

DRUG COURT PRACTITIONER FACT SHEET

TARGETING THE RIGHT PARTICIPANTS FOR ADULT DRUG COURTS PART ONE OF A TWO-PART SERIES¹

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INTRODUCTION

Adult drug courts are not designed to treat all drug-involved adult offenders. They were created to fill a specific service gap for drug-dependent offenders who were not responding to existing correctional programs—the ones who were not adhering to standard probation conditions, who were being rearrested for new offenses soon after release from custody, and who were repeatedly returning to court on new charges or technical violations.

Admittedly, eligibility criteria for some of the earliest drug courts did not clearly reflect this limited objective. Largely in an effort to avoid appearing “soft on crime” or to gain the buy-in of local prosecutors or other stakeholders, some of the earliest drug courts began as pre-plea diversion programs for first-time, drug-possession cases. The goal, however, was not to remain fixated on this low-level population, but rather to expand upon and focus the admissions criteria once the programs proved their worth and science identified the best populations to serve.

¹ A companion fact sheet to this document, entitled *Alternative Tracks in Adult Drug Courts: Matching Your Program to the Needs of Your Clients*, is available from the National Drug Court Institute at www.NDCl.org

A substantial body of research now indicates which drug-involved offenders are most in need of the full array of services embodied in the “10 Key Components” of drug courts (NADCP, 1997). These are the offenders who are (1) substance dependent and (2) at risk of failing in less intensive rehabilitation programs. Drug courts that focus their efforts on these individuals—referred to as *high-risk/high-need* offenders—reduce crime approximately twice as much as those serving less serious offenders (Lowenkamp et al., 2005; Fielding et al., 2002) and return approximately 50 percent greater cost-benefits to their communities (Bhati et al., 2008).

A substantial body of research indicates which drug-involved offenders need drug court.

This finding has important implications for determining eligible offenses for drug courts. Compared with programs serving only drug-possession cases, drug courts that also served individuals charged with theft and property crimes driven by a drug addiction have yielded nearly twice the cost savings (Carey et al., 2008).² The reason for this relates to the types of crimes being avoided. Drug courts that serve only drug-possession cases may offset relatively low-level crimes that do not incur high victimization or incarceration costs, such as petty theft, drug possession, trespassing, and traffic offenses (Downey & Roman, 2010). As a result, they may pass on small or negligible cost-benefits to their communities.

² There is also evidence that offenders with violence histories performed as well, or better, than nonviolent offenders in drug courts (Carey et al., 2008; Saum & Hiller, 2008; Saum et al., 2001). Thus, prohibitions in the federal Omnibus Crime Control Act of 1997 and some state statutes against admitting violent offenders into drug courts may not be justified on empirical grounds of effectiveness or cost effectiveness. This assumes, of course, that the offenders are dependent on illicit drugs or alcohol and are otherwise eligible for a community-based disposition.

The lessons from this research are clear. It is time for drug courts to revisit their admissions criteria to ensure that they are serving the optimal target population of offenders who are most in need of their services and at greatest risk for future relapse and crime. Alternatively, drug courts that are unable or unwilling to alter their admissions criteria should consider revising their program to ensure the services they offer are appropriately matched to the needs and risk levels of their client population. A companion document to this fact sheet, entitled *Alternative Tracks in Adult Drug Courts: Matching Your Program to the Needs of Your Clients*, describes evidence-based approaches to adapting drug court regimens to the needs of various types of participants.

HIGH PROGNOSTIC RISK

According to what is generally known as the *Risk Principle*, intensive programs such as drug courts have been shown to produce the greatest benefits for offenders who have relatively more severe antisocial backgrounds or treatment-resistant histories (Andrews & Bonta, 2010; Taxman & Marlowe, 2006). Referred to as *high-risk* offenders, these individuals tend to have a relatively poorer prognosis for success in standard rehabilitation programs and typically require more concentrated and sustained interventions to dislodge their entrenched, negative behavioral patterns. Research reveals that it is these high-risk offenders who are most in need of the intensive supervision services embodied in the 10 Key Components of drug courts (Lowenkamp et al., 2005; Fielding et al., 2002; Marlowe et al., 2006, 2007; Festinger et al., 2002).

Defining Risk

In the context of the present discussion, the term *high risk* refers to the likelihood that an offender will not succeed on standard supervision and will continue to engage in the same pattern of behavior that got him or her into trouble in the first place. In other words, it refers to a relatively poorer prognosis for success in traditional rehabilitation services. For this reason, it is most accurately referred to as *prognostic risk* (Marlowe, 2009).

The term does not necessarily refer to a risk for violence or dangerousness. Most risk-assessment tools that are administered in routine practice by probation agencies or corrections departments were validated against the likelihood of offenders absconding on bond, violating the terms of their probation, or reoffending, and not against the likelihood of their committing a violent act. Although assessment tools do exist to measure the risk of violence (Campbell et al., 2009), they are more commonly used when treating habitual sex offenders or conducting forensic evaluations in serious felony cases.

This distinction between prognostic risk and violence risk is critical. Some drug courts may screen high prognostic-risk offenders out of their programs because they perceive them (wrongly) as necessarily being a threat to others or somehow less suited for the services. On the contrary, research indicates that the higher the prognostic risk, the more appropriate it may be to refer a drug-dependent individual to drug court, assuming that a community-based disposition is warranted and apt to be imposed in the case.

Low-risk offenders, on the other hand, are less likely to be on a fixed antisocial trajectory and are already predisposed to improve their conduct following a run-in with the law. Therefore, intensive interventions like drug courts may offer small incremental benefits for these individuals, but at a substantial cost (DeMatteo et al., 2006). Worse still, low-risk offenders may learn antisocial attitudes and behaviors from associating with high-risk offenders, which can make their outcomes worse (Lowenkamp & Latessa, 2004; McCord, 2003; Petrosino et al., 2000).

HIGH CRIMINOGENIC NEED

Criminogenic needs refer to clinical disorders or functional impairments that, if treated, substantially reduce the likelihood of continued engagement in crime (Andrews & Bonta,

2010). The most common criminogenic needs among offenders include substance dependence (also known as addiction), major psychiatric disorders, brain injury, or a lack of basic employment or daily living skills (Belenko, 2006; Simpson & Knight, 2007). Failing to address these serious deficits leaves the individual vulnerable to repeated

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failures and continued involvement in crime, whereas effectively addressing them is associated with improved functioning and the avoidance of crime (Smith et al., 2009).

Individuals who are dependent on drugs or alcohol commonly suffer from cravings to use the substance, and may experience painful or uncomfortable withdrawal symptoms when they attempt to become abstinent (American Psychiatric Association, 2000). It is now understood that these symptoms often reflect a form of neurological or neurochemical damage to the brain (Baler & Volkow, 2006; Dackis & O'Brien, 2005; Goldstein et al., 2009). Formal treatment is required for such individuals to reduce their cravings and

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withdrawal symptoms, teach them concrete skills to resist drugs and alcohol, and provide them with effective coping strategies to deal with daily stressors and challenges (Chandler et al., 2009). In some cases, medication or residential treatment will also be needed, at least during the early phases of treatment. Research is clear that failing to provide an adequate dose or modality of treatment for addicted individuals is associated with significantly poorer outcomes (De Leon et al., 2008, 2010; Karno & Longabaugh, 2007; Vieira et al., 2009; Belenko, 2006). It is for this reason that drug courts require participants to complete an intensive regimen of substance abuse treatment and other indicated rehabilitation services.

What is not always appreciated, however, is that treatment can also be too intense. Placing non-dependent or low-risk individuals into residential or group-based treatment, for example, has been associated with significantly poorer outcomes and higher recidivism (Lovins et al., 2007; Lowenkamp & Latessa, 2005; Szalavitz, 2010; Wexler et al., 2004). Perhaps spending time with addicted peers unduly normalizes the drug-using lifestyle, or perhaps treatment requirements interfere with participants' engagement in productive activities, such as work, school, or parenting. Whatever the rationale, it appears that providing too much treatment is not merely a potential waste of scarce resources. It can also lead to what are called *iatrogenic effects*, in which outcomes are made worse.

It is unwarranted to assume that simply because an individual was arrested for a drug offense, he or she must be dependent on drugs and in need of formal substance abuse treatment. At least half of drug-involved offenders abuse alcohol or other drugs but are not dependent (National Center on Addiction and Substance Abuse, 2010; Fazel et al., 2006; DeMatteo et al., 2009). They may repeatedly ingest these substances under circumstances that are potentially dangerous to themselves and others, but their usage is still largely under voluntary control. For such individuals, alternative programs, which do not rely on formal substance abuse treatment to achieve their desired aims, may be preferable to drug courts.

ASSESSMENT

It is beyond the scope of this fact sheet to review the large number of assessment tools that are available for assessing prognostic risk and criminogenic need. Some recommended readings are provided at the end of this document. However, a few general points merit consideration.

Many risk assessment tools that are commonly used by drug courts, probation agencies, and corrections departments are adequately suited to predicting prognostic risk. So long as an instrument has been empirically validated against the likelihood of criminal recidivism or failure on supervision (preferably with the studies being published in peer-reviewed journals), it is likely to perform adequately for present purposes. It is essential to ensure that the instrument is equivalently predictive for racial, ethnic, and gender subgroups that are represented in the drug court population. Assuming a risk instrument significantly predicts outcomes and is unbiased in its predictions, it should serve well for helping to identify the target population for a drug court.

Where drug courts are often deficient is in the assessment of clinical diagnosis. Many drug courts employ brief screening instruments to assess substance abuse or dependence. By design, screening instruments are intended to cast a wide net, meaning they are apt to identify a substantial number of false positives for a substance use disorder, especially substance dependence. If a screening tool is used, then any positive classification should be followed up with a more in-depth clinical evaluation to confirm the initial diagnostic impression. Otherwise, there is a serious concern that individuals who are substance abusers or misusers may be grouped together with those who are truly substance dependent.

The best approach is often to administer a structured or semi-structured interview that is congruent with the diagnostic criteria contained in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). The DSM is the official diagnostic classification system for substance use disorders and psychiatric disorders in the United States. It is currently in its fourth amended edition (DSM-IV-TR;

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American Psychiatric Association, 2000), and a fifth edition is forthcoming. It is important to ensure that one's evaluators are properly skilled in the administration of the interview and are well trained on the DSM nomenclature. Unless the evaluators have a clear understanding of the intent of the items and the meaning of the diagnostic criteria, they may be likely to systematically over-diagnose or under-diagnose substance dependence.

In some drug courts, the assessments of prognostic risk and criminogenic need may be performed by different evaluators or agencies. For example, the probation department might perform the risk assessment and the treatment program might assign the clinical diagnosis. The important task is to combine the two sets of assessment results so that each participant can be assigned to the appropriate level of both treatment and supervision.

The assessment of prognostic risk and criminogenic need should be completed before the requirements of the program are determined.

Some drug courts may postpone the assessments until after participants have been admitted to the program and the conditions of supervision have been ordered. This puts the cart before the horse. The assessment of prognostic risk and criminogenic need should be completed before the requirements of the program are determined, ideally before the disposition of the case. This will help to

DSM-IV-TR Diagnostic Criteria For Substance Dependence

Substance dependence is a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

- 1. Tolerance, as defined by either of the following:**
 - a. A need for markedly increased amounts of the substance to achieve intoxication or the desired effect.**
 - b. Markedly diminished effects with continued use of the same amount of the substance.**
- 2. Withdrawal, as manifested by either of the following:**
 - a. The characteristic withdrawal syndrome for the substance.**
 - b. The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.**
- 3. The substance is often taken in larger amounts or over a longer period than was intended.**
- 4. There is a persistent desire or unsuccessful efforts to cut down or control substance use.**
- 5. A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects.**
- 6. Important social, occupational, or recreational activities are given up or reduced because of substance use.**
- 7. The substance use is continued despite the knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).**

Source: American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.). Washington DC: American Psychiatric Press; at pp. 197–98.

ensure the requirements are based on the actual needs and risk level of the participants, rather than on preconceived notions about what all drug offenders should be required to do. If a drug court is unable, for practical reasons, to complete the assessments prior to entry, then participants might be required

to undergo a brief observational period before the formal conditions of treatment and supervision are entered.

Finally, bear in mind that the focus of the present discussion is on determining initial eligibility for drug court. Once participants

have entered treatment, clinicians or case managers will conduct more in-depth clinical evaluations to develop the treatment plan. It is the responsibility of clinical staff members to make clinical decisions, such as determining the appropriate level of care and identifying other problems that may require remedial attention, including medical conditions, mental illness, or employment problems. The role of the drug court judge and other nonclinical team members is to ensure that participants comply with the recommended treatment regimens.

SUITABILITY DETERMINATIONS

After determining legal and clinical eligibility for the program, some drug courts may further screen potential participants regarding their “suitability” for the program. The suitability determinations are often based on the team members’ subjective impressions about an offender’s motivation for change or preparedness for treatment. Research indicates that such suitability determinations have no impact on drug court graduation rates or post-program recidivism (Carey & Perkins, 2008). Because they have the potential to systematically exclude eligible individuals from drug court for reasons that are empirically invalid, such practices should ordinarily be avoided.

ALTERNATIVE DRUG COURT TRACKS

In some jurisdictions, the drug court may be the most effective, or perhaps only, program serving as an alternative to incarceration that has staff members with expertise in managing drug-involved offenders. Moreover, some smaller or rural communities may not have sufficient numbers of drug-involved offenders to justify having multiple programs, each serving different target populations. Under such circumstances, the most effective or humane course of action may be to admit low-risk or non-addicted participants into the drug court.

Research indicates that suitability determinations have no impact on drug court graduation rates or post-program recidivism.

If a drug court intends to serve a heterogeneous range of drug-involved offenders, then the program should consider making substantive modifications to accommodate the diverse needs and risk levels of its participants. This can be accomplished by developing alternate tracks within the drug court, which place different treatment and supervisory conditions on participants. As noted earlier, a companion fact sheet offers concrete suggestions for developing and administering alternative tracks within a drug court.

If a drug court intends to serve a heterogeneous range of drug-involved offenders, then the program should consider making substantive modifications.

CONCLUSION

No one intervention should be expected to work for all individuals. Every professional discipline—from medicine to psychology to social work to criminology—has come to learn that programs have target populations for whom they are most effective, and non-target populations for whom they may be ineffective, unduly costly, or even harmful. It is the sign of a mature field that can match its clients to the most appropriate services to optimize outcomes and utilize resources most efficiently.

Drug courts are no exception. More than two decades of research has identified which individuals respond best to the drug court model and yield the largest returns on investment for taxpayers. These are the individuals who have negative risk factors for failure in less intensive treatment or supervisory programs, and who meet diagnostic criteria for substance dependence.

Evidence suggests that drug courts can potentially double their effectiveness and cost-effectiveness by focusing their efforts on this high-risk/high-need target population. This will require some drug courts to reassess their current eligibility criteria and, in some cases, redouble their efforts to ensure the proper population is accepted in the future. Unfortunately, there is no shortage of substance-dependent, prison-bound offenders. The more drug courts meet the needs of these individuals, the healthier they and their families will be, the safer our communities will be, and fewer will be the burdens placed on public dollars.

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Fact Sheet Quiz: What Did You Learn?

Test your new knowledge. Answer these questions based on the Fact Sheet text.

1. Research suggests the optimal target population for a drug court is:

(check all that apply)

- A First-time drug offenders
- B Drug experimenters
- C Addicted individuals
- D Individuals who would ordinarily have a poor prognosis for success in substance abuse treatment
- E Nonviolent offenders

2. The most commonly used risk instruments are valid tools for:

(check all that apply)

- A Predicting failure on standard supervision
- B Developing treatment plans
- C Screening out the most violent offenders
- D Diagnosing addiction

3. As this term is most commonly used in typical correctional practice, "high risk" refers to offenders who:

(check all that apply)

- A Are likely to commit violent or dangerous acts
- B Abuse seriously addictive drugs, like methamphetamine or heroin
- C Are sexual predators
- D Are relatively less likely to respond to treatment or rehabilitation
- E Should receive a jail or prison sentence

4. Compared to drug courts that treat low-risk and low-need participants, drug courts that serve high-risk and high-need participants have been shown to have:

(check all that apply)

- A Twice the effect for reducing crime
- B Fifty percent greater cost benefits
- C More instances of drug dealing on the premises
- D More instances of assaults against staff members or other participants

5. Which of the following needs among offenders are criminogenic, meaning they frequently play a substantial causative role in crime:

(check all that apply)

- A Low self-esteem
- B Weak muscle tone
- C Severe mental illness
- D Lack of job skills
- E Substance dependence
- F Drug possession

Answers: 1: C and D, 2: A, 3: D, 4: A and B, 5: C, D and E



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INTRODUCTION

More than two decades of research indicates which types of adult offenders are most in need of the full complement of services embodied in the “10 Key Components” of drug courts (NADCP, 1997).¹ These are the individuals who are (1) substance dependent and (2) at risk of failing in less intensive rehabilitation programs. Drug courts that focus their efforts on these individuals—referred to as *high-risk/high-need* offenders—reduce crime approximately twice as much as those serving less serious offenders and return approximately 50 percent greater cost-benefits to their communities.

For a number of reasons, however, it may not always be possible or desirable for a drug court to target high-risk and high-need participants exclusively. To gain the buy-in of local prosecutors, the public, or other stakeholders, it may be necessary for some drug courts to begin by treating less serious offenders and to expand the admissions criteria after they have proven their safety and efficacy. Moreover, in some communities the drug court may be the most effective, or perhaps only, program serving as an alternative to incarceration that has staff members with expertise in managing drug-involved offenders. If low-risk or non-addicted individuals are ineligible for drug court, they may have no other option but to face prosecution, and possibly incarceration, without an opportunity to be diverted into an effective rehabilitative disposition.

¹ This research is reviewed in a companion fact sheet to this document, entitled *Targeting the Right Participants for Adult Drug Courts*, which is available from the National Drug Court Institute at www.NDCI.org

If a drug court has such compelling reasons to serve low-risk or low-need individuals, it should consider making substantive modifications to its program to accommodate the characteristics of its participants. This document describes a conceptual framework and evidence-based practice recommendations for designing alternative tracks within a drug court to serve different types of adult participants.

Research indicates which types of adult offenders are most in need of the full complement of services embodied in the 10 Key Components of drug courts.

THE RISK AND NEED PRINCIPLES

No one intervention is appropriately suited for all drug-involved offenders. According to what are known as the Risk Principle and the Need Principle, the most effective and cost-efficient outcomes are achieved when treatment and supervision services are tailored to the (1) prognostic risk level and (2) criminogenic needs of the participants (Andrews & Bonta, 2010; Taxman & Marlowe, 2006).

Prognostic risk refers to the characteristics of offenders that predict relatively poorer outcomes in standard rehabilitation programs. Among drug-involved offenders, the most reliable and robust prognostic risk factors include a younger age, male gender, early onset of substance abuse or delinquency, prior felony convictions, previously unsuccessful treatment attempts, a diagnosis of antisocial personality disorder, and regular contacts with antisocial or substance-abusing peers (Marlowe et al., 2003). *Criminogenic needs* refer to clinical disorders or functional impairments that, if

treated, significantly reduce the likelihood of future involvement in crime. The most common criminogenic needs among offenders include a diagnosis of substance dependence or addiction, major mental illness, and a lack of basic employment or daily living skills (Belenko, 2006; Simpson & Knight, 2007).

Prognostic risk and criminogenic need indicate what level of treatment and supervision are likely to be required to manage an offender, and what consequences should ensue for new instances of alcohol or other drug use. Generally speaking, the higher the prognostic risk level, the more intensive the supervision services should be (Lowenkamp et al., 2006). Similarly, the higher the need level, the more intensive the treatment services should be (Smith et al., 2009). Drug-involved offenders who are both high-risk and high-need typically require the full array of treatment and supervision services embodied in the 10 Key Components of drug courts.

The converse, however, is also true. The lower the risk level, the less intensive the supervision services should be. And the lower the need level, the less intensive the treatment services should be. Providing too much treatment or too much supervision is not merely a potential waste of scarce resources. It can increase crime or substance abuse by exposing individuals to more seriously impaired or antisocial peers, or by interfering with their engagement in productive activities such as work, school, or parenting (Lowenkamp & Latessa, 2004; McCord, 2003). Individuals who are low-risk and/or low-need typically do not require the full menu of services specified in the 10 Key Components.

RISK AND NEED MATRIX

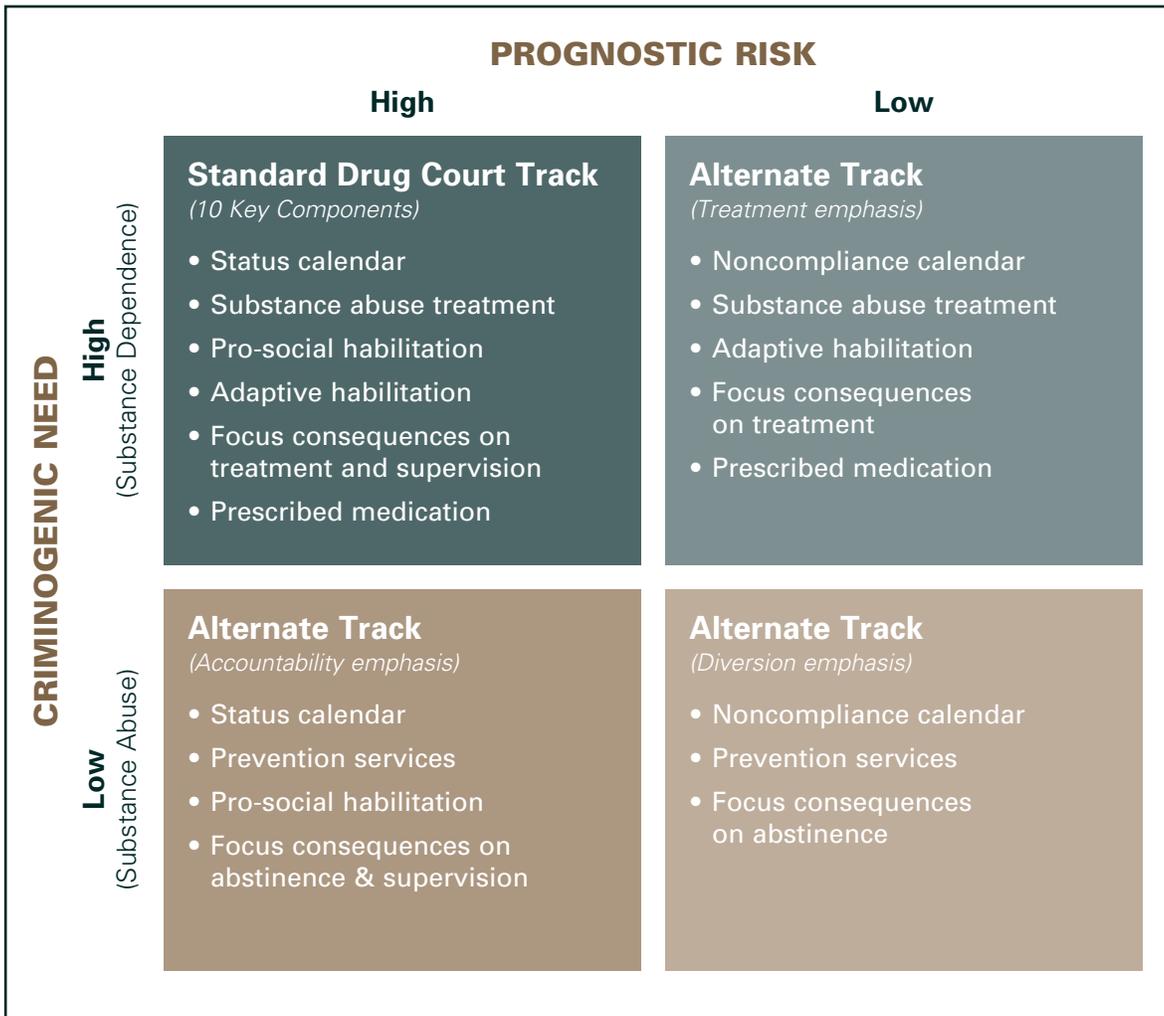
Conceptually, prognostic risk and criminogenic need may be crossed in a two-by-two matrix, yielding four quadrants that indicate whether each participant may be classified as high-risk

and high-need (HR/HN), low-risk and high-need (LR/HN), high-risk and low-need (HR/LN) or low-risk and low-need (LR/LN). To be most effective and cost-efficient, treatment and supervision services should be specifically tailored to the risk/need profile of the offender. Interventions that are well-suited for participants in one quadrant may be a waste of resources or contraindicated for those in another quadrant.

Figure 1 summarizes alternative treatment and supervisory regimens that might be

administered within a drug court to serve different types of participants. The purpose of this figure is not to describe all of the interventions that should be administered in a drug court. As will be discussed, some services such as drug testing, community surveillance, and positive incentives should be administered to *all* participants regardless of their risk level or clinical diagnosis. The aim here is to highlight the specific adaptations that research suggests should be implemented in a drug court to serve different offender subtypes.

FIGURE 1: Alternative Tracks Within An Adult Drug Court



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

High Prognostic Risk

High Criminogenic Need
(Substance Dependence)

Standard Drug Court Track

(10 Key Components)

- Status calendar
- Substance abuse treatment
- Pro-social habilitation
- Adaptive habilitation
- Focus consequences on treatment and supervision
- Prescribed medication

HIGH RISK & HIGH NEED (HR/HN)

Participants in the upper left quadrant are dependent on alcohol or other drugs, and are also at risk for failure in standard correctional rehabilitation programs. They may, for example, have begun abusing substances or committing delinquent acts at an early age, failed previously in less intensive dispositions, or been diagnosed with antisocial personality disorder. Research confirms that the full array of drug court services embodied in the 10 Key Components is typically required for this high-risk/high-need group (Carey et al., 2008; Carey et al., in press). Key services that should ordinarily be provided to these participants include:

Status Calendar: Participants in this quadrant should appear frequently in court for the judge to review their progress in treatment and administer suitable consequences where indicated. Evidence suggests status hearings should be held no less frequently than bi-weekly (every 2 weeks) for at least the first few months of the program, until the participants have achieved a stable interval of sobriety and are regularly engaged in treatment (Marlowe et al., 2006, 2007; Carey et al., 2008; Festinger et al., 2002).

Substance Abuse Treatment: Individuals who are substance dependent commonly experience cravings to use the substance and may suffer uncomfortable withdrawal symptoms when they attempt to become abstinent (American Psychiatric Association, 2000). These symptoms often reflect a form of neurological or neurochemical damage to the brain (Baler & Volkow, 2006; Dackis & O'Brien, 2005). Formal treatment is required for such individuals to reduce their cravings and withdrawal symptoms, provide them with concrete skills to resist drugs and alcohol, and teach them effective coping strategies for dealing with daily stressors. In some instances, residential, inpatient, or sober-living services may be required to stabilize the individual and prepare him or her for longer-term outpatient treatment (e.g., Belenko & Peugh, 2005). Research is clear that failing to provide an adequate dose or modality of treatment for substance dependent offenders produces poor outcomes and higher recidivism rates (Smith et al., 2009; Chandler et al., 2009; Vieira et al., 2009).

Failing to provide an adequate dose or modality of treatment for substance dependent offenders produces poor outcomes and higher recidivism rates.

Pro-social Habilitation: Individuals in this quadrant may lack the inclination to engage in productive activities such as work, school, or parenting. They may not attach importance to the assumption of responsible roles and may endorse antisocial attitudes and values. Interventions that focus on remediating such "criminal thinking" patterns can be beneficial for maintaining positive outcomes with these

individuals (Heck, 2008; Knight et al., 2006; Lowenkamp et al., 2009). Evidence suggests a minimum dosage of 200 hours of cognitive-behavioral services may be required to reduce criminal recidivism in this difficult-to-treat group (Bourgon & Armstrong, 2005; Latessa & Sperber, 2010).

Adaptive Habilitation: Individuals in this quadrant may also be deficient in adaptive life skills, such as employability, education, financial management, and homemaking (e.g., Belenko, 2006). Adaptive habilitation services will often be required to teach them vocational skills, address educational deficits, improve daily living skills, and model effective interpersonal problem-solving strategies.

Focus Consequences on Treatment and Supervision: For these individuals, compliance with the conditions of supervision and treatment is the primary (or “proximal”) goal. Failure to attend scheduled appointments or to deliver urine specimens should be met with relatively higher-magnitude sanctions to ensure conformance with their principal obligations. On the other hand, abstinence is a more difficult (or “distal”) goal for these individuals. Lower-magnitude, treatment-oriented responses should typically ensue for substance use during the early phases of the program. This will allow punitive consequences for substance use to be ratcheted up in intensity after treatment has had a chance to take effect.

Prescribed Medication: As was noted earlier, substance dependence is often a neurological or neurochemical disorder that may, in some cases, require medical intervention. The use of appropriately prescribed medications by a qualified addiction psychiatrist constitutes an evidence-based practice for addicted offenders (National Institute on Drug Abuse, 2006; Chandler et al., 2009) and should be available in appropriate cases.

Low Prognostic Risk

High Criminogenic Need
(Substance Dependence)

Alternate Track

(Treatment emphasis)

- Noncompliance calendar
- Substance abuse treatment
- Adaptive habilitation
- Focus consequences on treatment
- Prescribed medication

LOW RISK & HIGH NEED (LR/HN)

Individuals in the upper right quadrant are dependent on alcohol or other drugs, but do not have substantial prognostic risk factors that would predict failure in standard treatment interventions. For these low-risk/high-need individuals, the primary emphasis should be on ensuring the provision of needed treatment services.

For low-risk/high-need individuals, the primary emphasis should be on ensuring the provision of needed treatment services.

Noncompliance Calendar: Individuals with this profile do not appear to require supervision on a status calendar. Research suggests they can perform as well, or better, on a non-compliance calendar (Festinger et al., 2002; Marlowe et al., 2006, 2007). Rather than spending substantial time in court interacting with high-risk antisocial peers, they should focus their energies in treatment. However, if they stop going to treatment, they should be brought immediately before the judge to receive a swift and certain sanction to ensure

that they reengage quickly. Although research has not addressed this point, it might be appropriate to hold status hearings for these individuals on an infrequent basis, such as monthly or bi-monthly, for the judge to offer encouragement and administer rewards.

Substance Abuse Treatment: Because these participants are substance dependent, they, too, require formal substance abuse treatment services. The focus of treatment should be essentially the same as described above; however, evidence suggests low-risk individuals should not be treated in the same counseling groups or milieu as high-risk individuals because they may come to adopt antisocial attitudes or values (Lowenkamp & Latessa, 2004).

Adaptive Habilitation: Although these individuals may not endorse antisocial values, they frequently require adaptive habilitation services such as vocational or educational assistance, family therapy, or mental health counseling. Evidence suggests a more moderate dosage of approximately 100 hours of services may be sufficient to reduce recidivism with this group (Bourgon & Armstrong, 2005).

Focus Consequences on Treatment: Treatment attendance should be the primary or proximal focus for these individuals. Failing to attend treatment should trigger a noncompliance hearing and elicit a substantial sanction to ensure future compliance with the treatment plan. Because abstinence is a more distal goal for these individuals, treatment-oriented responses should ordinarily ensue for substance use during the early phases of the program.

Prescribed Medication: As discussed above, the use of appropriately prescribed medications by a qualified addiction psychiatrist may be indicated for some addicted offenders.

High Prognostic Risk

Low Criminogenic Need
(Substance Abuse)

Alternate Track

(Accountability emphasis)

- Status calendar
- Prevention services
- Pro-social habilitation
- Focus consequences on abstinence & supervision

HIGH RISK & LOW NEED (HR/LN)

Participants in the lower left quadrant are non-dependent substance abusers, but they nevertheless have substantial risk factors for failure on standard supervision. For these high-risk/low-need individuals, the emphasis should be on closely monitoring their behavior, holding them accountable for their conduct, and teaching them pro-social life skills.

For high-risk/low-need individuals, the emphasis should be on closely monitoring their behavior, holding them accountable for their conduct, and teaching them pro-social life skills.

Status Calendar: Because they are at risk for failing to comply with standard supervision requirements, these individuals should appear in court on a status calendar for the judge to review their progress and impose suitable consequences. As noted previously, status hearings should generally be held at least bi-weekly until the case has stabilized.

Prevention Services: At least half of drug-involved offenders abuse alcohol or other drugs, but do not meet diagnostic criteria for dependence (National Center on Addiction and Substance Abuse, 2010; DeMatteo et al., 2009; Belenko & Peugh, 2005). They may experience repeated adverse consequences of substance use, such as multiple criminal arrests or car accidents, but their usage is largely under voluntary control. Providing formal substance abuse treatment for such individuals can lead to higher substance abuse and a greater likelihood of eventually becoming addicted (Lovins et al., 2007; Lowenkamp & Latessa, 2005; Szalavitz, 2010). Instead, non-addicted substance abusers are better suited to secondary prevention services, also known as early intervention (DeMatteo et al., 2006). Examples of secondary prevention services include psycho-educational groups that teach participants about the dangers of drugs and alcohol, and activity-scheduling exercises that re-orient their daily activities away from drug-related peers and events.

Pro-Social Habilitation: Pro-social habilitation services will often be necessary for these high-risk individuals to remediate criminal thinking patterns and teach them adaptive interpersonal problem-solving skills. As noted previously, at least 200 hours of cognitive-behavioral services may be needed to reduce criminal activity among high-risk offenders.

Focus Consequences on Abstinence and Supervision: For these individuals, compliance with supervision and abstinence from alcohol and other drugs are short-term or proximal expectations. They are generally capable of attending sessions and desisting from substance use fairly readily; therefore, higher-magnitude sanctions should be imposed from the outset to rapidly deter substance use and failures to appear.

Low Prognostic Risk

Low Criminogenic Need
(Substance Abuse)

Alternate Track

(Diversion emphasis)

- Noncompliance calendar
- Prevention services
- Focus consequences on abstinence

LOW RISK & LOW NEED (LR/LN)

Individuals in the lower right quadrant potentially have the most to lose from participating in a traditional drug court. Contact with high-risk or substance-dependent peers has the potential to expose them to antisocial influences and values. Moreover, the intensive requirements of a drug court might interfere with their engagement in productive

Individuals in the lower right quadrant potentially have the most to lose from participating in a traditional drug court.

activities, such as work, school, or parenting. It is typically unnecessary to expend substantial resources on this group because they have a low probability of recidivism from the outset. The best course of action may be to use the current arrest episode as a “teachable moment” to alter their trajectory of substance abuse and divert them from the criminal justice system. In many instances, it may be appropriate to reduce the length of the program to approximately 4 to 6 months, rather than insist on a uniform period of 12 to 24 months.

Noncompliance Calendar: These individuals can typically be supervised on a noncompliance calendar. It is generally not desirable to have them spend substantial time in court or at a probation office, because this will require them to interact with higher-risk offenders. In addition, attending frequent court hearings or probation appointments might interfere with their ability to meet daily responsibilities.

Prevention Services: Individuals in this quadrant generally do not require formal substance abuse treatment services. Instead, they are best suited to a secondary prevention or early intervention approach as described previously. It is often advisable to administer these services on an individual basis or in separately stratified groups, so as to reduce their associations with higher-risk and higher-need peers.

Focus Consequences on Abstinence: For these individuals, abstinence is the proximal goal. Drug and alcohol use are under their voluntary control and should not be permitted to continue. Given that substance abuse may be the primary, if not sole, presenting problem for these individuals, it may often be appropriate to focus the case-management plan primarily on deterring this particular behavior.

ADJUSTING TRACKS

No assessment tool is perfectly reliable and valid. There will often be an appreciable number of false positives and false negatives in any drug court, meaning the assessment tools may overestimate or underestimate the level of risk or need in some cases. In addition, many drug-involved offenders may be poor informants and the information they provide may be erroneous, exaggerated, or minimized. If assessors do not have an opportunity to confirm participants' verbal self-reports by reviewing official records,

administering drug tests, or interviewing collaterals (e.g., family members), the results could be a poor or incomplete reflection of the participants' needs and risk factors.

No assessment tool is perfectly reliable and valid.

For this reason, assessment results should only be considered a starting point for initially assigning participants to tracks. A participant's subsequent performance in the program should serve as a guide for adjusting the conditions of the program. If, for example, a participant is assessed as being low risk, but then fails to attend treatment sessions or to deliver urine specimens, it might be appropriate to transfer that individual to a bi-weekly status calendar. There is no reason for a drug court to be stuck with an erroneous or ineffective assignment. During the entry procedures for the program, participants should be clearly informed that the requirements of the program can and will be adjusted based on their performance in the program.

A participant's subsequent performance in the program should serve as a guide for adjusting the conditions of the program.

Recent studies have examined what are called *adaptive interventions* in drug courts. Adaptive interventions employ *a priori* (that is, pre-specified) criteria for determining when and how to adjust services in response to participants' performance. For example, missing a pre-determined number of counseling

sessions might trigger a reassignment of a participant to a bi-weekly status calendar. Early findings suggest such methods may substantially improve outcomes in drug courts and perhaps reduce the length and cost of the program (Marlowe et al., 2008, 2009, in press). Strategies such as this might be used to adjust participants' obligations in drug court without adding undue complexity or burden for the staff.

DRUG TESTING AND OTHER SURVEILLANCE

The only way to be confident that participants are adjusting well to their assigned tracks is to regularly and continually monitor their performance in the program. Assume, for example, that a participant is erroneously assessed as being low risk and non-addicted, and is assigned to a noncompliance calendar and prevention services. If drug testing is not performed frequently, the staff may never come to learn that the participant is actually substance dependent and continuing to abuse alcohol or other drugs.

Therefore, regardless of which track participants are assigned to, they should be carefully monitored via frequent drug testing and other surveillance strategies, such as home visits. Research indicates that drug testing should generally be performed no less frequently than twice per week on a truly random basis for at least the first several months of the program (Carey et al., 2008). In addition, outcomes are better and more cost effective when community corrections officers conduct home visits and other community surveillance activities (Carey et al., 2008). By applying surveillance strategies to all participants, the drug court team can rest better assured that the requirements of the program are up to the task of serving each participant's clinical needs and prognostic risk level.

CONCLUSION

Adult drug courts elicit the most effective and cost-efficient results for offenders who are high risk and high need. There may be good reasons, however, for some drug courts to admit less-serious or less-impaired individuals into their programs. Under such circumstances, research suggests that the drug court team should modify its conditions to meet the clinical and criminological profiles of its clientele.

The only way to be confident that participants are adjusting well to their assigned tracks is to regularly and continually monitor their performance.

One way to accomplish this task is to develop alternative tracks within the drug court that are adapted to the clinical diagnosis and prognostic risk level of the participants. Procedures should be in place to continuously monitor participants' success in the tracks to ensure the program is meeting their needs and holding them suitably accountable for their actions. In this way, drug courts can make the greatest contributions to public health and public safety, while keeping a watchful eye toward the interests of taxpayers. Further research is needed to validate and improve upon these tracks and determine how best to administer them in day-to-day drug court practice.

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Test Your Knowledge: Alternative Tracks in Drug Courts

Test your new knowledge. Answer these questions based on the Fact Sheet text.

1. For high-risk participants, drug courts should:

(check all that apply)

- A Focus on sanctions more than rewards because of the risk to public safety
- B Hold status hearings at least monthly
- C Address criminal-thinking and interpersonal problem-solving issues
- D Use restrictive sanctions, such as jail or home detention, to bring about long-term abstinence from drugs and alcohol
- E Apply higher-magnitude sanctions for lying or failing to attend sessions

2. A 13-year-old boy begins to hang out with the wrong crowd and starts using cigarettes, beer, and marijuana. By the age of 15, he moves on to harder drugs and is stealing pharmaceuticals from his mother's medicine cabinet. By the time he is 16, he is chronically truant from school, committing petty thefts in the neighborhood, and selling drugs to other children at school. Now at the age of 23, he has just been arrested for burglary of a business establishment and drug possession, and he is compulsively addicted to prescription opioids. This is his third arrest. For this individual, the most effective disposition would most likely include which of the following elements:

(check all that apply)

- A Prison or jail because he is a drug dealer
- B Court hearings at least every 2 weeks
- C Vocational or educational counseling
- D A psychiatric evaluation for possible addiction medication
- E High-magnitude sanctions for positive drug tests
- F High-magnitude sanctions for missed counseling sessions

3. Poor outcomes or negative side effects have been associated with:

(check all that apply)

- A Mixing high-risk and low-risk participants together in groups
- B Providing only psycho-education to addicted individuals

C Accepting violent offenders or drug dealers into drug courts

D Providing residential treatment to non-addicted substance abusers

E The use of methadone maintenance for heroin-addicted offenders

4. A 33-year-old woman has been using methamphetamine on nearly a daily basis for more than 6 years. She had tried marijuana and alcohol occasionally before that, but didn't really like it. She supports her meth habit through prostitution, theft, and drug dealing. This is her first arrest for the attempted sale of methamphetamine to an undercover narcotics officer. She has no treatment history. For this woman, the most effective disposition would most likely include which of the following elements:

(check all that apply)

A Court hearings as needed to address poor compliance in treatment

B Psycho-educational groups addressing the dangers of drugs and alcohol

C High-magnitude sanctions for missed therapy sessions

D High-magnitude sanctions for positive drug tests

E Intensive addiction treatment

5. Research suggests urine drug testing should be:

(check all that apply)

A Performed at least once per week

B Performed on a truly random basis

C Reduced in frequency as a reward for good behavior

D Combined with other surveillance techniques, such as home visits

E Performed more frequently for high-risk and/or high-need offenders

4: A, C and E; 5: B and D

Answers: 1: C and E; 2: B, C, D and F; 3: A, B and D;