

**CHANGE-FOCUSED DRUG COURTS:
EXAMINING THE CRITICAL INGREDIENTS OF
POSITIVE BEHAVIOR CHANGE**
By Michael D. Clark, MSW, CSW

This article focuses on improving the effectiveness of the therapeutic approach in leading to positive behavior change with drug court participants. The intent is to speak to all drug court team members — especially those (judges, lawyers, probation agents) whose roles and responsibilities have not been traditionally linked to the treatment field.

New information gained from an extensive meta-analysis that reviewed 40 years of therapy outcome studies is reviewed. This important research sought to identify the ingredients of positive behavior change. The study shows that, although treatment has been found effective, no single approach or theory among the more than 200 recognized therapy models has proven to be reliably better than any other. Regardless of many claims, there are no clear “winners.” The research postulates that the effective aspects of treatment are trans-theoretical — that is, that any model’s effectiveness is due to factors that are common to all therapies. This article discusses these “four common factors”: client factors, relationship factors, hope and expectancy, and model/technique.

In applying this information to work with drug court participants, this article points to research-informed strategies — including the strength-based approach — that can translate some of therapy’s complex practices into commonsensical and usable methods for community treatment staff and drug court personnel. The goal of this article is to increase a curative approach by all who participate in the work of drug court, especially those from the non-therapeutic professional roles.

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[9] Four common factors among treatment modalities appear to be the key to treatment effectiveness.

INFLUENCE OF CLIENT FACTORS

[10] Attributes that clients possess when they enter treatment account for 40% of behavior change.

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[20] Practitioners work with the client, encouraging individual responsibility and concentrating on the client's strengths and weaknesses to help initiate change.

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IMPLICATIONS FOR
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**STRENGTH-BASED
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**STRENGTH-BASED
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[24] Staff need to work on building the alliance with clients immediately through a two-sided exchange, and monitor the client's perception of the alliance.

INTRODUCTION

The basic mission of working with challenging offenders is to induce positive behavior change. This mission has two levels. First, agency and court personnel work to secure the compliance of probationers or other offenders with the rules and requirements of the law and of their respective programs. This first level generally focuses on promoting lawful behavior, consistent attendance at school or work, family stability, and abstinence from illicit drugs and alcohol.

Progressive, more ambitious agency staffs strive for a second level of change. Their programs move beyond compliance to seek sustained and autonomous behavior change, facilitated by empowerment and personal “growth.” Regardless of program levels, the drug court field is preoccupied with a desire to find effective approaches that will modify substance-abusing behavior. This search is as consuming as it is worthwhile and necessary.

Nationally, there is public debate on the relative effectiveness of punitive, supervisory, and rehabilitative approaches in modifying substance-abusing behavior. Public policy has increasingly focused on punishment and monitoring of offenders, at the expense of treatment. One needs only to consider that seventy cents of every dollar designated for the “war on drugs” are assigned to law enforcement and interdiction on the supply side (Office of National Drug Control Policy, February 2002). At the extreme, there are some who, persuaded by the belief that addiction constitutes moral failure, call for an end to all healthcare funding for this issue; frustrated by relapse and a lack of encouraging success rates, they are dissuaded by the arguments for treatment. A recent interview with recovery expert Paul Earley, MD, conducted by Public Broadcasting journalist Bill Moyers illustrates the dilemma:

Moyers: That's the knock on treatment from people I talk to. They say, look at all the people who relapse. Look at all the people that never make it. So, why should we invest in treatment given the poor success rate?

Earley: Because it works just as well as treatment for any chronic illness. Chronic illnesses are marked by relapse. Recent data shows that. People don't comply with their anti-hypertensive medicines or their diabetic medicines to keep the diabetes under control. They do just as poorly as addicts or alcoholics do. But you don't hear people saying, "Well, you know those diabetics, they're not following their insulin regimens, so we just ought to stop giving healthcare dollars to them. Let 'em die." It's a prejudice. But what happens with addicts is that they piss people off in a big way. They piss off families and, even worse off, they piss off the police and they make people angry because they're doing something which is destructive, not only to themselves but to others. And so, it's right to be angry in some ways. If you feel angry about addiction, that's right. But let that anger be a catalyst for us to figure out how to do it better rather than [figuring out a way to] punish a person (www.thirteen.org, 2002).

At the same time that this punishment/treatment debate was occurring, the American Psychological Association (APA) supported a research initiative that assembled the world's leading outcome researchers to review forty years of psychotherapy outcomes and detail the subsequent implications for direct practice. The initial findings of this research indicate that treatment *is* effective in helping human problems. The authors of this study, Mark Hubble, Barry Duncan, and Scott Miller observe effective catalysts of positive behavior change: "Study after study,

meta-analysis, and scholarly reviews have legitimized psychologically-based or informed interventions. Regarding at least its general efficacy, few believe that therapy needs to be put to the test any longer (Hubble, Duncan, and Miller, 1999).”

Clinical outcome authors and researchers, Ted Asay and Michael Lambert, commenting on previous studies report, “These reviews leave little doubt. Therapy is effective. Treated patients fare much better than the untreated (Asay and Lambert, 1999).” These studies parallel research regarding the efficacy of treatment delivered by drug courts. Steven Belenko, reporting on drug court outcomes for the National Center on Addiction and Substance Abuse, found that there is a reduction in drug use and criminal activity while participants are in drug court programs (Belenko, 2001). Nevertheless, treatment and rehabilitation efforts are under close scrutiny and scorned by many. Gordon Bazemore and Mark Umbriet, developers of the restorative justice model, explain this scorn: “[I]t is difficult to convince most citizens that (criminal) justice treatment programs provide anything other than benefits to offenders (e.g., services...activities) while asking them for little or nothing in return (Bazemore and Umbriet, 1998).”

The punishment/treatment debate has, in fact, been worthwhile in the development of treatment approaches. Restorative justice expert Robert Coates reports, “The debate has had its impact upon practice, forcing practitioners to be even more thoughtful in developing intervention strategies. The debate about the value of rehabilitation has had considerable positive effect on rehabilitation efforts. More attention is being directed at how caseworkers and others can have positive impact on the client and on the client’s social network (Coates, 1998).”

Although the APA research examined psychotherapy outcomes, its findings also are critically important to the treatment initiatives of remedial drug court work. Regarding this research into the effectual elements of treatment, John J. Murphy, a proponent of strength-based strategies in the field of education, states: “[T]he empirical evidence...has profound implications for the manner in which practitioners approach clients of any age and in any setting (Murphy, 1999).”

COMMON FACTORS

Having concluded that treatment is effective, the APA’s study made a second finding that is at least equally significant: None of the numerous treatment models studied has proven to be reliably better than any other (Hubble, Duncan, and Miller, 1999). Barry Duncan and Scott Miller report: “Despite the fortunes spent on weekend workshops selling the latest fashion, the competition among the more than 200 therapeutic schools amounts to little more than the competition among aspirin, Advil, and Tylenol. All of them relieve pain and work better than no treatment at all. None stands head and shoulders above the rest (Miller, Duncan, and Hubble, 1997).” This conclusion has been repeatedly upheld in subsequent studies (Miller, Duncan, and Hubble, 1997).

[9] If no theory or model can claim that it is better than the others, then what accounts for the overall efficacy of treatment? Researchers, including Michael Lambert and Mark Hubble, sifted through four decades of outcome data to postulate that the beneficial effects of treatment largely result from processes shared by the various models and their recommended techniques (Lambert, 1992; Hubble, Duncan, and Miller, 1999). Simply put, similarities, rather than differences, in the various models seem to be responsible for change. Each of the varied treatment models aids change by accessing certain common factors that, when present, have

curative powers. Lambert concluded from extensive research data that there were four of these common factors (Lambert, 1992):

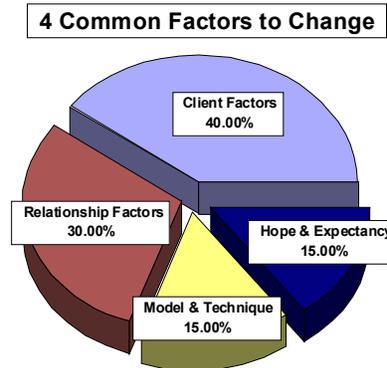
- Client factors — the client's preexisting assets and challenges;
- Relationship factors — the connection between client and staff;
- Hope and expectancy — the client's expectation that therapeutic work will lead to positive change; and
- Model/technique — staff procedures, techniques, and beliefs.

These factors that raise the effectiveness of treatment are trans-theoretical — that is, all of the various treatment theories and approaches recognize their importance to some degree. Without intentionally focusing on them, all therapies seem to be more effective when they promote these common factors in their own unique ways.

Hubble, Duncan, and Miller speak to this important research finding:

In 1992, Brigham Young University's Michael Lambert proposed four therapeutic factors...as the principal elements accounting for improvement in clients. Although not derived from strict statistical analysis, he wrote that they embody what empirical studies suggest about psychotherapy outcome. Lambert added that the research base for this interpretation for the factors was extensive; spanned decades; dealt with a large number of adult disorders and a variety of research designs, including naturalistic observations, epidemiological studies, comparative clinical trials, and experimental analogues (Hubble, Duncan, and Miller, 1999).

Hubble, Duncan, and Miller also drew upon Lambert's earlier work that rated some factors as more influential in changing behavior than others and ascribed a weighting scale to them. Lambert then ranked and prioritized the common factors according to their amount of influence on positive behavior change. With 100 percent representing a total positive behavior change, Figure 1 depicts the four factors and their percentage contribution to positive change.



Lambert, 1992

Figure 1.

Source: Lambert, M.J. (1992). Psychotherapy outcome research: implications for integrative and eclectic therapists. In J.C. Norcross, & M.R. Goldfried (Eds.), *Handbook of psychotherapy integration*. New York, NY: Basic Books.

Client Factors

[10] According to Lambert, client factors — not what offenders and their families receive from staff, but what they possess as they enter the doors of our drug courts and agencies — are the largest contributor to behavior change (forty percent). Client factors are both internal (optimism, skills, interests, social proclivities, aspirations, past successes) and external (a helpful uncle, employment, membership in a faith community). Client factors also include fortuitous events that are controlled by neither the

drug court staff nor the program participant: an abusing boyfriend moving out and away from the family, a chance school or employment experience instilling renewed interest, a lesson “hitting home” as, for example, when a close friend or peer is seriously harmed by illicit drug use.

The difficulties of encouraging referrals to participate in treatment are two-fold: first, staff must build trust and find effective methods to encourage those in treatment to participate. Second, staff must be persuaded to break the ‘norm’ of dictating behavior, and allow participants increased choice and autonomy.

Many treatment programs are not individualized (regardless of their claims), nor do they offer true choices in programming. Furthermore, staff often resists client input. The views and opinions of participants may be markedly different from those of staff. Consequently, staff may be resistant to seeking and integrating input from participants about “what works” in their own treatment. Staff should recognize that acknowledging and accepting the beliefs and positions of a participant is not the same as agreeing with or acquiescing to them.

Such an approach affirms the participant’s role in his or her treatment. Indeed, the common-factors research confirmed just this point: that it is the drug court defendant and his or her family, not the staff or providers, who make treatment work. This finding does not indicate that program structure or staff efforts are useless. It does suggest, however, that the instruction in interventions and treatment models offered by universities and training institutes may be more effective if coupled with a focus on the input of those actually in treatment.

Duncan and Miller summarize this research by noting the real ‘engine’ of change is the client, thus implying that

our time might be better utilized by finding more ways to employ the client in the process of change (Duncan and Miller, 2000). Ironically, what it takes to realize difficult behavior change in the real world is not always fostered or modeled during staff-client interactions. Change rests with a participant's full participation, energy and commitment. However, if staff assumes a role where their ideas and expertise consistently trump those of the client, the participant is relegated to a passive role. If a client's experiences and know-how are subjugated to the wisdom and methods of the professional, then the term drug court "participant" could well be in danger of becoming an incongruous or contradictory term.

Many research endeavors examine the process of engagement and work with voluntary clients. This context is not always comparable to the mandated nature of drug court efforts. Drug court clients are generally conceived of as "involuntary," where withdrawal from substance use is a non-negotiable mandate. While keeping our directives in focus, it is important to consider we have more latitude in allowing greater participant input, both in how one might strive for sobriety and how one might sustain it.

Therapeutic Relationship Factors

[11] Relationship factors, or therapeutic alliance, make up about thirty percent of the contribution to change. *Alliance* means the extent that the counselor and client can collaborate. Conditions that engender an alliance include reciprocal understanding, mutual affirmation, emotional attachment and respect (Lambert, 1992). *Relationship* means the strength of the alliance that develops between the program participant and staff. Relationship factors include perceived empathy, acceptance, warmth, and self-expression (Lambert, 1992).

Perceived Empathy

[12] Communication studies consistently report that verbal communication is prone to error; the listener does not always receive the complete message (Anderson, 1997; Seligman, 2000). Parts of the intended message are either inadequately articulated by the speaker or incorrectly understood by the listener. A dialogue between two people resembles listening to a cell phone that crackles with static from weak reception: even if one listens closely, much of the transmission will be garbled or missing.

Perceived empathy involves a drug court participant's belief that they are listened to and understood. Relationships develop as staff becomes committed to understanding their clients and make consistent efforts toward "filling in the gaps" of communication. An important technique for improving communication is "reflective listening," in which the staff member constantly checks the accuracy of what he or she believes the client has said. This author believes that most staff members, regardless of whether they have previously been trained in reflective listening, seldom, if ever, use this technique. The technique is simple to understand but difficult to use consistently and correctly.

Evidence shows that "accurate empathy" is a condition of behavior change. William Miller and Stephen Rollnick state: "Accurate empathy involves skillful reflective listening that clarifies and amplifies the client's own experiencing and meaning, without imposing the therapist's own material. Accurate empathy has been found to promote therapeutic change in general and recovery from addictive behaviors in particular (Miller and Rollnick, 1991)." Compliance can occur without the program participant feeling understood, but real change cannot.

Perceived empathy is a term that corrects a previous bias in research. Most outcome studies measured empathy and the strength of the staff-client alliance through counselor reports. But in fact, the drug court participant's assessment of the alliance matters more. Experts on the therapeutic relationship and authors of the 1999 book, *How Clients Make Therapy Work: The process of active self-healing*, Karen Tallman and Arthur Bohart, report "[f]indings abound that the client's perceptions of the relationship or alliance, more so than the counselor's, correlate more highly with therapeutic outcome (Tallman and Bohart, 1999)." Further research completed at the University of Quebec by Canadian psychologist Alexandra Bachelor found that the client's perception of the alliance is a stronger predictor of outcome than the counselor's view (Bachelor, 1991).

The tendency to privilege staff evaluations over clients' perceptions occurs frequently in justice work. For example, while providing onsite technical assistance to an established juvenile drug court, the author experienced a chance encounter with a group of juvenile probationers who were milling outside the court building awaiting their weekly progress review hearings. The author began an impromptu conversation, inquiring as to their personal evaluations of their drug court program. Their responses were both forthcoming and enthusiastic. Encouraged, the author brought this information to the next staff meeting, only to find that the program staff members immediately dismissed this important information because of its source.

Acceptance

Acceptance relates to the extent that any treatment program fits into the participant's and family's worldview and beliefs. Kazdin (1980) found that the client's ability to accept a particular procedure is a major determinant of its use and ultimate success (Kazdin, 1980).

[13] More recent studies found a greater acceptance of treatment and better compliance with interventions when rationales were congruent with clients' perceptions of themselves, the target problems, and the clients' ideas for changing their lives (Conoley, 1991; as cited in Duncan and Miller, 2000).

An acid test for any drug court program lies in the answer to the question, "To what extent are interventions predetermined?" That is, are participants turned into passive recipients of prepackaged programming, or is programming flexible enough that it may be customized to the individual? Progressive drug court programs make an effort to include clients and promote their participation. In workshops on strength-based programming, many staff are surprised to learn that they have more leeway to alter and adapt programming than they first believed. The results of this effort can be remarkable. As solution-focused therapy expert John Murphy notes, "The notion of acceptability reflects good common sense: people tend to do what makes sense to them and what they believe will work. It is hardly profound to suggest that the best way to determine what is appealing and feasible for a person is '*to ask them*' (Emphasis added) (Murphy, 1999)." In this "asking" profound differences in efficacy are realized. Solution-focused therapists Ben Furman and Tapani Ahola report that the counselor-client relationship is developed and the alliance strengthened as clients and their families are allowed to have a say in defining the problem[s], setting goals, and deciding what methods or tasks will be used to reach those goals (Furman and Ahola, 1992).

Drug court team members have extenuating circumstances to consider when allowing client participation at this advanced level. In the mandated arena of drug court programs, abstinence from drugs and alcohol is a primary

goal that is non-negotiable — the goal remains in force whether the participant agrees or not. However, the drug court can still seek the client’s thoughts and possible ideas for his or her ideas to achieve that goal. Drug courts should be analogous to a job hunter who wanders a community career fair looking for the most interesting and profitable “fit” with prospective employers. Programs should allow choices to be made across a “smorgasbord” of treatment options, allowing the referral to choose the option that is most relevant to them. Being allowed to choose (or collaboratively design) a treatment option that makes sense to the participant — aligned with the participant’s age, gender, culture, way of thinking/life experiences — will increase the participant’s motivation to participate. John Murphy is clear as to this effort, “[t]he therapeutic alliance is enhanced by ... [t]ailoring therapeutic tasks and suggestions to the client instead of requiring the client to conform to the therapist’s chosen model and beliefs (Murphy, 1999).” A previous justice article on strength-based practice argues that programs need to stay close to the probationer’s and family’s definition of the problem (and their own unique methods), as they are the ones who will be asked to make the necessary changes (Clark, 1998). Researchers who have studied the influence of hope and expectations on counseling outcomes, C.R. Snyder, Scott Michael, and Jennifer Cheavens echo this idea, arguing that staff must listen closely to program participants. If staff do not, they may establish therapeutic goals “that are more for the helper than for the helped (Snyder, Michael, and Cheavens, 1999).”

Warmth/Self-Expression

[14] These two conditions for building relationships are intertwined. Extending warmth (attention, concern, and interest) occurs in tandem with allowing a drug court client’s self-expression. All staff must understand and embrace a long-held credo from the counseling field: Listening is

curative. As Karen Tallman and Arthur Bohart report, “Research strongly suggests that what clients find helpful in therapy has little to do with the techniques that therapists find so important. The most helpful factor [is] having a time and a place to focus on themselves and talk (Tallman and Bohart, 1999).” Others have found that giving traumatized individuals a chance to “tell their story” and engage in “account making” is a pathway to healing. A rather obscure but interesting earlier study showed that paying juvenile delinquents to talk into a tape recorder about their problems and experiences led to meaningful improvements in their behavior, including fewer arrests (Tallman and Bohart, 1999).

Staff would be wise to critically examine their methods in building alliances with participants, both programmatically and individually. Duncan and Miller state emphatically, “Clients’ favorable ratings of the alliance are the best predictors of success — more predictive than diagnosis, approach, counselor or any other variable (Duncan and Miller, 2000).”

Hope and Expectancy

[15] The next contributor to change (fifteen percent) is hope and expectancy; that is, the referral’s hope and expectancy that change will occur as a result of entering drug court programming. This author believes that in practice, staff may encourage hope and expectancy by (1) conveying an attitude of hope without minimizing the problems and pain that accompany the offender’s situation; (2) turning the focus of treatment toward the present and future instead of the past; and (3) instilling a sense of empowerment and possibility to counteract the demoralization and passive resignation often found in drug court participants who have persistent problems.

Conveying an Attitude of Hope without Minimizing the Problem

[16] Instilling hope has more complexity than simple encouragement. Participants need to believe that taking part in drug court programming will improve their situation. Therefore, during the orientation phase of programming, many successful drug court programs provide convincing testimonials of success and program efficacy. Researchers on the condition of hope, Snyder, Michael, and Cheavens, indicate that the new client must sense that the assigned staff member, working in that particular setting, has helped others reach their goals (Snyder, Michael, and Cheavens, 1999).

Troubled participants and their families often feel “stuck” in problem states. This feeling can be based partly on negative attitudes that allow no escape from problems (i.e., “I *can’t* change,” “You don’t understand — I *have* to hang out with my using friends”). Strength-based work may instill hope while also acknowledging problems and pain. One strength-based strategy encourages staff to allow the participant’s problem to coexist with the emerging solution. In many instances within remedial drug court work (and throughout the helping professions), there is a mindset to conquer, eliminate, or “kill” the problem. Oftentimes it is helpful and much more expedient to allow the problem to remain, to coexist with an emerging solution or healthy behavior that is being developed.

Bill O’Hanlon, a strength-based author and therapist, describes a helpful metaphor that originated in an old vaudeville routine: Two ingratiating waiters approaching the narrow kitchen door repeatedly defer to the other. “After you,” one offers. “No, please, after you,” the other replies. Finally, at the same moment, they both decide to act and turn into the door simultaneously, only to wedge their shoulders in the small opening. O’Hanlon advises adult staff to consider

the idea of “creating a second door” and allowing conflicting feelings and conditions to coexist (O’Hanlon, 2000). A client could feel scared and hopeless about his ability to begin abstinence from drugs and yet marshal the confidence to avoid using “just for today.” A painfully shy young woman may simultaneously fear the crowded gathering and yet find the courage to join it. Trying to convince the shy client that there’s “no need to be shy,” or that there’s “nothing to be afraid of,” is an uphill climb with dubious results. The conflicting dichotomies of continuing drug use or movements toward sobriety, hesitancy or action, fear or confidence may exist as “both/and” rather than being framed as an “either/or” choice. Staff need not eliminate the negative to instill the positive.

This is not just a meaningless play on words. There is a popular slogan among practitioners of strength-based approaches: “The person is not the problem; the problem is the problem.” Strength-based practice takes that idea a step further to assert that the problem is actually the person’s *relationship* to the problem.

Becoming Future-Focused

[17] Focusing on past failures usually results in demoralization and resignation. Hope is future-focused. When any drug court staff member keeps remedial efforts focused on the future, positive outcomes are enhanced (Clark, 1998).¹ The “problem” is generally found in the present and its roots in the past. The “solution,” however, is generally started in the present with efforts aimed at the future.

European therapists Ben Furman and Tapani Ahola, authors of the book, *Solution Talk: Hosting Therapeutic Conversations*, report that the single most useful thing

¹ I have described future-focused questions that help orient both youth and staff to solution building.

remedial staff could do in the time they spend with troubled drug court clients is to get them to look ahead and describe what is happening when the problem is envisioned as “solved,” or is not considered to be as bad (Furman and Ahola, 1992). These therapists, using strength-based strategies, believe that if goals are to be immediately helpful and meaningful to the program participant and family, they must first be conceived and constructed through visions of a “problem-free future.” It is through this forward looking, “harnessing” of the future, that goals for present actions (first steps) become known (Furman and Ahola, 1992).

An important way to “harness” the future is by employing “miracle,” or outcome-questions (Berg and Miller, 1992): “What if you go to sleep tonight and a miracle happens and the problems that brought you into this drug court are solved?” “Because you are asleep, you don’t know the miracle happened. When you wake up tomorrow, what would you notice as you go about your day that tells you a miracle has happened and things are different?” “What else?” “Imagine, for a moment, that we are now six months or more in the future, after we have worked together and the problems that brought you to our drug court have been solved. What will be different in your life, six months from now, that will tell you the problem is solved?” “What else?”

The miracle question is the hallmark of the solution-focused therapy model. A “miracle” in this context is simply the present or future without the problem. By this treatment method, the counselor orients the drug court participant and family toward their desired outcome by helping them construct a different future. Helping a participant and family establish goals needs to be preceded by an understanding of what they want to happen. If therapists find no past successes to build on, they may help the family form a different future by imagining a “miracle.” As many justice workers have experienced, it often is difficult to stop a family from

engaging in “problem talk” and to start searching for solutions. If a program participant and family are prompted to imagine a positive future, they may begin to view their present difficulties as transitory. The miracle question is used to identify the client’s goals to reach program completion or other successful criteria.

The miracle question is followed by other questions that shape the evolving description into small, specific behavioral goals: “What will be the smallest sign that this (outcome) is happening?” “When you are no longer (using drugs, breaking the law, etc.), what will you be doing instead?” “What will be the first sign this is happening?” “What do you know about (yourself, your family, your past) that tells you this could happen for you (DeJong and Berg, 2002)?”

Empowerment and Possibility

[18] Drug court programs encourage hope and expectancy when they help clients establish goals and act to realize them. All programs will list large (macro) outcomes or final goals to reach graduation and program completion. Similarly, most remedial plans are established for large issues and long-standing presenting complaints. These plans usually list large problem behaviors to be resolved by a specified date set many months into the future. The problem is that these goals are too big for day-to-day work. Instead, efficacious goal setting should “think small.” Goals should be shaped into small steps. According to the “one-week rule” of strength-based practice, a worker and a drug court participant should never mutually establish any goal that cannot be reached in the next seven days. Some staff go further and employ a “48-hour rule” to make a goal seem more obtainable and to begin behavior change. Short time frames propel “first steps” and put into motion small

incremental movements to change. “What can you do after you get home today? By tomorrow afternoon?”

Snyder, Michael, and Cheavens found that a large portion of client improvement, studies suggesting as much as 56% to 71% of total client change, can occur in the early stages of treatment (Snyder, Michael, and Cheavens, 1999). Interestingly, this improvement happens before clients learn the methods or strategies for change that programs stand ready to teach. How could change begin to occur before program direction, teaching, and support may be delivered? These motivational researchers posit:

As Ilardi and Craighead (1994) pointed out, clients have usually not even learned the supposedly “active” mechanism for change by the time improvement occurs in these early stages of treatment. Rather, the rapid response of clients must be a product of the common factors — especially hope. On this point, several researchers and authors have highlighted the pivotal role that hope plays in early and subsequent improvement in psychotherapy... (Snyder, Michael, and Cheavens, 1999).

Ilardi and Craighead note that the instillation of hope and expectancy of change is not simply a precondition for change; it is change (Snyder, Michael, and Cheavens, 1999).

Model and Technique

[19] Another small contributor to change may be found in model and technique (fifteen percent): staff procedures, techniques, and beliefs, broadly defined as our therapeutic structure and healing rituals. It is humbling to consider that a majority of what practitioners have been taught — the various models of interventions and their suggested techniques — might well constitute one of the

smallest contributions to change. Furthermore, programs and techniques are deemed helpful only to the extent that they promote the other common factors.

Nevertheless, the strategies and methods that staff provides to drug court participants are helpful, yet for reasons that are contrary to popular beliefs. Tallman and Bohart explain:

Clients utilize and tailor what each approach provides to address their problems. Even *if* different techniques have different specific effects, clients take these effects, individualize them to their specific purposes, and use them. ... In short, what turns out to be most important is how each client uses the device or method, more than the device or method itself. Clients then are the “magicians” with the special healing powers. [Staff] set the stage and serves as assistants who provide the conditions under which this magic can operate. They do not provide the magic, although they may provide means for mobilizing, channeling, and focusing the client’s magic (Emphasis in original) (Tallman and Bohart, 1999).

It appears that, rather than mediating change directly, techniques used by staff simply activate the natural healing propensity of participants. Therefore, it is important to use techniques and develop requirements that facilitate a participant’s progress.

The Strengths Approach

[20] This study of the common factors becomes the research pillars for the strengths approach in the helping professions (Saleebey, 1992; 1997; 2002; Clark, 1998; 2001a). The Strength-based approach is an emerging movement that has caught the attention of many who work

with court-mandated (involuntary) clients. Recent efforts have applied this approach to criminal justice, juvenile delinquency, and drug courts (Clark, 1997b; 1999; 2001a; 2001b). These justice workers have favored a strength-based practice approach because it uncovers and makes use of clients' preexisting abilities (Clark, 1995b; 1997b; 1998). The strength-based approach is drawn from numerous positive models of potential, optimism, and possibility, including the strengths perspective (Saleebey, 1992; 1997; 2002), resilience (Werner and Smith, 1992; S.J. Wolin and S. Wolin, 1993; Fraser, 1997), optimism (Seligman, 1991), hardiness (Kobasa, 1979), asset-building (Benson, 1997), empowerment (Gutiérrez, Parsons, and Cox, 1998), motivational interviewing (Miller and Rollnick, 1991), and solution-focused approaches (Berg and Miller, 1992; Clark, 1996; 1997a; Berg, et al., 1998; Berg and Reuss, 1998; DeJong and Berg, 1998). The goal of strength-based practice is to encourage the individual's sense of responsibility for his or her actions, thereby altering law-breaking behavior. This approach does so by considering the science of positive behavior change. Interests and efforts are aimed at *initiating* positive movements, or beginning the "first steps" necessary to change the trajectory of one's life. The strength-based approach is not so much a collection of techniques to apply *on* someone as it is the efforts or goals treatment providers should strive to achieve *with* the client. This approach focuses more on what the client has rather than what he or she does not have; it considers the successes of the clients and families, rather than their failures. The approach works to resolve presenting problems through a focus on potential rather than pathology.

The strengths approach also encourages a balanced view of the individual's weaknesses and strengths. Consider that deficit-based work can engender a myopic view of clients by considering only their problems and failures. This reductive slant can obscure the difference between the terms

“accurate” and “balanced.” The contrast between these terms can be found in a simple analogy. If anyone were assigned to shadow a drug court professional for a full day, watching for and listing only their failures and shortcomings, there could be ample foibles to report at the end of any twenty-four hour period. Assuming this full day report was factual and error-free; the information could be reported as *accurate*. However accurate, it would not represent a balanced or equilibrate view of this person. There would be a second dimension of strengths, merit and successes left unreported and (more importantly) unused. Some staff might champion the accuracy of their negative observations as they draw conclusions about clients, yet strength-based practitioners bemoan the lack of thoroughness and integrity. Strength-based practice calls for a balanced consideration of a client, reporting and considering failure and success, mistakes and accomplishments, pathology and potential. Adopting a balanced view can pay a double-dividend: marshaling more resources to resolve presenting problems while lending more credence and respect to the participant — necessary ingredients to increase motivation and cooperation.

Martin Seligman, past president of the APA and advocate of a strengths revival in the field of psychology (Positive Psychology), called on the alcohol and other drug (AOD) treatment field to “learn how to build the qualities that help individuals and communities, not just to endure and survive, but also to flourish (Seligman, 2000).” Drug court work should not only fix what is wrong, but nurture what is best. The strength-based model, because it focuses on the common factors, facilitates this process.

IMPLICATIONS FOR PRACTICE

Certain issues and opportunities arise in revising programs to incorporate strength-based techniques.

[21] 1. All drug court team members can become *change-focused*.

Duncan and Miller list several interesting research findings regarding drug court team members in direct service roles (Duncan and Miller, 2000):

- Andrew Christensen and Neil Jacobson, in their evaluation of counselor effectiveness with clients, found no differences between professionals and paraprofessionals or between more and less experienced therapists (Christensen and Jacobson, 1994).
- Hans Strupp and Suzanne Hadley found that experienced therapists were no more helpful than a group of untrained college professors (Strupp and Hadley, 1979).
- Jacobson (1995) determined that novice graduate students were more effective at couples' therapy than trained professionals (Jacobson, 1985).

It may be surprising to learn that there is little or no difference in effectiveness regardless of training and experience. It is not the author's intent to impugn credentials or expertise. Rather, these findings convey that these novices or paraprofessionals were able to match treatment effectiveness by somehow integrating the common factors where the trained professionals may have lost sight of what was truly effective.

Indeed, the findings offer important support to drug court staff. Knowledge of the four common factors penetrates the mystique surrounding "therapy" and illuminates what is truly "therapeutic": positive behavior change. By applying strength-based techniques in their work, more staff members (across multiple disciplines) may begin to build the all-important alliance with clients and work to enhance the factors of change with drug court referrals and their families. Because of the complexity found in many presenting problems, professional therapy and therapeutic

treatment will always be needed as adjunct services to specialty courts. The “good news” of this common factors research is that therapeutic work is not just the domain of treatment professionals. All professionals working with drug court participants, especially judges, lawyers and probation agents may adopt and utilize techniques that most effectively induce positive behavior change.

A further issue with becoming changed-focused involves the alcohol and drug abuse treatment field’s use of mental health diagnoses. Although a diagnosis may be very helpful in providing information and direction for subsequent treatment efforts, Duncan and Miller note that the rendering of a diagnosis itself could also impede change. Establishing a diagnosis is akin to taking a “snapshot” — a moment-in-time photograph. The problem is that a diagnosis conveys the idea that conditions and behaviors described by the diagnosis are static and constant, even permanent. The author believes that strength-based practitioners, however, offer a different — and far more productive view of the reported problems:

The magnitude, severity, and frequency of problems are in flux, constantly changing. In this regard, clients will report better and worse days, times free of symptoms, and moments when their problems seem to get the best of them. With or without prompting, they can describe these changes – the ebb and flow of the problem’s presence and ascendancy in their daily affairs. From this standpoint, it might be said that change itself is a powerful client factor, affecting the lives of clients before, during, and after (treatment) (Duncan and Miller, 2000).

Carol Lankton, who has authored several books and articles on strength-based approaches cautions, “We find what we look for and expect to find. To *perceive* is to make choices in interpretation (Emphasis added) (Lankton, 1994).” It does

not help anyone to see problem behavior as fixed or static or to view the person who engages in the behavior as “damaged goods” and incapable of change.

Viewing drug court participants through a change-focused lens, listening and remaining alert to how they are changing, will help staff recognize the participants’ resources and the strengths that are enabling and supporting their progress (Clark, 1996; 1997b; 2001a; Berg and Reuss, 1998). Staff may utilize two lines of inquiry to help identify this change. First, questions could be asked about “pretreatment change”: “After serious trouble has occurred, many people notice good changes have already started before they start in our drug court. What changes have you noticed in your situation? How is this different from before? How did you get these changes to happen?”

Numerous studies from the counseling field have found that a majority of clients make significant changes in their problem patterns in the time between scheduling their initial appointment and actually entering treatment (Berg, 1994). Just experiencing some type of start or initiation of change can begin positive movement. Single-subject research has recorded similar responses from youth and families newly assigned to the author’s juvenile probation caseload (Clark, 1995a). The important point is that client and family rarely report these changes spontaneously. Staff must ask questions about these changes or they remain hidden. Many believe that if problems are ignored, they seem to move underground, where they grow and fester and return even stronger. However, when solutions are ignored, they simply fade away unnoticed and, more importantly, remain unused.

The second (and ongoing) line of inquiry identifies change that occurs between appointments or program sessions. When change is found, drug court staff need to

investigate and amplify: “How did you do this?” “How did you know that would work?” “How did you manage to take this important step to turn things around?” “What does this say about you?” “What would you need to do to keep this going (do this again) (Clark, 1998)?”

When sitting down with a participant during a scheduled report time, many staff will check on issues by using a preformed mental list of questions. These questions become routine: “Were there any violations of program rules this week?” “Have all urine drops been ‘clean’?” “Are you in compliance with all program requirements?” “Have you missed any school/work this past week?” “Have you made all treatment sessions since our last meeting?” These questions are important, but they do not represent a full line of inquiry. When inquiries become routine, they narrow the investigation and bypass many other instances of change. Open-ended questions that search for positive changes should be asked as well.

Finally, becoming change-focused summons drug court teams to be students of motivation and behavior change. Drug court teams would be wise to consider how the Motivational Interviewing model integrates two theories of motivation and self-change (Miller, Rollnick, and Moyers, 1998). The first involves value/expectancy theory, where the participant attempts to answer the initial questions, “Should I do this?” “Is this me?” Or more specifically, “*Why* should I do this?” Motivational Interviewing model developers William R. Miller and Stephen Rollnick believe “why” is an important issue that must be resolved, and participants usually wrestle with resolving this issue at the initial or earliest stage of treatment.

Participants will then move to grapple with a second important issue — self-efficacy theory. Here, participants attempt to answer the questions, “Now that I’ve decided I

should do this...can I?" "Do I have the skills?" "Is this too hard for me (Miller, Rollnick, and Moyers, 1998)?" Regarding self-efficacy issues, researchers Snyder, Michael, and Cheavens call for interventions to raise self-efficacy by employing two efforts. First, inducing "personal-efficacy thinking" (e.g., "I *can* do it") and then setting mutual, concrete, and obtainable goals to enhance "pathways thinking" (e.g., "Here's *how* I do it") (Snyder, Michael, and Cheavens, 1999).

Instilling self-efficacy is critical. Motivation experts Miller and Rollnick caution that programs can bombard incoming participants with prescriptive advice on "how to" change, while the participant is still deciding whether to change, and finding the commitment to change (Miller and Rollnick, 1991). Miller and Rollnick believe that giving prescriptive advice too early can steal focus from these early value decisions and can actually impede motivation.

The author has advised drug court staff to focus program retreats on these two theories for revising their programs and practices. Drug court teams can easily spend a morning examining the motivational issues embedded in the participant dilemma "why should I change" and then spend the afternoon examining the two self-efficacy issues of "can I do this" (personal-efficacy thinking) and "how do I do this" (pathways thinking). Meeting these two conditions helps turn the wheel of behavior change.

[22] 2. Staff should share the "expert" role with the participant and family.

Staff has become accustomed to guiding and directing participants. Although dispensing advice and setting limits will always be a part of the staff's work, the common-factors research suggests that staff members must share the lead with participants and their families in order to

improve treatment outcomes. Regarding this, several issues are worth noting.

First, as encouraging as this common-factors research is to some, it may be considered threatening to others. Treatment providers or other staff may feel their treatment experience and conventional roles are being called into question. A balance must be struck between the experience and expertise of the drug court team member and the inclusion of the common factors for effective service delivery. Professional expertise will still be required and in great demand for working with clients, but the strategies that professionals employ will make a significant difference to whether they succeed. To be a committed advocate of change requires a focus not on technique but on the client (i.e., the participant and his or her family) as the common denominator in behavior change. Duncan and Miller address this change of focus: “Models that help the therapist approach the client’s goals differently, establish a better match with the client’s world view, capitalize on chance events, or utilize environmental supports are likely to prove the most beneficial in resolving a treatment impasse (Duncan and Miller, 2000).”

Second, staff may be skeptical of the exact implications of the common-factors research. For example, staff may think that sharing the expert role with challenging drug court clients means that they are to acquiesce to the stated immature or illogical desires of the participant with whom they are working. In fact, staff should not. Any goals stated by the client that are not interdependent with healthy relationships or that jeopardize health and safety (their own or others’) are unacceptable. Staff may understand without agreeing, however, and they may identify without acquiescing.

Adopting a strength-based approach means reconfiguring our notions of accountability. Sharing the

expert role involves a review of accountability. Quite simply, current work that favors the views of professional staff over those of the client places too much responsibility for change on the shoulders of staff.

To provide a more thorough explanation of this approach requires first removing a commonly held misconception about strength-based practice. Some critics believe the ultimate goal of strength-based practice is naively centered on establishing a positive relationship. They also mistakenly assume that the staff member is compelled to give the client Pollyanna-like compliments, even in the face of the client's obvious wrongdoing and personal chaos (i.e., telling a shoplifter that he is "skillful" or re-framing drug dealing as demonstrating "fiscal competence"). Although it is true that a positive relationship and compliments have an important place in the strength-based approach, they are only important for their capacity to foster behavior change and help clients rise above their difficulties. If complimenting clients to ensure a positive relationship is an end to itself, it becomes a narcissistic enterprise. Staff engaged in drug court must challenge clients to move beyond their difficulties and help them marshal strengths to meet those challenges.

Compare how both the traditional and strengths-based approaches regard accountability. The traditional or current problem-solving approaches entrenched in the treatment field require staff to work hard at understanding the problem, ascertaining who is responsible, learning of the problem's origins, and discovering how it is maintained. Accountability is realized when a participant owns up to the wrong. Admission is paramount for the assumption of responsibility. Strength-based practice, on the other hand, does not assume that the ownership of guilt is somehow automatically curative.

Consider an idea forwarded by Jacobs from the sports psychology field (Jacobs, 1995). When an athlete has performed poorly, the coach spends little time reviewing the error or fixing blame before beginning corrective work. In the sports model, coaches are discouraged from waiting for the athlete to verbally assume responsibility or to assume responsibility passively. Instead, once the athlete understands what he or she has done wrong, the coach quickly reviews the error and focuses on encouraging behavior change. Accountability and responsibility for a negative performance are assumed when the athlete begins to change his or her performance.

Insoo Berg, co-founder of the solution-focused therapy model, has reported that the problem-focused model and its emphasis on moving the offender merely to “own up to the guilt” about the past does not hold the offender sufficiently responsible for change in the future (Berg, 1995). Moreover, too much time and energy are spent determining the causal relationship rather than expecting and demanding changes. The strength-based approach holds that accountability is realized through behavior change, not passive admission. From the beginning of contact, there is an expectation that the drug court participant will *do something* about the immediate concern. Strength-based practice is based on the belief that starting “first steps” and initiating action are all-important.

When staff views are favored over those of clients, staff indirectly assumes too much responsibility for change—which should rest instead with the client. For this reason, some strength-based agencies assist a client with writing his or her own reports to the court. The client then continues this process by verbally delivering his or her progress summary directly to the judge during the court hearing. The author believes that ownership of the treatment plan (and, consequently, empowerment) is thereby increased.

Third, staff may be reluctant to invite more participation, or to share the lead with a client if they believe their clients are not up to the task. Indeed, some clients may be troubled and causing trouble to others; yet the vast majority of clients are also capable and competent to begin and sustain needed changes. Consider the perplexing research cited by Anthony Maluccio, professor of social work at Boston College, which found that workers consistently underestimated client strengths and had more negative perceptions of clients and their ability to change *than the clients had of themselves* (Emphasis added) (Maluccio, 1979). Drug court teams must guard against an “us versus them” attitude.

Although many believe the strengths approach offers advantages for raising client motivation, the justice field continues a steady diet of finding, diagnosing, and treating failure and pathology (Clark, 2001b). But if practitioners believe clients and family members have strengths, practitioners may then look for and find them to use in their work with their clients.

Strength-based work asks staff members to forgo this pessimism and take an optimistic view. In their book, *Re-Educating Troubled Youth*, strength-based advocates Larry Brendtro and Arlin Ness give a good description of this dichotomy within juvenile justice:

[S]ome might argue that optimism about antisocial youth is itself a thinking error, a Pollyanna illusion that nasty kids are really little cherubs. However, pessimism is seldom useful and often leads to feelings of powerlessness, frustration, and depression. In contrast, optimism feeds a sense of efficacy and motivates coping and adaptive behavior, even in the face of difficult odds (Brendtro and Ness, 1983).

Forty years of motivational research has provided ample evidence supporting this optimistic view. Motivational researchers Leake and King found that if you expect that change will occur with your clients, your expectation of change will influence their behavior (Miller and Rollnick, 1991). A drug court staff member's belief in the participant's ability to change can be a significant determinant of treatment outcome. Norman Cousins, who published landmark research at California's UCLA Medical School regarding the power of optimism in disease management, also found that helping efforts are more effective when the staff member believes in the client's capabilities and believes that the client can surmount the obstacles to positive behavior (Cousins, 1989). Believing in the client is the axis around which this model turns.

The reverse also may be true. Staff could approach a client with negative expectations, expecting very little if not the worst. One on-site drug court evaluation, which included a review of the orientation materials distributed to all prospective participants beginning the referral process, found twelve sanctions listed for breaking program rules and only five incentives for successful participation. The staff obviously expected that participants would resist and break the rules — and communicated that expectation to incoming referrals. In fact, this was not the staff's intent; they revised their materials to incorporate a more equal ratio of incentives and sanctions.

[23] 3. Treatment should not simply fix what is broken; it should nurture what is best.

Fixing what is broken or solving a problem only returns someone to equilibrium. The strengths perspective finds that the "good life" entails more than simply removing what is wrong. Compliance and obedience are critically important first steps, but they are poor final outcomes. Final

outcomes should target positive change and growth. At one point, the field of psychiatry had become so slanted to the negative that when a client under assessment was found not to have any problems they were described as “asymptomatic.” Health is more than the absence of illness.

The necessary and defining characteristics of our courts, namely setting limits, metamorphose in specialty courts to establishing treatment goals that are positively framed. Court orders that generally call for an end of an illegal or unwanted behavior are not goals. Goals are desired ends that are framed as the presence or start of a positive behavior (Berg and Miller, 1992). It is hard to be consciously aware of the absence of something, or of “not doing” something as we go about our day. It is far easier to recognize “doing something,” that is, an action or effort. “I won’t talk back to my boss” is reframed as “counting to ten when angry,” or “talking to another recovering person, acquaintance, or friend about how angry I am.” When drug court participants or family members suggest goals posed with “never,” “not,” “don’t,” or “won’t,” questions are asked, “What will you do instead?” Vague, future conditions also need a concrete beginning. “So what do you need *to do* to start feeling better about yourself?”

When the common-factors research is incorporated and greater client and family participation is allowed, they become catalysts for greater gains (Nissen and Clark, in press). There is an emerging drug court adage, “beyond abstinence,” that speaks to the critical consideration of *what will take the place of alcohol and other drug use* (James-Andrews, 2001)? This is not a secondary consideration; that is, it is not something for drug court programs to consider after abstinence has occurred and the participant has stabilized. Rather, it becomes an aspect of goal setting that can help to engender abstinence from the very start of programming. Programs need to look beyond the reduction

of law-breaking behavior to facilitate aspirations, vocational interests, and hobbies as identified by the participant or through vocational (or retraining) assessments. Drug court programs could provide new learning opportunities for participants, helping them to find new interests and identify positive pursuits, based on their proclivities and passions.

Staff spend a good deal of time learning how to connect with clients but do not consider how to make themselves and the drug court programming interesting enough that referrals will want to connect with the staff (Edgette, 2002). Supporting this notion of “beyond abstinence,” author and noted solution-focused therapist Hiam Omer notes, “Motivation is not a quantum of energy residing in the client, but evolves from the formulation of goals (Omer, 1996).” To the extent that staff may attract the referral with useful opportunities and connections to helpful resources — primarily as assessed and indicated by the participant — the “alliance” is built through collaborative goal-setting.

[24] 4. A greater concentration on building a therapeutic alliance between staff and drug court participant.

Two alliance-building issues for drug court staff are key to this consideration:

A. The Alliance Must Be Formed Quickly. This article has explained how influential the staff-client alliance proves to be in inducing positive behavior change. The common-factors research also indicates, however, that staff must work fast to build the alliance. Both Mohl and his co-authors and Plotnicov point out that the impact of establishing the alliance early in treatment, generally by the fourth or fifth meeting, is critical to treatment outcome (as cited in Duncan and Miller, 2000).

Many programs begin with intensive orientation. One example of this is “Jump Start,” found in the Santa Clara County, California, juvenile drug court. In this program, new participants attend intensive orientation sessions to familiarize themselves with program requirements during their first thirty days of participation in the program. These “jump starts” may be very helpful in orienting the new participant to program regulations.

Upon closer inspection, however, most intensive orientations are primarily one-sided. They are solely constructed for the new referrals to come to understand and acclimate themselves to the program structure, schedule, and requirements. Instead, to establish the alliance between staff and client quickly, orientations should focus more on reciprocity. That is, warmly greeting new participants and introducing the staff to them is not enough. Drug court team members and program staff must take a corresponding intensive “jump” by making a concerted effort to meet, quickly become familiar with, and even charm the incoming participant.

Some may chafe at the recommendation for staff to “woo” incoming drug court referrals, but the research is clear: the participant’s perceptions of the alliance determine the outcome of treatment. Skeptics need only consider the largest outcome study ever undertaken, the NIMH Treatment of Depression Collaborative Research Project, which found that improvement was only minimally related to the type of treatment received but was heavily determined by the client-rated quality of the relationship (Blatt, 1996). Even if this study could be ignored, approximately one thousand other studies on alliance-building report the same finding (As cited in Hubble, Duncan, and Miller, 1999).

B. Alliance-Building Is As Varied As the Client.

There is a difference between “understanding” and “doing.” It is simple to understand how important the staff/participant alliance is to treatment outcomes and to place a majority of emphasis there. Actually building the alliance is quite another matter. All drug court participants are different and, because of different personality styles, they will evaluate the conditions of a positive alliance in differing ways. Alexandra Bachelor (1995) found that almost half of all clients wanted to be listened to (empathic reflections) and respected, while another forty percent wanted more “expert” advice from staff to promote direction and allow self-understanding (to “make sense” of issues). A smaller group wanted input, and saw the alliance as a 50-50 partnership in which they felt the need to contribute and have as much input as the staff (counselor) (as cited in Duncan and Miller, 2000). Duncan and Miller state: “The degree and intensity of [staff/counselor] input vary and are driven by the client’s expectations of our role. Some clients want a lot from us in terms of generating ideas while others prefer to keep us in a sounding board role (Duncan and Miller, 2000.)”

Table 1
Implications for Practice

- 1. All drug court team members can become change-focused.**
- Regardless of professional role and prior training, any drug court team member can become more therapeutic if they adopt the attitudes and skills suggested by this common factors research. This is especially true for judges, attorneys and probation staff.
 - Teams need to avoid viewing the participants as static or fixed (“This participant is *always* like this”) and be vigilant for sometimes small changes in thinking or behaving — realizing that change is occurring constantly, and these changes often go unnoticed, and more importantly, unused.
 - Schedule drug court staff retreats to strategize how programming can incorporate two important motivational theories — value/expectancy theory that occurs early in treatment (“Should I do this? Why should I change?”) which is followed by self-efficacy theory (Can I do this – Do I have what it takes? And “How do I do this?”). Become students of motivation and behavior change by enlisting strategies that help participants answer these critical questions raised when faced with self-change.

2. Staff should share the “expert” role with the participant and family.

- Motivation and treatment outcomes are increased when teams encourage high levels of participation from program participants. This is best accomplished by allowing participants to be the “experts” on their lives and experiences.
- Although teaching, motivating and helping will always be part of our work, remember there is no one “correct” point of view and the client’s view should be given equal weight to our own. If we don’t listen and include the ideas of our clients, then drug court programming is established more for the staff than for the participants.
- Drug courts are an involuntary arena where court orders are in ascendancy. Even if abstinence from illicit drugs and alcohol is a mandate and will be non-negotiable, we can still allow the participant more voice in how to strive for abstinence and how to sustain it. Forty years of motivation research is clear; we must allow more participation by the client and not subjugate their views to our own.

3. Treatment should not simply fix what is broken; It should nurture what is best.

- Securing compliance and obedience are important first objectives to reach with new drug court participants; but we should avoid the mistake of viewing them as final outcomes. Strength-based drug courts strive for second tier goals that include positive behavior change, social and career enhancement and personal growth. Teams must keep an eye on efforts for both levels.
- Change-focused drug courts are mindful of the adage “beyond abstinence” that prompts programming to look at what will take the place of illicit drug and alcohol use. Drug court treatment goals should not be confused with probation (court) orders. Goals cannot be set as the absence of something or the withdrawal of an unwanted behavior. They must be framed as the start of a positive behavior or the presence of a new condition or activity. Strength-based assessments are helpful in finding client resources as well as proclivities and desires, interests and wants.
- We spend time learning how to better connect with our clients but we must also make drug court programming interesting enough that referrals will want to *connect with us!*

4. A greater concentration on building a therapeutic alliance between staff and drug court participant.

- Research shows that if any real and lasting improvement is to occur with our participants, it will happen through a therapeutic relationship (alliance) where the client perceives that drug court team members respect them, care about them, and will listen to them in a non-judgmental fashion. All change hinges on this relationship so this is not just something for “treatment” staff to engage in, it *must be a priority for all team members*. Regardless of how much a team member interacts with a participant, their interactions contribute to a climate and a culture, influencing progress — or the lack of it.
- Start by assuming the client is a reasonable person who has become stuck in a difficult situation.
- Realize cooperation is not a characteristic solely of the client— theirs alone to give to us (cooperative) or to withhold (resistant). Cooperation comes from the interaction between staff and client. By how we interact with participants, we can influence the level of cooperation shown by program clients.
- Research finds that staff perceptions of the client-staff relationship has little bearing on outcome, however the client’s perception of the alliance is a strong indicator to positive outcome. Teams must quickly establish the relationship and consistently monitor its quality...by directly polling the participant(s).

Staff working with a drug court referral not only must court and woo new participants, but also they need to survey participants continually about their perceptions and ratings of the staff-participant alliance. Simply put, staff cannot modify or alter their approach to a client based on his perceptions if the staff does not know the client’s perceptions. Duncan and Miller cite a critical effort that has profound implications for staff-client interactions: “Influencing the client’s perceptions of the alliance represents *the most direct impact we can have on change* (Emphasis added) (Duncan and Miller, 2000).”

CONCLUSION

The common factors research has only recently been published. Presently, many in the fields of psychiatry, psychology, and social work are grappling with its findings. Armed with this knowledge, drug court staff and community treatment providers may become familiar with the techniques that engage the common factors. All who work with drug court referrals will benefit from these empirical findings on the pathways to change.

This article does not impeach current efforts, but rather the belief that staff and providers are the “engine” of change. Researchers have bemoaned the fact that inquiries of treatment outcomes over several decades have studied all the wrong elements — the models, techniques, and staff — while ignoring the most important contributor to change: the offender and his or her family. The obsessive question: “How do we get drug court participants sober?” — is answered simply: “*We don’t.*” This common factors research is clear: change rests with the clients. Drug court staff and community treatment providers have the responsibility of creating the structure and the atmosphere that are conducive to change.

Staff expertise will always be vital and needed, but only if it changes one’s focus to guiding the three critical ingredients to motivation — the participant’s resources, perceptions, and participation. Participant and family motivation is not static or fixed but dynamic, and it may be influenced and increased. Aligning direct practice efforts to influence and increase the common factors could help advance clients along this motivational continuum.

Most articles, whether research-oriented or practice-based, generally end with a call for further research — a call so routine that it has almost become a de facto signature line.

Consider, however, that the four factors common to all successful treatment have been illuminated by literally thousands of research studies. Although qualitative and quantitative analysis is invaluable to improve our practical methods, research cannot accomplish this mission unless staff first assimilates it. So, without denying the importance of research, this article does not end by urging more; it encourages all who work with drug court participants to stop and review this compelling research. Keeping in mind the necessary continuum of “research, policy, and practice,” drug court team members should routinely pause to integrate research. Now is that time.

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