities***	***Time Frame***	***Individual Responsible***
✓Local Community Mental Health Centers				
✓Local Mental Health Practitioners				
✓Emergency Rooms and Hospitals				
✓Crisis/Mobile Response Teams				
✓Other Services:				
✓Other Services:				

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