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The Multi-Site Adult Drug Court Evaluation:

The Drug Court Experience

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Florida
Osceola County Drug Court—Kissimmee, FL
Volusia County Adult Drug Court Program—Deland, FL

Georgia
Fulton County Drug Court—Atlanta, Georgia
Hall County Drug Court—Gainesville, GA

Illinois
Cook County Drug Court Rehabilitation Alternative Program (R.A.P.)—Chicago, IL
Kane County Rehabilitation Court—St. Charles, IL

New York
Auburn Drug and Alcohol Treatment Court—Auburn, NY
Batavia City Drug Treatment Court—Batavia, NY
City of Niagara Falls Drug Treatment Court—Niagara Falls, NY
Finger Lakes Drug Court (Canandaigua City)—Canandaigua, NY
Finger Lakes Drug Court, Felony Division (Ontario County)—Canandaigua, NY
Lackawanna City Drug Court—Lackawanna, NY
Syracuse Community Treatment Court—Syracuse, NY
Wayne County Drug Treatment Court—Lyons, NY

Pennsylvania
Chester County Drug Court—West Chester, PA
Philadelphia Treatment Court—Philadelphia, PA

South Carolina
York County Drug Treatment Court—York, SC

Washington
CHART Court (Snohomish County)—Everett, WA
King County Drug Diversion Court—Seattle, WA
Kitsap County Adult Drug Court—Port Orchard, WA
Pierce County Felony Drug Court—Tacoma, WA
Thurston County Drug Court Program—Olympia, WA

Comparison Sites
Human Services Associates, Inc.—Orlando, FL
Stewart-Marchman Center for Chemical Independence—Daytona Beach, FL
Illinois TASC—Chicago, IL
Judicial Division 3, North Carolina Probation—NC
Judicial Division 4, North Carolina Probation—NC
Pierce County Drug Offender Sentencing Alternative and Breaking the Cycle—Tacoma, WA

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Highlights

Key Features of the Multi-Site Adult Drug Court Evaluation

The Justice Policy Center at the Urban Institute, RTI International, and the Center for Court Innovation conducted a multi-year, process, impact, and cost-benefit evaluation of drug court impact funded by the National Institute of Justice. The objectives of the National Institute of Justice's *Multi-Site Adult Drug Court Evaluation* (*MADCE*) were to evaluate the effects of drug courts on substance use, crime, and other outcomes, and to illuminate which policies and practices, and which offender attitudes, are responsible for any positive effects that were detected.

Portrait of Adult Drug Courts. A web-based survey of drug courts that primarily served adult clients and had been operational at least one year was conducted between February through June 2004 to develop a portrait of drug courts, and to identify variation across key participant and program domains. Of 593 drug courts that met those criteria, 380 (64 percent) completed the Adult Drug Court Survey.

Process, Impact, and Cost-Benefit Components. The MADCE study tests a series of theoretically-grounded hypotheses on drug court participants and comparison group subjects across 23 drug courts, and 6 comparison sites. NIJ's evaluation (1) tests the hypothesis that drug court participants have lower rates of drug use and criminal activity and show improved functioning compared to similar offenders not offered drug court; (2) tests the effects of variation in drug courts on the outcomes of participants; and (3) assesses drug court costs and benefits. Impact analyses incorporate a multi-level framework. Specifically, individual-level outcomes are modeled as a function of drug court status (drug court or comparison site); exposure to various court policies (e.g., treatment, judicial status hearings, drug testing, and case management), and offender attitudes (e.g., perceptions of the judge, perceived consequences of noncompliance, and motivation to change), while controlling for personal and community characteristics on which the 1,781 offenders and 29 sites may differ.

Findings from the Adult Drug Court Survey guided the selection of adult drug courts, and comparison sites, which were chosen to ensure variation in eligibility criteria, program requirements, community settings, and treatment and testing practices. *MADCE drug courts* included two courts in Florida, two courts in Illinois, two courts in Georgia, eight courts in New York, two courts in Pennsylvania, one court in South Carolina, and six courts in Washington. *Comparison sites* included two sites in Florida, one site in Illinois, two sites in North Carolina, and one site in Washington. Site visits were conducted to each location from mid-year 2004 through early 2005, and again in the spring of 2006, to review program operations, hold semi-structured interviews with key stakeholders, and perform structured court observations.

Study participants were recruited using a rolling enrollment from March 2005 through June 2006. Three waves of participant surveys were administered using Computer Assisted Personal

Interview (CAPI) technology, and Buccal Swab Oral Fluids drug tests were collected at the third survey wave from consenting non-incarcerated participants, as shown below:

Survey and Oral Sample Data Collection and Response Rates

	Dates of Survey Administration	Drug Court Group	Comparison Group	Total Number
Baseline Interviews	March 2005 – June 2006	1,157	627	1,784
6-Month Interviews	August 2005 – December 2006	1,012	528	1,540 (86% of baseline sample)
18-Month Interview	September 2006 – January 2008	952	525	1477 (83% of baseline sample)
18-Month Oral fluids Samples	September 2006 – January 2008	764	383	1147 (95% of non-incarcerated, 18- month sample)

Additional data were obtained from administrative records from the National Crime Information Center at the Federal Bureau of Investigation and state-level databases to capture recidivism at 24 months following baseline.

Design Strengths. Overall, the MADCE research approach has a number of strengths. First, the study was theory-driven based on a conceptual framework spelling out the linkages between drug courts strategies and individual behavior change. Second, the size of the pooled sample and the collection of both offender data and process evaluation data from courts allowed us to open the "black box" of effective drug court practices far beyond past studies of individual drug courts. Third, although quasi-experimental, the MADCE design affords many benefits that a traditional experimental study could not provide. Since we did not require courts to be large enough to generate potentially eligible drug court participants to populate both treatment and control samples, we were able to include small- to medium-sized courts, as well as large courts, the latter of which had already been the subject of a sizable number of drug court studies. The results of this diverse range of community contexts are likely to yield more generalizable results than those from courts in only the largest urban centers. Fourth, by including courts that vary in size, we likely increased the breadth of variation in drug court practices that we were able to study, beyond what would have been possible in the limited number of sites that might have supported a randomized experiment. Lastly, we ultimately were able to include many more drug courts—23 in total—than was originally planned given our ability to geographically cluster sites and pool data across sites.

Given the MADCE quasi-experimental design, however, we had to address three important threats to validity when implementing the impact study: (1) selection bias, (2) attrition bias, and (3) clustering of outcomes within sites. The first two problems—selection and attrition—were handled simultaneously with *propensity score modeling* and a strategy that we refer to as *super weighting*. The third problem—site-level clustering—was handled with *hierarchical modeling*.

Volume 3. The Multi-Site Adult Drug Court Evaluation: The Drug Court Experience

This volume presents NIJ's process evaluation findings and, in some cases, also details results (i.e., outcomes) for the 23 courts and their program participants who were studied in the MADCE research. Key findings include the following:

- The drug court programs selected for the MADCE study represent substantial variety in terms of several drug court features. Although there is variation across eligibility criteria in these courts, most factor in criminal history and substance abuse history. All of the MADCE drug courts—with some variation in implementation practices—require clients to: sign contracts, participate in mandatory substance abuse treatment, attend case management meetings, appear at frequent judicial status hearings in court, and submit to drug testing. Also, all of these programs have policies for sanctioning clients who do not comply with program requirements, and all but one court provides rewards to clients for compliant behavior. [Chapter 2]

- As clients near the end of their drug court participation, all but two courts require them to be clean and sober for a specific period of time. Time to graduation across courts was an average of 17 months. Seventeen of the courts are diversion programs in which either some or all of the clients who successfully graduate have their charges dismissed. Only five courts do not dismiss charges for any of their clients. [Chapter 2]

- While some of the drug court practices conform to those outlined in 1997 by the Office of Justice Programs and the National Association for Drug Court Professionals as key components of the drug court model, others do not. [Chapter 2]

- A notable difference between drug courts and traditional criminal processing is that drug court participants are required to have more contacts with the justice system during their participation period. Between more frequent judicial status hearings and more frequent contacts with the supervision officer, drug court participants receive vastly greater monitoring and supervision. The nature of that supervision, however, varies across drug courts. [Chapter 3]

- Treatment motivation diminished for both drug court and comparison groups during their first six months post-enrollment in the MADCE study; however, the decrease was significantly greater among the comparison group members. On average, the comparison group's motivation decreased by almost twice that of the drug court participants. [Chapter 4]

- Drug court participants were more likely than comparison group members to receive all types of treatment. [Chapter 4]

- Among those who received treatment, drug court participants were more likely than comparison group members to receive individual counseling, group counseling, self-help support groups, and residential treatment (the four modalities we considered in this set of

analyses). Additionally, drug court participants who had treatment received significantly more of it as measured by the average number of total treatment episodes (i.e., intensity). [Chapter 4]

- Drug court participants received treatment earlier (onset), and for longer periods of time (duration), than the comparison group. In all cases, except residential treatment, these differences were statistically significant. [Chapter 4]

- Drug court participants tended to have steadier treatment experiences. In general, drug court participants were significantly less likely to receive no treatment, and somewhat more likely have experienced either sustained treatment or gradual declines in treatment. [Chapter 4]

- Drug court participants were statistically significantly less likely than the comparison group to spend at least one month without any treatment in the form of individual counseling, group counseling, or self-help groups. Further, they were significantly more likely to spend at least one month in which they simultaneously received any two or all three of these treatment modalities (concurrent treatment). [Chapter 4]

- There was essentially no difference between the drug court cohort and comparison group members with respect to the likelihood of receiving mental health residential treatment. [Chapter 4]

- Drug court participants' perceptions tended to take shape quite early in the drug court experience. Only half of the individual measures examined changed significantly in their mean rankings across three waves of surveying; and, most of the measures that did vary significantly (in the statistical sense) did so by a patently small magnitude. Perceptions of procedural and distributive justice in particular were influenced by a small number of preexisting offender characteristics (e.g., age, sex, and classification with clinical depression on a multi-item screening tool). However, it was also the case that perceptions systematically varied from court to court—suggesting that drug court policies and practices can make a difference in either fostering these attitudes and perceptions, or not. [Chapter 5]

- Perceptions of procedural justice—and especially attitudes towards the drug court judge—as well as perceptions of distributive justice and the perceived severity of the sentence to be imposed upon drug court failure significantly predicted compliance, criminal behavior, and drug use at follow-up. [Chapter 5]

- Perceptions related to the deterrent effects of interim sanctions, although a mainstay of drug court policy and practice, did not predict participant behavioral outcomes. [Chapter 5]

- The average 18-month retention rate was 71 percent. [Chapter 6]

- Retention at 18 months was significantly more likely among those who: were older, employed or in school at baseline, had a primary drug of choice other than marijuana, had less prior criminal activity, were not depressed at baseline, and did not have a narcissistic personality disorder. [Chapter 6]

- Retention seems to be an important indicator of future positive outcomes. [Chapter 6]

Chapter 1. Introduction

Shelli B. Rossman

Beginning in 2003, the Justice Policy Center at the Urban Institute (UI-JPC) partnered with RTI International (RTI) and the Center for Court Innovation (CCI) to conduct the Multi-Site Adult Drug Court Evaluation (MADCE) funded by the National Institute of Justice (NIJ). The main objectives of this project were to evaluate the effect of drug courts compared to other criminal justice responses for individuals with substance use issues, and to examine the effect of different drug court practices and key components on participant outcomes. The project was structured in two phases. During the first phase, the research team undertook a one-year planning process in which we developed instruments and data collection protocols, as well as conducted the web-based MADCE Adult Drug Court Survey both to develop a picture of active adult drug courts, and to complete site selection. The second phase entailed three major components focused on performing process, impact, and cost-benefit evaluations.

Findings from the MADCE study are presented in the Executive Summary/Synthesis and four volumes detailing the research activities and findings. This volume presents process evaluation findings and, in some cases, also details results (i.e., outcomes) for the 23 courts and their program participants who were studied in the MADCE research. The chapters describe various aspects of the MADCE drug courts:

- *Chapter 2. Description of the Drug Court Sites in the Multi-Site Adult Drug Court Evaluation* by Janine M. Zweig, Urban Institute, presents information about the programs in which study members participated to provide a context for interpreting results covered in other project products about how drug courts affect individuals' lives. Specifically, this chapter describes contextual characteristics of the courts, drug court eligibility requirements, program participation requirements, graduation requirements, and drug court management.

- *Chapter 3. Drug Court Supervision* by Dana Kralstein, Center for Court Innovation, and Christine Lindquist, RTI International, uses data from the six-month interviews conducted for the impact study and court observations conducted for the process study to detail several dimensions of supervision, including direct court supervision (status hearings, contact with court professionals), monitoring and case management (case management/supervision contacts, supervision requirements, drug testing), and participant compliance (sanctions and incentives). The results revealed relatively intensive supervision among the 23 courts, yet some variability across courts.

- *Chapter 4. Treatment in Adult Drug Courts*, by Shelli B. Rossman and P. Mitchell Downey, The Urban Institute, describes assessment and treatment requirements for the 23 drug courts that participated in the MADCE, as compared to a larger sample of adult treatment courts, using data from a national survey conducted in 2004 and field visits performed to MADCE sites in 2006. In addition, the authors describe four dimensions of treatment—incidence, onset, intensity, and duration—and other aspects of treatment

(such as client participation in concurrent treatment modalities and treatment trajectories) based on analysis of three waves of individual surveys with drug court participants and a comparison group of substance abusers.

- *Chapter 5. The Role of Drug Court Participant Attitudes and Perceptions*, by Kelli Henry, Center for Court Innovation, presents findings on participants' attitudes and perceptions regarding their drug court experiences and on whether these characteristics influence drug court outcomes. Drawing on data from baseline, 6-, and 18-month interviews (conducted with 877 respondents in the 23 drug court programs who completed all three waves), the analysis found that perceptions of procedural justice—and especially attitudes towards the drug court judge—as well as perceptions of distributive justice and the perceived severity of the sentence to be imposed upon drug court failure all significantly predicted compliance, criminal behavior, and drug use at follow-up. However, perceptions related to the deterrent effects of interim sanctions, although a mainstay of drug court policy and practice, did not predict participant behavioral outcomes.

- *Chapter 6. Drug Court Retention*, by Dana Kralstein, Center for Court Innovation, uses three waves of self-reported data to examine 6- and 18-month retention rates across the 23 drug courts that participated in MADCE. In addition, the author reports on participants' reasons for leaving drug courts, the background predictors of 18-month retention, and the extent to which 18-month retention is associated with other positive outcomes such as reduced drug use, criminal behavior, schooling or increased employment, and depression.

Chapter 2. Description of the Drug Court Sites in the Multi-Site Adult Drug Court Evaluation

Janine M. Zweig

Introduction

The National Institute of Justice's (NIJ's) Multi-Site Adult Drug Court Evaluation (MADCE) was conducted by the Justice Policy Center at the Urban Institute (UI-JPC), along with RTI International (RTI) and the Center for Court Innovation (CCI). The goals of the MADCE are to:

- *Test whether drug courts work for participants* by reducing drug use, crime, and multiple other problems associated with drug abuse, in comparison with similar offenders not exposed to drug courts.

- *Examine for whom drug courts work best* by isolating key individual factors such as levels of risk of re-offending and severity of drug addictions that make drug courts more or less effective in achieving their desired outcomes.

- *Explain how drug courts work* by studying key changes in offenders' attitudes while in drug court that may influence the effectiveness of the program, and by studying the implementation of drug court program policies and practices that may lead to more successful outcomes for participants.

- *Examine whether drug courts generate cost savings* for the criminal justice system and other public institutions.

The outcome study includes 23 drug courts located in seven geographic "clusters" across the United States. The drug courts were selected to reflect variation in program strategies and approaches being implemented in drug courts throughout the country. Two MADCE data sources, described below, help us understand court operations within this sample of courts (see Volume 1 for detailed discussion of methodology).

This chapter provides information about the 23 courts included in NIJ's MADCE outcome evaluation. Information about the programs in which study members participate provides important context for interpreting results presented in other project products about how drug courts affect individuals' lives. Using the two data sources described below, we document contextual characteristics of the courts, drug court eligibility requirements, program participation requirements, graduation requirements, and drug court management. Notably, the information provided here is based on what the program staff reported about their court policies and operations and, to a lesser extent, evaluation team members' observations of how the courts were implemented. Thus, the information presented represents that which would be considered policy

or "official" program information in contrast to what clients actually reported experiencing in the programs when we surveyed them directly.

Data Sources

The current chapter describes information provided from two data sources. First, during the initial phase of the study we implemented the MADCE Adult Drug Court Survey (see Volume 2 for details). Between February and June 2004, we conducted a web-based survey of drug courts that primarily served adults and had been in operation for at least one year at that time. The survey included five major sections, as well as subsections covering more specific topics within each area. The five sections were: (1) General Information, including population served, points of entry into the program, and case flow; (2) Program Structure, including program characteristics, eligibility criteria, and substance abuse assessment; (3) Program Operations, including management information systems, entry into the drug court program, program staffing, case management, and program contacts; (4) Treatment and Drug Testing, including substance abuse treatment services and drug testing; and (5) Courtroom Practices, including courtroom practices, infractions and sanctions, achievements, and graduation.

A total of 380 drug courts completed the survey, including the 23 courts that were selected for the outcome study. The survey response rate was 64 percent of the 593 courts identified across the United States that met the eligibility requirements of primarily serving adults and being in operation for at least one year at that time. Although national in scope, the sample is not nationally representative per se. Regardless, it provides an important foundation for understanding drug court programs throughout the country. In several places in the current chapter, we compare the 23 courts in the outcome component of NIJ's evaluation to the full sample of 380 courts.

Second, process evaluation site visits were conducted to the 23 sites participating in the outcome evaluation. Between February and June 2006, evaluation team members visited each court in the study to meet with and interview stakeholders, and conduct observations of drug court staffing meetings and court hearings. Program structure and management, operations, treatment, drug testing, and courtroom practices were explored in greater detail through open-ended questions and observations.

Contextual Characteristics of Drug Court Sites

Many of the courts included in NIJ's MADCE outcome evaluation had been in operation for several years before the study. For instance, 3 courts (13 percent) started in 1994, and 13 courts (57 percent) started between 1996 and 1999. The remaining seven courts (30 percent) started between 2000 and 2003, with only three of these started in 2002 and 2003, meaning they were relatively young courts at the time the MADCE study began in 2004.

Most courts in the sample were operating in relatively populated areas of the country. Just under one-quarter of the drug courts (5 courts, 22 percent) were operating in rural areas. Ten courts (43 percent) operated in urban areas, and eight courts (35 percent) operated in suburban areas.

Notably, the 23 courts participating in the outcome study were more urban than the full sample of courts who responded to our web-based survey (see Volume 2 for details). The full sample of courts (N=380) showed that 41 percent operated in rural areas, 40 percent in urban areas, and 18 percent in suburban areas.

Table 3-2.1 shows the percent of courts and the number of active cases they served. As with geographic area, the size of courts in the outcome study sample is proportionally different when compared to the full sample of courts. Among the full sample, 46 percent of courts across the country served less than 50 participants at any one time, but only 13 percent of the courts in the outcome study served less than 50 participants. On the other hand, 8 percent of the courts across the country served 300 or more clients, whereas 17 percent of the courts in the outcome study served that number of clients. This was likely due to our site selection process, in which we intentionally chose sites able to enroll a sufficient number of clients into the study for analytic purposes.

Table 3-2.1. Number of Active Participants in Outcome Study Drug Court Programs

Participants	Percent of Courts
Less than 50	13
50 to 74	22
75 to 99	13
100 to 149	13
150 to 199	13
200 to 299	9
300 or more	17

Source: Urban Institute Adult Drug Court Survey

The point in the criminal justice process at which clients can enter the drug court program varied among the courts in the outcome study. In 30 percent of the courts (N=7), all participants came into drug court before a plea was entered into the court. In 43 percent of courts (N=10), all participants came into the drug court after a plea was entered into the court. For the remaining 26 percent of courts (N=6), participants could enter into the drug court at both points in the criminal justice process—meaning the courts accepted some participants before a plea was entered and others after a plea was entered, depending on the point at which the person was referred to the programs.

Drug Court Eligibility Requirements

Many drug courts across the country have capacity limitations or public safety concerns that prevent them from being able to serve all drug-involved offenders. Thus, all drug courts have criteria by which offenders become eligible to participate, and some courts have very elaborate eligibility standards that must be met. Many programs have criteria related to substance use issues, as well as current criminal charges and the individual's full criminal history. We asked

court representatives during the web-based survey what their *minimum* criteria was in order to be eligible to enroll in the program. Table 3-2.2 shows that, at a minimum, most of the courts in the outcome study required individuals to have an eligible charge and a clinical assessment showing substance use issues in order to be considered for the drug court program. But, in most cases several other criteria apply, as discussed below.

Table 3-2.2. Minimum Eligibility Criteria for Outcome Study Drug Court Programs

Criteria	Percent of Courts
Eligible charge alone	17
Eligible drug charge alone	0
Eligible charge and a clinical assessment	74
Eligible drug charge and a clinical assessment	9
Eligible charge, positive drug test, and a clinical assessment	0
Eligible drug charge, positive drug test, and a clinical assessment	0
Other	0

Source: Urban Institute Adult Drug Court Survey

Drug Use

People with varying drug abuse issues are allowed to enter into drug courts depending on the courts' eligibility around substance use issues. Thus, courts serve very different clientele when it comes to drug problems. Of the 23 courts in the outcome study sample, 9 courts (39 percent) admit only those who are diagnosed as addicted to or dependent on drugs; 9 courts (39 percent) admit frequent or regular users, as well as those diagnosed as addicted; and 5 courts (22 percent) admit anyone who uses illegal drugs. As a result, when asked about the substance use profiles of their clients, only 6 courts (26 percent) reported serving a group who are primarily severe cocaine/crack, heroin, or methadone dependent users, while the other 17 courts (74 percent) reported serving a mix of clients who are either primarily severe cocaine/crack, heroin, or methadone dependent users, or primarily marijuana users (or those who minimally use other drugs). In 18 courts (28 percent), defendants can get into the drug court program for solely a marijuana abuse issue, and in 12 courts (52 percent), defendants can get into the drug court program for only an alcohol abuse issue.

Table 3-2.3 shows how the drug courts in this sample identify substance abuse issues to determine eligibility. Nearly all use some professional standards by which they examine a person's drug abuse issues—83 percent of courts (N=19) use clinical assessments, and 91 percent (N=21) use the professional judgment of the person conducting the initial screening. A majority also use a person's self-reported history of drug use (78 percent) and drug treatment (61

Getting into the Drug Court Program: Court Profile

One court in the study has a several step process for getting into the program. A person in this jurisdiction is arraigned within a day or two after arrest. During arraignment, either the defense attorney or assistant district attorney will ask the defendant about his/her interest in drug court. At this point, a person is only screened out of the program for extensive criminal histories, prior drug court participation, or if the person is part of the mental health court program. If the person is interested, the drug court coordinator conducts a screening and asks the person to appear at the next drug court hearing the following Thursday. Before that hearing, the coordinator presents the results of the screening to the drug court team at the staffing meeting. After team discussion, the person will be asked again if s/he is interested in the drug court program during his/her court appearance. If the person still expresses interest, s/he is sent to a treatment provider to undergo a full assessment before the next Thursday's court appearance. The drug court team discusses the full assessment results at another staffing meeting. At this point, the team is looking for drug dependency or an extensive use history, and will rule out people with severe mental health or physical health problems. By the person's third drug court appearance, s/he will have an outpatient assessment completed and a treatment plan in place. At this point, the defendant will plea to charges and be given a drug court contract to sign, at which point the person is considered officially enrolled in the program.

percent) to uncover someone's current problems. Far fewer courts use drug test results (26 percent) or contact family members, friends, employers, or other acquaintances to learn about a person's substance use issues (nearly 22 percent).

Table 3-2.3. Sources of Information Used to Determine Drug Court Eligibility

Source of Information	Percent of Courts
Clinical assessments	83
Drug test results	26
Self-reported drug use history	78
Self-reported drug treatment history	61
Professional judgment of the person conducting initial screening	91
Contact with family member, friend, employer, or other acquaintance	22

Source: Urban Institute Adult Drug Court Survey

Criminal Charges and History

When asked about the most serious type of prior convictions participants were allowed to have in order to be eligible for drug court, 22 courts had some limits based on criminal history. Six courts (27 percent) reported that non-violent misdemeanor offenses were the most serious type of

prior conviction allowed, and 16 courts (73 percent) reported that non-violent felony offenses were the most serious type of prior conviction allowed. When asked about the maximum number of prior convictions that were allowed for someone to be eligible for drug court, of the 21 courts that responded, 18 (86 percent) allowed five or more prior convictions or reported having no limit to the number of prior convictions. One court reported that only one prior conviction was allowed, and another court reported allowing only two prior convictions to remain eligible for drug court.

When taking into account criminal history and current charges, complex decision making processes are undertaken in many courts. Most have several charges they allow and several they do not allow. Even with an eligible and ineligible list of charges, exceptions are often made and courts use their own personal assessments about defendants to allow them into the drug court program. Below are examples that illustrate different eligibility standards for courts in the MADCE sample:

- In one court, all drug and non-drug arrests are eligible for consideration in drug court, except for violent felonies (current or prior offenses), sex offenses (current or prior offenses), or driving while intoxicated.

- Another drug court program is a felony diversion program that accepts defendants charged with drug possession, forgery, theft, and probation violations. Prior felony sex crimes and violent offense convictions are not eligible in the program. Defendants involved in drug dealing are also not eligible, although some low-level delivery of controlled substances offenses are accepted.

- Still another program only takes non-violent felons based on current charges and prior record along with substance use issues based on drug assessment results. However, the court also considers the defendant's potential for success and level of motivation before deeming someone eligible.

- In another MADCE program, defendants are ineligible for drug court if they have any prior drug sales conviction (although exceptions to this have been made for particular clients) or any prior violent felony arrest leading to either a violent felony or misdemeanor conviction. Domestic violence charges also are not allowed, although exceptions to this have been made for particular clients.

- Finally, in the last court example, the defendant *must* be charged with a felony and *must* also be identified as addicted to drugs or alcohol based on results of the screening instrument.

Drug Court Participation Requirements and Sanction and Reward Policies

In 1997, the Drug Courts Program Office (DCPO) in the Office of Justice Programs (OJP) promulgated the ten key components of drug court models, based on recommendations from an interdisciplinary committee of interested parties (Office of Justice Programs and National Association of Drug Court Professionals 1997). These components appear to be part of the operations of the courts in the MADCE outcome study. As discussed below, drug court programs require clients to sign contracts agreeing to particular rules or conditions, to participate in several activities, to be subject to sanction and reward policies, and to meet certain goals before being eligible for graduation. Many of these practices are based on the ten components. Below we describe these aspects of programs for our drug court sample.

Contracts

Although not all drug courts in operation in the U.S. require their clients to sign contracts in order to participate in the program, this feature is characteristic of all 23 of the courts in the MADCE outcome study. Almost all courts (21 courts, 91 percent) require clients to sign contracts agreeing to program rules, and the majority of courts (19 courts, 83 percent) also include a waiver of clients' rights in court in the signed contract. Just under half of the courts (11 courts, 48 percent) have clients sign a contract agreeing to the alternative sentence for failure to comply with drug court requirements, and just over half (12 courts, 52 percent) have participants sign treatment contracts with providers that agree to program rules.

Drug Court Contracts: Court Profile

In one court in the study, drug court contracts document what will happen for clients if they graduate or fail the program. If a client graduates, what happens afterward depends on the original charge with which the client came into drug court. Misdemeanor charges are dismissed. Felony charges are sometimes dismissed and sometimes result in a misdemeanor conviction; although if convicted, the person is not given probation.

However, if a client fails in this drug court program, then s/he knows what will happen next. For a misdemeanor charge, the person can receive up to one year in jail. The misdemeanor is rarely restored to probation. In practice, the judge tries to give the person "credit" for the time s/he spent in the drug court program. For a felony charge, the person might receive up to the maximum prison time allowed under state law.

Drug Court Participant Activities

One key component of the drug court model is to identify potential clients and get them into the program as early as possible in the criminal justice process (OJP/NADCP 1997). For 12 courts in the MADCE outcome study (52 percent), a person's initial appearance in drug court comes within 15 days of his/her arrest; one court reported that the initial appearance in drug court happens within 3 days of the arrest. Other courts take longer to get people into the drug court, in part due to the point at which clients are allowed to enter the program.

Other key components of drug courts include access to treatment and to rehabilitative services, ongoing judicial interaction, and drug testing to monitor progress (OJP/NADCP 1997). All of the drug courts in the MADCE sample require clients to participate in substance abuse treatment and case management, to attend judicial status hearings, and to submit to drug testing.

Drug Court Program Requirements: Court Profile

One drug court has several program requirements. Participants are required to pay $750 (if they can afford to) and sign a program contract.

The program has five phases. Individuals are mandated to substance abuse treatment during all five phases of the program. The types of treatment offered include detoxification, residential treatment, outpatient group therapy, and outpatient individual therapy. Attendance at self-help meetings is mandatory, as well. The time spent in treatment each week is lessened as a person progresses through the program phases.

Case management is a central aspect of this drug court program, and is provided by drug court staff. During Phase 1, clients must meet with a case manager at least twice per month, and then one time per month thereafter. However, because the case management is provided in the same physical location as the treatment being offered, the contact between case managers and clients is even more frequent than what is required. Case managers assist clients with compliance requirements, employment status and job searches, housing issues, and drug screens and the resulting consequences.

During the first phase, clients attend court hearings every two weeks, or more often if it is needed for clients who might benefit from more contact with the judge. Court hearings reduce to once every three to four weeks during Phase 2, and then once per month during Phases 3 through 5. Clients are drug tested, at random, twice weekly for all phases, except for the last three months of the program during which they have drug tests once or twice per month.

Substance Abuse Treatment

Once clients enter into drug court, compliance with substance abuse treatment becomes a major focus of their activity. For the courts in the MADCE outcome study, many are able to get their clients into substance abuse treatment within one week of a person's first appearance in court: six courts (26 percent) get clients entered in treatment within one day, and six courts (26 percent) do so within one week. Another seven courts (30 percent) report being able to get clients entered in treatment within 15 days of their initial court appearance, and four courts (17 percent) do so within 16 to 30 days from the client's start.

The drug courts provide access to multiple modalities of substance abuse treatment. Most courts are able to refer clients to residential programs, outpatient programs (intensive, individual, and group treatment modalities), detoxification, drug education, relapse prevention, and self-help groups. More information about the substance abuse treatment available from the MADCE courts can be found in Chapter 4 (*Treatment in Adult Drug Courts,* later in this volume).

Case Management

Case management is provided to clients by drug court staff in 17 (74 percent) of the courts included in the MADCE outcome study. The other six programs provide case management services through court partners. In three courts (13 percent), case management is provided by probation staff; and in the remaining three courts (13 percent), case management is provided by substance abuse treatment staff.

Frequency of required case management meetings generally lessens as participants move through the drug court programming. At least for the initial phase of the drug court program, 13 courts (57 percent) require that clients see their case managers once per week. Six courts (26 percent) require case managements meetings more than once weekly during initial programming, and four courts (17 percent) require such meetings less than one time per week.

Judicial Status Hearings

MADCE drug court sites require clients to participate in judicial status hearings. As with case management, the frequency of these hearings lessens over time. During the initial phase of the program, clients participate in weekly judicial status hearings in 15 courts (65 percent), twice monthly status hearing in 6 courts (26 percent), and monthly status hearing in 2 courts (9 percent).

Drug Testing

Drug court clients participate in drug tests in each of the MADCE courts to monitor progress toward becoming clean and maintaining sobriety. Drug test specimens are collected by a variety of drug court team members. In ten courts (43 percent), drug court staff is the primary collectors of specimens. Another ten courts (43 percent) rely on their treatment partners to conduct drug tests, and two courts (9 percent) use probation staff for drug testing. One court (4 percent) uses a local drug laboratory.

Regardless of who conducts the tests, all of the courts require clients to frequently comply with drug testing during the initial phase of the program experience. During this initial phase, 19 courts (83 percent) drug test clients more than one time per week; the remaining four courts (17 percent) test clients once per week. Similar to case management and judicial status hearings, the frequency of drug tests declines as clients progress through the program.

Sanctions and Rewards

Another key component of drug courts is a coordinated strategy to respond to participants' compliance and noncompliance (OJP/NADCP 1997). OJP/NADCP recommended a graduated sanctions approach to respond to noncompliance and a reward system to respond to compliance. In the MADCE outcome study courts, all the courts provide sanctions to participants if they do not comply with program rules, and all but one court provide rewards to participants for complying.

Best practices around sanctioning posit that responses should be predictable and certain to program participants, and should happen swiftly. Ten courts (43 percent) have a formal sanction schedule. Of these, six courts give these sanction schedules to clients so they are fully aware of what to expect in response to particular behaviors, and they can see how sanctions become more severe with repeated infractions. Of the courts that have schedules, eight courts report that the schedule is routinely followed; two courts report that it is followed only some of the time.

Three-quarters of courts (17 courts) report that clients receive a sanction for every positive drug test. All courts report that repeated infractions can lead to more severe sanctions—13 courts (57 percent) report that repeated infractions always lead to more severe sanctions, and 10 courts (43 percent) report that repeated infractions only sometimes lead to more severe sanctions. Sanctions given for positive drug tests and sanctions given for infractions other than positive drug tests are given with similar swiftness for courts. Two courts (9 percent) give sanctions within a day of detection of the infraction regardless of what the infraction is. Eight courts (35 percent) do so within a week of detection if the infraction is a positive drug test, and nine courts (39 percent) do so within a week of detection for infractions other than positive drug tests, regardless of whether or not the participant receiving the sanction has a court appearance during that time. Eleven courts (48 percent) give sanctions during the participant's next court appearance when an individual has a positive drug test, and ten courts (43 percent) give sanctions during the next court appearance when the infraction is something other than a positive drug test, regardless of how long it will be before that court date. The remaining two courts did not identify a particular timeframe for giving sanctions after detection of program infraction.

Most courts (20 courts, 87 percent) do not allow anyone other than the judge to sanction a program participant. For the three courts that do allow program staff other than the judge to give sanctions, two courts allow drug court case managers to mete out sanctions, one court allows other drug court staff, one court allows the treatment provider, and two courts allow probation officers.

The courts in the MADCE outcome study provide rewards to clients for a variety of behaviors related to sobriety, program

Drug Court Program Sanctioning Policies: Court Profiles

One specific court has a written schedule of sanctions identifying which particular infractions will lead to particular sanctions. A sanction will be imposed in response to any and all infractions that are detected, and at the discretion of the judge with input from the drug court team. The written schedule of sanctions is a part of the applicant's program packet. Some examples of response to infractions include: two community service hours for being late to meetings (office meetings or group meetings); two community service hours for turning in late Alcoholics Anonymous/Narcotics Anonymous (AA/NA) slips; three community service hours for missing an office visit; three community service hours, plus two additional AA/NA meetings for missing a group session; and doubling community service hours for missing community service that was given as a sanction. Other sanctions include using electronic monitoring, jail time, imposition of curfews, and extra individual and group counseling sessions.

Using a different approach, another court, makes sanctioning decisions on a case-by-case basis. The only firm rule regarding sanctions is that lying will result in a jail sanction for the participant. Other types of sanctions include community service, essays, and jury box time. This court provides its sanctions quickly—on the same day in many cases, especially if a drug test is positive on a court appearance day. If a client's infraction is caught on a day other than when s/he is to appear in court, s/he is scheduled to appear before the judge on the very next court date. The program does not wait for the next time the person was originally to be in court.

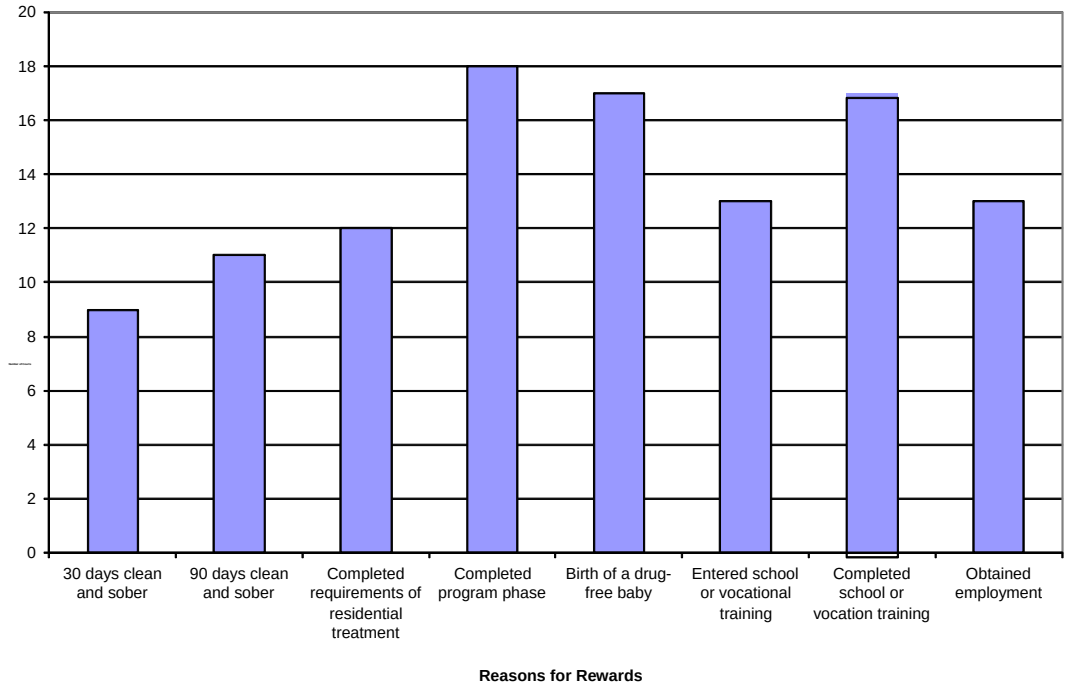
requirements, and personal achievements. Figure 3-2.1 documents the number of courts providing rewards for particular reasons. Nine courts (39 percent) provide rewards for clients being clean and sober for 30 days, and 11 courts (48 percent) do so for 90 days of sobriety. Some courts provide rewards related to program milestones: 12 (52 percent) give rewards to clients who complete the requirements of residential treatment programs, and 18 (78 percent) provide rewards to clients who complete a phase of the drug court program. In terms of personal achievements, 17 courts (74 percent) provide rewards to women who give birth to drug-free babies, 13 courts (57 percent) provide rewards to people who enter an educational program or vocational training, 17 (74 percent) do so for completing an educational program or vocational training, and 13 (57 percent) do so for obtaining employment.

Drug Court Program Graduation Requirements and Length: Court Profiles

One court has several program requirements that must be fulfilled before graduation. Clients must receive a minimum of 10 months of treatment, although court staff has found that the program typically takes clients 18 months to complete, because some clients seem to get "hung up" at the beginning of their time in the program and fail to make treatment progress. In addition, payment of restitution also can delay someone from graduating from the program. Because restitution payment is a requirement to graduate, this court does not allow people into the program who owe more than $1,500.

A different court also has several graduation requirements, including: obtaining and maintaining a 12-step sponsor, achieving 180 consecutive days clean and sober, paying all program fees in full, obtaining and maintaining an address, having no violations for 45 consecutive days, paying all court and restitution fees, submitting copies of pay stubs or school registration/grades, and applying for completion of the last phase of the program.

Figure 3-2.1. Number of Courts Providing Rewards for the Identified Reasons



Drug Court Graduation

Most drug courts require that clients spend at least some time clean and sober, as well as some time in the program without being sanctioned before they are eligible to graduate. Seven courts (30 percent) require clients to be clean and sober for six months, and another five courts (22 percent) require clients to be clean for 12 months. Nine courts (39 percent) require that clients be clean and sober for two to five months before they can graduate. Only two courts (9 percent) do not have such a requirement.

What Happens after Graduation?

In one MADCE court, defendants plead guilty as part of drug court program entry. After successful completion of the program and graduation, the person's sentence may or may not be deferred. If the sentence is deferred, the person's plea is actually vacated and the case is dismissed. If the sentence is not deferred, a person's probation will be satisfactorily terminated upon graduation from drug court.

In a different court, the drug court program has an aftercare program. This program extends to one year after graduation. The graduate appears in General Sessions court in front of a Circuit Court Judge, the guilty plea is withdrawn, and the case is dismissed. The Drug Treatment Court Staff prepare an Expungement Order for the defendant six months after completion of the program as long as the defendant remains clean, sober, and free of legal trouble.

More courts do not require clients to be in the program without receiving sanctions for a certain period of time before they can graduate than do not require clients to be clean and sober. Eleven courts (48 percent) do not have any such requirement regarding sanctions before clients become eligible for graduation. The time required to be sanction-free also seems to be shorter than the time required to be clean and sober. Four courts (17 percent) require it for one or two months, seven courts (30 percent) require it for three or four months, and one court (4 percent) requires it for five months.

Requirements for participants to be sober or sanction-free mean that participants may need to be in drug court programs for quite some time before they achieve success and can graduate. When asked how long it actually took their clients to graduate from the program, regardless of the program requirements, the average time to graduation among the 21 programs that responded was 17.3 months. Table 3-2.4 documents the time to graduation for these courts. The majority of courts (12 courts, 57 percent) graduate clients between 13 and 18 months. Only two courts (10 percent) have clients in their programs for more than 24 months.

What happens to participants' charges after they graduate from the program depends on the drug court. For 12 of the courts in the study (55 percent), the charges against participants are dismissed for all of their clients.[1] Another five (23 percent) dismiss charges for some, but not all of their clients. Only five courts (23 percent) do not dismiss charges for any of their clients. Additionally, six courts (27 percent) reduce charges for some of their clients, and two courts reduce charges for all of the clients. Across the country, some courts require that participants be on probation after they successfully complete the drug court program. In our sample, only one court (5 percent) required that all of their successful clients remain on probation after graduation.

[1] Note that information about what happens to participants' charges after graduation and about probation after graduation was only available for 22 courts.

Another six courts (27 percent) required some of their successful clients to remain on probation. Fifteen courts—a full 68 percent—did not require any of their clients to be on probation after graduation. Nearly all courts—21 of 23—reported that drug court clients are made aware of what happens after graduation.

Table 3-2.4. Time to Graduation for 21 Courts

Time to Graduation	Percent of Courts
12 months	19
13 to 18 months	57
19 to 24 months	14
More than 24 months	10

Drug Court Management

Drug court programs are designed to address multiple issues for clients—assisting clients with accessing substance abuse treatment and other rehabilitative services, while at the same time holding them accountable to criminal justice procedures. As a result, drug court programs are often implemented by a team of stakeholders representing various positions in this collaborative model and employed by a variety of public and private agencies. Teams include multiple partners from the criminal justice, treatment, and service fields, each with a different role in making the program work. Often drug court partners meet on a regular basis in order to successfully implement the program and its goals. Typically, these meetings—called team staffing meetings─ are a time when staff discuss program operation issues, individual client progress, program response to client compliance and noncompliance, and what will occur at upcoming judicial status hearings.

Drug Court Team Staffing Meetings

Because the collaborative model is integral to the implementation of drug court programs, the MADCE research team observed regular team staffing meetings in 20 of the 23 courts in the study during site visits conducted between February and June 2006 in order to systematically document a variety of practices. Table 3-2.5 documents the elements of the meetings observed during the visits with programs. Three-quarters of the courts (15 courts) conducted team staffing meetings on a weekly basis. Two courts (10 percent) conducted such meetings every other week, and three courts (15 percent) conducted meetings more than once per week. On average, these meetings lasted about one hour, and just under three minutes was spent on each participant whose case was discussed.

The Drug Court Team Approach: Court Profile

In one county, the drug court program has several partners on their drug court team. Regular partners include the judge, the assistant district attorney, two defense attorneys contracted by the drug court program, the program director, the assistant program director (who is responsible for ensuring the sustainability of the program), the program coordinator (who coordinates the clinical program and performs the administrative functions), substance abuse treatment staff (three full-time county-employed clinicians and two contracted clinicians), a case manager, and a law enforcement representative from the Sheriff's department (who conducts home visits to enforce curfew, participates in the decision-making process, and weighs in on legal screening). The program has other advisers who include pretrial intervention staff and a variety of mental health treatment providers.

Drug court team staffing meetings occur the day before the drug court hearings, and include the regular partners listed above. At these meetings, potential new clients are discussed in order to determine if they are appropriate for the program; existing clients who are to appear in the court the following day also are discussed. All team members participate in the discussion and decision making. In most cases, team members know if a sanction is to be applied for an infraction because they follow a sanctions schedule. In addition, the judge always tells the other team members about his plan for action before the court hearing.

During the team staffing meetings we observed on site, the judge was in attendance 100 percent of the time. Project coordinators and defense attorneys attended in 17 courts (85 percent), prosecutors attended in 16 courts (80 percent), substance abuse treatment liaisons attended in 14 courts (70 percent), case managers attended in 10 courts (50 percent), and probation officers attended in 10 courts (50 percent). A variety of other team members attended in various court sites, including representatives from law enforcement, court clerks, administrators, and mental health partners. Regardless of who attended, either the judge or the project coordinator led the team staffing meeting. In more than half of the courts (11 courts, 55 percent), the judge led the meeting alone; in seven courts (35 percent), the project coordinator led the meeting; and in two cases, the judge and project coordinator co-led the meeting.

MADCE researchers rated each staff person on the extent to which they participated during the meeting; we used a five-point scale, with 1 being "did not participate" and 5 being "participated thoroughly." On average, the judge participated the most across courts (mean=4.9), followed by

Table 3-2.5. Observed Drug Court Team Staffing Meetings at 20 Drug Court Sites

Staffing Characteristics	Percent of Courts
Frequency of staffing	
Every other week	10
Weekly	75
More than once a week	15
Who Attends the Staffing	
Judge(s)	100
Project/Resource Coordinator(s)	85
Defense Attorney(s)	85
Prosecutor(s)	80
Treatment Liaison(s)	70
Case Manager(s)	50
Probation Officer(s)	50
Other(s)	
Clerk(s)	20
Law Enforcement (Police/Corrections)	15
Drug Court Administration	15
Mental Health	10
Health Department	5
Participation in the staffing (Scale of 1 to 5)[1]	
Judge(s)	4.9
Project/Resource Coordinator(s)	3.7
Defense Attorney(s)	2.7
Prosecutor(s)	2.7
Treatment Liaison(s)	3.8
Case Manager(s)	3.3
Probation Officer(s)	2.9
Who runs the staffing	
Judge(s)	55
Project/Resource Coordinator(s)	35
Both	10
Who made the final decisions on participant response	
Judge(s)	75
Team Consensus	25
Length of Staffing Meeting (in minutes)[2]	
Mean across courts	64.85
Range across courts	13.00 - 170.00
Average discussion per case (in minutes)	
Mean across courts	2.64
Range across courts	0.60 - 6.00

[1] *MADCE team observers rated the level of participation of each drug court team member on a scale of 1 to 5, with 1 being "did not participate" and 5 being "participated thoroughly".*
[2] *This reflects the length of the staffing meeting observed; the MADCE team made every effort to observe the whole meeting.*

treatment liaisons (mean=3.8), project coordinators (mean=3.7), and case managers (mean=3.3). Prosecutors, defense attorneys, and probation officers participated the least amount (mean=2.7, mean=2.7, mean=2.9, respectively).

In line with attendance, leadership, and participation rates, judges also were the ones most frequently to decide about the response of the court to individual participant compliance or noncompliance. In 15 courts (75 percent), the judge made such decisions. In only five courts (25 percent) did the team reach a consensus on such decisions.

Conclusions

The drug court programs selected for the MADCE study represent substantial variety across several drug court components. Although there is variation across eligibility criteria in these courts, most factor in criminal history and substance abuse history. All of the drug courts require clients to sign contracts to participate, to participate in mandatory substance abuse treatment, to participate in case management meetings, to appear at judicial status hearings in court, and to submit to drug testing, although with variations in implementation practices. Also, all of these programs have policies whereby they administer sanctions to clients who do not comply with program requirements, and all but one court provides rewards to clients for compliant behavior.

As clients near the end of their drug court participation, all but two courts require them to be clean and sober for a specific period of time. Time to graduation across courts was an average of 17 months. Seventeen of the courts are diversion programs in which either all or some of the clients that successfully graduate have their charges dismissed. Only five courts do not dismiss charges for any of their clients.

While some of the practices described here conform to those outlined in 1997 by OJP/NADCP as key components of the drug court model, others do not. This variation is important because it allows us to test the effectiveness of different implementation practices. Describing these practices here provides important context for understanding the outcome results presented in other MADCE report chapters. Further, while there are some differences between the 23 courts and the full group of 380 courts surveyed during the first phase of this project, these programs represent a variety of practices found throughout the United States.

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Chapter 3. Drug Court Supervision

Dana Kralstein and Christine Lindquist

Introduction

Intensive supervision is thought to be a fundamental component of drug courts, which are specialized courts for drug-involved offenders, in which participants receive a combination of substance abuse treatment and ongoing court supervision of the treatment process. Court supervision includes frequent judicial status hearings, direct interaction at those hearings with the drug court judge, frequent contact with a case manager or supervision officer, drug testing, sanctions for noncompliance, and positive incentives for compliance. Drug court guidelines specify ideal standards with respect to supervision intensity. For example, *Defining Drug Courts: the Key Components* includes frequent drug testing, a coordinated strategy in response to compliance, and ongoing judicial interaction with each participant as critical components of drug courts (Office of Justice Programs and National Association of Drug Court Professionals 1997).

Despite prescriptive information about what drug courts *should* do to adequately supervise clients, there is limited information about the actual supervision that takes place, and certainly not much across multiple sites. Many process evaluations of drug courts rely on the perspective of the drug court team and the review of written program materials about court policies, but do not focus on the actual "dosage" of supervision (or other services) received by the participants themselves. The variability in supervision intensity across drug courts has not been explored in a systematic manner, partially because many previous studies have focused on a single drug court or a very small number of courts.

Two multi-site evaluations have documented variation in drug court policies and practices related to supervision. An evaluation of 11 drug courts in New York State identified policies across the courts with respect to sanctioning practices (Rempel, Fox-Kralstein, et al. 2003). A recent evaluation of 18 adult drug courts, which characterized the courts as "yes/no" on each of the ten key components of drug courts, identified variability across the courts with respect to the frequency of drug tests (and procedures), several dimensions of sanction and incentive practices, and the role of the judge (Carey, Finigan, and Pukstas 2008). In addition to these two evaluations, a larger body of work has explored the impact of individual drug court components on various dimensions of success, using a single-site design or employing a small number of sites. For example, the impact of judicial status hearings, characteristics of the judge, and sanctions and incentives on program effectiveness have been examined (see for example, Marlowe, Festinger, et al. 2003; Harrell, Cavanagh, and Roman 1999; Marlowe, Festinger, and Lee 2004; Marlowe 2004; Senjo and Leip 2001). While this research is critical to understanding *how* drug courts work, it is also important to document—in a standardized manner—the actual experiences among drug court participants across a diverse set of drug courts.

The National Institute of Justice's (NIJ's) Multi-Site Adult Drug Court Evaluation (MADCE), which was conducted by the Urban Institute, RTI International, and the Center for Court

Innovation, offers an opportunity to explore variation in several dimensions of supervision across 23 drug courts. This chapter uses two primary sources of data, including (1) data from in-person interviews conducted with drug court participants approximately six months after their enrollment (as part of a longitudinal series of interviews), and (2) data from structured court observations and observations of team staffings conducted by NIJ's MADCE team during site visits (see Volume 1 for a detailed discussion of methodology). Using these data, several dimensions of supervision intensity were explored, including:

- *Contact with the judge and attorneys,* including judicial status hearings, contact with other court professionals, and courtroom dynamics.

- *Case management,* including case management/supervision officer contacts, drug tests and breathalyzers, and other supervision requirements.

- *Responses to participant compliance,* including sanctions and incentives reported by drug court participants, and responses to compliance/noncompliance as observed by evaluation staff during observations.

After providing a brief summary of the methodological approach used in the MADCE, findings in each of these areas are presented.

Data and Methods

The MADCE included 23 drug courts and 6 comparison sites selected through a rigorous site selection process from 8 different states across the country. Offenders in all 29 sites were interviewed at three points in time: baseline (at enrollment into the drug court program),[2] 6 months after baseline, and 18 months after baseline. The original sample size at baseline was 1,156, and study attrition rates were low: 13 percent at the 6-month interview, 18 percent at the 18-month interview, and 24 percent when considering respondents interviewed at both follow-up time points. The survey instrument was administered in-person via computer assisted personal interviewing (CAPI) and included questions about prior and current criminal behavior, prior and current drug treatment, prior and current drug use, socio-demographic characteristics, drug court participation, attitudes about the court experience, and supervision details. The survey data were supplemented by oral fluid samples, which were collected at the 18-month interviews from all offenders who consented to test for the presence of substances.[3] In addition, official administrative data were collected from the National Crime Information Center and each state to assess formal recidivism.

This chapter uses interview data obtained for drug court participants at the six-month follow-up interview. This time point captures the period of "maximum" program intensity (when nearly all

[2] The average days between enrollment in the program and timing of baseline interviews were 30.6 days (significantly longer for the comparison group—31.1 days—than the participant group—29.7 days). Eighteen percent of the baseline respondents were incarcerated during the baseline interview, with significantly more of the comparison group incarcerated (22 percent) than the drug court group (16 percent).
[3] Oral fluids samples were not obtained for individuals who were incarcerated at the time of the 18-month interview.

participants were actively enrolled). During each interview, drug court participants were asked several questions regarding the following dimensions of their supervision:

- *Contacts with the judges and attorneys*, which includes the number of judicial status hearings they attended, the number of contacts they had with the defense attorneys, and the number of contacts with the prosecutors since the baseline interview.

- *Contacts with the supervision officers*, which includes clarification of which team member provided the actual case management (i.e., drug court case manager, probation officer, parole officer, or pretrial supervision officer) and the number of various types of contacts, including face-to-face, as well as phone contacts with the supervision officers.

- *Drug testing*, which includes questions about the frequency of various types of drug testing conducted, including breathalyzers, as well as non-alcohol drug tests.

- *Supervision requirements*, which includes an extensive array of possible supervision conditions that respondents indicated applied to their drug court experiences.

- *Court responses to compliance and noncompliance*, which includes questions about the number and type of sanctions and rewards received.

The current chapter also uses court observation data gathered by the research team during comprehensive site visits to each program in February through June 2006. Interview and observation guides were developed for the site visits. The teams spent approximately two days at each site, with site visits scheduled to coincide with judicial status hearings (and team staffings). During the site visits, in addition to conducting semi-structured interviews with key staff and partners, structured observations of judicial status hearings and drug court team staffings were conducted. These observations documented overall procedures of the staffings/court hearings (e.g., stakeholders in attendance, level of participation, decision-making process, courtroom dynamics, information sharing, demeanor of judges), as well as the disposition of each individual case discussed/heard (e.g., type of appearance, compliance status, court response, judicial interaction).

The structured courtroom observation data collection included the following components:

- *Length* of each appearance.

- *Staff who participated* in each appearance.

- *Judicial demeanor*—observers were asked to check off all that applied for each appearance with respect to how the judge conducted him/herself (possible options were "respectful", "fair", "attentive", "caring", "consistent/predictable", "knowledgeable", "enthusiastic", "funny", "stern", and "intimidating").

- *Judicial interaction*—observers were asked to check off all that applied for each appearance with respect to how the judge interacted with the defendant (possible options

were "Judge talked directly to defendant," "Judge had regular eye contact with defendant," "Judge asked non-probing questions of defendant," "Judge asked probing questions of defendant," "Judge offered instructions/advice to defendant," "defendant asked questions/made statements," "Judge explained consequences of compliance," "Judge explained consequences of Noncompliance," "Judge directed comments to audience," "Judge spoke off-record to defendant," and "defendant displayed art/talent").

- A *compliance assessment* of each appearance—observers noted whether each drug court participant received a "good report" or "bad report" for compliance (i.e., a participant received a "bad report" if there was any mention of noncompliance in the court appearance).

- Any *sanctions or rewards* given to each participant in court.

Contact with the Judges and Attorneys

Although it is widely recognized that a key difference between drug courts and traditional criminal processing is that drug court participants are required to attend frequent judicial status hearings, few previous studies have explored the variation in intensity of criminal justice system contact or used participant reports of the contact they have received. The following information focuses on drug court participants' contact with various players in the criminal justice system based on both interview and court observation data.

As shown in Table 3-3.1, 94 percent of all participants across the 23 drug courts included in the MADCE reported that they attended regular status hearings, anywhere from 0 to 15 times per month for an average of just below two times per month at risk (with months at risk reflecting months between the baseline and six-month interview when the participant was not incarcerated). Participants appeared to have regular contact with the defense attorneys and prosecuting attorneys as well, but not nearly as often as with the judges, implying that these attorneys were not always present for the regular status hearings. Forty-six percent of participants reported having contact with their defense attorney, approximately once every two months (0.51 per month at risk). About one-third of participants (32 percent) reported having contact with the prosecutor, on average once every three months (0.37 per month at risk).

Table 3-3.1. Contacts With Judge and Attorneys, per Month at Risk
23 Drug Courts, Six Months After Baseline

Type of Contact	Total Participants N = 1009
Any judicial status hearings	94%
# judicial status hearings/month at risk	1.87
Range of judicial status hearings/month at risk	0 - 14.67
Any contact with defense attorney	46%
# contacts with defense attorney/month at risk	0.51
Range of contacts with defense attorney/month at risk	0 - 10.00
Any contact with prosecutor	32%
# contacts with prosecutor/month at risk	0.37
Range of contacts with prosecutor/month at risk	0 - 13.29

Source: Urban Institute MADCE Survey of Substance-Abusing Offenders
Note: Month at risk measures the time between the baseline and six-month interviews when respondents were not incarcerated.

The average length of a court appearance, as documented in the court observations conducted by the MADCE team, was almost 3.5 minutes, as shown in Table 3-3.2. There was also significant variation by court, as the average length of court appearances ranged from 1 to 8 minutes across the 23 sites. The most active team members during those observed court appearances were the judges, participating in nearly all (92 percent) of the appearances. Other than the judges, the drug court coordinators (31 percent), prosecutors (25 percent), defense attorneys (24 percent), and treatment liaisons (21 percent) all made regular contributions at those hearings. Probation officers (14 percent) and case managers (12 percent) were less involved in the court session.

Prior literature indicates that judges may be particularly important players in the drug court process (see Marlowe et al. 2003). MADCE team members rated the drug court judges fairly high on displaying respectful (4.50 out of 5.00), fair (4.45), and attentive (4.36) demeanors. The judges were rarely rated as stern (2.68) or intimidating (2.23). The drug court judges almost always spoke directly to the defendants (94 percent) and had regular eye contact (92 percent), as opposed to speaking to the defendants' representatives, the attorneys, as in traditional criminal court. In more than half of the observed appearances, the judges asked questions of the defendants: 60 percent asked non-probing questions, and 55 percent asked probing questions. The interaction regularly allowed the participants to converse with the judges in court, not only in answering questions, but also in asking questions or making statements (42 percent). The conversations between judges and defendants remained public, however, and rarely rose to off-record discussion (2 percent).

Table 3-3.2. Courtroom Dynamics
22 Drug Courts

Courtroom Characteristics	Ratings
Length per court appearance (in minutes)	
Mean across courts	3.21
Range across courts	1.00 - 8.00
	% Appearances Observed
Participation in judicial status hearings	
% judge participated	92%
% project/resource coordinator participated	31%
% dedicated prosecutor participated	25%
% dedicated defense attorney participated	24%
% treatment liaison participated	21%
% probation participated	14%
% case manager participated	12%
Judicial Demeanor (Scale of 1 to 5)[1]	
Respectful	4.50
Fair	4.45
Attentive	4.36
Caring	3.91
Consistent/predictable	3.90
Knowledgeable	3.82
Enthusiastic	3.50
Funny	3.00
Stern	2.68
Intimidating	2.23
Judicial interaction with defendant	
Judge talked directly to defendant	94%
Judge had regular eye contact with defendant	92%
Judge asked non-probing questions of defendant	60%
Judge asked probing questions of defendant	55%
Judge offered instructions/advice to defendant	42%
Defendant asked questions/made statements	42%
Judge explained consequences of non-compliance	28%
Judge explained consequences of compliance	22%
Judge directed comments to audience	14%
Judge spoke off-record to defendant	2%
Defendant displayed art/talent	1%

[1] *MADCE team observers rated the demeanor of the judge on a scale of 1 to 5, with 1 being "strongly disagree" and 5 being "strongly agree."*

Case Management and Drug Testing

Drug courts monitor participants in a variety of ways, including individual supervision and case management, drug testing, and the imposition of a variety of other requirements. In order to learn about drug court monitoring as actually experienced by participants, respondents in the longitudinal interview component were asked a variety of questions on this topic.

According to the drug court participants, the primary staff member responsible for supervising them tended to be a case manager employed by the drug court (as reported by 89 percent of participants). As shown in Table 3-3.3, the remaining respondents reported that a combination of a drug court case manager and other staff, such as probation, parole, or pre-trial supervision performed this function. Nearly three-quarters of drug court participants reported having any phone contact with their supervision officer within the past six months, with monthly contacts ranging widely across participants. Nearly all participants (93 percent) reported having any in-person contact with their supervision officer, with the number of contacts per month averaging 3.5 (although substantial variability was observed).

Table 3-3.3. Contacts With Case Manager, per Month at Risk
23 Drug Courts, Six Months After Baseline

Contacts	Total Participants N = 1,009
Main Supervision Officer (SO)	
Drug Court case manager (>75% participants)	89%
Combination drug court case manager and probation/parole officer/pretrial supervision officer	11%
Any phone contact with SO	73%
# contacts with SO/month at risk	1.48
Range of contacts with SO/month at risk	0 - 50.83
Any face-to-face contact with SO	93%
# contacts with SO/month at risk	3.47
Range of contacts with SO/month at risk	0 - 63.92

Source: Urban Institute MADCE Survey of Substance-Abusing Offenders
Note: Month at risk measures the time between the baseline and six-month interviews when respondents were not incarcerated.

Drug testing appeared to occur frequently among the sample, as shown in Table 3-3.4. The vast majority of participants (93 percent) reported receiving at least one drug test within the past six months, with an average of 5.7 per month. Breathalyzer tests were less common, reported by less than half of respondents (45 percent). For both types of tests, the range of tests per month was quite wide. The frequency of drug tests and breathalyzers are reflective of the resources available in each court and the differences in policies across courts. Specifically, courts may wish to more frequently test participants with more severe charges or who are in outpatient treatment; a court's

drug test frequency, then, will reflect the make-up of its participant charges and treatment modalities.

Table 3-3.4. Alcohol and Drug Testing, per Month at Risk

23 Drug Courts, Six Months after Baseline

Testing	Total Participants N = 1,009
Any Drug Tests (Non-Alcohol)	93%
# drug tests/month at risk	5.71
Range of drug tests/month at risk	0 - 32.97
Any Breathalyzers	45%
# breathalyzers/month at risk	0.42
Range of breathalyzers/month at risk	0 - 21.12

Source: Urban Institute MADCE Survey of Substance-Abusing Offenders
Note: Month at risk measures the time between the baseline and six-month interviews when respondents were not incarcerated.

Across the 23 drug courts, participants reported having many supervision requirements, as shown in Table 3-3.5. Overall, the sample reported an average of ten requirements. Not surprisingly, the most commonly reported requirement was attending drug treatment, which was reported by at least half of the participants in each of the 23 courts. All of the respondents who reported that attending drug or alcohol treatment was required also indicated that following the rules of such treatment was a requirement of supervision, and most (92 percent) also reported that completing treatment was a requirement. Nearly all drug court participants (95 percent) across the 23 courts reported that showing up on time to required court hearings, appointments, and treatment programs was required.

Table 3-3.5. Court Supervision Requirements

23 Drug Courts, Six Months After Baseline

Supervision Requirements	# of Courts (23)	All Participants (N = 686)[1]
Total # Supervision Requirements (Out of 18)		9.91
Less than 8 requirements	4 (17%)	
8 - 10.99 requirements	14 (61%)	
11+ requirements	5 (22%)	
Range of Supervision Requirements		6.76 - 13.00 *)*
Legal Requirements		
Not carrying a weapon		88%
Reported by more than 50% participants	23 (100%)	
Reported by less than 50% participants	0	

(continued)

Table 3-3.5. Court Supervision Requirements (Cont'd)
23 Drug Courts, Six Months After Baseline

Supervision Requirements	# of Courts (23)	All Participants (N = 686)[1]
Meeting with a case manager		83%
Reported by more than 50% participants	20 (87%)	
Reported by less than 50% participants	3 (13%)	
Paying court ordered payments, fees		61%
Reported by more than 50% participants	16 (70%)	
Reported by less than 50% participants	7 (30%)	
Meeting with a pretrial officer/probation officer/parole officer		38%
Reported by more than 50% participants	10 (43%)	
Reported by less than 50% participants	13 (57%)	
Electronic monitoring/house arrest/daily reporting		2%
Reported by more than 50% participants	0	
Reported by less than 50% participants	23 (100%)	
Drug Treatment Requirements		
Attending drug/alcohol treatment		96%
Reported by more than 50% participants	23 (100%)	
Reported by less than 50% participants	0	
Unscheduled / random drug tests		88%
Reported by more than 50% participants	21 (91%)	
Reported by less than 50% participants	2 (9%)	
Taking regularly scheduled drug tests		61%
Reported by more than 50% participants	16 (70%)	
Reported by less than 50% participants	7 (30%)	
If attending drug tx is required:		
Following rules of drug/alcohol tx required		100%
Reported by 100% participants	23 (100%)	
Completing tx required		92%
Reported by more than 50% participants	22 (96%)	
Reported by less than 50% participants	1 (4%)	
Behavioral Requirements		
Showing up on time to required court hearings, appointments, tx programs		95%
Reported by more than 50% participants	23 (100%)	
Reported by less than 50% participants	0	

(continued)

Table 3-3.5. Court Supervision Requirements (Cont'd)
23 Drug Courts, Six Months After Baseline

Supervision Requirements	# of Courts (23)	All Participants (N = 686)[1]
Having a good attitude		73%
Reported by more than 50% participants	18 (78%)	
Reported by less than 50% participants	5 (22%)	
Community Requirements		
Not frequenting places where drugs/alcohol sold		90%
Reported by more than 50% participants	23 (100%)	
Reported by less than 50% participants	0	
Not associating with gang members		63%
Reported by more than 50% participants	17 (74%)	
Reported by less than 50% participants	6 (26%)	
Not associating with people with felony convictions		57%
Reported by more than 50% participants	15 (65%)	
Reported by less than 50% participants	8 (35%)	
Not associating with victim of your crime		50%
Reported by more than 50% participants	11 (48%)	
Reported by less than 50% participants	12 (52%)	
Doing community service		14%
Reported by more than 50% participants	2 (9%)	
Reported by less than 50% participants	21 (91%)	
Other Programs		
Other programs (batterer intervention, anger management, etc.)		13%
Reported by more than 50% participants	0	
Reported by less than 50% participants	23 (100%)	
Mental health tx		10%
Reported by more than 50% participants	0	
Reported by less than 50% participants	23 (100%)	

Source: Urban Institute MADCE Survey of Substance-Abusing Offenders

Notes: Supervision requirements and violations were not asked of respondents until March 8, 2006; these questions were only asked of respondents who were on supervision since baseline (686 participants, 68% of the complete drug court participant sample).

Court Responses to Participant Compliance

Another key component of drug courts is the use of sanctions to respond to noncompliance, and incentives to recognize achievements. In the MADCE, the use of sanctions and rewards was documented from the perspective of the participants, as well as through structured court observations by the research team.

Noncompliance: Sanctions

Slightly more than half (56 percent) of participants reported having received a sanction, for an average number of sanctions of 0.71 per month at risk (i.e., months when not incarcerated). As shown in Table 3-3.6, 52 percent of participants reported getting a sanction from the judge, whereas 25 percent reported receiving a sanction from the supervision officer. Of participants who reported committing at least one supervision violation, the ratio of sanctions per supervision violation was 1.32. Most of the sanctions were non-jail (84 percent); only 16 percent of sanctions received were to spend some time in jail.[4] Of participants who reported at least one supervision violation, only about one-third of those violations (0.35) received a jail sanction in response.

Table 3-3.6. Court Supervision – Sanctions
23 Drug Courts, Six Months after Baseline

Sanctions	Total Participants N = 1,009
Any sanctions	56%
# sanctions/month at risk	0.71
% sanctions that are jail	16%
Received at Least One Sanction from Judge	52%
Received at Least One Sanction from Supervision Officer	25%
Of those with at least one supervision violation:[1]	(N = 283)
Ratio of sanctions per supervision violation	1.32
Ratio of jail sanctions to supervision violation	0.35

Source: Urban Institute MADCE Survey of Substance-Abusing Offenders

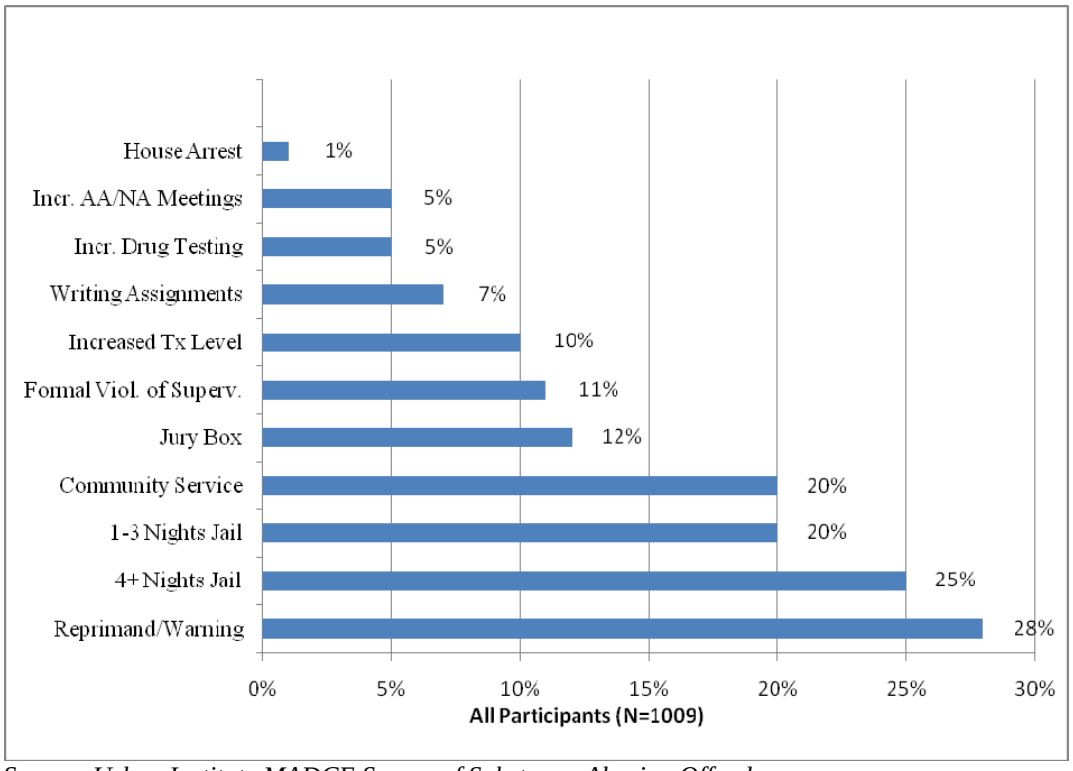
[1] *Supervision requirements and violations were not asked of respondents until March 8, 2006; these questions were only asked of respondents who were on supervision since baseline (686 participants, 68% of the complete drug court participant sample).*

The types of sanctions most often reported by participants are explored in greater detail in Figure 3-3.1. The most common sanctions reported were a reprimand or warning (28 percent), four or

[4] A single participant may receive multiple sanctions. Table 3-3.6 shows the distribution of *sanctions*, whereas Figure 3-3.1 shows the percentage of *participants* who received at least one of the specific sanctions.

more nights in jail (25 percent), less than four nights in jail (20 percent), and community service (20 percent). Although, anecdotally, jury box and essay/writing assignment sanctions are often considered quintessential drug court tools, they were not frequently used among our sample—only 12 percent reported sitting in the jury box, and 7 percent reported receiving a writing assignment. Sanctions involving clinical responses were used much less often than the purely punitive ones; 10 percent of participants reported an increase in their treatment level, 5 percent reported an increase in the frequency of drug testing, and 5 percent reported an increase in their required Alcoholics Anonymous/Narcotics Anonymous meeting attendance.

Figure 3-3.1. Types of Sanctions
23 Drug Courts, Six Months After Baseline



Source: Urban Institute MADCE Survey of Substance-Abusing Offenders
Note: Each participant may receive multiple sanctions, resulting in the total adding up to more than 100%.

Table 3-3.7 displays responses to noncompliance in the courtroom, as documented in the court observations conducted by the MADCE research team during site visits. Of those participants who had received a negative compliance report in court (i.e., participants who had an infraction that might result in a sanction response), 32 percent received an admonishment from the judge, and 14 percent received an admonishment from another member on the drug court team. Forty-eight percent received another miscellaneous sanction, and three percent were failed out of the drug court. About one-quarter of those with negative compliance reports did not receive any sanctions in court.

Table 3-3.7. Responses to Noncompliance in the Courtroom
14 Drug Courts

Responses to Noncompliance	
Of those participants who received a negative compliance report in court:	
Received admonishment from judge	32%
Received admonishment from other staff	14%
Was failed out of the drug court	3%
Received other sanction	48%
Received no court response	26%

Compliance and Achievements: Rewards

Drug courts not only respond punitively to noncompliance, many judges and drug court staff also like to recognize compliance and achievements with positive incentives or rewards. In the MADCE sample, 85 percent of the drug court participants reported receiving at least one reward, with an average of 3.00 per month at risk. Interestingly, the rate of incentives is more than four times greater than the rate of sanctions received per month at risk (0.71). As seen in Table 3-3.8, the vast majority of rewards were non-tangible—limited to praise from the judge or supervision officer (63 percent).[5]

Table 3-3.8. Court Supervision – Rewards, per Month at Risk
23 Drug Courts, Six Months after Baseline

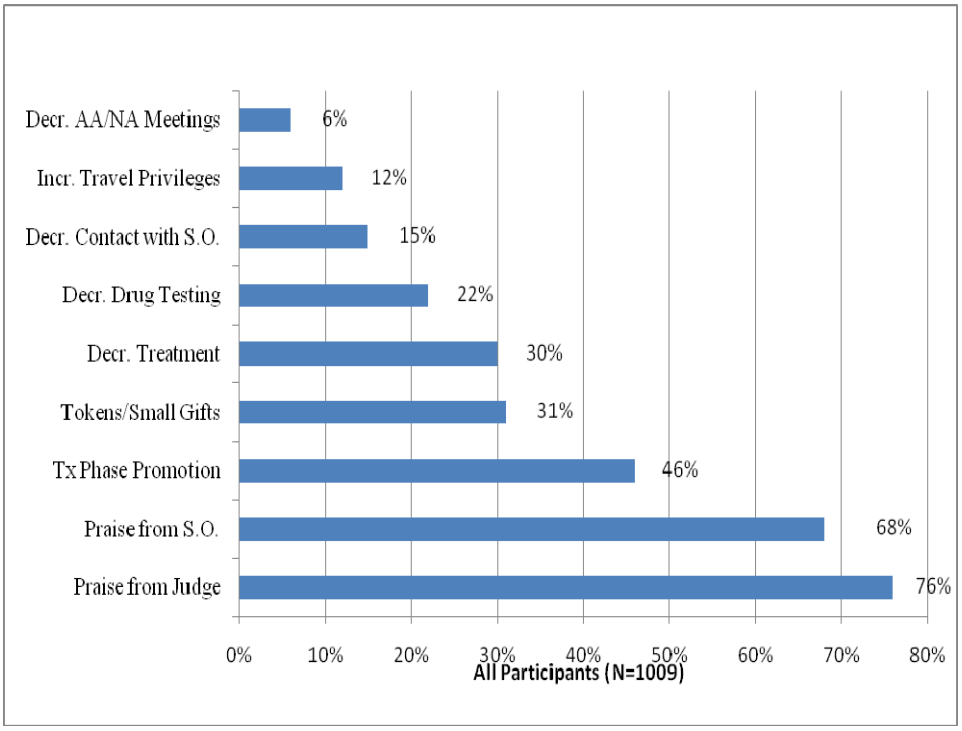
Rewards	**Total Participants N = 1,009**
Any Incentives	85%
# incentives/month at risk	3.00
% incentives that are praise (from judge or supervision officer)	63%

Source: Urban Institute MADCE Survey of Substance-Abusing Offenders
Note: Month at risk measures the time between the baseline and six-month interviews when respondents were not incarcerated.

More specifically, as seen in Figure 3-3.2, praise from the judge (76 percent) and praise from the supervision officer (68 percent) were, by far, the most common rewards. Other common rewards included a treatment phase promotion (46 percent), tokens or small gifts (31 percent), and a decrease in the treatment level (30 percent). Unlike responses to noncompliance, in which most were purely punitive, treatment-related positive responses were more common.

[5] A single participant may receive multiple rewards. Table 3-3.8 shows the distribution of *rewards*, whereas Figure 3-3.2 shows the percentage of *participants* who received at least one of the specific rewards.

Figure 3-3.2. Types of Incentives
23 Drug Courts, Six Months After Baseline



Source: Urban Institute MADCE Survey of Substance-Abusing Offenders
Note: Each participant may receive multiple rewards, resulting in the total adding up to more than 100%.

Table 3-3.9 reports the responses to compliance and achievements in the courtroom as observed by the MADCE team. Of participants who received a positive compliance report, 67 percent received praise from the judge, and 51 percent received applause. In only 9 percent of cases in which participants had a positive compliance report was public praise given by another non-judge staff member. Despite the frequency of praise by the judge, shaking hands with the client occurred only rarely (5 percent).

Table 3-3.9. Responses to Compliance in the Courtroom
14 Drug Courts

Responses to Compliance	
Of those participants who received a positive compliance report in court:	
Received praise from judge	67%
Received applause	51%
Received praise from other staff	9%
Shook hands with judge	5%
Received other reward	10%

Conclusions

Drug court monitoring and supervision are thought to be key components of what makes drug courts different from, and more effective than, traditional criminal justice processing. This chapter examined the variation in this component across the 23 drug courts in the MADCE study.

A notable difference between drug courts and traditional criminal processing is that drug court participants are required to have more contacts with the justice system during their participation period. Between more frequent judicial status hearings and more frequent contacts with the supervision officers, drug court participants receive vastly greater monitoring and supervision. The nature of that supervision, though, varies across drug courts. The variation explored in this chapter lays the groundwork for a more in-depth analysis of the relationship between various drug court polices, practices, and desired outcomes in future research.

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Chapter 4. Treatment in Adult Drug Courts

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Introduction

Alcohol and drug abuse or dependency have been identified as key contributing factors in the commission of many crimes (Anglin and Perrochet 1998; Ball, Schaffer, and Nurco 1983; Boyum and Kleiman 2002; Brownstein, Baxi, et al. 1992; Condon and Smith 2003; Dawkins 1997; DeLeon 1988a; DeLeon 1988b; Harrison and Gfroerer 1992; Inciardi 1992; Inciardi and Pottieger 1994; Johnson, Goldstein et al. 1985; MacCoun and Reuter 2001; Miller and Gold 1994; Mocan and Tekin 2004). The literature suggests treatment can be effective in reducing demand for substance use and associated criminal offending. Substance abusers often come into contact with the criminal justice system—rather than other health or social systems—presenting opportunities for intervention and treatment prior to, during, after, or in lieu of incarceration (National Institute on Drug Abuse 2009). In response, numerous state and local governments have implemented problem-solving courts—drug treatment courts (or, simply, drug courts)—that offer treatment-based alternatives to incarceration for substance-using offenders.

Drug courts essentially emerged as a grassroots movement from a model implemented in June 1989 as a partnership among the Court, the State Attorney's Office, and the Public Defender's Office in Miami-Dade County, FL, to deal with drug-related crimes and drug-using offenders by offering court-monitored drug treatment to reduce both defendants' drug use and the constant recycling of such offenders through the court system. Subsequently, other jurisdictions began handling their drug-related crimes in a similar fashion. Drug courts proliferated with the passage of Title V of the Violent Crime Control and Law Enforcement Act of 1994 (Public Law 103-322)—also known as the 1994 Crime Act—that authorized the Attorney General to award and administer discretionary grants to states, local governments, Indian tribal governments, and state or local courts to plan, implement, or enhance drug courts in which judges continuously supervised the progress of nonviolent offenders with substance abuse problems.[6]

The court programs were expected to incorporate both treatment services and judicial sanctions for noncompliance. In addition, the Act specifically required drug courts to include: (1) mandatory testing for the use of prohibited substances; (2) diversion, probation, or other supervised releases with the possibility of prosecution, confinement, or incarceration for failure to demonstrate adequate progress or to complete program requirements; and (3) ancillary services, such as relapse prevention, health care, education, vocational training, job placement, housing assistance, and child care assistance (Government Accounting Office 1995). The grants

[6] Until the 1994 Crime Act, there was no federal grant program specifically designed for drug courts. However, some drug court programs received funding or technical assistance from the Bureau of Justice Assistance (BJA) or Department of Health and Human Services' Center for Substance Abuse Treatment (CSAT).

could not be used by courts solely for the purpose of expediting case processing of drug crimes, nor could they be used for programs that permitted violent offenders[7] to participate (GAO 1995).

The 1994 Crime Act also authorized the Attorney General to provide for a national evaluation of the impact and effectiveness of the federal grants. While a number of evaluations of individual drug court programs had been performed, no national impact evaluation had been conducted as of October 2002, when the National Institute of Justice (NIJ), in cooperation with the Drug Court Program Offices (DCPO), requested proposals for the *National Drug Court Evaluation Multi-Site Longitudinal Impact Study* (National Institute of Justice 2002). The study—subsequently renamed NIJ's *Multi-Site Adult Drug Court Evaluation (MADCE)*—was intended to conduct offender-based, longitudinal research to evaluate the impact of drug court participation on post-program outcomes, specifically, recidivism.

The Justice Policy Center at the Urban Institute (UI-JPC) partnered with RTI International (RTI) and the Center for Court Innovation (CCI) to conduct the MADCE research. The study included 23 drug courts and 6 comparison sites located in seven geographic "clusters" across the United States. The court programs participating in MADCE were selected to reflect variation in drug court strategies and approaches implemented throughout the U.S. This chapter provides information about (1) the treatment provided by the 23 courts included in the MADCE research and (2) the differences in treatment experiences reported by drug court participants and members of the comparison group. The information is drawn from three data sources: the MADCE Adult Drug Court Survey conducted during the initial one-year planning phase, field visits to the MADCE study sites, and three waves of offender surveys, as described below.

The Treatment Context

Substance abuse is a complex disorder that can affect many aspects of an individual's life, including family relationships, functioning at work or school, and legal status in the community. Because of the complexity and pervasive consequences of substance abuse, treatment typically involves several components, some of which focus directly on the individual's alcohol or drug use, while others (e.g., life skills, cognitive-based therapies, employment training) address helping the addicted individual to not only achieve abstinence, but also productive membership in the family and society.

In the U.S., substance abuse treatment takes place in a variety of settings using a host of different behavioral and pharmacological approaches: more than 13,000 specialized drug treatment facilities provide counseling, behavioral therapy, medication, case management, and other types of services to persons with substance use disorders; treatment also is delivered in physicians' offices and medical or mental health clinics (NIDA 2009). Treatment practitioners include case managers, certified substance abuse counselors, physicians, psychiatrists, psychologists, nurses, and social workers. Although some treatment approaches are typically associated with particular treatment settings, various therapeutic interventions or services can be included in any given setting.

[7] Violent offenders are defined as persons charged with, or convicted of, offenses involving a firearm, dangerous weapon, death, serious bodily injury, or force; or persons who have one or more prior convictions for a violent felony crime.

Continuum of Care

Ideally, a full complement of services related to treatment of defendants for alcohol and substance abuse, as well as co-occurring mental health disorders, encompasses a range of care that permits individuals to access those services that meet their specific needs. A reasonably comprehensive continuum of care might include (Rossman, Gouvis, et al. 1999, NIDA 2009, University of Washington 2010):

- *Pretreatment services* such as substance abuse education, monitoring, and screening.

- *Screening*—which typically does not require extensive staff training—is generally viewed as quickly capturing basic information, systematically, about an individual's risks and needs in order to determine whether a fuller assessment is warranted. The goal of screening for substance abuse is to identify those persons whose presenting characteristics indicate a potential problem with alcohol, drugs, or co-occurring disorders (e.g., substance abuse and mental health issues) that may require treatment intervention. Screening protocols generally capture such information as: recent or current substance use, current or past treatment history, health problems, mental health history and current status, results of testing for substance use, social issues or problems (e.g., housing arrangements or homelessness, family dysfunction, employment or financial instability, or homelessness) (Mellow, Christensen, et al. 2010; Substance Abuse and Mental Health Services Administration and Center for Substance Abuse Treatment 1993).

- *Assessment* to determine individual characteristics and life circumstances that might influence and inform the treatment planning process. Assessment should provide more comprehensive and holistic information than screening—including such components as a clinical interview, personal history taking, biological testing, and paper-and-pencil testing—and may take several hours or more than a single session to complete. Essentially, the process is intended to be both *descriptive* (i.e., identifying individual strengths, weaknesses, and readiness for treatment) and *prescriptive* (i.e., recommending the level of treatment commensurate with an individual's needs). SAMHSA/CSAT (1993) recommends that assessments detail the extent and severity of the substance abuse problem, the individual's level of maturity and readiness for treatment, co-occurring problems, the type of intervention that will be necessary to address the problems, the resources (e.g., personal motivation, family support, social support, educational and vocational skills) the individual can muster to help solve the problems, and how the individual will be engaged in the treatment process. Assessment instruments also may be geared towards assessing the treatment and treatment process itself, or for documenting treatment outcomes.

- *Detoxification* **(**often dubbed "detox"), which typically involves a brief, medically supervised withdrawal from a substance. Although this generally takes place as an inpatient service in a hospital or medical setting, individuals needing detox also may be treated in outpatient settings. Detox can take any number of days, but most often does not exceed one week to ten days. Some programs do not offer medical detoxification, but

instead rely on social detoxification that does not use medication to assist the physical withdrawal from drugs.

- *Outpatient treatment***,** using different therapeutic milieus such as psychotherapy, individual or group counseling, or pharmacologic support, but also might include such outpatient programming as cognitive behavioral therapy, anger management, marital or family counseling, vocational therapy, or life skills training. Some treatment models are relatively intensive, requiring nine or more hours of treatment weekly in a structured setting that incorporates a "manualized" treatment approach. Others are considerably less intensive in terms of treatment hours, or far more informal with respect to the systematic delivery of the intervention. Generally speaking, most communities lack truly integrated outpatient substance abuse and mental health treatment programs, although they may have the capacity to offer each intervention in separate settings or using staff who have not been cross-trained on both substance abuse and mental health interventions.

- *Residential treatment* that ranges from community-based treatment in such settings as halfway houses, social model recovery homes or sober living sites, and transitional housing to more intensive inpatient residential programs that use specific treatment modalities (e.g., reality therapy) or function as Therapeutic Communities. Residential treatment programs may be either short (30 days) or longer term (90 days or more). For a variety of reasons (including, but not limited to conservation of resources), community-based interventions are typically favored over inpatient residential treatment; however, there clearly are circumstances under which inpatient care is needed on either a short- or longer-term basis.

- *Self-help or support groups*—such as Alcoholics Anonymous (AA), Narcotics Anonymous (NA)**,** or Cocaine Anonymous (CA)—are based on the 12-step model of recovery that has a largely spiritual base, focuses on abstinence, and encourages active participation in self-help meetings and related activities. Well-known and well-respected, such groups are often used as an adjunct to treatment; however, some practitioners do not consider self-help groups to be treatment since they are facilitated by lay leaders (former substance abusers) and are not intended to provide therapy or counseling. As individuals become members, they may be linked to a sponsor, who is a person in recovery. The role of a sponsor in relation to a newer member is akin to a mentor.

Treatment Approaches

Generally speaking, treatment approaches for substance abuse—with or without co-occurring mental health disorders—include pharmacotherapies, psychoanalysis, cognitive therapies, behavior therapies, or a combination of these approaches, as briefly described below (All About Counseling 1998, NIDA 2009):

- Common *pharmacotherapies*, for instance, use Naltrexone, Acamprosate, Disulfiram, or Topiramate for alcohol abuse; while Methadone, Buprenorphine, or Naltrexone may be used for opioid addiction.

- *Cognitive therapies*, such as rational-emotive, cognitive-behavioral, reality, and transactional analysis, are based on the belief that an individual's thoughts are directly connected to how the individual feels. The cognitive therapies focus on helping clients identify distorted thinking that causes emotional discomfort or other difficulties. Common traits among the cognitive approaches include a collaborative relationship between client and therapist, homework between sessions, and the tendency for treatment to be of short duration. These therapies are best known for treating mild depression, anxiety, and anger problems.

- *Behavioral treatments* help engage people in drug abuse treatment, provide incentives for them to remain abstinent, modify their attitudes and behaviors related to drug abuse, and increase their life skills to handle stressful circumstances and environmental cues that may trigger intense craving for drugs and prompt another cycle of compulsive abuse. Therapy often includes homework, behavioral experiments, role-playing, assertiveness training, and self-management training. Like cognitive therapy, the approach involves the collaboration between client and therapist, and is usually of short duration.

- *Psychoanalytic therapies* involve analyzing the root causes of behavior and feelings by exploring the unconscious mind and the conscious mind's relation to it. Many theories and therapies (e.g., hypnotherapy, object-relations, Progoff's Intensive Journal Therapy, Jungian)—dealing with unconscious motivation—have evolved from the original Freudian psychoanalysis that uses free-association, dreams, and transference, as well other strategies to help clients know the function of their own minds. Other psychoanalytic therapeutic approaches—Adlerian, Rogerian person-centered, gestalt—are based on different theoretical premises, but tend to use similar interventive techniques. Usually the duration of therapy is lengthy; however, some therapists currently use psychoanalytic techniques as short-term interventions.

As shown in Figure 3-4.1, the National Institute on Drug Abuse (NIDA 2009: 2-5) has identified 13 principles of effective treatment.

Figure 3-4.1. Thirteen Principles of Effective Treatment

1. **Addiction is a complex, but treatable disease that affects brain function and behavior.** Drugs of abuse alter the brain's structure and function, resulting in changes that persist long after drug use has ceased. This may explain why drug abusers are at risk for relapse even after long periods of abstinence and despite the potentially devastating consequences.

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

3. **Treatment needs to be readily available.** Because drug-addicted individuals may be uncertain about entering treatment, taking advantage of available services the moment people are ready for treatment is critical. Potential patients can be lost if treatment is not immediately available or readily accessible. As with other chronic diseases, the earlier treatment is offered in the disease process, the greater the likelihood of positive outcomes.

4. **Effective treatment attends to multiple needs of the individual, not just his or her drug abuse.** To be effective, treatment must address the individual's drug abuse and any associated medical, psychological, social, vocational, and legal problems. It is also important that treatment be appropriate to the individual's age, gender, ethnicity, and culture.

5. **Remaining in treatment for an adequate period of time is critical.** The appropriate duration for an individual depends on the type and degree of his or her problems and needs. Research indicates that most addicted individuals need at least 3 months in treatment to significantly reduce or stop their drug use and that the best outcomes occur with longer durations of treatment. Recovery from drug addiction is a long term process and frequently requires multiple episodes of treatment. As with other chronic illnesses, relapses to drug abuse can occur and should signal a need for treatment to be reinstated or adjusted. Because individuals often leave treatment prematurely, programs should include strategies to engage and keep patients in treatment.

6. **Counseling—individual and/or group—and other behavioral therapies are the most commonly used forms of drug abuse treatment.** Behavioral therapies vary in their focus and may involve addressing a patient's motivation to change, providing incentives for abstinence, building skills to resist drug use, replacing drug-using activities with constructive and rewarding prosocial activities, improving problem-solving skills, and facilitating better interpersonal relationships. Also, participation in group therapy and other peer support programs during and following treatment can help maintain abstinence.

7. **Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.** For example, methadone and buprenorphine are effective in helping individuals addicted to heroin or other opioids stabilize their lives and reduce their illicit drug use. Naltrexone is also an effective medication for some opioid-addicted individuals and some patients with alcohol dependence. Other medications for alcohol dependence include acamprosate, disulfiram, and topiramate. For persons addicted to nicotine, a nicotine replacement product (such as patches, gum, or lozenges) or an oral medication (such as bupropion or varenicline) can be an effective component of treatment when part of a comprehensive behavioral treatment program.

Figure 3-4.1. Thirteen Principles of Effective Treatment (Cont'd)

8. **An individual's treatment and services plan must be assessed continually and modified as necessary to ensure that it meets his or her changing needs.** A patient may require varying combinations of services and treatment components during the course of treatment and recovery. In addition to counseling or psychotherapy, a patient may require medication, medical services, family therapy, parenting instruction, vocational rehabilitation, and/or social and legal services. For many patients, a continuing care approach provides the best results, with the treatment intensity varying according to a person's changing needs.

9. **Many drug-addicted individuals also have other mental disorders.** Because drug abuse and addiction—both of which are mental disorders—often co-occur with other mental illnesses, patients presenting with one condition should be assessed for the other(s). And when these problems co-occur, treatment should address both (or all), including the use of medications as appropriate.

10. **Medically assisted detoxification is only the first stage of addiction treatment and by itself does little to change long-term drug abuse.** Although medically assisted detoxification can safely manage the acute physical symptoms of withdrawal and, for some, can pave the way for effective long-term addiction treatment, detoxification alone is rarely sufficient to help addicted individuals achieve long-term abstinence. Thus, patients should be encouraged to continue drug treatment following detoxification. Motivational enhancement and incentive strategies, begun at initial patient intake, can improve treatment engagement.

11. **Treatment does not need to be voluntary to be effective.** Sanctions or enticements from family, employment settings, and/or the criminal justice system can significantly increase treatment entry, retention rates, and the ultimate success of drug treatment interventions.

12. **Drug use during treatment must be monitored continuously, as lapses during treatment do occur.** Knowing their drug use is being monitored can be a powerful incentive for patients and can help them withstand urges to use drugs. Monitoring also provides an early indication of a return to drug use, signaling a possible need to adjust an individual's treatment plan to better meet his or her needs.

13. **Treatment programs should assess patients for the presence of HIV/ AIDS, hepatitis B and C, tuberculosis, and other infectious diseases, as well as provide targeted risk-reduction counseling to help patients modify or change behaviors that place them at risk of contracting or spreading infectious diseases.** Typically, drug abuse treatment addresses some of the drug-related behaviors that put people at risk of infectious diseases. Targeted counseling specifically focused on reducing infectious disease risk can help patients further reduce or avoid substance-related and other high-risk behaviors. Counseling can also help those who are already infected to manage their illness. Moreover, engaging in substance abuse treatment can facilitate adherence to other medical treatments. Patients may be reluctant to accept screening for HIV (and other infectious diseases); therefore, it is incumbent upon treatment providers to encourage and support HIV screening and inform patients that highly active antiretroviral therapy (HAART) has proven effective in combating HIV, including among drug-abusing populations.

Source: NIDA 2009: 2-5

Data Sources

The current chapter describes information provided from three data sources (see Volume 1 for detailed discussion of MADCE methodology). First, during the initial phase of the study, we implemented the MADCE Adult Drug Court Survey; that is, between February and June 2004, we conducted a web-based survey of drug courts that primarily served adults and had been in operation for at least one year at that time. The survey included five major sections, as well as subsections covering more specific topics within each area. The five sections were (1) General Information, including population served, points of entry into the program, and case flow; (2) Program Structure, including program characteristics, eligibility criteria, and substance abuse assessment; (3) Program Operations, including management information systems, entry into the drug court program, program staffing, case management, and program contacts; (4) Treatment and Drug Testing, including substance abuse treatment services and drug testing; and (5) Courtroom Practices, including courtroom practices, infractions and sanctions, achievements, and graduation (see Volume 2 for details). Relevant to treatment, we asked adult drug courts that had been in operation at least one year to indicate:

- The sources of information used to determine if defendants were eligible for drug court enrollment.
- The assessment tools used to determine clinical eligibility.
- Whether the drug court conducted formal mental health screenings.
- Whether the drug court ran its own substance abuse treatment program (i.e., treatment providers were hired such that the program was operated directly by the court).
- How many substance providers serve drug court participants.
- The types of substance abuse treatment available to drug court participants at that time.
- How much difficulty the program had finding residential, intensive outpatient, outpatient individual counseling, or outpatient group counseling slots for drug court participants.
- Whether the drug court integrated mental health and substance abuse treatment for participants with co-occurring disorders.

A total of 380 drug courts completed the survey, including the 23 courts that were subsequently selected for the quasi-experimental MADCE study. The survey response rate was 64 percent of the 593 courts identified across the U.S. that met the eligibility requirements of primarily serving adults and being in operation for at least one year at that time. Although national in scope, the sample is not nationally representative per se; nonetheless, it provides an important foundation for understanding drug court programs throughout the country. In several places in this chapter, we compare the 23 courts in the outcome component of the evaluation to the full sample of 380 courts (of which they were a subset).

Second, process evaluation site visits were conducted to the 23 sites participating in the outcome evaluation.[8] Between February and June 2006, evaluation team members visited each court in the study to meet with and interview stakeholders, and conduct observations of drug court staffing meetings and court hearings. Program structure and management, operations, treatment, drug testing, and courtroom practices were explored in greater detail through open-ended questions and observations. During our field visits to MADCE sites, we collected such information as:

- Whether the courts accepted individuals on methadone (52.2 percent did), with severe mental health disorders (87 percent did), or with severe physical health problems (100 percent did).

- Number of treatment providers used by the site.

- Whether a phased approach is used, and what this entails.

- Median time (hours/day and days/week) drug court participants were assigned to various treatment modalities.

- Percentage of the drug court participants who were initially assigned to short- or long-term inpatient treatment, as well as the percentage ever assigned to long-term residential treatment.

Lastly, one of the key data sources for the MADCE research is interview data gathered from drug court participants and comparison offenders[9] at baseline, 6 months post-baseline, and 18 months post-baseline:

- *Baseline interviews* document respondents' experiences and behaviors as close to the point at which they began their drug court participation/comparison conditions as possible (ideally, before they began treatment or regular status hearings).

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[8]Two rounds of site visits were conducted. The first round of site visits occurred at the conclusion of the site selection process and primarily focused on confirming the viability of the site for inclusion in the impact evaluation and negotiating logistical details pertaining to data collection for the offender interviews. We also documented program organization and operations (via semi-structured interviews and the collection of existing materials), including program structure and key staff; enrollment and case flow; availability of administrative data; the intake process; phases and requirements for court hearings, treatment attendance, case management, drug testing, and supervision; and sanctions and rewards. The second round was conducted to obtain programmatic data that could be used as site-level variables in impact analyses and otherwise assist in the interpretation of evaluation findings. The timing of the second round was selected to reflect program operations during the baseline enrollment timeframe.

[9] The MADCE impact component included six comparison sites representing the diverse set of activities employed in jurisdictions throughout the country that do not implement drug courts, including several that used alternative modes of treatment for drug-involved offenders. A portion of our comparison sample came from counties that did indeed have drug courts, but either had more drug-involved offenders than could be enrolled in drug court or had drug-involved offenders who did not meet the criteria for that jurisdiction's drug court, but met criteria for drug courts in other areas of the country. Selecting comparison group members who did not meet the eligibility criteria for a particular drug court, but who could have met criteria in other drug courts in the country was considered acceptable because the MADCE study design entailed pooling the comparison group members across the comparison sites (rather than a one-to-one drug court versus comparison site design).

- *Six-month follow-up interviews* capture respondents' experiences throughout the initial—and most intensive—phase of drug court participation (or whatever alternative comparison members experienced).
- *Eighteen-month follow-up interviews* reflect longer-term experiences, including a timeframe when the majority of the drug court cohort had concluded their drug court program participation.

For the analyses presented below, only the responses of the 877 drug court participants and the 472 comparison members who answered all three waves were used.

The content of the instruments was similar across the three interviews. The instruments were extremely comprehensive, covering a diverse set of outcomes (criminal behavior, compliance with supervision, substance use, mental health, employment, income, and family functioning), background characteristics (substance use history and addiction severity, physical and mental health), "in program" experiences (supervision intensity, court experiences, substance abuse treatment, support services), attitudes (treatment motivation) and perceptions. [10] Questions about substance abuse treatment post-enrollment in the MADCE study asked respondents:

- Whether they had received any treatment specifically with regard to the following treatment types: detox, emergency room for drug or alcohol treatment, outpatient individual counseling, outpatient group counseling, support groups, residential treatment, pharmacologic, or alternative (e.g., acupuncture, meditation, biofeedback).
- In which months each treatment type was received.
- In months where treatment was reported, how days of treatment were received by treatment type.

Treatment Motivation

A full description of NIJ's MADCE sample of individuals is detailed in *The Multi-Site Adult Drug Court Evaluation—Baseline Characteristics of Study Participants* (Volume 1, Chapter 6). Excerpts relevant to treatment motivation and other topics of interest related to the treatment domain are presented in Appendix A.

[10] Individual items and scales were selected based on a detailed review of existing items and scales successfully used with criminal justice-involved populations. Priority was given to items/scales with strong psychometric qualities. Several standardized scales were adapted for use, including: The Addiction Severity Index (Gavin, Ross, and Skinner 1989); Texas Christian University (TCU) Treatment Motivation Scales (problem recognition, desire for help, treatment readiness, external pressure (Knight, Holcom, and Simpson 1994); The Stages of Change Readiness and Treatment Eagerness Scale (SOCRATES, including problem recognition, ambivalence, and taking steps (Miller and Tonigan 1996); CES-D short form depression scale (Andresen, Malmgren, et al. 1994); and Anti-Social Personality Disorder (APD) and Narcissism scales derived from the structured clinical interview for the DSM-IV-TR (with the official diagnostic criteria framed in the format of structured interview questions) (American Psychiatric Association 2000).

As presented in Table 3-4.1, using a simple t-test, we tested whether there was a statistically significant difference in the change in motivation for treatment during the first six months of drug court. The first six months were selected because that is the period during which drug court might be expected to have the largest impact on motivation to receive treatment. Three motivation scales were used as described briefly below and detailed in Appendix B. The first scale was the TCU Treatment Motivation Scale comprised of four indices: problem recognition (9 items), desire for help (7 items), treatment readiness (6 items), and external pressure (5 items). The second scale—Treatment Eagerness—includes three indices: problem recognition (7 items), ambivalence (4 items), and taking steps (6 items). Lastly, the third scale averaged the previous two scales.

Table 3-4.1. Early Changes in Treatment Motivation, by Group

	Change in 1st Scale	Change in 2nd Scale	Change in 3rd Scale
Drug Court Group	-0.34***	-0.30***	-0.33***
Comparison Group	-0.64	-0.52	-0.58

Source: Urban Institute MADCE Survey of Substance-Abusing Offenders
** Significant at p = 0.10*
*** Significant at p = 0.05*
**** Significant at p = 0.01*

For all scales and both groups, on average, motivation diminished over the first six months. However, the decrease was significantly greater among the comparison group. On average, the comparison group's motivation decreased by almost twice that of the drug court group. This difference is highly statistically significant.

Treatment Practices

Figure 3-4.2 provides brief descriptions of the treatment aspects of several of the 23 MADCE courts to illustrate the variability among this cohort.

Eligibility Determinations and Use of Assessment Tools

Table 3-4.2 presents the sources of information used to determine eligibility by the 23 drug courts that participated in the MADCE research and the full sample of courts (N=376 valid responses, including the 23 court sites) that responded to our national survey. Although more than 80 percent of the courts in each sample reported using clinical assessments, a large number also used other sources of information to assess substance use issues, such that eligibility is not based solely on clinical criteria. Many of the courts report relying (at least partially) on less

Figure 3-4.2. Snapshots of Treatment in the MADCE Programs

Court 1:

Legally appropriate cases undergo the New York state Universal Treatment Application (UTA) psychosocial assessment administered by the coordinator, and are screened for motivation and severe mental health issues, but rarely excluded on either of these grounds. The Drug Court's Methadone Policy makes it acceptable to enroll individuals on methadone, if this is clinically appropriate; such clients can graduate while on methadone; however, only one participant has required methadone, and this participant saw a provider an hour away. The program has Memoranda of Understanding (MOUs) with two primary intensive outpatient programs (IOPs), the county mental health services agency, and several area inpatient programs. Both IOPs offer similar programs.

The first IOP includes: (1) group sessions of 12 clients per group for 2.5 hours, twice weekly for approximately six months (52 sessions), using a curriculum that involves discussions of feelings, family issues, and anger; (2) an educational program, consisting of weekly 1.5-hour sessions, for 12 weeks, that focus on medical aspects of alcohol and drug use using a lot of films that deal with denial, stages of change, and details of how each key drug affects the body; (3) continuing care group that has a heavy relapse prevention focus (discussion of relapse signs and triggers) and entails 12 1.5-hour weekly sessions beginning after the 26-week outpatient program (making the total duration of treatment 40 weeks); and (4) biweekly one-hour individual meetings (more frequently, if needed) that continue after clients have completed the standard package of group sessions until their drug court participation is complete. The provider makes referrals to inpatient and county mental health services, as needed.

The second IOP program lasts four months or 50 sessions (three per week) for two hours each, with 10 to 14 clients led by one counselor (one group) or two counselors (the other group), using a curriculum that covers introduction to drug addiction, review of medical aspects of addiction, and review of effects on home life. Their early recovery program entails two-hour weekly sessions for 16 weeks that cover triggers to relapse and discussion of outside experiences in reintegration; the aftercare program entails one-hour sessions for 12 weeks continuing the themes developed in the early recovery group. Participants can make appointments for individual sessions at any time; some have weekly meetings, but monthly is more typical.

Court 2:

A treatment staff member (who works for the probation department) conducts the assessment interviews either in jail (if the candidate is detained) or in the court office, using the Texas Christian University screen and the Addiction Severity Index (ASI) and covering such information as: demographics, date of birth, race, number of children, residence, educational and employment background, prior department of corrections history, any treatment services received while in jail or prison, prior criminal justice history, drug use history, prior treatment history and outcomes of treatment episodes, prior psychiatric history, any medications currently taking, whether they were using drugs when arrested, whether they have any tattoos and if so why, and what the police will say about them when contacted. Methadone is allowed; although no one has graduated while on methadone, in theory, that would not be prohibited. The drug court works with six inpatient and eight outpatient providers, and has MOUs with all of these providers.

Approximately 40 percent of participants begin in a 90-day inpatient program, arranged by the treatment staff. (There is no long-term residential available in the area.) Typical inpatient programming consists of 25 hours per week of group and individual sessions of at least one one-hour per week. The group curriculum includes information on relapse prevention, learning about dual diagnoses, anger management, and domestic violence education. Also, two or three groups per week focus on recreational/leisure activities; and a family educational group is held for everyone once per week. All participants are assigned a primary treatment counselor who holds individual sessions with the participant and is responsible for submitting treatment progress reports to the drug court. Drug testing is random (only automatic if the participant has left the building). Treatment staff will recommend the "least restrictive" modality possible.

Figure 3-4.2. Snapshots of Treatment in the MADCE Programs (Cont'd)

Outpatient programs will be recommended as the first modality (in lieu of inpatient as the initial intervention) for those with support in the community who do not habitually use drugs. When the first modality is intensive outpatient, treatment staff will give the participant contact information on area facilities, but the participant must reach out to a program. Treatment program hours, days per week, and curriculum vary by program. Typical intensive outpatient programs usually involve three 4-hour groups per week and one individual session per week (1-1.5 hours), entailing a total of about 12 to 15 hours per week. After completing outpatient treatment, participants must have three "pro-social" contacts per week (e.g., AA/NA meetings, other approved group activities).

Court 3:

The program is structured in three phases. **Phase I** requirements—typically lasting five to eight months—include: (1) the development of Initial Individualized Treatment Plans, (2) attendance at the weekly two-hour substance abuse education group (ten week curriculum), (3) weekly 1.5-hour Moral Reconation Therapy (MRT) groups using the Thinking for Good workbook (10 modules), (4) individual counseling (1/2 hour per week or 1 hour every two weeks, as decided by the drug court team) , 4) weekly 1.5-hour group counseling (process) sessions, (5) weekly 1.5 to 2-hour Seeking Safety groups, (6) weekly 1.5-hour Cognitive Self Change (CSC) groups, (7) two recovery/support groups (e.g., AA, NA) per week, and (8) $25.00 weekly payment for services. To advance to Phase II, participants need to: have 60 consecutive sober days, be current with all fees, obtain a stable and verifiable address 4 weeks prior to advancement, have no violations for the previous 14 days, purchase MRT workbook 1 week prior to advancement, submit a copy of their high school diploma or complete GED orientation and take pre-tests, and fill out a phase advancement application.

Phase II requirements ─ typically lasting seven to nine months—include (1) updating the Individualized Treatment Plan, (2) weekly 1.5-hour MRT sessions, (3) weekly 2-hour substance abuse education, (4) individual counseling (1/2 hour per week or 1 hour every 2 weeks, as decided by the drug court team), (5) weekly 1.5-hour group counseling (process) sessions, (6) weekly 1.5-hour CSC groups, and (7) $25.00 weekly payment for services. To advance to Phase III participants need to obtain a 12-step sponsor, be 60 days clean and sober (120 days total), be current in all program fees, obtain and maintain a verifiable stable address, have no program violations for at least 30 days, read the book *Tuesday's with Morrie* and write a four-page paper about it, submit their high school diploma or GED, purchase Gorski Relapse Prevention book, submit a copy of a pay stub verifying full-time employment, and complete an application to advance to Phase III.

Phase III requirements which take a minimum of four months, include: (1) updating the treatment plan; (2) weekly 1.5-hour group counseling (process) sessions; (3) individual counseling (as decided by the drug court team); (4) weekly 1.5 hour enhancement groups on relapse prevention (Gorski); (5) completion of a Personal Recovery Plan (PRP) and presentation in group; (6) completion of MRT Steps 13, 14, and 15; and 7) 25 weekly payment for services. Treatment-related graduation requirements include: (1) obtaining/maintaining a 12-step sponsor, (2) achieve 180 consecutive days clean and sober, (3) submitting a copy of the PRP, (4) payment of all program fees in full, and (5) application for completion of Phase 3.

Court 4:

This is a county drug court with four locations, each of which relies on different treatment providers. Clients may be referred to providers outside the county for residential treatment, although the court has access to providers within the county. The table below depicts the basic structure of treatment. The program has a slightly different schedule for advancement for cases ordered by the court to long-term (180 days) treatment.

Figure 3-4.2. Snapshots of Treatment in the MADCE Programs (Cont'd)

In Phase 1, participants receive five sessions of group therapy per week and attend AA/NA five times per week, once per day. The minimum time in treatment to advance to the next stage is approximately 26 days, which includes

at least 20 group therapy sessions. Individuals are required to have 20 consecutive clean days to qualify for phase advancement.

In Phase 2, participants attend three sessions of group therapy per week and are required to attend AA/NA four times per week. The minimum time in treatment to advance to the next stage is approximately 90 days. Individuals are required to have 45 consecutive clean days to qualify for phase advancement. Additionally, a First Step fee of $12.48 per case must be paid in full within the first 30 days in Phase 2, a treatment fee of $180 must be satisfied, and the individual must complete ten hours of community service.

In Phase 3, participants attend two sessions of group therapy per week for one month, after which they attend group therapy once per week. Attendance requirements for AA/NA remain at four times per week. The minimum time in treatment to advance to the final phase is approximately 150 days. Individuals are required to have 120 consecutive clean days to qualify for phase advancement. Additional requirements include payment of $300 as a treatment fee, and completion of an additional ten hours of community service.

Phase 4 is considered an after care phase. Participants receive one session per month of individual therapy (instead of the group therapy required in earlier phases, and are required to attend AA/NA as instructed by their counselor. They also must attain 30 consecutive clean days and pay all court-ordered fees in order to graduate.

objective sources of information, such as self-reported drug use history and the professional judgment of the person conducting the initial screening; for example, four courts (17.4 percent) in the MADCE sample reported using only professional judgment to make eligibility determinations.

Table 3-4.2. Sources of Information Used to Determine Drug Court Eligibility

Source of Information	Percent of MADCE Courts (N=23)	Percent of National Court Survey Respondents (N=376)
Clinical assessments	82.6	88.0
Drug test results	26.1	45.5
Self-reported drug use history	78.2	80.1
Self-reported drug treatment history	60.9	68.9
Professional judgment of the person conducting initial screening	91.3	86.4
Contact with family member, friend, employer, or other acquaintance	21.7	34.6

Source: Urban Institute Survey of Adult Drug Courts

Many drug courts use several sources of information, including both objective and subjective measures of substance use, to determine eligibility. In the MADCE 23-court sample, three combinations accounted for 56.5 percent of responses; in the nationwide sample, the same three combinations accounted for 54.5 percent of all responses. The most frequent combination reported by MADCE courts includes the use of four items: clinical assessments, self-reported drug use history, self-reported drug treatment history, and the professional judgment of the person conducting the initial screening; this was reported by 30.4 percent of the MADCE courts and 17.7 percent of the nationwide survey respondents. The second most frequent combination reported by the MADCE sample (17.4 percent) includes all of the items shown in Table 3-4.2, *except* for contact with family members, friends, employers, or other acquaintances. This pattern was the third most frequent combination of information sources reported by 14.5 percent of the nationwide survey respondents. The third most common pattern—use of all six information sources listed in Table 3-4.2— reported by 8.7 percent of the MADCE courts was the most frequent combination reported by the nationwide survey respondents (23.3 percent).

Those that indeed used clinical assessment tools reported the specific tool, or tools, they used to assess substance use issues for program participants (see Table 3-4.3). Although a large majority uses some standardized assessment tool, such as the Addiction Severity Index (ASI), many courts are using non-standardized assessment instruments. The most widely used clinical assessment by courts in our survey is the ASI (52.2 percent of the MADCE subsample and 60.4 percent of the nationwide sample). In the MADCE sample, 30.4 percent used an "instrument designed by drug court staff," as compared to 19.6 percent of the nationwide sample. Nearly half of each sample (48.9 percent of the nationwide sample and 43.5 percent of the MADCE courts) reported using instruments other than those specified in the survey. Respondents indicated the "other" instruments they used; in both samples, frequently mentioned "other" instruments were the American Society of Addiction Medicine (ASAM) Patient Placement Criteria and the Substance Abuse Subtle Screening Inventory (SASSI). In the MADCE sample, three courts (13 percent) reported using the Diagnostic and Statistical Manual of Mental Disorders *(*DSM-IV*)* in combination with other instruments.

An analysis of all the possible combinations of assessment tools used may be more revealing than knowing the most frequently used tools. In the MADCE sample, 65.2 percent used a combination of assessment tools, but no particular patterns emerged. In the nationwide sample, our analysis showed that three patterns of assessment tools accounted for the majority of responses (62.5 percent). The most frequent pattern of assessment tools (for 27.5 percent of courts) was the sole use of the ASI. The next most frequent pattern of tools (for 21.8 percent of courts) was the single selection of some "Other" assessment instrument. Finally, the third most frequent pattern (for 13.3 percent of courts) was the use of the ASI in combination with some "Other" assessment instrument.

In addition to assessments for substance abuse issues, about 4 percent of the MADCE courts and 13.2 percent of courts in the nationwide sample reported conducting formal mental health screenings for all defendants. Another 30 percent of the MADCE courts and 36.1 percent of the larger sample conduct such screenings only for some defendants. The majority of the MADCE courts (65.2 percent) and about half of the drug courts in the nationwide sample (50.7 percent) do

not conduct formal mental health screenings. Of those that do conduct mental health screenings, the majority use screening instruments other than the set of standard instruments that we identified as possible responses in the survey (see Table 3-4.4). Some of these "other" instruments are standardized (e.g., Brief Psychiatric Rating Scale, DSM-IV R), while others are tools that have been developed by drug court staff for their own program's purposes and use.

Table 3-4.3. Instruments Used When Clinical Assessments are Conducted

Assessment Tool	Percent of MADCE Courts (N=23)	Percent of National Court Survey Respondents (N=376)
None	17.4	2.1
Addiction Severity Index(ASI)	52.2	60.4
Offender Profile Index (OPI)	0	2.1
Alcohol Dependence Scale (ADS)	4.3	6.0
Drug Dependence Scale (DDS)	9.0	6.3
Simple Screening Instrument	13.0	13.6
Texas Christian University Prevention Management and Evaluation System	0	2.4
American Drug and Alcohol Survey (ADAS)	0	3.3
Instrument designed by court staff	30.4	19.6
Other	43.5	48.9

Source: Urban Institute Survey of Adult Drug Courts

Table 3-4.4. Instruments Used When Formal Mental Health Screening is Conducted

Assessment Tool	Percent of MADCE Courts (N=8)	Percent of National Court Survey Respondents (N=160)
Beck Depression Inventory (BDI)	0	14.4
Brief Symptom Inventory (BSI)	13.0	11.3
Referral Decision Scale (RDS)	0	3.1
Symptom Checklist 90 Revised (SCL-90R)	0	3.8
Other	21.7	67.5

Source: Urban Institute Survey of Adult Drug Courts

Types of Treatment Provided

The provision of substance abuse treatment is clearly a principal function of drug courts. Both the 10 key components identified by the Office of Justice Programs and the National Association of Drug Court Professionals (OJP/NADCP 1997) and the 13 principles of effective treatment identified by NIDA (2009) highlight the desirability of multiple treatment modalities that can be tailored to individual needs, along with other supportive services that enable the provision of comprehensive support for abstinence. The majority of drug court programs rely on multiple substance abuse treatment providers to serve their clients (see Table 3-4.5). In the MADCE subset, 21.7 percent—compared with 20 percent of the nationwide drug court sample—operate their own substance abuse treatment program, meaning treatment staff is hired and the program is directly operated by the court.

In order to determine what specific types of substance abuse services are given to drug court participants, we provided court respondents with a list of 14 distinct types of treatment services and asked them to indicate which of the services are available to their participants (see Table 3-4.6). We found that almost all of the MADCE courts and those in the nationwide sample provide residential, intensive outpatient, outpatient individual counseling, outpatient group counseling, drug education, self-help, and relapse prevention. These findings may speak to the actual availability of these services in these locations, rather than the courts' interest in providing them. While 87.0 percent of the MADCE courts provide detoxification, only about two-thirds (67.5 percent) of courts in the nationwide sample indicated that detox is available. Since many drug courts do not admit individuals using methadone into their programs, it is not surprising that relatively few courts in either group reported that methadone maintenance and methadone-to-abstinence treatment were available. Versions of therapeutic communities (TCs) are embraced by slightly more than half of the MADCE courts, but only a substantial minority of courts in the

Table 3-4.5. Number of Substance Abuse Providers That Serve Drug Court Participants

Number of Providers	Percent of MADCE Courts (N=23)	Percent of National Court Survey Respondents (N=378)
1	17.4	26.5
2	17.4	13.8
3 to 5	30.4	26.5
6 to 10	4.3	12.7
11 to 20	30.4	10.1
21 to 50	0	9.3
51 to 100	0	1.3

Source: Urban Institute Survey of Adult Drug Courts

Table 3-4.6. Types of Substance Abuse Treatment Services Provided

Assessment Tool	Percent of MADCE Courts (N=23)	Percent of National Court Survey Respondents (N=378)
Residential	91.3	84
Intensive Outpatient	100.0	91.5
Individual Counseling (Outpatient)	95.7	97.4
Group Counseling (Outpatient)	100.0	97.9
Detoxification	87.0	67.5
Drug Education	78.3	86.8
Methadone Maintenance	34.8	18.0
Methadone to Abstinence	30.4	20.9
Pharmacologic Interventions	21.5	23.0
Acupuncture	34.8	18.0
Self-Help Support Groups (e.g., AA, NA)	91.3	93.9
Relapse Prevention	91.3	88.9
Prison- or Jail-Based Therapeutic Community	52.2	29.4
Community-Based Therapeutic Community	56.5	39.4

Source: Urban Institute Survey of Adult Drug Courts

nationwide sample (with 29.4 percent reporting that TCs are available to participants in prison or jail, and 39.4 percent reporting that TCs are available in community-based settings). Despite the often cited use of acupuncture as an alternative therapy in drug courts, only 34.8 percent of the MADCE courts and 18 percent of the larger sample reported use of acupuncture.

We also asked court respondents whether or not their programs integrated mental health and substance abuse treatment for defendants with co-occurring disorders. The majority of courts indicated that they do integrate mental health and substance abuse treatment (see Table 3-4.7). However, this finding is somewhat surprising given our findings that more than half of responding courts do not appear to conduct formal mental health screening for clients.

Table 3-4.7. Drug Courts Integrate Mental Health and Substance Abuse Treatment for Defendants With Co-Occurring Disorders

Integrated Substance Abuse and Mental Health Treatment	Percent of MADCE Courts (N=21)	Percent of National Court Survey Respondents (N=376)
Yes	76.19	79.3
No, defendants with co-occurring disorders are excluded from drug court	0	6.9
No, treatment is not integrated	23.81	13.8

Source: Urban Institute Survey of Adult Drug Courts

Treatment Availability

In general, drug courts can only extend treatment to program participants when local providers have available openings for clients to start treatment (unless, of course, the court operates its own treatment program). Of the four most common types of treatment provided across the courts, not surprisingly, programs reported having the greatest difficulty finding treatment slots in residential facilities, while they indicated considerably less trouble finding available slots in outpatient programs (see Table 3-4.8). Approximately 10 percent (i.e., 8.7 percent of the MADCE courts and 11.4 percent of the nationwide sample) reportedly never have problems finding slots for clients in residential treatment; whereas almost half (47.8 of the MADCE group and 45.2 percent of the nationwide sample) have trouble finding such slots often or always. (See Chapter 5 in Volume 2 for differences in difficulty finding treatment slots based on regional and geographic location of drug courts.)

Many of the courts in the MADCE sample are able to get their clients into substance abuse treatment within one week of a person's first appearance in court: six courts (26 percent) enter clients in treatment within one day, and six courts (26 percent) do so within one week. Another seven courts (30 percent) report being able to get clients into treatment within 15 days of their initial court appearance, and four courts (17 percent) do so within 16 to 30 days from the client's start.

Table 3-4.8. How Often Drug Courts Have Trouble Finding Available Treatment Slots

Treatment Type	Percent of MADCE Courts*				Percent of National Court Survey Respondents**			
	Never	Sometimes	Often	Always	Never	Sometimes	Often	Always
Residential	8.7	43.5	34.8	13.0	11.4	43.4	27.1	18.1
Intensive Outpatient	69.6	26.1	0	4.3	66.9	24.4	6.8	1.9
Individual Counseling (Outpatient)	68.2	27.3	4.6	0	71.2	24.8	3.7	0.3
Group Counseling (Outpatient)	69.6	26.1	4.3	0	79.3	17.6	3.2	0.0

Source: Urban Institute Survey of Adult Drug Courts
**Note: Valid responses range from N=22 to N=23*
***Note: Valid responses range from N=369 to N=376*

Four Dimensions of Treatment: Incidence, Intensity, Onset, and Duration

Using the responses to the individual surveys, we compared the post-enrollment experiences of drug court participants to those of the substance-abusing offenders in the comparison jurisdictions regarding eight types of substance abuse treatment—detox, individual counseling, group counseling, self-help support groups, pharmacologic interventions, emergency room treatment for substance abuse, alternative treatments (e.g., acupuncture), and residential treatment—and mental health residential treatment. We calculated the weighted percentage of the drug court cohort and the comparison group who were receiving each type of treatment during the 19 months following baseline. The numerator (people receiving treatment) was based on self-reported treatment experiences and included anyone who reported at least one treatment episode during the month. [11] To avoid double counting, we assumed that the last month on which respondents reported during the 6- month interview was the same month as the first month on which they reported during the 18-month interview.

We analyzed four dimensions of treatment, defined as follows:

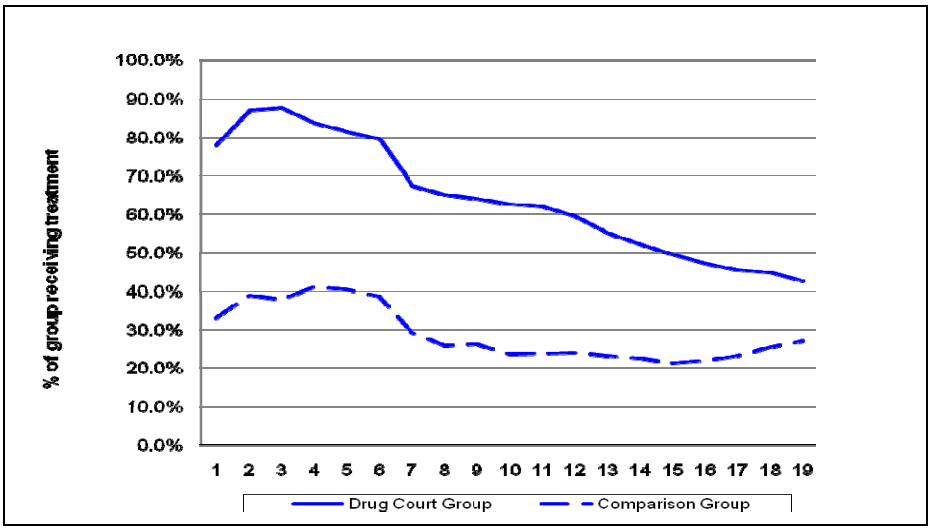
[11] The denominator (eligible people in the group) was restricted to only those who spent at least half of the given month not incarcerated. Those who spent more than half the month incarcerated were considered ineligible for treatment, although they may have received treatment while incarcerated. If such individuals received treatment while incarcerated, this treatment was not counted.

- *Incidence*: Did individuals receive the treatment at all?
- *Intensity*: Throughout the full sample period, how many times did individuals receive treatment?
- *Onset*: How many months after the baseline interview did individuals began receiving the treatment?
- *Duration*: During how many of the sampled months did individuals receive treatment?

For each of the last three dimensions, we calculated averages, minimums, and maximums only for the individuals who received the specific treatment modality. We also calculated these measures for each site separately to examine cross-site variation, and across group assignment (i.e., the entire drug court group as separate from the comparison group). We did not test for differences between individual sites; however, we used simple t-tests to test whether averages were statistically significantly different between the drug court and comparison groups.

As shown in Figures 3-4.3 through 3-4.7, in most months, notably more drug court participants received treatment than comparison members for all types of treatment except detox, emergency room visits, residential treatment, and pharmacologic interventions. For both groups, and nearly all types of treatment, incidence is highest during the first six months and steadily declines thereafter. At their peaks in the first five months following baseline, nearly 90 percent of drug court participants were receiving some type of treatment, as compared to approximately 40 percent of the comparison group. Further, at the end of 19 months post-baseline, drug court participants were still considerably more likely than comparison participants (50 percent versus 30 percent, respectively) to be receiving some type of treatment. This suggests that possibly after drug court completion, participants continued receiving treatment at greater levels than would have been the case without drug court.

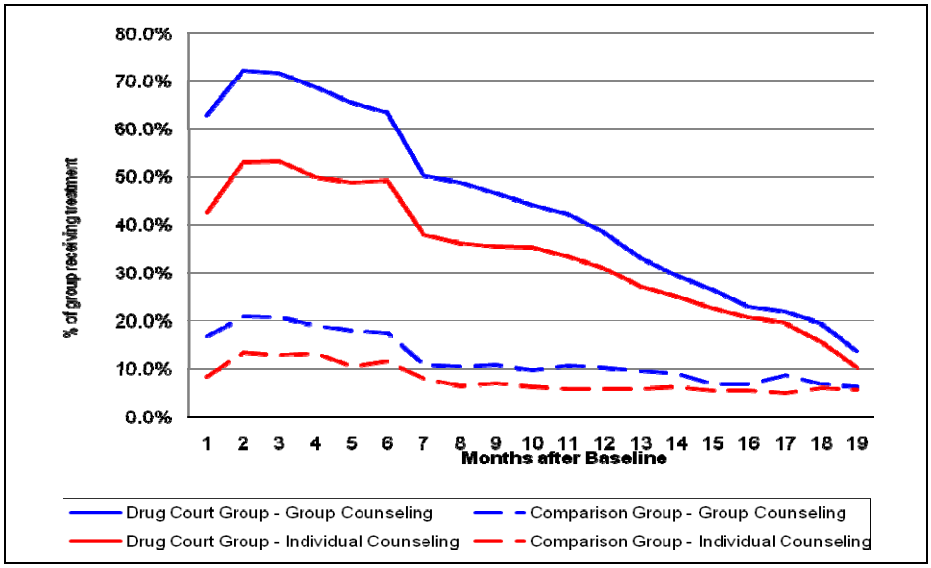
Figure 3-4.3. Any Treatment Received, by Group



Source: Urban Institute MADCE Survey of Substance-Abusing Offenders

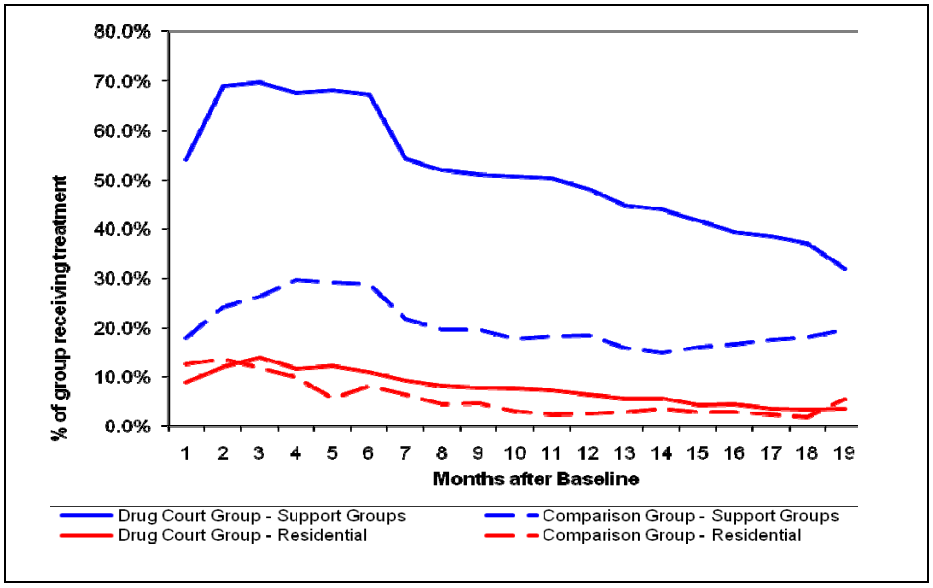
The comparison group appears more likely to receive residential treatment in the initial two months following baseline. Throughout the rest of the period, however, the treatment group remains somewhat more likely. A possible explanation is that individuals who repeatedly relapse early on in the "business-as-usual" comparison jurisdictions may elect residential treatment to avoid a longer period of incarceration, while drug courts tend to take full advantage of increased supervision opportunities and graduated sanctions, enabling them to use residential treatment as a last resort.

Figure 3-4.4 . Counseling, by Group



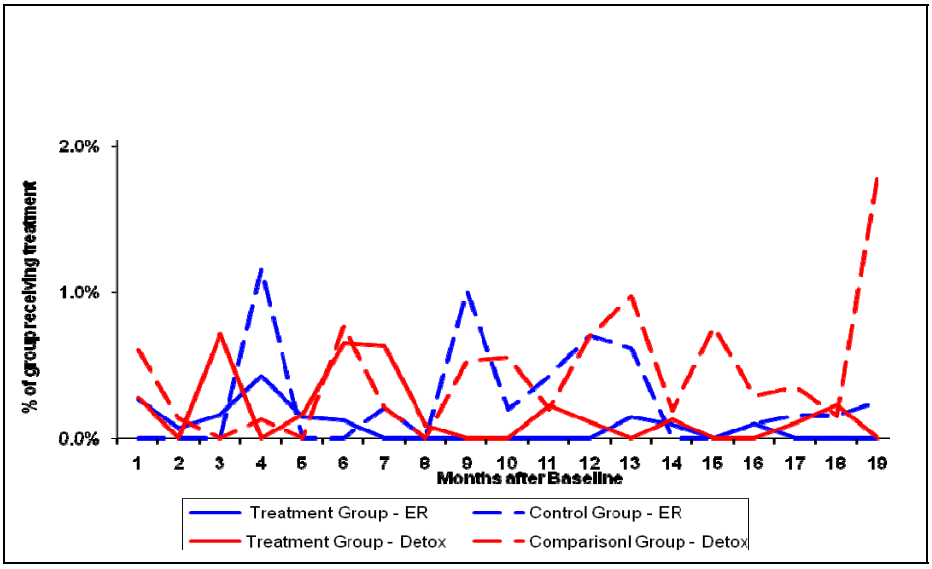
Source: Urban Institute MADCE Survey of Substance-Abusing Offenders

Figure 3-4.5. Support Groups and Residential Treatment, by Group



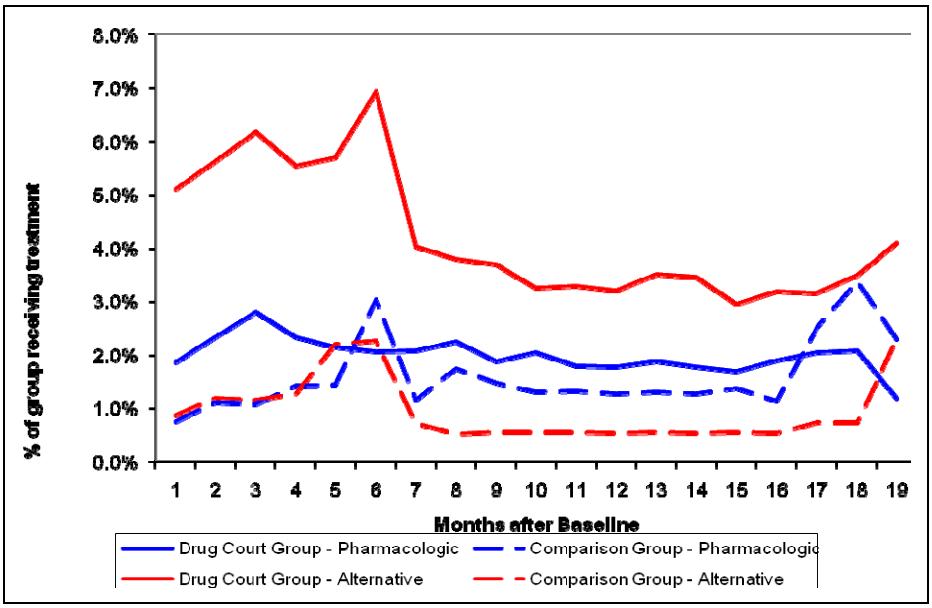
Source: Urban Institute MADCE Survey of Substance-Abusing Offenders

Figure 3-4.6. Use of Emergency Room and Detoxification, by Group



Source: Urban Institute MADCE Survey of Substance-Abusing Offenders

Figure 3-4.7. Pharmacologic and Alternative Treatment, by Group



Source: Urban Institute MADCE Survey of Substance-Abusing Offenders

Cross-Site Variation

In this section, we discuss cross-site variation for the four most common forms of drug treatment: individual and group counseling, self-help groups such as Alcoholics or Narcotics Anonymous (AA/NA), and residential treatment programs.

As shown in Tables 3-4.9 through 3-4.12, drug court participants were more likely than comparison group members to receive treatment for the four modalities we considered. Additionally, those who had treatment received significantly more of it as measured by the average number of total treatment episodes (i.e., intensity).

Table 3-4.9. Incidence and Intensity of Individual Counseling, by Site and Group

Site	Site N	Percent Who Received Treatment	Average Treatment Intensity	Minimum Intensity	Maximum Intensity
MADCE Drug Courts					
1	69	82%	10.4	1	32
2	34	67%	15.9	1	41
3	58	18%	62.3	4	183
4	14	23%	20.9	5	34
5	59	19%	25.4	2	88
6	6	41%	45.9	45	48
7	26	94%	22.1	1	93
8	20	83%	28.9	8	76
9	38	98%	21.9	1	136
10	30	79%	29.4	4	85
11	79	25%	28.4	2	112
12	23	83%	12.9	3	30
13	39	91%	13.6	1	78
14	14	96%	19.3	3	76
15	35	84%	28.1	4	76
16	41	90%	36.0	1	111
17	19	15%	10.5	3	19
18	79	84%	21.2	1	103
19	40	94%	16.6	1	95
20	80	88%	14.4	1	44
21	29	92%	11.0	1	55
22	28	97%	32.7	9	75
23	17	100%	16.9	2	40
Drug Court Total	**877**	**65%*** **	**21.4*** **	**1**	**183**
Comparison Jurisdictions[a]					
24	7	30%	12.5	12	13
25	52	17%	6.4	1	48
26	120	19%	20.5	3	82
27	216	21%	14.5	1	72
28	77	40%	7.9	1	31
Comparison Total	**472**	**23%**	**12.7**	**1**	**82**

Source: Urban Institute MADCE Survey of Substance-Abusing Offenders

a. For this analysis, site 27 is not broken down into two sites (representing two distinct judicial districts within the same state).

*** *Significant at p = 0.01*

Table 3-4.10. Incidence and Intensity of Group Counseling, by Site and Group

Site	Site N	Percent Who Received Treatment	Average Treatment Intensity	Minimum Intensity	Maximum Intensity
MADCE Drug Courts					
1	69	90%	52.5	1	96
2	34	96%	104.6	8	250
3	58	53%	112.4	18	281
4	14	81%	98.3	24	241
5	59	34%	46.0	2	110
6	6	41%	179.6	43	242
7	26	86%	74.9	2	228
8	20	84%	39.7	1	88
9	38	92%	66.0	6	203
10	30	80%	56.0	9	225
11	79	95%	107.5	2	260
12	23	95%	82.8	5	315
13	39	93%	48.0	5	236
14	14	100%	44.8	10	181
15	35	74%	31.4	8	108
16	41	89%	93.2	14	237
17	19	13%	135.9	82	176
18	79	97%	73.1	2	251
19	40	96%	107.5	12	217
20	80	89%	70.0	2	188
21	29	92%	82.1	17	163
22	28	100%	97.7	8	173
23	17	100%	43.5	2	90
Drug Court Total	**877**	**80%*** **	**78.6*** **	**1**	**315**
Comparison Jurisdictions[a]					
24	7	49%	23.2	8	30
25	52	23%	14.1	1	156
26	120	31%	48.3	1	164
27	216	45%	36.9	1	170
28	77	42%	41.5	1	145
Comparison Total	**472**	**38%**	**37.6**	**1**	**170**

Source: Urban Institute MADCE Survey of Substance-Abusing Offenders

a. For this analysis, site 27 is not broken down into two sites (representing two distinct judicial districts within the same state).

*** *Significant at p = 0.01*

Table 3-4.11. Incidence and Intensity of Self-Help Support Groups, by Site and Group

Site	Site N	Percent Who Received Treatment	Average Treatment Intensity	Minimum Intensity	Maximum Intensity
MADCE Drug Courts					
1	69	95%	75.3	1	346
2	34	97%	198.0	5	492
3	58	76%	172.0	8	523
4	14	76%	134.6	42	446
5	59	41%	41.0	1	188
6	6	52%	262.0	54	371
7	26	89%	142.7	13	481
8	20	57%	125.5	6	404
9	38	67%	169.0	4	351
10	30	81%	91.9	2	275
11	79	57%	129.3	1	507
12	23	100%	86.4	2	394
13	39	77%	111.4	2	388
14	14	100%	199.1	30	373
15	35	83%	78.7	5	326
16	41	43%	75.0	6	410
17	19	100%	211.8	61	558
18	79	93%	152.5	8	493
19	40	100%	212.0	21	442
20	80	90%	200.0	7	580
21	29	96%	180.4	9	352
22	28	100%	138.8	21	296
23	17	100%	152.5	8	352
Drug Court Total	**877**	**78%*** **	**143.7*** **	**1**	**580**
Comparison Jurisdictions[a]					
24	7	80%	46.2	9	92
25	52	12%	42.5	2	262
26	120	41%	72.3	6	350
27	216	52%	102.0	1	471
28	77	43%	97.9	2	524
Comparison Total	**472**	**42%**	**89**	**1**	**524**

Source: Urban Institute MADCE Survey of Substance-Abusing Offenders

a. For this analysis, site 27 is not broken down into two sites (representing two distinct judicial districts within the same state).

*** *Significant at p = 0.01*

Table 3-4.12. Incidence and Intensity of Residential Treatment, by Site and Group

Site	Site N	Percent Who Received Treatment	Average Treatment Intensity	Minimum Intensity	Maximum Intensity
MADCE Drug Courts					
1	69	22%	152.9	6	360
2	34	36%	142.8	30	300
3	58	22%	148.5	39	265
4	14	23%	222.1	156	339
5	59	34%	96.9	7	393
6	6	41%	179.4	117	316
7	26	40%	54.5	7	227
8	20	30%	138.7	85	217
9	38	66%	176.5	14	571
10	30	19%	189.1	7	450
11	79	57%	42.9	10	182
12	23	63%	181.8	27	373
13	39	52%	171.3	21	540
14	14	17%	156.2	3	393
15	35	0%			
16	41	32%	103.4	5	290
17	19	12%	22.5	10	30
18	79	35%	86.4	26	447
19	40	35%	45.6	7	328
20	80	24%	62.5	7	232
21	29	14%	30.4	28	32
22	28	13%	25.3	21	38
23	17	12%	84.8	70	98
Drug Court Total	**877**	**32%*** **	**105.5***	**3**	**571**
Comparison Jurisdictions[a]					
24	7	15%	76.0	76	76
25	52	8%	81.6	53	132
26	120	46%	102.9	4	284
27	216	22%	74.8	4	411
28	77	13%	70.0	15	230
Comparison Total	**472**	**25%**	**88.1**	**4**	**411**

Source: Urban Institute MADCE Survey of Substance-Abusing Offenders

a. For this analysis, site 27 is not broken down into two sites (representing two distinct judicial districts within the same state).

*** *Significant at p = 0.01*

As depicted in Tables 3-4.13 through 3-4.16, drug court participants received treatment earlier, and for longer periods of time, than the comparison group. In all cases, except residential treatment, these differences were statistically significant. On average, drug court participants began counseling (both individual and group) and support groups three months before their comparison counterparts. Drug court participants, on *average*, started each treatment type two to

three months after baseline, while comparisons did not start, on *average*, until five months after baseline. Moreover, drug court participants received treatment for statistically significantly longer periods of time. Drug court participants, on *average*, received treatment for four months more than the comparison group. Drug court participants tended to receive counseling (both individual and group) for approximately nine months, compared to only five months for comparison members; and self-help group participation typically lasted nearly one year.

Table 3-4.13. Onset and Duration of Individual Counseling, by Site and Group

Site	Relevant N	Onset (Month in Which Treatment Started)			Duration (Number of Months, Whether or Not Consecutive)		
		Mean	Min.	Max.	Mean	Min.	Max.
MADCE Drug Courts							
1	56	2.5	1	17	6.0	1	14
2	23	2.6	1	18	9.1	1	18
3	10	1.4	1	6	10.0	1	18
4	3	1.0	1	1	8.8	5	18
5	11	5.7	1	17	3.5	1	11
6	2	3.1	1	4	9.4	6	11
7	24	1.6	1	6	9.8	1	19
8	17	2.7	1	15	7.8	2	19
9	37	2.9	1	16	7.2	1	19
10	24	1.8	1	6	6.7	2	18
11	19	2.7	1	6	6.9	1	18
12	19	2.4	1	11	6.6	1	12
13	35	2.3	1	6	6.4	1	17
14	13	1.5	1	4	8.8	3	16
15	29	2.1	1	13	7.0	1	18
16	37	3.0	1	15	8.9	1	19
17	3	10.2	1	19	7.7	1	18
18	66	2.3	1	17	11.1	1	19
19	37	1.6	1	9	13.2	1	19
20	70	2.3	1	13	12.0	1	19
21	27	3.0	1	19	8.5	1	19
22	27	1.8	1	7	11.7	2	18
23	17	2.2	1	9	10.1	2	19
Drug Court Total	**570**	**2.5*** **	**1**	**19**	**8.9*** **	**1**	**19**
Comparison Jurisdictions							
24	2	2.5	2	3	4.0	4	4
25	9	11.7	1	18	2.3	1	12
26	22	1.5	1	6	3.7	1	7
27	45	5.7	1	19	6.2	1	16
28	31	5.9	1	16	6.4	1	15
Comparison Total	**109**	**5.5**	**1**	**19**	**5.3**	**1**	**16**

Source: Urban Institute MADCE Survey of Substance-Abusing Offenders

a. For this analysis, site 27 is not broken down into two sites (representing two distinct judicial districts within the same state).

*** *Significant at p = 0.01*

There is substantial variation across drug courts. For example, for individual counseling, the proportion of participants who received the therapy varies from just 15 percent to 100 percent,

and the *average* intensity varied from 10 episodes during 18 months (average in Court 1) to more than 60 episodes during 18 months (average in Court 3). Likewise, the average duration of individual counseling varied from 3.5 months (Court 1) to more than 13 months of treatment (Court 19), on average. For residential treatment, there also was considerable cross-court variation. Where it is least common, none of the 35 participants in Court 15 received residential treatment, as compared to Court 9, where two-thirds of the 38 participants received residential treatment. Like individual counseling, average intensity among those who received residential treatment varied from only 22 days in Court 17 to more than 180 days in Court 12.[12]

There was little variation in treatment onset, however. For most of the MADCE courts, all forms of treatment started early. In a few exceptional cases, particular treatment modalities did not tend to start until six months after baseline, but this was rare. Most courts started most treatments (for most clients) within the first three months.

Table 3-4.14. Onset and Duration of Group Counseling, by Site and Group

Site	Relevant N	Onset (Month in Which Treatment Started)			Duration (Number of Months, Whether or Not Consecutive)		
		Mean	Min.	Max.	Mean	Min.	Max.
MADCE Drug Courts							
1	62	1.5	1	17	8.4	1	17
2	33	2.6	1	17	10.0	1	19
3	31	1.4	1	10	8.9	2	19
4	11	2.8	1	13	9.3	6	19
5	20	5.8	1	17	4.4	1	12
6	2	2.4	1	3	10.1	6	12
7	22	1.4	1	5	8.8	1	18
8	17	4.0	1	16	7.3	3	17
9	35	2.2	1	16	9.0	1	19
10	24	1.2	1	4	7.1	1	18
11	75	2.1	1	9	8.5	1	18
12	22	1.7	1	5	7.5	2	18
13	36	2.1	1	6	6.6	1	18
14	14	1.3	1	4	8.3	1	17
15	26	2.5	1	17	6.2		18
16	36	2.0	1	10	9.6	1	19
17	2	4.6	1	6	13.0	1	18
18	76	2.1	1	17	10.5	1	19
19	38	1.8	1	16	13.3	1	19
20	71	1.6	1	13	12.3	1	20

(continued)

[12] While the average intensity is higher in Court 4, we did not feel that the number of individuals on whom this average is based was large enough for reliable discussion.

Table 3-4.14. Onset and Duration of Group Counseling, by Site and Group (Cont'd)

21	27	1.1	1	3	12.3	2	19
22	28	1.9	1	18	12.0	2	19
23	17	1.4	1	8	9.4	4	19
Drug Court Total	**702**	**2.1*** **	**1**	**18**	**9.4*** **	**1**	**20**
Comparison Jurisdictions[a]							
24	3	8.9	2	12	6.1	3	8
25	12	4.4	1	17	2.5	3	12
26	37	3.4	1	17	3.5	1	7
27	98	5.4	1	19	5.4	1	19
28	32	6.0	1	19	6.4	1	15
Comparison Total	**179**	**5.1**	**1**	**19**	**5.0**	**1**	**19**

Source: Urban Institute MADCE Survey of Substance-Abusing Offenders
a. For this analysis, site 27 is not broken down into two sites (representing two distinct judicial districts within the same state).
*** *Significant at p = 0.01*

Table 3-4.15. Onset and Duration of Self-Help Support Groups, by Site and Group

Site	Relevant N	Onset (Month in Which Treatment Started)			Duration (Number of Months, Whether or Not Consecutive)		
		Mean	Min.	Max.	Mean	Min.	Max.
MADCE Drug Courts							
1	66	1.7	1	10	9.4	1	19
2	33	1.7	1	13	10.8	1	20
3	44	1.6	1	12	9.9	2	20
4	11	1.3	1	6	12.3	5	18
5	23	5.7	1	17	5.5	1	17
6	3	4.2	1	6	13.4	12	17
7	23	1.4	1	6	12.4	4	20
8	11	1.8	1	5	8.3	4	19
9	25	3.1	1	19	11.0	1	19
10	24	1.8	1	6	7.1	1	18
11	45	3.3	1	11	8.8	1	19
12	23	2.0	1	5	8.3	1	19
13	29	2.4	1	11	10.0	1	19
14	14	1.1	1	2	14.4	2	19
15	29	1.7	1	6	10.7	3	20
16	18	5.2	1	15	7.0	1	18
17	19	1.0	1	2	16.5	6	19
18	74	1.8	1	16	12.6	2	20
19	40	1.7	1	14	15.0	2	20
20	72	1.5	1	16	14.7	1	20
21	28	1.6	1	7	14.1	2	20
22	27	1.7	1	4	12.8	2	19

(continued)

Table 3-4.15. Onset and Duration of Self-Help Support Groups, by Site and Group (Cont'd)

23	17	2.0	1	7	13.4	2	19
Drug Court Total	684	**2.1*** **	**1**	**19**	**11.2*** **	**1**	**20**
Comparison Jurisdictions[a]							
24	6	6.5	1	12	7.9	2	17
25	6	9.3	3	16	3.7	1	13
26	49	5.1	1	19	5.5	1	14
27	110	3.2	1	20	9.1	1	20
28	33	5.9	1	19	8.1	1	18
Comparison Total	198	**4.6**	**1**	**20**	**7.7**	**1**	**20**

Source: Urban Institute MADCE Survey of Substance-Abusing Offenders
a. For this analysis, site 27 is not broken down into two sites (representing two distinct judicial districts within the same state).
*** *Significant at p = 0.01*

Table 3-4.16. Onset and Duration of Residential Treatment, by Site and Group

Site	Relevant N	Onset (Month in Which Treatment Started)			Duration (Number of Months, Whether or Not Consecutive)		
		Mean	Min.	Max.	Mean	Min.	Max.
MADCE Drug Courts							
1	15	3.7	1	10	5.6	1	12
2	12	7.2	2	17	5.3	1	11
3	13	4.6	1	16	5.3	3	9
4	3	1.0	1	1	7.8	5	11
5	20	6.0	1	17	4.0	1	14
6	2	1.7	1	2	7.6	6	11
7	10	4.4	1	12	2.2	1	8
8	6	3.2	1	6	5.2	1	8
9	25	3.0	1	13	6.3	1	19
10	6	6.0	1	15	6.7	1	14
11	45	3.8	1	18	2.1	1	7
12	15	2.5	1	8	6.7	1	13
13	20	2.0	1	6	6.3	2	19
14	2	4.7	2	10	6.2	3	15
15	0					2	
16	13	8.3	5	15	3.8	3	10
17	2	9.0	7	12	1.0	8	1
18	28	5.9	1	13	3.5	1	17
19	14	2.9	1	12	2.0	1	11
20	19	7.3	1	16	3.1	1	10
21	4	4.6	1	6	2.0	2	2
22	4	3.8	2	7	2.0	1	2
23	2	6.9	6	8	4.0	2	4
Drug Court Total	**281**	**4.7**	**1**	**18**	**4.1**	**1**	**19**

(continued)

Table 3-4.16. Onset and Duration of Residential Treatment, by Site and Group (Cont'd)

Comparison Jurisdictions[a]								
	24	1	4.0	4	4	3.0	2	3
	25	4	6.9	3	10	3.7	1	5
	26	55	3.4	1	19	4.0	1	10
	27	48	7.1	1	19	3.3	1	14
	28	10	7.3	3	16	3.5	1	10
Comparison Total		**118**	**5.3**	**1**	**19**	**3.6**	**1**	**14**

Source: Urban Institute MADCE Survey of Substance-Abusing Offenders
a. For this analysis, site 27 is not broken down into two sites (representing two distinct judicial districts within the same state).

Trajectories of Treatment

For each of the four types of treatment discussed in the preceding analysis, we used group-based trajectory modeling to model different trajectories of treatment. Group-based trajectory modeling was first applied in criminal justice to study criminal careers over the life-course (Nagin and Land 1993) and has since been used numerous times in that literature (see, for example, Weisburd, Bushway, and Lum 2004). The method requires longitudinal data and fits a series of trajectories to the data that describe all individuals. Different trajectories are typically used to summarize different types of individuals. Given the number of trajectories, the shape of those trajectories, the number of individuals represented by each trajectory, and which individuals are represented by each trajectory are all determined by the model. The number of trajectories is selected to best fit the data.

We implemented group-based trajectory modeling using the Traj procedure developed for SAS (Jones, Nagin, and Roeder 2001; Jones and Nagin 2007). Following Jones et al. (2001), we (1) selected the best fitting model based on the Bayesian Information Criterion (BIC), and (2) used the "risk factor" framework to calculate whether drug court increased the probability that an individual will belong to each trajectory, relative to the comparison group.

Tables 3-4.17 through 3-4.20 summarize the impacts of drug court participation on group membership, and indicate the statistical significance of these impacts. This information is only useful in conjunction with the corresponding plotted trajectories presented in Figures 3-4.8 through 3-4.11.

Treatment trajectories can be thought of as having two major properties: the level and the change. In general, the majority of individuals' treatment experiences declined over time. For a few, however, treatment remained constant throughout the full period (e.g., Individual Counseling group 5, Support Groups group 4) or even sharply increased after some time (e.g., Individual Counseling group 3, Residential Treatment group 1). Some of the groups with declines displayed sharp drops (e.g., Individual Counseling group 4, Group Counseling group 3), while others declined very gradually (e.g., Support Groups group 5, Residential Treatment group 5). These different trajectories represent the different experiences of *individuals* in the sample,

and display heterogeneity across treatment experiences that could not be captured with other methods.

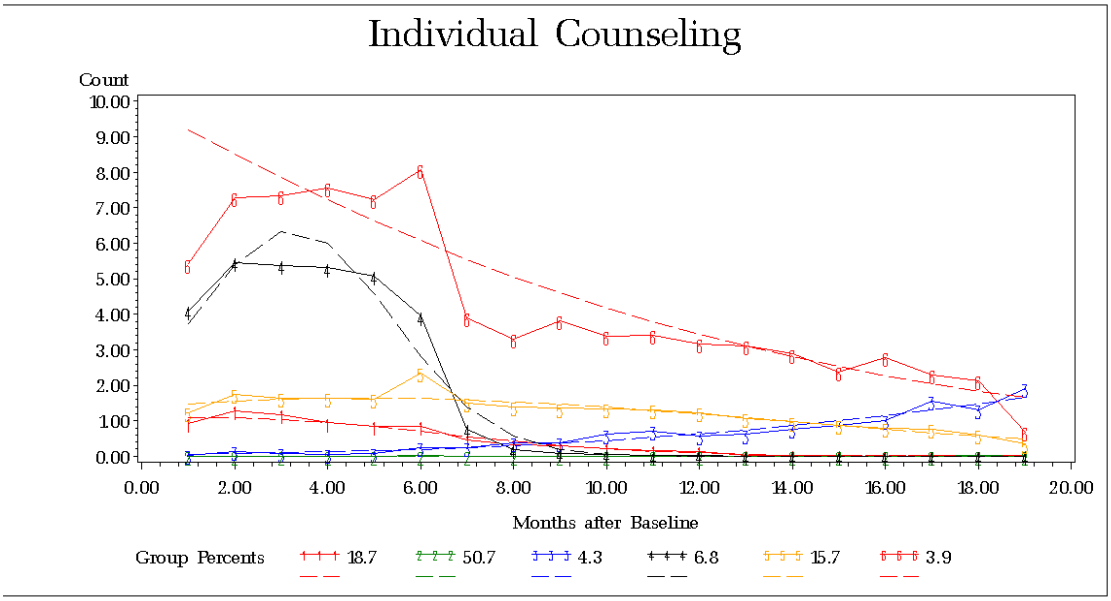
In general, drug court participants were significantly less likely to be in groups that received no treatment and appeared somewhat more likely to be in groups that experienced gradual declines or sustained treatment. This indicates that drug court participants tended to have steadier treatment experiences.

Table 3-4.17. Description of Trajectories of Individual Counseling

Individual Counseling				
	Group Description	**Size**	**Impact of Drug Court**	**Stat. Signif.**
Group 1 (red)	Little counseling (1/mo.), gradually declines to none (by month 10)	18.7% of sample	-	-
Group 2 (green)	No counseling	50.7%	Less likely	Yes ($p<0.01$)
Group 3 (blue)	No counseling initially, but increases later on (starting after month 6 increases to 2.5/mo.)	4.3%	Less likely	Yes ($p=0.03$)
Group 4 (black)	Substantial counseling early (5/mo.), quickly drops to none (by month 9)	6.8%	More likely	No ($p=0.20$)
Group 5 (orange)	Little counseling (1.5/mo.) sustained throughout sample period	15.7%	More likely	Yes ($p=0.04$)
Group 6 (also red)	Substantial counseling early (7/mo.), gradually declines (3/mo. by month 19)	3.9%	More likely	Yes ($p=0.02$)

Source: Urban Institute MADCE Survey of Substance-Abusing Offenders

Figure 3-4.8. Plots of Trajectories of Individual Counseling



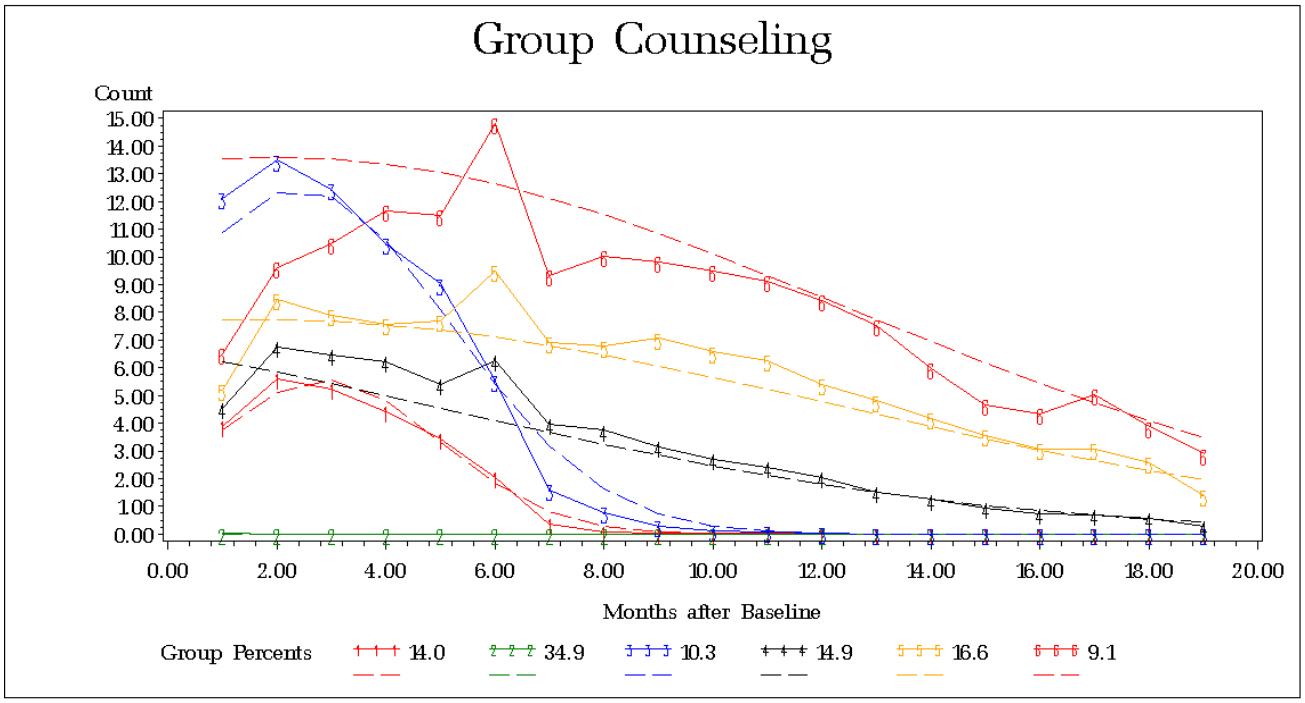
Source: Urban Institute MADCE Survey of Substance-Abusing Offenders

Table 3-4.18. Description of Trajectories of Group Counseling

Group Counseling				
	Group Description	**Size**	**Impact of Drug Court**	**Stat. Signif.**
Group 1 (red)	Mild counseling early (5/mo.), quickly drops to none (by month 8)	14% of sample	-	-
Group 2 (green)	No counseling	34.9%	Less likely	Yes (p<0.01)
Group 3 (blue)	Substantial counseling early (13/mo.), quickly drops to none (by month 10)	10.3%	More likely	No (p=0.17)
Group 4 (black)	Mild counseling early (5/mo.), gradually declines (1/mo. by month 19)	14.9%	More likely	Yes (p<0.01)
Group 5 (orange)	Moderate counseling early (8/mo.), gradually declines (3/mo. by month 19)	16.6%	More likely	Yes (p=0.05)
Group 6 (also red)	Substantial counseling early(13/mo.), gradually declines (4/mo. by month 19)	9.1%	More likely	No (p=0.23)

Source: Urban Institute MADCE Survey of Substance-Abusing Offenders

Figure 3-4.9. Plots of Trajectories of Group Counseling



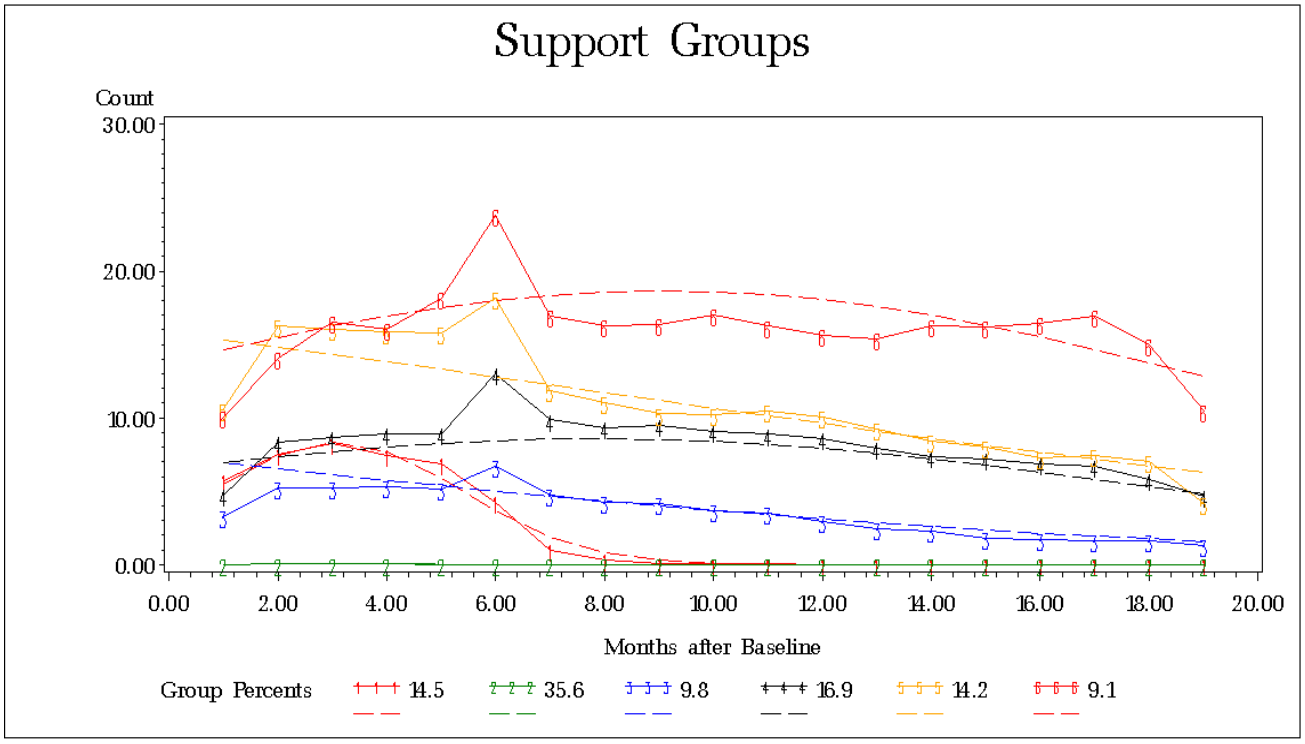
Source: Urban Institute MADCE Survey of Substance-Abusing Offenders

Table 3-4.19. Description of Trajectories of Self-Help Support Groups

Support Groups				
	Group Description	**Size**	**Impact of Drug Court**	**Stat. Signif.**
Group 1 (red)	Moderate treatment early (8/mo.), declines quickly to none (by month 8)	14.5% of sample	-	-
Group 2 (green)	No treatment	35.6%	Less likely	Yes ($p<0.01$)
Group 3 (blue)	Moderate treatment early (8/mo.), declines gradually over sample (2/mo. by month 19)	9.8%	Less likely	No ($p=0.34$)
Group 4 (black)	Moderate treatment early (8/mo.), remains steady throughout sample	16.9%	More likely	No ($p=0.16$)
Group 5 (orange)	Substantial treatment early (15/mo.), declines gradually over sample (8/mo. by month 19)	14.2%	More likely	No ($p=0.14$)
Group 6 (also red)	Substantial treatment early (15/mo.), remains steady throughout sample	9.1%	Less likely	No ($p=0.68$)

Source: Urban Institute MADCE Survey of Substance-Abusing Offenders

Figure 3-4.10. Plots of Trajectories of Self-Help Support Groups



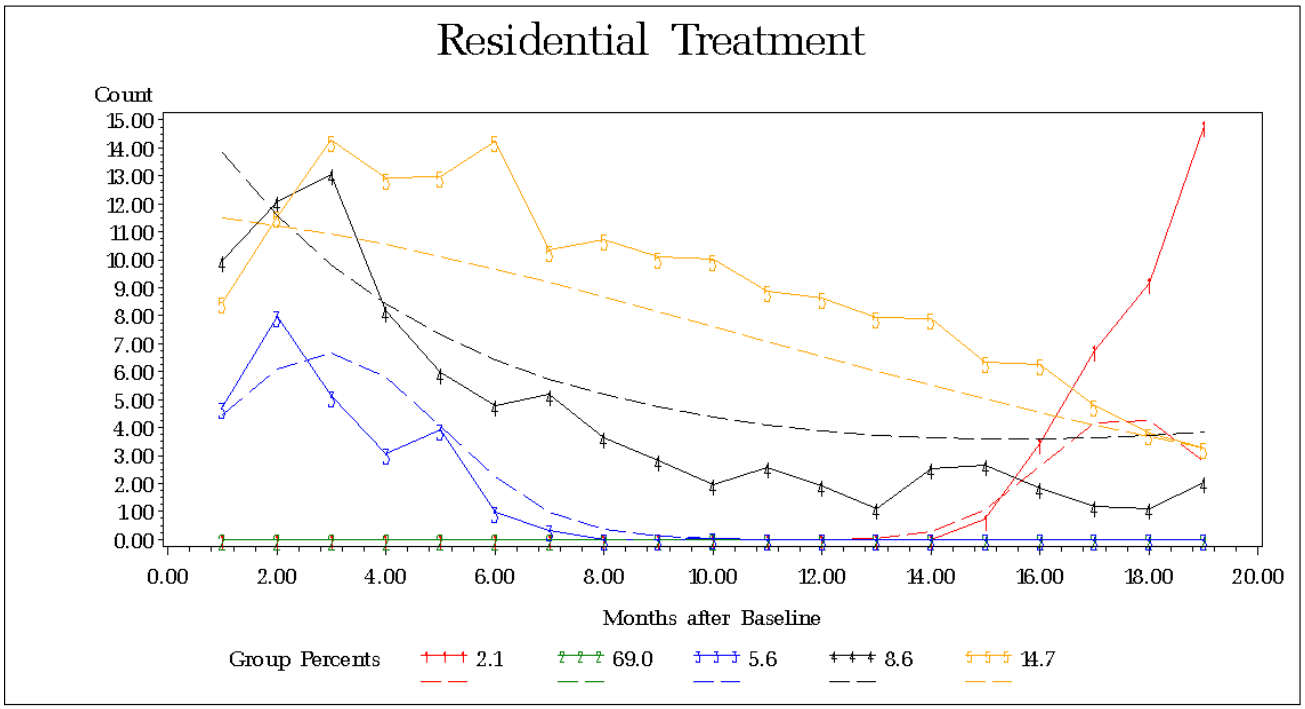
Source: Urban Institute MADCE Survey of Substance-Abusing Offenders

Table 3-4.20. Description of Trajectories of Residential Treatment

Residential Treatment				
	Group Description	**Size**	**Impact of Drug Court**	**Stat. Signif.**
Group 1 (red)	Didn't receive treatment until end of sample	2.1% of sample	-	-
Group 2 (green)	No treatment	69%	More likely	No (p=0.37)
Group 3 (blue)	Received residential treatment early and none after 6 months	5.6%	More likely	No (p=0.11)
Group 4 (black)	Received significant treatment early before sharply declining, but continued significant treatment during full sample	8.6%	More likely	No (p=0.63)
Group 5 (orange)	Received significant treatment early and slowly declined throughout sample; continued significant treatment during full sample	14.7%	More likely	Yes (p=0.06)

Source: Urban Institute MADCE Survey of Substance-Abusing Offenders

Figure 3-4.11. Plots of Trajectories of Residential Treatment



Source: Urban Institute MADCE Survey of Substance-Abusing Offenders

Concurrent Treatment

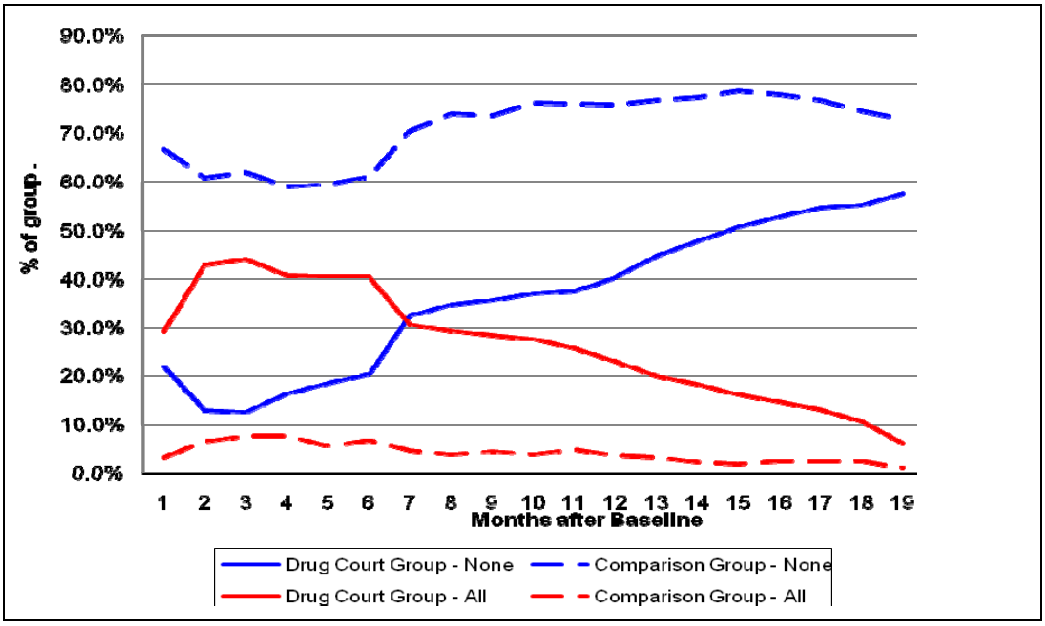
We also conducted two analyses to examine concurrent treatment in the drug court and comparison samples. Both analyses focus on three treatment modalities: outpatient individual counseling, and outpatient group counseling, and self- help support groups such as AA or NA. Five categories were constructed:

- None of these modalities.
- All modalities (i.e., individual counseling, group counseling, self-help support groups).
- Individual and group counseling.
- Individual counseling and self-help support groups.
- Group counseling and self-help support groups.

We calculated the number of months during the full follow-up period that individuals reported receiving at least one episode of the particular treatment. If the individuals' monthly treatment experience fit into one of the five categories, they were classified accordingly. [13]

In the first analysis, we calculated the portion of each group who fell into each of the five categories during each month of the follow-up period, displaying the progression of the categories over time. (Note: numerators and denominators were calculated mirroring the procedures described earlier for analyses of treatment by month. Table 3-4.21 and Figures 3-4.12 and 3-4.13 present these data.

Figure 3-4.12. No Concurrent Treatment and All Three Treatments Concurrently, by Month and Group



Source: Urban Institute MADCE Survey of Substance-Abusing Offenders

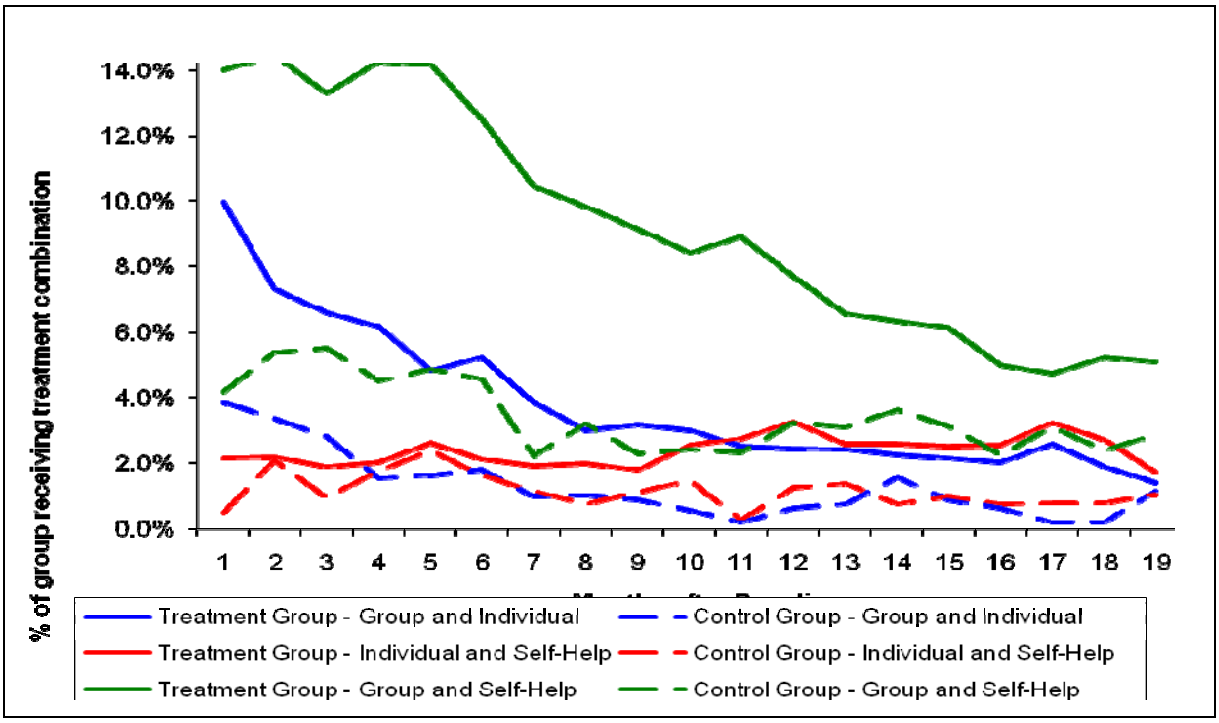
[13] Note that these categories are mutually exclusive, but not exhaustive; i.e., individuals who received only one of the considered modalities would not fall into any of these categories.

Table 3-4.21. Concurrent Treatment, by Month and Group

	Month																		
	M1	**M2**	**M3**	**M4**	**M5**	**M6**	**M7**	**M8**	**M9**	**M10**	**M11**	**M12**	**M13**	**M14**	**M15**	**M16**	**M17**	**M18**	**M19**
No Individual Counseling, Group Counseling, or Support Groups																			
Drug Court	21.9%	13.0%	12.5%	16.3%	18.5%	20.3%	32.6%	34.8%	35.8%	37.1%	37.7%	40.4%	44.7%	47.7%	50.6%	52.7%	54.6%	55.2%	57.4%
Comparison	66.7%	60.8%	61.9%	58.9%	59.4%	61.0%	70.6%	74.0%	73.7%	76.3%	76.1%	76.0%	76.8%	77.4%	78.7%	77.9%	76.8%	74.5%	72.9%
Concurrent Individual Counseling, Group Counseling, and Support Groups																			
Drug Court	29.3%	43.0%	44.1%	40.8%	40.5%	40.6%	30.6%	29.2%	28.4%	27.5%	25.7%	23.1%	20.0%	18.2%	16.1%	14.7%	13.1%	10.7%	6.1%
Comparison	3.3%	6.5%	7.7%	7.6%	5.5%	6.6%	4.6%	3.9%	4.5%	3.7%	4.9%	3.7%	3.3%	2.3%	1.9%	2.5%	2.5%	2.4%	1.2%
Concurrent Individual and Group Counseling																			
Drug Court	9.9%	7.3%	6.6%	6.2%	4.8%	5.2%	3.8%	3.0%	3.1%	3.0%	2.5%	2.5%	2.4%	2.3%	2.1%	2.0%	2.6%	1.9%	1.4%
Comparison	3.8%	3.4%	2.8%	1.5%	1.6%	1.8%	1.0%	1.0%	0.9%	0.5%	0.2%	0.6%	0.7%	1.6%	0.9%	0.6%	0.2%	0.2%	1.1%
Concurrent Individual Counseling and Support Groups																			
Drug Court	2.1%	2.2%	1.9%	2.0%	2.6%	2.1%	1.9%	2.0%	1.8%	2.5%	2.7%	3.3%	2.6%	2.6%	2.5%	2.5%	3.2%	2.7%	1.7%
Comparison	0.5%	2.1%	0.9%	1.7%	2.4%	1.6%	1.1%	0.7%	1.1%	1.5%	0.2%	1.2%	1.4%	0.8%	1.0%	0.8%	0.8%	0.8%	1.0%
Concurrent Group Counseling and Support Groups																			
Drug Court	14.0%	14.5%	13.3%	14.3%	14.2%	12.5%	10.4%	9.8%	9.1%	8.4%	8.9%	7.7%	6.6%	6.3%	6.1%	5.0%	4.7%	5.2%	5.1%
Comparison	4.2%	5.4%	5.5%	4.5%	4.9%	4.6%	2.2%	3.2%	2.3%	2.4%	2.3%	3.2%	3.1%	3.6%	3.1%	2.3%	3.1%	2.4%	2.9%

Source: Urban Institute MADCE Survey of Substance-Abusing Offenders

Figure 3-4.13. Combinations of Concurrent Treatment, by Month and Group



Source: Urban Institute MADCE Survey of Substance-Abusing Offenders

The second analysis was a standard t-test for significant differences between the drug court participant and comparison groups on (1) the percent of the group who spent at least one month in the given treatment combination, and (2) among those who spent some time in the treatment combination, the average number of months they spent in the situation. These results are displayed in the Table 3-4.22.

Drug court participants were statistically significantly less likely to spend at least one month without any of the above types of treatment, and significantly more likely to spend at least one month in each of the other four scenarios. Beyond statistical significance, the estimated magnitudes are noteworthy. Nine out of ten comparison group individuals spent at least one month with none of these types or treatment. Among those who spent some time without any of these types, the average number of months in that scenario was one full year. Also, drug court participants were four times as likely as comparison group participants (56 percent versus 14 percent) to spend at least one month receiving all three types of treatment. This is a considerable difference.

As previously mentioned, among those who spent at least one month without any of these treatments, the average number of months spent in that situation was one year for the comparison group, compared to less than five months for the treatment group. Thus, not only are drug court participants significantly less likely to receive no treatment, but those who fall into that category are in that situation for less time. Drug court participants tended to spend longer periods of time under all other treatment combinations, and most differences are statistically significant. Among

those who spent at least one month receiving all three types of treatment, drug court participants average three more months under this scenario.

Table 3-4.22. Significant Differences in Concurrent Treatment

	Percent of Group Who Spent Some Time in Combination		Number of Months Spent in Combination	
	Treatment Group	Control Group	Treatment Group	Control Group
None of the Three	67.1***	91.1	8.7***	12.1
All of the Three	55.6***	13.5	8.1***	4.8
Individual and Group Counseling	17.9***	7.7	3.6**	2.6
Individual Counseling and Self-Help Groups	10.1***	6.4	3.9*	2.8
Group Counseling and Self-Help Groups	33.6***	12.6	4.6	4.2

Source: Urban Institute MADCE Survey of Substance-Abusing Offenders
** Significant at p = 0.10*
*** Significant at p = 0.05*
**** Significant at p = 0.01*

The accompanying table and graphs show that the prevalence of each treatment combination decreases over time, as no treatment becomes more common, as is to be expected. This trend is far more pronounced, however, for drug court participants. For drug court participants, after seven months, they are more likely to receive none of the above treatments than they are to receive all three, but there is still a good chance that they will receive one or more. Across all time periods and all combinations of treatment, drug court participants are considerably more likely to report receiving treatment than their comparison counterparts.

Mental Health Treatment

Using a simple t-test, we tested whether there was a statistically significant difference in the frequency or duration of residential mental health treatment reported by survey respondents. Respondents were told to consider residential mental health treatment as a place where a person lives away from home to receive services and care for their mental health, emotions, or nerves; they were instructed to not count hospital stays for mental health care and to exclude residential care for substance abuse treatment only.

As shown in Table 3-4.23, the likelihood of receiving residential mental health treatment was essentially identical for both groups. However, drug court participants who received treatment appeared to receive considerably longer treatment. This difference is not statistically significant because of the small number of individuals receiving treatment and the wide variation in the amount of treatment received. The difference in average days of treatment received between the two groups is dramatically increased by one outlier in the treatment group (258 days = more than

8 months). When we exclude this outlier, the average number of days of treatment for the treatment group drops to 28, still more than the 21 days for the comparison group, but still statistically insignificant.

Table 3-4.23. Residential Mental Health Treatment, by Group

	Receiving Mental Health Treatment	Average Days of Treatment	Minimum Days of Treatment	Maximum Days of Treatment
Drug Court Group	3.3% (31 of 877)	40	1	258
Drug Court Group (Without Outlier)	3.2% (30 of 876)	28	1	179
Comparison Group	3.4% (12 of 472)	21	1	83

Source: Urban Institute MADCE Survey of Substance-Abusing Offenders
** Significant at p = 0.10*
*** Significant at p = 0.05*
**** Significant at p = 0.01*

Conclusions

This chapter examines treatment from two perspectives:

- Court-reported descriptive information about program characteristics and operations for the 23 drug courts that participated in MADCE, as compared to the larger nationwide sample of adult drug courts (of which the MADCE courts were a subset) that had been operational for a minimum of one year at the time they were surveyed.

- Self-reported information from drug court participants and comparison group members who completed all three waves of the MADCE individual surveys (i.e., baseline at enrollment and 6- and 18-months after enrollment).

We depict adult drug court characteristics and operations in the treatment domain, including such features as: information sources used to make eligibility determinations, use of assessment tools, types of treatment provided, and treatment availability. In the process, we demonstrate the similarities and variation among both the 23 MADCE adult drug courts and the larger sample of 380 drug court programs that completed the web-based nationwide survey of adult drug courts conducted by UI in 2004 as part of Phase 1 of the MADCE study. Also, we draw on information collected during our field visits to participating sites to illustrate some of the different approaches to treatment that have been implemented by the drug courts participating in the MADCE study.

Using the responses to the MADCE individual surveys regarding eight types of substance abuse treatment—detox, individual counseling, group counseling self-help support groups, pharmacologic interventions, emergency room treatment for substance abuse, alternative

treatments (e.g., acupuncture), and residential treatment—and mental health residential treatment, we compare the post-enrollment treatment experiences of drug court participants to those of the substance-abusing offenders in the comparison jurisdictions on several dimensions, including: treatment motivation, incidence of treatment, intensity of treatment, first receipt of treatment (onset), and duration. In virtually all instances, drug court participants fared better than their comparison counterparts, often displaying differences that were statistically significant. We found that:

- Treatment motivation diminished for both drug court and comparison groups during the first six months post-enrollment in the MADCE study; however, the decrease was significantly greater among the comparison group. On average, the comparison group's motivation decreased by almost twice that of the drug court group.

- Drug court participants were more likely than comparison group members to receive all types of treatment, except detox, emergency room visits, residential treatment, and pharmacologic interventions.

- Among those who received treatment, drug court participants were more likely than comparison group members to receive individual counseling, group counseling, self-help support groups, and residential treatment (the four modalities we considered in this set of analyses). Additionally, drug court participants who had treatment received significantly more of it as measured by the average number of total treatment episodes (i.e., intensity).

- Drug court participants received treatment earlier (onset), and for longer periods of time (duration), than the comparison group. In all cases, except residential treatment, these differences were statistically significant.

- Drug court participants tended to have steadier treatment experiences. In general, drug court participants were significantly less likely to be in groups that received no treatment, and appeared somewhat more likely to be in groups that experienced gradual declines or sustained treatment.

- Drug court participants were statistically significantly less likely than the comparison group to spend at least one month without any treatment in the form of individual counseling, group counseling, or self-help groups. Further, they were significantly more likely to spend at least one month in which they simultaneously received any two or all three of these treatment modalities (concurrent treatment).

- There was essentially no difference between the two groups with respect to the likelihood of receiving mental health residential treatment.

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Chapter 5. The Role of Drug Court Participant Attitudes and Perceptions

Kelli Henry

Introduction

Drug courts are specialized courts for drug-involved offenders, in which participants receive a combination of substance abuse treatment and intensive judicial supervision of the treatment process. Such supervision typically includes frequent judicial status hearings with direct conversational interaction between judge and participant, regular drug testing, meetings with court-affiliated case managers, judicial praise, and other tangible rewards for progress, and interim sanctions for noncompliance. Successful graduates may have the charges against them dismissed or reduced, while those who fail may receive jail or prison sentences.

The purpose of this chapter is to understand the nature of participants' attitudes and perceptions regarding their drug court experience, and to determine whether those attitudes and perceptions influence drug court outcomes. The principal domains examined here are *procedural justice*, concerning the perceived fairness of the adjudication process; *distributive justice*, concerning the perceived fairness of the final case outcome; and *threat of sanctions*, concerning the perceived consequences of noncompliance. Although a broader literature with other court-involved populations suggests that these kinds of perceptions may significantly influence offender outcomes, remarkably little research has directly tested the impact of these perceptions within drug courts.

This chapter draws on data from the National Institute of Justice's (NIJ's) Multi-Site Adult Drug Court Evaluation (MADCE). The MADCE includes 23 drug courts and 6 comparison sites selected from 8 states across the country. Offenders in all 29 sites were surveyed in three waves: at baseline, and 6 and 18 months after enrollment. (The baseline surveys took place within the first six weeks after enrollment.) The survey instruments included domains such as prior and current criminal behavior, prior and current drug treatment, prior and current drug use, socio-demographic characteristics, service and supervision experiences during drug court participation, and perceptions and attitudes about the court experience. An oral fluids drug test was conducted at the 18-month interview; official recidivism data were collected both from federal and state sources; and research staff conducted two comprehensive site visits at each program to gather data for a process evaluation. However, the present study solely draws upon offender survey data, examining results for the 877 drug court participants who were surveyed in all three waves. The analyses contained therein lay the groundwork for a comprehensive analysis of both the attitudinal and policy mediators of offender outcomes across both drug court and comparison samples, to be included as part of the MADCE (see Chapter 6 in Volume 4).

Prior Research on Procedural and Distributive Justice

Procedural justice concerns the perceived fairness of court procedures and interpersonal treatment while a case is processed, whereas *distributive justice* concerns the fairness of the final outcome (i.e., whether the litigant "won" or "lost"). Surprisingly, some research suggests that perceptions of procedural justice exert more influence on their litigants' overall view of the court than their perceptions of distributive justice (e.g., Casper, Tyler, and Fisher 1988; Tyler and Huo 2002; Sunshine and Tyler 2003). Beyond its mere impact on perceptions, several studies also demonstrate that when litigants believe the court process was fair they become more likely to comply with court orders and to follow the law (Lind, Kulik, et al. 1993; Paternoster, Brame, et al. 1997; Pruitt, Pierce, et al. 1993; Thibault and Walker 1975; Tyler and Huo 2002).

Tyler (1990) distinguishes three specific dimensions of procedural justice. They are (1) *voice*—litigants have an opportunity to have their side of the story heard); (2) *respect*—litigants perceive that the judge, attorneys, and court staff treat them with dignity and respect; and (3) *neutrality*—litigants perceive that the decision-making process is unbiased and trustworthy. Others tease out additional dimensions, notably *understanding* (litigants comprehend the language used in court and the decisions that are made) and *helpfulness* (litigants perceive that court actors are interested in their personal situation to the extent that the law allows) (see Frazer 2006).

Unfortunately, barely any research examines whether perceptions related either to procedural or distributive fairness influence outcomes specifically within drug courts. On a theoretical level, the drug court model certainly relies on the idea that, through ongoing judicial status hearings, the judge can serve as a fair, trusted, and even revered guide, providing participants with crucial motivation and support (Farole, Puffett, et al. 2005; Hora, Schma, and Rosenthal 1999; Schma 2000). Furthermore, research by Marlowe and colleagues confirms that, especially with "high risk" participants, judicial status hearings in fact elicit improved drug court retention rates (Marlowe, Festinger, et al. 2003). Yet, this line of research does not clarify what exactly it is about these status hearings that makes a difference. Two studies of problem-solving "community courts" both find that litigant perceptions of procedural fairness are higher in community than in conventional courts; and find, in addition, that perceptions of the judge exert a greater influence on overall perceptions than any other court actor (Abuwala and Farole 2008, Frazer 2006). However, these studies do not test the critical link found in the broader procedural justice literature between procedural justice and future law-abiding behavior. In the one completed drug court study that has taken this step, Gottfredson and colleagues (2007) find that participants in the Baltimore drug court who have greater perceptions of procedural justice show evidence of less recidivism and less follow-up drug use. With its nationwide, 23-site scope, the present study can obviously provide an invaluable boost to this budding literature.

Prior Research on Threat of Sanctions

If procedural justice is the "carrot," then instilling a real threat of adverse consequences for noncompliance is the "stick." In a drug court context, this threat sub-divides into two essential forms: (1) the legal coercion entailed by the threat of a potentially lengthy jail or prison sentence

for program failure; and 2) the threat of interim sanctions, up to and including short jail stays, that fall short of final program termination.

Legal Coercion: Threat of Jail or Prison

Several treatment studies confirm that facing the legal consequence of incarceration can improve treatment outcomes (Anglin, Brecht, and Maddahian 1989; DeLeon 1988; Hiller, Knight, et al. 1998). Within drug courts, one study found that facing a longer predetermined jail or prison alternative in the event of program failure increases the likelihood of participant compliance (Rempel and DeStefano 2001). However, other research found mixed results regarding the impact of the objective length of the expected jail or prison sentence (Gottfredson, Kearley, et al. 2003; Rempel, Fox-Kralstein, et al. 2003). Cutting through some of these conflicting results, research by Young and Belenko (2002) suggests that what truly matters is not necessarily the objective sentence that will be imposed in response to program failure but participant *perceptions* of what the sentence will be and how undesirable it would be to receive such a sentence. Since drug courts may vary in the degree to which they inform and remind participants of the exact legal ramifications of program failure, and participants may vary in the degree to which they grasp whatever they are told, perceptions of legal coercion can therefore vary both from court to court and from individual to individual. The present study can take advantage of this variation to explore whether those who perceive greater legal coercion are in fact more likely to achieve positive program outcomes.

Interim Sanctions

Interim sanctions include such requirements as having more frequent court appearances, having to sit for several consecutive days in jury box, having to write an essay, or serving a short stay in jail (usually up to a week). Such sanctions might be imposed in response to violations such as positive or missed drug tests, treatment or court absences, absconding from treatment, or violating other rules of either the drug court or the assigned treatment program. Research with other offender populations has found that sanctions are effective to the extent that they exhibit *certainty* (used in response to every infraction), *celerity* (imposed soon after the underlying infraction occurs), *severity* (sufficiently serious to deter future misconduct), and *consistency* (similar sanctions are applied in response to similar misconduct from different offenders (e.g., see Marlowe and Kirby 1999). Regardless of the characteristics of the sanctions themselves, other research finds that offenders are more prone to alter their behavior when they are closely monitored and, accordingly, become convinced that justice authorities will detect their noncompliance in the first place (Young and Belenko 2002).

Considering that interim sanctions have long been a staple of adult drug courts (e.g., see Office of Justice Programs and the National Association of Drug Court Professionals 1997), it is remarkable that barely any drug court-specific research has rigorously examined their effectiveness. An important and often cited exception is a 1998 randomized experiment, in which drug-involved offenders in Washington, DC, were assigned either to drug testing coupled with interim sanctions for noncompliance or to drug-testing only. The results demonstrated lower rates of post-program drug use and criminal behavior among those assigned to sanctions (Harrell,

Cavanagh, and Roman 1999). A more recent study with similarly positive findings concerns Hawaii's "Project Hope" program, which utilized a rigorous system of short-term jail sanctions in response to noncompliance with probation (Hawken and Kleiman 2009). While obviously relevant, these two studies did not specifically concern a drug court program, and Project Hope made predominant use of short jail sanctions, rather than the diverse menu of interim sanctions that are commonly employed within drug courts.

Research Questions

This chapter examines both the nature of participant perceptions in adult drug courts and the mediating role of these perceptions (if any) in influencing offender outcomes. The four primary research questions are as follows:

1. What is the nature of drug court participants' attitudes and perceptions regarding procedural justice, distributive justice, legal coercion, and interim sanctions?

2. Do these attitudes and perceptions change during the course of drug court participation, and, if so, how do they change?

3. What, if any, background characteristics do drug court participants bring with them that influence their attitudes and perceptions?

4. What, if any, attitudes and perceptions lead to positive drug court outcomes?

Research Design and Methodology

The Drug Court Sample

The MADCE sample included 1,781 offenders interviewed at baseline, 1,533 at 6 months, and 1,474 at 18 months. The drug court sample (not including offenders from the comparison sites) consisted of 1,156 offenders, which reduced to 1,009 at 6 months, 951 at 18 months, and 877 who were interviewed at *both* of the follow-up waves. These 877 offenders comprised the sample for the present research. The participants originated in 23 sites located in the following states: Washington (6), Illinois (2), New York (8), Pennsylvania (2), Georgia (2), Florida (2), and South Carolina (1).

Measures of Participant Attitudes and Perceptions

At each survey wave, drug court offenders were asked a series of questions within each of the domains of interest. They are briefly summarized as follows; Appendix C contains the specific question wording for each survey item, as well as the reliability coefficients for each multi-item index.

- *Procedural Justice:* Primary measures included a seven-item index concerning attitudes

towards the offender's "supervision officer" (typically the drug court case manager), a nine-item index concerning attitudes towards the judge, and an 18-item index concerning attitudes towards the court experience (without reference to specific court players). Largely following Tyler (1990), and in light of confirmatory reliability analyses, the 18-item court procedural justice index was sub-divided into a six-item sub-index regarding "voice," a two-item index regarding "understanding," a three-item index regarding "neutrality," and a six-item index regarding treatment with "dignity/respect." (One of the original 18 items did not belong on any of the four sub-indexes.) All individual question items, and hence all of the aforementioned indices, involved five-point Likert scales.

- *Distributive Justice:* There was one straightforward question, "Overall, how do you rate the fairness of the outcome you received" (on a four-point scale).

- *Legal Coercion: Consequence of Program Failure:* There were two relevant questions respectively involving the "most likely sentence" upon program failure (nothing, probation, or jail/prison) and "how bad" that sentence would be (not bad at all, somewhat bad, or extremely bad). Since more than 80 percent of respondents respectively answered "jail/prison" to the first of these questions, and "extremely bad" to the second, both questions were recoded as dichotomous measures, grouping all other answers into a single category.

- *Interim Sanctions:* Primary measures included two indices. First, a ten-item "certainty of response to drug use" index concerned the perceived likelihood that the judge or supervision officer would find out if the participant used drugs. Second, a 12-item "perceived undesirability of sanctions" index concerned the undesirability ("How bad would it be…") of receiving each one of a series of interim sanctions. In addition, a "deterrence score," representing the product of the two aforementioned indices, combined *both* the expectation of receiving sanctions and their perceived undesirability. As shown in Appendix C, three final measures concerned the perceived fairness of sanctions, participant understanding of what behaviors result in sanctions, and whether or not sanctions received came as a surprise (answered only by those who received a sanction).

Outcome Measures

Analyses tested the impact of attitudes and perceptions on three outcomes, all concerning behavior throughout the one-year period just prior to the 18-month survey. They were (1) *program compliance:* total number of supervision violations, (2) c*riminal behavior:* number of criminal acts (regardless of whether they led to an arrest), and (3) *drug use:* number of days of use per month of any of eight drugs (alcohol, marijuana, cocaine, heroin, amphetamines, hallucinogens, illegal use of methadone, and illegal use of prescription drugs).

Offender Background Measures

Several analyses examined the impact of offender background characteristics on select perceptions. Relevant domains were *demographics* (age, sex, race/ethnicity), *social ties* (high school degree/GED, employed/in school, married), *drug use* (primary drug of choice, days of use per month in the six months before baseline), *criminal history* (number of criminal acts in the six months before baseline), and *mental health* (multi-item inventories for depression, anti-social personality, and narcissistic personality).

Control Variables: Retention and Risk Scores

In longitudinal studies, an important priority is to reduce attrition bias that can occur when subjects are not retained for follow-up research interviews. To reduce this bias, each drug court offender in our sample was assigned a *retention score* representing the participant's predicted probability of retention at both follow-up survey waves, given observed background characteristics. The retention score serves as a single variable, summing the effect of all other characteristics, that was used as a covariate control in explanatory analyses that sought to test the relationship between perceptions and outcomes (see Chapter 2 in Volume 4 for methodological details).

A *risk score* represents the sum effect of multiple baseline characteristics on the prevalence of adverse outcomes. Separate risk scores were created to represent the risks that more days of drug use and more criminal acts in the year prior to the 18-month survey have on drug court outcomes. The score for criminal acts also was used as a control variable when predicting supervision violations, which could include criminal behavior or other violations of program rules. The scores were based on the regression coefficients obtained from Poisson regression equations that included those specific baseline characteristics listed above under offender background measures. The pragmatic purpose of these scores is, within analyses examining the relationship between perceptions and outcomes, to control for the impact of offender background with a single risk score covariate, rather than large numbers of baseline covariates that would otherwise engender a substantial reduction in degrees of freedom and unnecessary complexity in our statistical models.

Results 1: Drug Court Participant Attitudes and Perceptions

Table 3-5.1 shows mean participant attitudes and perceptions across each of our individual measures six months after program entry. The most positive rating was for an indicator regarding sanctions, asking whether the respondent understood what behavior resulted in sanctions (99 percent). Otherwise, among the Likert-scaled items, participants gave particularly high ratings regarding their attitudes toward their supervision officer (4.27), understanding of what went on in court (4.19), and attitudes toward the judge (4.11). The findings suggest that after six months of program participation, participants largely believed that the drug court process was fair.

Table 3-5.1. Drug Court Participant Attitudes and Perceptions Six Months after Enrollment

	Mean	Intraclass Correlation (1)
Procedural Justice		
Attitudes toward supervision officer (7-item index, 1-5 scale)	4.27	8%***
Attitudes toward judge (9-item index, 1-5 scale)	4.11	11%***
Perceptions of court procedural justice (18-item index, 1-5 scale)	3.78	8%***
Voice (6-item sub-index, 1-5 scale)	3.34	6%***
Understanding (2-item sub-index, 1-5 scale)	4.19	2%
Neutrality (3-item sub-index, 1-5 scale)	3.58	8%***
Dignity/respect (6-item sub-index, 1-5 scale)	3.85	7%***
Distributive Justice		
Perceived fairness of outcome (1-4 scale)	3.26	4%***
Legal Coercion		
Most likely sentence upon failing drug court = "jail"	87%	26%***
Most likely sentence upon failing drug court = "extremely bad"	84%	15%***
Sanctions		
Certainty of response to drug use (10-item index, 1-4 scale)	2.95	21%***
Perceived undesirability of sanctions (12-item index, 1-3 scale)	2.38	8%***
Deterrence score: perceived sanction severity (product of preceding two items)	7.06	20%***
Understands behaviors that result in sanctions	99%	41%***
Sanctions received came as surprise (2)	30%	3%**
Sanctions received were perceived as unfair (2)	32%	13%***

Source: Urban Institute MADCE Survey of Substance-Abusing Offenders
*+p<.10, *p<.05, **p<.01, ***p<.001*

Notes: Results for this table only were computed using HLM 6.04 software, which enables examining whether site-level factors significantly contribute to the variation in individual drug court participant perceptions. The exact size of the n varies between data elements, ranging from n=640 to n=1156, except as noted in footnote (2).

(1) The intraclass correlation coefficient (ICC) indicates the percent of the variation in drug court participant responses that is explained by their court of origin. A statistically significant ICC demonstrates that court-level factors (e.g., court policies and practices or aspects of the judicial demeanor of each court's judge) significantly explains the participant perceptions in question.

(2) The question was only answered by participants who reported receiving a sanction, n=488.

Table 3-5.1 also presents the intraclass correlation coefficient (ICC) for each measure.[14] The ICC

[14] The intraclass correlation coefficient (ICC) indicates the percent of the variation in drug court participant responses that is explained by their court of origin. A significant ICC demonstrates that court-level factors, such as court-level policies and practices or aspects of the judicial demeanor of each court's judge, significantly explain participant perceptions. The displayed intraclass correlation coefficients were computed in HLM 6.04, a statistical package that facilitates the analysis of data in which the individual observations are nested within higher-order contexts, such as particular sites or jurisdictions (see Raudenbush and Bryk 2002). In general, the methodology adopted in NIJ's Multi-Site Adult Drug Court Evaluation involved the computation of all impact estimates—

was significant for every measure, except for respondent understanding of what went on in court. The practical implication is that the high ratings of understanding did not vary from one drug court to another. For all of the other measures, the significant ICC means that perceptions varied by site, suggesting, in particular, that the practices implemented in some courts result in more positive (or different) perceptions than in other courts. On most measures, the ICC was highly significant, but not of a particularly large magnitude (ranging from 2 percent to 11 percent), indicating that even within courts, there is also significant variation from one individual to another. A notable exception is respondent understanding of behavior that resulted in sanctions, where 41 percent of the variance resided between drug courts (due to only a small number of courts having participants who did not gain this understanding). Other measures with a relatively high ICC were most likely sentence upon failing drug court = "jail," where 26 percent of the variance stemmed from court-level differences, and perceived certainty of response to drug use, where 21 percent of the variance was court-related.

Results 2: Participant Attitudes and Perceptions over Time

This section examines participant attitudes and perceptions over time, taking snapshots of opinions at three different points after program entry (baseline, 6 months, and 18 months). Note that the baseline survey truly reflects *in-program* attitudes, because that survey was administered up to six weeks after drug court admission, time enough for multiple experiences with the judge, case manager, treatment provider, and other court components to have taken place. Table 3-5.2 presents mean participant attitudes and perceptions at all three waves, along with ANOVA results regarding whether opinions significantly changed over time. Overall, 8 of 16 measures did not significantly change (at least at $p < .05$), indicating a substantial degree of stability in participant perceptions after they are first formed in the early stages of drug court participation. In addition, even among the measures that did change significantly, a visual inspection of the results in Table 3-5.2 makes clear that the changes were rarely of great magnitude.

The measure with the most demonstrable change was perceptions of court neutrality (which increased from 3.08 at baseline, to 3.77 at 6 months, to 3.80 at 18 months). Also increasing significantly (though by a small absolute magnitude) was the perception that sanctions received were unfair (32 percent at 6 months to 34 percent at 18 months). Other measures that significantly changed over time, but in inconsistent directions across the three waves of surveying, were attitude toward supervision officer (4.19, 4.28, 4.15), most likely sentence upon failing drug court = "extremely bad" (83 percent, 84 percent, 78 percent), perception of having a voice in court (3.55, 3.36, 3.69), perceived undesirability of sanctions (2.30, 2.38, 2.35), and

involving a comparison of outcomes between drug court and comparison offenders – in an HLM framework (details on methodology in Chapter 2 of Volume 4). However, as in other chapters that solely analyze data for the smaller sample of 23 drug court sites, analyses in this chapter, besides those provided in Table 3-5.1, were not computed using such a framework (for this chapter, all other analyses were conducted in SPSS). To ensure that this decision did not substantively alter our reported findings, we performed test models (results not shown) for the regression equations reported in Tables 3-5.3 and 3-5.5 in HLM 6.04. While fewer independent variables were found to be significant predictors of the dependent variables (which results from the vastly reduced statistical power that comes with having an N of only 23 drug court sites at the site-level of analysis), the basic direction and strength of the regression coefficients did not change.

deterrence score (6.88, 7.04, 6.98). These latter findings suggest that participants' attitudes are not necessarily linear and cannot be understood fully without information regarding possible

Table 3-5.2. Change in Participant Attitudes and Perceptions: Baseline, 6 Months, and 18 Months

	Baseline	6 Months	18 Months	Significance of Change
Procedural Justice				
Attitudes toward supervision officer (7-item index, 1-5 scale)	4.19	4.28	4.15	*
Attitudes toward judge (9-item index, 1-5 scale)	4.00	4.11	4.04	no difference
Perceptions of court procedural justice (18-item index, 1-5 scale)	3.73	3.86	3.85	no difference
Voice (6-item index, 1-5 scale)	3.55	3.36	3.69	*
Understanding (2-item index, 1-5 scale)	4.14	4.21	4.25	+
Neutrality (3-item index, 1-5 scale)	3.08	3.77	3.8	***
Dignity/respect (6-item index, 1-5 scale)	3.78	3.94	3.92	no difference
Distributive Justice				
Perceived fairness of outcome (1-4 scale)	3.24	3.27	321%	no difference
Legal Coercion				
Most likely sentence upon failing drug court="jail"	89%	86%	87%	no difference
Most likely sentence upon failing drug court="extremely bad"	83%	84%	78%	**
Sanctions				
Certainty of response to drug use (10-item index, 1-4 scale)	2.98	2.95	2.95	no difference
Perceived undesirability of sanctions (12-item index, 1-3 scale)	2.3	2.38	2.35	***
Deterrence score: perceived sanction severity (product of preceding two items)	6.88	7.04	6.98	+
Understands behaviors that result in sanctions	95%	99%	97%	no difference
Sanctions received came as surprise(1)	na	30%	27%	no difference
Sanctions received were perceived as unfair(1)	na	32%	34%	*

Source: Urban Institute MADCE Survey of Substance-Abusing Offenders
*+p<.10, *p<.05, **p<.01, ***p<.001*
Notes: Significance tests were based on repeated measures ANOVAs. Cases were only included in this analysis if data was available at all three periods. The size of the n varies between data elements: n ranges between n=609 and n=876, except for the last two data elements-- see footnote (1).
(1) The question was only answered by participants who reported receiving a sanction. At baseline no participant had yet received a sanction, so there is no data reported for baseline. For the 6-month and 18-month follow-up periods, however, n=398 and n=488, respectively.

intervening factors, for example, about staff changes in case managers, noncompliance detection policies, or an experience of sanctions that may color perceptions in the short-term but not the long-term.

Results 3: Baseline Predictors of Drug Court Participant Attitudes and Perceptions

This section reveals the results of an analysis that used baseline participant characteristics to predict attitudes and perceptions at six months. Table 3-5.3 presents the results of linear regressions where participant demographics, social ties, drug use and treatment history, criminal history, and mental health status were used to predict attitudes toward the judge, perceived procedural justice, and perceived fairness of outcome at six months. Previous research indicates that preexisting characteristics can influence these particular types of perceptions, with nonwhite court litigants especially likely to report negative perceptions of procedural justice and of trust in the court overall than white litigants (Tyler and Huo 2002, Tyler and Wakslak 2004). However, the previous literature had not produced any clear hypotheses regarding the relationship between offender background and perceptions regarding the threat of sanctions; and test analyses (not shown) detected barely any significant predictors of these latter perceptions.

The results show that, controlling for all variables in a single analysis, age, marijuana as the drug of choice, and depression were the most consistent and powerful predictors of participant attitudes toward the judge, perceived court procedural justice, and perceived fairness of the outcome. An older age predicted positive perceptions whereas a primary drug of marijuana and screening as depressed at baseline (based on a multi-item inventory) predicted less positive perceptions across all three outcomes. In addition, men held significantly less positive perceptions of procedural justice (encompassing both perceptions of the judge and of court procedural justice), but gender did not significantly predict perceived distributive justice (fairness of the outcome). Educational background was only significantly associated with one outcome—perceptions of the judge; contrary to what was expected, participants with at least a high school education or equivalent had less positive perceptions of the judge than those participants with less education. Finally, those who screened with narcissistic personality disorder (based on a multi-item inventory) had less positive perceptions of court procedural justice, but neither of the personality disorders we examined (also including anti-social personality) significantly predicted the other two outcomes. These findings suggest that drug court participants come with characteristics over which drug court personnel and policy have little control, but that, nevertheless, predict attitudes and perceptions of procedural and distributive justice. At the same time, the relatively small number of preexisting characteristics with significant effects (and model R^2 statistics that are less than .100 in each of the regressions presented in Table 3-5.3) suggests that there is also plenty of opportunity for drug courts to shape or reshape perceptions.

Table 3-5.3. Baseline Predictors of Drug Court Participant Attitudes and Perceptions Six Months After Enrollment

	Attitudes Toward judge	Perceived Court Procedural Justice	Perceived Fairness of Outcome
Demographics			
Age	.228***	.163***	.071+
Male	-.127***	-.115***	-.015
Race/ethnicity			
White	.012	.049	-.051
Black	.009	-.016	-.071
HS degree/GED or higher	-.091**	-.049	-.051
Social Ties			
Employed or in school	.001	.036	.056+
Married	-.008	.007	.065*
Drug Use and Treatment History			
Primary drug of choice (proxy measure)			
Alcohol	-.062+	-.064+	-.055
Marijuana	-.123**	-.120**	-.084*
Cocaine (any form)	-.105**	-.063	-.002
Average days of drug use (6 months pre-baseline) (1)	.057	.053	.070+
Criminal History			
Number of criminal acts (6 months pre-baseline)	-.032	-.023	-.016
Mental Health			
Depression	-.108**	-.153***	-.098**
Anti-social personality disorder	.018	.045	-.013
Narcissistic personality disorder	.019	-.066*	.010
Intercept	3.917***	3.675***	3.231***
R-Squared	.096	.090	.037
N	1002	1005	1004

Source: Urban Institute MADCE Survey of Substance-Abusing Offenders
*+p<.10, *p<.05, **p<.01, ***p<.001.*
Notes: The standardized regression coefficient estimates (β) were computed using the ordinary least squares method to model the regression equation.

(1) Self-reported average days of drug use per month in the six months before program entry takes into account use of the following drugs: alcohol, amphetamines, cocaine, hallucinogens, heroin, marijuana, illegal use of methadone, and illegal use of prescription drugs.

Results 4: Relationship of Participant Attitudes and Perceptions with Compliance, Criminal Behavior, and Drug Use Outcomes

This section examines which participant attitudes and perceptions play a role in explaining drug court outcomes. Table 3-5.4 presents the simple correlations of perceptions at the six-month mark with three key outcomes at the 18-month mark: the number of supervision violations, number of criminal acts, and days of drug use per month (measured over the year prior to the 18-month survey).

In general, across nearly all of the individual measures examined, greater perceptions of procedural and distributive justice were significantly correlated with less frequent noncompliance, criminal behavior, and drug use. Perhaps the most powerful pattern of correlation is observed between attitudes toward the judge and the three outcome measures (correlations of -.092, -.088, and -.149 respectively). Strong correlations were also observed between overall perceptions of court procedural justice and the three outcomes (correlations of -.069, -.071, and -.127). Among the four procedural justice sub-indices, perceptions of court neutrality and dignity/respect elicited particularly high correlations with outcomes.

However, only one of seven measures concerning perceptions of legal coercion and of interim sanctions was correlated with outcomes: perceiving the most likely sentence upon failing drug court as "extremely bad". None of the measures tapping the concept of deterrence through interim sanctions— that is, perceived certainty of sanctions for drug use, perceived undesirability of sanctions, deterrence score, and participant understanding of the behavior that results in sanctions—correlated with outcomes.

Table 3-5.5 presents the results of a follow-up multivariate analysis (utilizing the Poisson specification) examining the types of perceptions that most strongly predict compliance, criminal behavior, and drug use outcomes. The predictors included three attitudinal measures, one from each of three domains (procedural justice, distributive justice, and legal coercion), selected based on the strength of their simple correlations, as presented above in Table 3-5.4. The three measures were attitudes toward the judge, perceived fairness of the outcome, and whether the most likely sentence upon failing drug court was perceived as "extremely bad." No variables from the perception of sanctions domain were included, as all of the measures examined failed to be correlated with the outcome variables of interest in Table 3-5.4. As control variables, the analysis also included the summary retention score and risk score variables whose relevance was described previously (see research design and methodology).

The results show that attitudes toward the judge (procedural justice), perceived fairness of the outcome (distributive justice), and whether the most likely sentence upon failing drug court was perceived as "extremely bad" (legal coercion) were all significant predictors of all three outcomes of interest—supervision violations, criminal acts, and days of drug use per month. It appears that a drug court participant's positive attitude toward the judge, their perception that the

outcome of their case was fair, and, particularly, their fear of failing drug court and thereby incurring a lengthy custodial sentence are all important predictors of supervision violations, criminal acts and drug use.

Table 3-5.4. Correlations of Participant Attitudes and Perceptions at Six Months with Select Compliance, Criminal Behavior, and Drug Use Outcomes in the Year Prior to the 18-Month Survey

	Number of Supervision Violations(1)	Number of Criminal Acts(2)	Days of Drug Use per Month(3)
Procedural Justice			
Attitudes toward supervision officer (7-item index, 1-5 scale)	-.034	-.042	-.083*
Attitudes toward judge (9-item index, 1-5 scale)	-.092**	-.088**	-.149***
Perceptions of court procedural justice (18-item index, 1-5 scale)	-.069*	-.071*	-.127***
Voice (6-item sub-index, 1-5 scale)	-.044	-.060+	-.101**
Understanding (2-item sub-index, 1-5 scale)	-.043	-.022	-.075*
Neutrality (3-item sub-index, 1-5 scale)	-.101**	-.085*	-.133***
Dignity/respect (6-item sub-index, 1-5 scale)	-.085*	-.081*	-.122***
Distributive Justice			
Perceived fairness of outcome (1-4 scale)	-.076*	-.076*	-.103**
Legal Coercion			
Most likely sentence upon failing drug court="jail"	-.010	-.047	-.066+
Most likely sentence upon failing drug court="extremely bad"	-.092**	-.082	-.084*
Sanctions			
Perceived likelihood of noncompliance detection (2-item index, 1-4 scale)	-.059+	-.035	-.034
Perceived certainty of response to noncompliance (20-item index, 1-4 scale)	.009	-.011	-.010
Perceived certainty of severe response="jail" or "prison") (4-item index, 1-4)	.023	.010	.058+
Perceived fairness of court use of sanctions (1-4 scale)	-.075*	-.059+	-.099**
Understands behaviors that result in sanctions (Yes/No)	-.019	.034	.042

Source: Urban Institute MADCE Survey of Substance-Abusing Offenders
*+p<.10, *p<.05, **p<.01, ***p<.001*
Notes: Results are Pearson's correlation coefficients (r). The size of the n varies between data elements: n ranges between n=849 and n=877.
(1) Self-reported total number of supervision violations in the 12 months preceding the 18-month interview.
(2) Self-reported total number of criminal acts in the 12 months preceding the 18-month interview.
(3) Self-reported average days of drug use per month in the 12 months preceding the 18-month interview and takes into account use of the following drugs: alcohol, amphetamines, cocaine, hallucinogens, heroin, marijuana, illegal use of methadone, and illegal use of prescription drugs.

Table 3-5.5. Multivariate Six-Month Attitudinal Predictors of Select Compliance, Criminal Behavior, and Drug Use Outcomes in the Year Prior to the 18-Month Survey

	Number of Supervision Violations(1)	Number of Criminal Acts(2)	Days of Drug Use per Month(3)
Demographic Scores			
Retention score	-.892*	-1.302***	-.541
Risk score=criminal acts	.604***	.986***	--
Risk score=drug use	--	--	.290***
Procedural Justice			
Attitudes toward judge	-.538***	-.148*	-.281***
Distributive Justice			
Perceived fairness of outcome	-.169***	-.170***	-.142**
Perception of Legal Coercion			
Most likely sentence upon failing drug court="extremely bad"	-.761***	-.551***	-.394**
Perception of Sanctions			
Perceived likelihood of noncompliance detection	-.179	-.133	.026
Intercept	4.760***	3.113***	3.291***
Chi-square	522.828***	600.256***	91.806***
N	843	847	847

Source: Urban Institute MADCE Survey of Substance-Abusing Offenders
*+p<.10, *p<.05, **p<.01, ***p<.001.*
Notes: The parameter estimates (B) are Poisson regression coefficients.

(1) Self-reported total number of supervision violations in the 12 months preceding the 18-month interview.

(2) Self-reported total number of criminal acts in the 12 months preceding the 18-month interview.

(3) Self-reported average days of drug use per month in the 12 months preceding the 18-month interview and takes into account use of the following drugs: alcohol, amphetamines, cocaine, hallucinogens, heroin, marijuana, illegal use of methadone, and illegal use of prescription drugs.

Conclusions

This chapter considered four types of offender attitudes and perceptions that the previous literature (primarily involving non-drug court populations) suggested might play an important role in influencing offender behavior. The results indicated that, overall, these perceptions tended to take shape quite early in the drug court experience. Only half of the individual measures examined changed significantly in their mean rankings across three waves of surveying; and, most of the measures that did vary significantly (in the statistical sense) did so by a patently small magnitude. Perceptions of procedural and distributive justice in particular were influenced by a small number of preexisting offender characteristics (e.g., age, sex, and classification with clinical depression on a multi-item screening tool). However, it was also the case that perceptions systematically varied from court to court—suggesting that drug court policies and practices can make a difference in either fostering these attitudes and perceptions or not.

Of particular importance, this chapter found that perceptions of procedural justice—and especially attitudes towards the drug court judge, as well as perceptions of distributive justice and the perceived severity of the sentence to be imposed upon drug court failure, all significantly predicted compliance, criminal behavior, and drug use at follow-up. Hence, taking steps to promote a fair court experience, and having a judge who can serve as an effective symbol of the court's commitment to fairness, neutrality, and respect, can improve concrete offender outcomes; as can the careful use of the court's coercive power to establish undesirable legal consequences of program failure. However, perceptions related to the deterrent effects of interim sanctions, although a mainstay of drug court policy and practice, did not predict participant behavioral outcomes.

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Chapter 6. Drug Court Retention

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Introduction

To break the cycle of relapse and recidivism, drug courts provide drug-involved defendants with a combination of community-based treatment and intensive judicial oversight of their cases. Participating defendants are required to appear in court for regular judicial status hearings, submit to random drug tests, attend treatment, and meet other program requirements. In evaluating the success of drug court programs, retention rates are a critical interim measure. A one-year retention rate, for example, indicates the percentage of participating defendants who, exactly one year after enrolling, had either graduated or remained active in the drug court program. Research spanning a variety of treatment populations finds that retention not only measures a program's success in sustaining participation, but also is an important predictor of positive long-term outcomes, such as reduced recidivism and drug use (e.g., see Anglin, Brecht, and Maddahian 1989; DeLeon 1988; Taxman 1998).

There are few prior studies examining drug court retention rates. Belenko (1998) estimated that drug courts nationwide have an average one-year retention rate of 60 percent. Other research suggests that this estimate may be conservative. For instance, a multi-site evaluation in New York State reported a median one-year retention rate of 66 percent across 11 drug courts, with 8 of the 11 courts having a one-year retention rate that exceeded 60 percent (Rempel, Fox-Kralstein, et al. 2003). Looking at a general treatment population (i.e., not necessarily mandated by a court), the retention rates are much lower. A 1993 study of community-based treatment programs nationwide found that *three-month* retention rates ranged from 30 percent to 60 percent (Condelli and DeLeon 1993). A 1997 study found that approximately half of those enrolling in outpatient treatment are retained for less than three months (Simpson, Joe, and Brown 1997). A 1994 study of therapeutic communities only involving residential treatment found one-year retention rates ranging from only 10 percent to 30 percent (Lewis and Ross 1994). These results suggest that drug courts have a far greater ability to engage drug-addicted offenders than community-based treatment without court supervision.

There are several theories that explain why drug courts have better retention rates than traditional community-based treatment. In particular, specific deterrence theory predicts that the legal leverage entailed by a criminal court mandate and the threat of jail or prison time for failing increases program attachment (Cissner and Rempel 2005). There is substantial support in the existing research that greater legal pressure leads both to an increased likelihood of treatment retention and to more positive long-term outcomes (e.g., see Anglin et al. 1989, DeLeon 1988, Rempel and DeStefano 2001, Young and Belenko 2002). Other elements of the drug court model, including intensive judicial supervision, court-based case management, or interim judicial sanctions and incentives also may contribute to higher retention rates (Carey, Finigan, and Pukstas 2008; Gottfredson, Kearley, et al. 2007).

Although the existing evidence points to comparatively high retention rates among those participating in drug courts, there is no reliable national estimate. There is no centralized drug court database that tracks retention across drug courts, and there have been few multi-site evaluations. Studies of the general treatment population are not appropriate to use as proxies for a court-mandated population. The goal of this chapter is to fill this gap in the literature by:

- Examining the ways in which participants leave the drug court.
- Documenting 6- and 18-month retention rates across 23 drug courts.
- Analyzing the background predictors of 18-month retention.
- Exploring the extent to which 18-month retention is associated with other positive outcomes, such as reduced drug use, criminal behavior, schooling or increased employment, and depression.

Data and Methods

The MADCE study includes 23 drug courts and 6 comparison sites selected from 8 states across the country. Offenders in all 29 sites were surveyed in three waves, at baseline, 6 months later, and 18 months after enrollment. The baseline surveys took place within six weeks of enrollment in the drug court or comparison condition. An oral fluid sample was collected at the 18-month interview from all offenders who were not incarcerated and who consented to test for the presence of substances. The survey instrument asks about: prior and current criminal behavior; prior and current drug treatment; prior and current drug use; socio-demographic characteristics; drug court participation; attitudes about the court experience; and supervision details. Official administrative data was collected from administrative data in each state and from the Federal Bureau of Investigation (FBI). In addition, NIJ's MADCE researchers conducted two comprehensive site visits at each program to gather data for a process evaluation.

This chapter uses data for drug court participants only from the longitudinal interviews at all three waves. The original sample size at baseline was 1,156, and study attrition rates were low: 13 percent at the 6-month wave, 18 percent at the 18-month wave. Overall, 76 percent of the original sample participated in all three interview waves.

Measuring Retention

Retention was measured from questions that asked respondents about their status at the time of the interview. On each survey, respondents were asked if they were currently participating in the drug court. Respondents in the drug court sample who were not currently participating in drug court were asked a series of questions about why they were no longer active.

- *Reasons for exiting the drug court* included "you graduated," "you dropped out of it yourself," "you were kicked out of it," and "you were put in jail." Those answering that they dropped out were then asked why they left the drug court voluntarily.

- *Reasons for dropping out of the drug court voluntarily* included the drug court "involved too much work," "costs too much," "conflicted with your work or child care responsibilities," "too hard or expensive to get to," "you were not satisfied with the services you were receiving," "there were too many restrictions on your lifestyle," "you did not think you needed the services being offered through the drug court program," "you did not get along with the people running the drug court," "you did not think the drug court program was fair," and "you dropped out for some other reason."

- *Sentences for having been kicked out of the drug court* included "jail/prison," "probation," "something else," and "nothing yet."

At 6 and 18 months, respectively, program retention rates were computed as the number of offenders who were currently participating or who had graduated, divided by the total number of drug court participants surveyed. It is unclear whether those who left the MADCE sample were more or less likely to be retained in the drug court; if the attrited were less likely to be retained in the drug court, their absence in the sample allows the retention rate estimates to be somewhat overstated. The extent of this potential attrition bias on retention rates is unknown.

Modeling Retention

In the analyses below, we first present statistics describing the sample, and then describe the regression analyses. The regression models regress retention on offender attributes. Select offender baseline characteristics were used as covariates to predict retention at 18 months. Relevant domains considered were *demographics* (i.e., age, gender, race/ethnicity), *social ties* (i.e., high school degree/GED, base 10 log of annual income, employed/enrolled in school, married, homeless, blood relatives involved with crime or drugs), *drug use* (i.e., primary drug of choice, average days of use per month in the six months before baseline, any residential treatment in the six months before baseline), *criminal history* (i.e., number of criminal acts in the six months before baseline), and *mental health* (i.e., depression, anti-social personality disorder, narcissistic personality disorder).

Retention was, in turn, explored as a signal of future positive outcomes at the 18-month interview. Four outcomes were considered using five measures:

- *Drug use*—any reported drug use in the year preceding the 18-month survey, and a positive oral specimen given at the 18-month survey.

- *Criminal behavior* in the year preceding the 18-month survey.

- *School or employment status* at the 18-month survey.

- *Depression* at the 18-month survey based on a series of questions that are part of a validated test of the incidence of depression.

Exiting the Drug Court

Table 3-6.1 examines the ways in which participants exited the drug courts. Eighteen months after the baseline interview, just over one-quarter (28 percent) of the participants were still active. More than half of those who had exited the drug courts (59 percent) had successfully completed the requirements and graduated. Twenty-six percent of exiting participants were involuntarily terminated (kicked out of the program or put in jail), whereas 15 percent voluntarily dropped out.

Table 3-6.1. Drug Court Exit for 23 Drug Courts, 18 Months after Baseline

Drug Court Exit	*Total Participants 951*
Currently in Drug Court	28%
Why no longer in drug court?	(N=674)
Graduated	59%
Involuntary Failure[1]	26%
Voluntary Failure	15%
If voluntary failure, why[2]	(N=89)
Too many restrictions on lifestyle	22%
Not satisfied with services received	12%
Drug court conflicted with work/child care responsibilities	9%
Drug court involved too much work	6%
Did not think drug court fair	5%
Drug court too hard or expensive to get to	3%
Did not think needed services being offered through drug court	3%
Drug court costs too much	2%
Did not get along with people running drug court	1%
Other reason	36%
What was the sentence for failure?	(N=270)
Jail/prison	74%
Probation	14%
Something else	5%
Nothing yet	7%

Source: Urban Institute MADCE Survey of Substance-Abusing Offenders

[1] Involuntary failure includes "kicked out" and "put in jail" as reasons for exiting the drug court.

[2] Respondents were only asked this question if voluntary failure (i.e., they dropped out of the drug court themselves).

Looking only at the 15 percent of participants who voluntarily dropped out of the drug court, the reasons were varied:

- 22 percent reported that the drug court required too many restrictions on their lifestyle.

- 12 percent reported that they were not satisfied with the services they received from the drug court.
- 9 percent reported that the drug court requirements conflicted with their work and child care responsibilities.
- 6 percent reported that the drug court required too much work on their part.
- 5 percent reported that the drug court was not fair.
- 45 percent reported some other reason.[15]

Among all of those who failed the drug court, either because they voluntarily dropped out or because they were forced to leave, the sentence was mostly jail or prison (74 percent). Fourteen percent of those participants said they were sentenced to probation, 5 percent to something else, and 7 percent reported they were not yet sentenced.

Drug Court Program Status and Retention

Figure 3-6.1 shows the program status of all drug court participants 6 and 18 months after baseline. At six months, 89 percent of participants were still active in the drug court, and the average retention rate was 90 percent. After 18 months, 28 percent were active, 43 percent of participants had successfully graduated from the drug court, and 29 percent had failed the program, either voluntarily or involuntarily. The average 18-month retention rate was 71 percent, down from 90 percent at 6 months, due to an increase in the number of failures. These retention rates are somewhat higher than Belenko's (1998) national average of 60 percent at one year.

Figure 3-6.2 shows the 18-month retention rates for each individual drug court in the MADCE sample. The retention rates range from a low of 39 percent in one court to a high of 93 percent in two courts. Most of the courts are in the 60 to 80 percent range, with an average of 71 percent, as previously noted. Nineteen of the 23 courts have a retention rate of at least 60 percent.

Baseline Covariates of Retention at 18 Months

When comparing the baseline characteristics of those participants who were retained at 18 months to those who were not, there are few significant differences, as seen in Table 3-6.2. At baseline, those who were eventually retained tended to:

[15] Of those in the "other" category, 3 percent reported that the drug court was too hard or expensive to physically get to, 3 percent did not think they needed the services the drug court offered, 2 percent thought the drug court cost too much money, 1 percent reported that they did not get along with the people running the drug court, and 36 percent simply indicated an unspecified reason.

Figure 3-6.1. Drug Court Program Status - at 6 and 18 Months

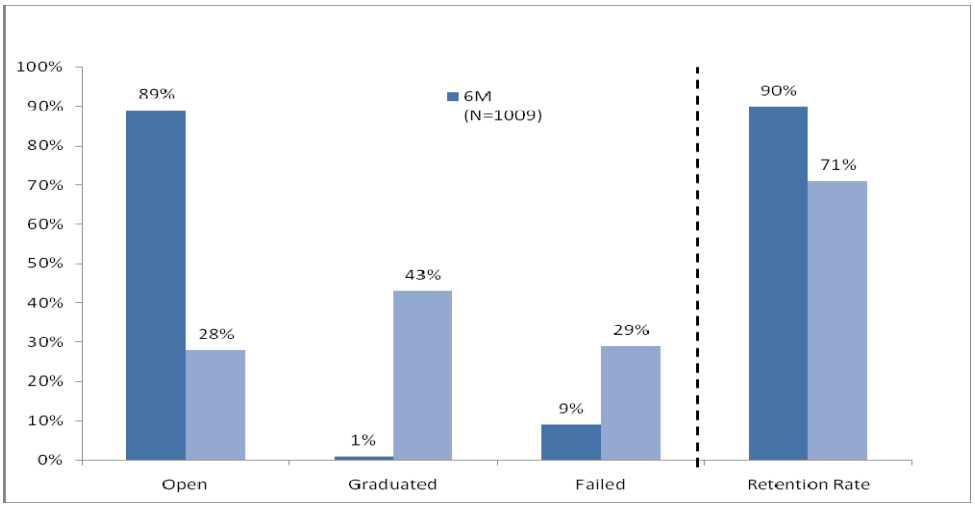
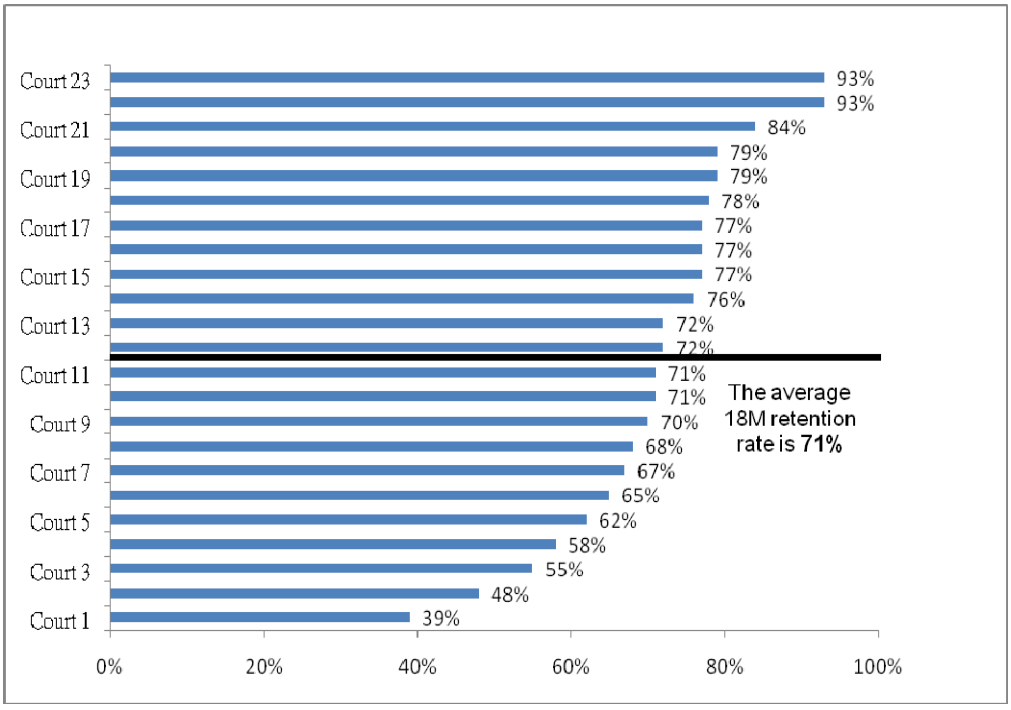


Figure 3-6.2. 18-Month Retention Rates at 23 Adult Drug Courts



- *Be older* ($p < .001$). There was almost a two-year difference in the average ages of those retained (33.71) versus those who were not retained (31.74).

- *Be employed or in school* ($p < .05$). Forty-five percent of the retained participants began their drug court participation in school or employed compared to only 37 percent of those not retained.

- *Have a primary drug of choice that was not marijuana* ($p < .05$). Twenty percent of those retained claimed marijuana as the primary drug of choice compared to 27 percent of the participants who were not retained.

- *Have less criminal activity* ($p < .05$). Retained participants reported 22.54 criminal acts in the six months before joining the drug court compared to 27.12 criminal acts for those not retained.

- *Suffer less from depression* ($p < .05$). Thirty-six percent of those retained were identified as depressed at baseline compared to 44 percent of those not retained.

- *Have a less narcissistic personality* ($p < .05$). Forty-six percent of those retained were identified as having narcissistic personality disorder compared to 53 percent of those not retained.

With one exception, these baseline covariates are not surprising. In general, the more mature participants who had a greater "stake in conformity" (e.g., Feder and Dugan 2002), and who were not held back by mental illness, were the ones who were more likely to be retained. The one exception was that those with a primary drug of marijuana were less likely to be retained than other drug users. Generally speaking, the opposite has previously been found. Prior literature has found that cocaine and heroin are particularly difficult addictions to manage and, consequently, those with a primary drug of cocaine or heroin are more likely to have negative outcomes in treatment in general, and in drug court specifically (Grella, Wugalter, and Anglin 1997; Longshore, Evans, et al. 2003; Peters and Murrin 1998; Peters, Haas, and Murrin 1999; Rempel and DeStefano 2001; Rempel et al. 2003).

A logistic regression was conducted to examine the relationship between the covariates and 18-month retention (see results shown in Appendix D); the findings were similar to the bivariate results just reported. Older participants who were in school or employed at baseline and whose primary drug of choice was not marijuana were especially likely to be retained. The findings on criminal activity and mental health were not found to be significant in the regression analysis. The only other notable finding was that those whose primary drug of choice was not cocaine (and not marijuana, as stated previously) were more likely to be retained. This last finding—that those whose primary drug of choice was cocaine are less likely to be retained—is consistent with the prior literature, as discussed above.

Table 3-6.2. Baseline Covariates of Retention for 23 Drug Court Sites, at 18 Months

	Total Participants = 936[1]	
Baseline Covariates	**Retained at 8M (N=665)**	**Not Retained at 18M (N=271)**
Demographics		
Age	33.71***	31.74
Male	67%	72%
Race/ethnicity		
Black	27%	31%
Hispanic	7%	5%
Other racial group	7%	8%
Social Ties		
High school degree or GED	63%	60%
Income (base 10 log of income)	4.59	4.49
Employed or enrolled in school	45%*	37%
Married	11%	11%
Homeless (any time in 6 months pre-baseline)	11%	14%
Blood relatives involved with crime or drugs[2]	1.84	1.92
Drug Use		
Primary drug of choice		
Marijuana	20%*	27%
Alcohol	12%	11%
Cocaine (any form)	37%	39%
Average days of use/month (6 months pre-baseline)	13.59	14.43
Any residential treatment (6 months pre-baseline)	10%	10%
Criminal History		
Number of criminal acts (6 months pre-baseline)	22.54*	27.12
Mental Health		
Depression	36%*	44%
Anti-social personality disorder	43%	45%
Narcissistic personality disorder	46%*	53%

Source: Urban Institute MADCE Survey of Substance-Abusing Offenders
*+p<.10, *p<.05, **p<.01, ***p<.001.*

[1] Fifteen participants were removed for this analysis because they were missing a value for one of the key variables.
[2] The blood relatives measure represents an index of 10 questions, each coded on a 0-10 scale.

Prior drug court and treatment studies have found that older age and being employed at intake predicted graduation and lower recidivism rates (Grella et al. 1997; Hser, Andlina, and Liu 1990; Longshore et al. 2003; Peters et al. 1999; Rempel et al. 2003). Another common finding confirmed here is that a reliable predictor of future criminal involvement is prior criminal involvement (Elliott and Menard 1996; Peters et al. 1999; Rempel et al. 2003; Thornberry, Lizotte, et al. 1994).

Outcomes by Retention Status

Since retention has often been considered a key signal of future of positive outcomes (e.g., see Rempel et al. 2003), we conducted a simple (bivariate) examination of outcomes by 18-month retention status to provide confirmation. As shown in Figure 3-6.3, those who are retained at 18 months had more positive outcomes on all five measures:

- *Drug Use (p<.001).* Retained participants were less likely to have used drugs in the year prior to the 18-month survey (50 percent, as compared to 78 percent of those not retained). Additionally, only 26 percent of those retained had positive oral specimens compared to 52 percent of those not retained.[16]

- *Criminal Behavior (p<.001).* Thirty-two percent of those who were retained reported having participated in criminal behavior in the year prior to the 18-month survey, as compared to 66 percent of those not retained.

- *School or Employment Status (p<.001).* Those who were retained were more likely to be involved in education or employment. Seventy-one percent of those retained were in school or working at 18 months, compared to 47 percent of those not retained.

- *Depression (p<.001).* Twenty-three percent of those participants retained were identified as being depressed at the 18-month survey compared to 38 percent of those not retained.

Conclusions

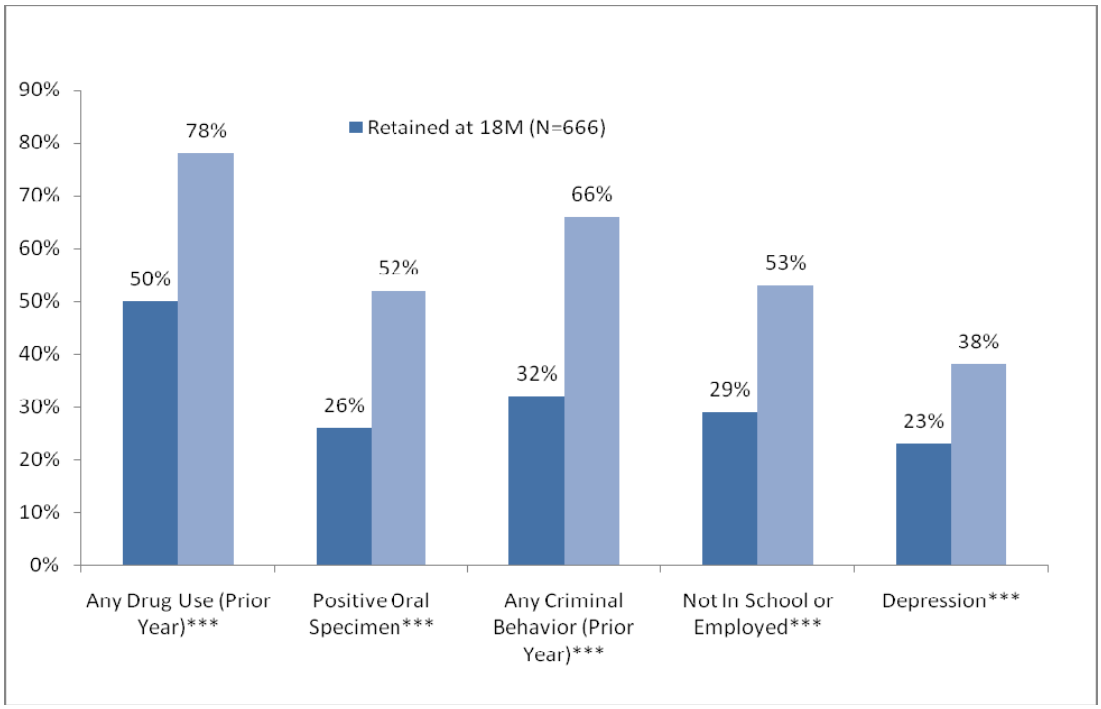
The 23 drug court sites in the study reported significantly higher retention rates than "treatment as usual" outside of drug courts and than earlier estimates of drug court retention. The average six-month retention rate was 90 percent. The average 18-month retention rate was 71 percent, ranging from 39 percent to 93 percent, and 19 of the 23 courts had retention rate higher than 60 percent.

Of those exiting the drug court, most graduated (59 percent), and the rest failed either involuntarily (26 percent) or voluntarily (15 percent). Most participants who failed the drug court were given a sentence of jail or prison (74 percent).

A number of baseline attributes appeared to predict 18-month retention. Retention at 18 months was significantly more likely among those who: were older, employed or in school at baseline, had a primary drug other than marijuana, had less prior criminal activity, were not depressed at baseline, and did not have a narcissistic personality disorder. In general, more mature participants who had more to lose and who were not held back by mental illness were more likely to be retained.

[16] Respondents were asked to separately consent to giving oral specimens for drug testing at the 18-month interview. There were 752 drug court participants who consented: 590 who were retained, and 162 who were not retained at 18 months.

Figure 3-6.3. Simple 18-Month Outcomes, by Retention Status at 18 Months



*** *p<.001* ** *p<.01* * *p<.05*
Notes: Respondents were asked to separately consent to provide oral specimens at the 18-month interview. There were 752 drug court participants who consented: 590 who were retained, and 162 who were not retained at 18 months.

Finally, outcomes were compared for those who were and were not retained at 18 months. Retained participants reported less drug use, less criminal activity, were more likely to be in school or employed, and were less likely to be depressed at the 18-month mark. These findings should not be interpreted to imply that retention, itself, caused the subsequent positive outcomes. However, the findings do demonstrate that retention strongly coincides with and signals these longer-term outcomes.

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Appendix A. Baseline Characteristics of Study Participants

Excerpted from *MADCE Volume 1. Chapter 6. NIJ's Multi-Site Adult Drug Court Evaluation—Baseline Characteristics of Study Participants*

Table 3-A.1 documents background characteristics reported by sample members during the baseline interview. Information is presented for both the drug court and comparison groups separately, as well as for the combined sample.

Table 3-A.1. Baseline Background Characteristics of Sample Members by Research Group

	Drug Court Group N=1,156	Comparison Group N=625	Total N=1,781
Male	68%+	72%	70%
Age			
18 to 25 years	30%**	23%	27%
26 to 33 years	23%	21%	22%
34 to 41 years	20%	26%	22%
42 to 49 years	20%	22%	21%
50 to 57 years	6%	7%	6%
58 to 65 years	1%	2%	1%
Average age (in years)	32.97***	35.06	33.71
Race/Ethnicity			
White	57%	50%	55%
Black/African American	29%	41%	33%
Hispanic / Latino	7%	5%	6%
Other (including multiracial)	7%	5%	6%
Highest Education Level			
Less than High school degree / GED	39%	45%	41%
High school degree/GED	35%	34%	35%
Some college or higher	26%	22%	25%
Currently in School or Working	43%+	38%	41%
Currently in School	8%	9%	9%
Currently Employed	39%**	32%	36%
Type of Job *(If employed)*			
Formal Pay	73%	58%	69%
Self-employment	11%	20%	14%
Casual Pay (pay under the table or off the books)	15%	22%	17%

(continued)

Table 3-A.1. Baseline Background Characteristics of Sample Members by Research Group (Cont'd)

	Drug Court Group N=1,156	Comparison Group N=625	Total N=1,781
Sources of Financial Support			
Job	35%*	30%	33%
Family	37%*	43%	39%
Friends	11%	13%	12%
Government programs	23%***	13%	20%
Other	13%	14%	14%
Average annual Income (based on a monthly estimate)	$11,659***	$8,944	$10,706
Homeless-Prior 6 Months	11%	13%	12%
Ever Been Homeless	47%	50%	48%

*Note: + p < .10 * p < .05 ** p < .01 *** p < .001*

Drug Use History

Both the drug court and comparison groups reported extensive drug use histories. Everyone in the study reported having used drugs of some sort in their lifetimes and 93 percent reported using drugs on a regular basis at some point in their lives.[17] The drugs that most participants used include alcohol, marijuana, cocaine, and hallucinogens or designer drugs. Nearly the entire sample had used alcohol and marijuana, with more than half using alcohol regularly at some point in their lives, and nearly two-thirds using marijuana regularly.

Drug Use Six Months Before Program Entry

The majority of study participants reported using drugs six months before program entry (see Table 3-A.2).

[17] Significantly more of the drug court group (95 percent) than the comparison group (90 percent) reported using drugs regularly.

Table 3-A.2. Drug Use Six Months Before Program Entry by Research Group

	Drug Court Group N=1,156	Comparison Group N=625	Total N=1,781
Any use of drugs	84%***	76%	81%
Any use of drugs other than marijuana or alcohol	61%***	51%	57%
Average days of use per month before program entry (on all drugs)	13.64***	11.79	12.90
Non-user (0 days)	16%***	24%	19%
Occasional user (1 to 8 days)	38%	35%	37%
Moderate user (9 to 19 days)	11%	12%	11%
Regular user (20 to 30 days)	36%	29%	34%
Average days of use per month before program entry (other than alcohol and marijuana)	7.92**	6.58	7.44
Non-user (0 days)	40%*	49%	44%
Occasional User (1 to 8 days)	36%	28%	33%
Moderate User (9 to 19 days)	8%	8%	8%
Regular User (20 to 30 days)	17%	15%	16%
Alcohol	61%	58%	60%
Average days of use per month	5.02	5.24	5.10
Heavy alcohol (defined as 4 or more drinks per day for women, 5 or more drinks per day for men)	41%	38%	40%
Average days of use per month	3.32	3.18	3.28
Marijuana	46%**	38%	43%
Average days of use per month	6.18***	4.21	5.50
Cocaine	44%***	34%	41%
Average days of use per month	4.17+	3.48	3.93
Heroin	11%	13%	12%
Average days of use per month	1.72	2.10	1.86
Hallucinogens or designer drugs	9%**	5%	8%
Average days of use per month	0.22*	0.08	0.17
Amphetamines	15%*	11%	14%
Average days of use per month	1.89**	1.18	1.64

(continued)

Table 3-A.2. Drug Use Six Months Before Program Entry by Research Group (Cont'd)

	Drug Court Group N=1,156	Comparison Group N=625	Total N=1,781
Illegal prescription drugs use	16%	13%	15%
Average days of use per month	1.27*	0.84	1.12
Illegal methadone use	4%	5%	4%
Average days of use per month	0.10	0.19	0.07
Use of drugs and alcohol at time of arrest	67%	64%	66%

*Note: + p < .10 * p < .05 ** p < .01 *** p < .001*

Primary Drug of Choice before Program Entry

Based on information about frequency of alcohol and drug use six months before program entry, we categorized responses into a primary drug of choice for study members reporting any use during that time. Crack cocaine was the most frequent primary drug of choice with 26 percent of the study sample in this category. The next most frequent primary drug of choice was marijuana with 22 percent of the sample in this category. Other primary drugs of choice included: alcohol (for 13 percent of the study sample), powder cocaine (for 10 percent), amphetamines (including methamphetamine; for 9 percent), and heroin (for 5 percent).

Alcohol and Drug Treatment Before Program Entry

Table 3-A.3 documents the proportion of sample members who reported receiving treatment in the months leading up to program enrollment. In the baseline interview, participants were asked to report their treatment experiences for the preceding six months (with experiences reported separately for each of the six months). In order to isolate treatment received before program entry, we excluded the most recent month (i.e., the month immediately prior to the baseline interview) because any treatment received during that timeframe was likely received through the respondent's participation in drug court, given the lag between enrollment in the program and completion of the baseline interview. Focusing only on this timeframe is our best attempt to isolate treatment that occurred before study members were enrolled in either drug court or the comparison group alternative.

Significantly more of the drug court group (42 percent) than the comparison group (23 percent) reported receiving some type of alcohol or drug treatment—excluding alternative approaches—and for a longer time (6.3 days versus 3.0 days) in the time period prior to program enrollment. When considering just clinical treatment (defined as detoxification, residential, medicinal intervention, outpatient group counseling, and outpatient individual counseling), 35 percent of

Table 3-A.3. Baseline Drug or Alcohol Treatment before Program Entry for Sample Members by Research Group

	Drug Court Group N=1,156	Comparison Group N=625	Total N=1,781
Any drug or alcohol treatment (excluding alternative approaches)	42%***	23%	35%
Total days per month of treatment (excluding alternative approaches)	6.29***	3.02	5.14
Clinical Treatment			
Any clinical drug or alcohol treatment	35%***	18%	29%
Total days per month of clinical treatment	4.15***	1.74	3.31
If any drug or alcohol treatment:			
Any detoxification program	10%	11%	10%
Average days per month of detoxification	0.36	0.46	0.38
Any residential treatment	24%	25%	24%
Average days per month of residential treatment	3.07	2.77	3.00
Any medicinal intervention (e.g. methadone maintenance, Naltrexone, etc.)	10%	8%	9%
Average days per month of medicinal intervention	2.02	1.39	1.87
Any outpatient group counseling	56%***	40%	52%
Average days per month of outpatient group counseling	3.81***	2.27	3.45
Any outpatient individual counseling	43%***	26%	39%
Average days per month of outpatient individual counseling	1.46*	0.66	1.28
Non-Clinical Treatment			
Any drug or alcohol self-help treatment	65%	71%	66%
Average days per month of self-help treatment	6.36	6.09	6.30
Any emergency room trips for drug or alcohol use	2%	2%	2%
Average emergency room trips per month for drug or alcohol use	0.02	0.03	0.03
Any alternative approaches to treatment (e.g. acupuncture, meditation, biofeedback)	12%**	7%	11%
Average days per month of alternative approaches to treatment	1.65*	0.78	1.45

*Note: + p < .10 * p < .05 ** p < .01 *** p < .001*

Note: In the baseline interview, participants were asked to report their treatment experiences for the preceding six months (with experiences reported separately for each of the six months). In order to isolate treatment received before program entry, we excluded the most recent month (i.e., the month immediately prior to the baseline interview) because any treatment received during that timeframe was likely received through the respondent's participation in drug court, given the lag between enrollment in the program and completion of the baseline interview.

the drug court group and 18 percent of the comparison group reported receiving such services. Differences between the groups are due to receipt of outpatient individual counseling and outpatient group counseling. Forty-three percent of the drug court group received outpatient individual counseling and 56 percent received outpatient group counseling versus 26 percent and 40 percent respectively for the comparison group. Similar rates of the two groups received residential treatment (24 percent), detoxification (10 percent), and medicinal interventions (9 percent).

Two-thirds of both samples obtained assistance from self-help groups such as Alcoholics Anonymous and Narcotics Anonymous. Only 11 percent of the study sample sought help through alternative approaches—such as acupuncture—although significantly more of the drug court group did so (12 percent) than the comparison group (7 percent).

Appendix B. Treatment Motivation

The analysis used three scales, as identified below:

- First Scale
  - TCU Treatment Motivation Scale (scale 1-8)
  - Higher indicates more motivated
  - Chronbach = 0.767
  - Index of
    - Problem recognition (9 items)
    - Desire for help (7 items)
    - Treatment readiness (6 items)
    - External Pressure (5 items)
- Second Scale
  - Treatment Eagerness (scale 1-8)
  - Higher indicates more motivated
  - Chronbach = 0.772
  - Index of
    - Problem recognition (7 items)
    - Ambivalence (4 items)
    - Taking steps (6 items)
- Third Scale
  - Treatment motivation (scale 1-8)
  - Higher indicates more motivated
  - Chronbach = 0.870
  - Average of previous two scales

TCU Treatment Motivation—Problem Recognition	
	Baseline/6 month/18 month Please listen to the following statements and indicate the answer that best describes you or the way you have been feeling **in the past 30 days.** Please tell me if these statements never, rarely, sometimes, often, or always apply:
_TREMO1	• Your drug or alcohol use has been a problem for you. (Never, Rarely, Sometimes, Often, Always)
_TREMO1A	• Your drug or alcohol use has been more trouble than it is worth. (Never, Rarely, Sometimes, Often, Always)
_TREMO1B	• Your drug or alcohol use has been causing problems with the law. (Never, Rarely, Sometimes, Often, Always)
_TREMO1C	• Your drug or alcohol use has been causing problems in thinking or doing your work. (Never, Rarely, Sometimes, Often, Always)

_TREMO1D	• Your drug or alcohol use has been causing problems with family or friends. (Never, Rarely, Sometimes, Often, Always)
_TREMO1E	• (*If person NOT incarcerated for the whole six months before baseline or time since last interview*) Your drug or alcohol use has been causing problems finding or keeping a job. (Never, Rarely, Sometimes, Often, Always)
_TREMO1F	• Your drug or alcohol use has been causing problems with your health. (Never, Rarely, Sometimes, Often, Always)
_TREMO1G	• Your drug or alcohol use has been making your life worse and worse. (Never, Rarely, Sometimes, Often, Always)
_TREMO1H	• Your drug or alcohol use is going to cause your death if you do not quit soon. (Never, Rarely, Sometimes, Often, Always)
TCU Treatment Motivation—Desire for Help	
	Baseline/6 month/18 month
_TREMO1I	• You need help in dealing with your drug or alcohol use. (Never, Rarely, Sometimes, Often, Always)
_TREMO1L	• It is urgent that you find help immediately for your drug or alcohol use. (Never, Rarely, Sometimes, Often, Always)
_TREMO1N	• You are tired of the problems caused by drugs or alcohol. (Never, Rarely, Sometimes, Often, Always)
_TREMO1O	• You will give up your friends and hangouts to solve your drug or alcohol problems. (Never, Rarely, Sometimes, Often, Always)
_TREMO1Q	• You can quit using drugs or alcohol without any help. (Never, Rarely, Sometimes, Often, Always)
_TREMO1R	• Your life has gone out of control. (Never, Rarely, Sometimes, Often, Always)
_TREMO1T	• You want to get your life straightened out. (Never, Rarely, Sometimes, Often, Always)
TCU Treatment Motivation—Treatment Readiness	
	Baseline/6 month/18 month
_TREMO1J	• You have too many outside responsibilities now to be in a treatment program. (Never, Rarely, Sometimes, Often, Always)
_TREMO1K	• Treatment programs seem too demanding for you. (Never, Rarely, Sometimes, Often, Always)
_TREMO1M	• Treatment may be your last chance to solve your drug or alcohol problems. (Never,

	Rarely, Sometimes, Often, Always)
_TREMO1P	• Treatment programs will not be very helpful to you. (Never, Rarely, Sometimes, Often, Always)
_TREMO1S	• Treatment programs can really help you. (Never, Rarely, Sometimes, Often, Always)
_TREMO1U	• You want to be in a drug or alcohol treatment program. (Never, Rarely, Sometimes, Often, Always)
TCU Treatment Motivation—External Pressure	
	Baseline/6 month/18 month
_TREMO1V	• *(If person NOT incarcerated for the whole six months before baseline or time since last interview)* You could be sent to jail or prison if you are not in treatment. (Never, Rarely, Sometimes, Often, Always)
_TREMO1W	• You feel a lot of pressure to be in treatment. (Never, Rarely, Sometimes, Often, Always)
_TREMO1X	• You have legal problems that require you to be in treatment. (Never, Rarely, Sometimes, Often, Always)
_TREMO1Y	• You are concerned about legal problems. (Never, Rarely, Sometimes, Often, Always)
_TREMO1Z	• You have family members who want you to be in treatment. (Never, Rarely, Sometimes, Often, Always)
Treatment Eagerness—Problem Recognition	
_TREMO4	• You really want to make changes in your drinking or drug use. (Never, Rarely, Sometimes, Often, Always)
_TREMO4B	• If you don't change your drinking or drug use soon, your problems are going to get worse. (Never, Rarely, Sometimes, Often, Always)
_TREMO4F	• You are a problem drinker(Never, Rarely, Sometimes, Often, Always)
_TREMO4I	• You have serious problems with drinking or drug use(Never, Rarely, Sometimes, Often, Always)
_TREMO4K	• Your drinking or drug use is causing a lot of harm. (Never, Rarely, Sometimes, Often, Always)
_TREMO4N	• You know that you have a drinking or drug problem (Never, Rarely, Sometimes, Often, Always)
_TREMO4P	• You are an alcoholic or addict (Never, Rarely, Sometimes, Often, Always)

Treatment Eagerness—Ambivalence	
_TREMO4A	• Sometimes you wonder if you are an alcoholic or drug addict. (Never, Rarely, Sometimes, Often, Always)
_TREMO4E	• Sometimes you wonder if your drinking or drug use is hurting other people. (Never, Rarely, Sometimes, Often, Always)
_TREMO4J	• Sometimes you wonder if you are in control of your drinking or drug use. (Never, Rarely, Sometimes, Often, Always)
_TREMO4O	• There are times when you wonder if you drink or use too much. (Never, Rarely, Sometimes, Often, Always)
Treatment Eagerness—Taking Steps	
_TREMO4C	• You have already started making some changes in your drinking or drug use. (Never, Rarely, Sometimes, Often, Always)
_TREMO4D	• You were drinking or using too much at one time, but you've managed to change your drinking or drug habits.: (Never, Rarely, Sometimes, Often, Always)
_TREMO4G	• You're not just thinking about changing your drinking or drug habit, you're already doing something about it. (Never, Rarely, Sometimes, Often, Always)
_TREMO4H	• You have already changed your drinking or drug use, and you are looking for ways to keep from slipping back into your old pattern. (Never, Rarely, Sometimes, Often, Always)
_TREMO4L	• You are actively doing things now to cut down or stop drinking or using drugs. (Never, Rarely, Sometimes, Often, Always)
_TREMO4M	• You want help to keep from going back to the drinking or drug problems that you had before. (Never, Rarely, Sometimes, Often, Always)
_TREMO4Q	• You are working hard to change your drinking or drug use. (Never, Rarely, Sometimes, Often, Always)
_TREMO4R	• You have made some changes to your drinking or drug habits, and you want some help to keep from going back to the way you used to drink or use drugs (Never, Rarely, Sometimes, Often, Always)

Appendix C: Indices, Sub-Indices, and Scales

Table 3-C.1. Procedural Justice Indices

Index	Item
Attitudes toward their supervision officer (7-item index, 1-5 scale: strongly agree, disagree, neither disagree or agree, agree, strongly agree; Cronbach's alpha = .916)	Your supervision officer . . . . . . is knowledgeable about your case. . . . knows you by name. . . . helps you to succeed. . . . emphasizes the importance of drug and alcohol treatment. . . . gives you a chance to tell your side of your story. . . . your supervision officer can be trusted to treat you fairly. . . . treats you with respect.
Attitudes toward the judge (9-item index, 1-5 scale: strongly agree, disagree, neither disagree or agree, agree, strongly agree; Cronbach's alpha = .903)	The judge . . . . . . is knowledgeable about your case. . . . knows you by name. . . . helps you to succeed. . . . emphasizes the importance of drug and alcohol treatment. . . . is intimidating and unapproachable. . . . remembers your situations and needs from hearing to hearing. . . . gives you a chance to tell your side of your story. . . . can be trusted to treat you fairly. . . . treats you with respect.
Perceptions of procedural justice (18-item index, 1-5 scale: strongly agree, disagree, neither disagree or agree, agree, strongly agree; Cronbach's alpha = .939)	You felt you had the opportunity to express your views in the court. You felt too intimidated or scared to say what you really felt in the court. People in the court spoke up on your behalf. The court took account of what you said in decision of what should be done. How much influence did you have over the agreement reached in the Court? (1-4 scale) You felt you had enough control over the way things were run in the court. You understood what was going on in the court. You understood what your rights were during the processing of the case. All sides had a fair chance to bring out the facts in the court. You felt that people who committed the same offense were treated the same way by courts.

	You were disadvantaged in court because of your age, income, sex, race, or some other reason. You felt pushed around in the court case by people with more power than you. During the court you felt pushed into things you did not agree with. You were treated unfairly by the court or the police. People were polite to you in court. You feel that you were treated with respect in the court. How much did you feel the court respected your rights? (1-4 scale) The court got the facts wrong.
Voice (6-item sub-index, 1-5 scale: strongly agree, disagree, neither disagree or agree, agree, strongly agree; Cronbach's alpha = .603)	You felt you had the opportunity to express your views in the court. You felt too intimidated or scared to say what you really felt in the court. People in the court spoke up on your behalf. The court took account of what you said in decision of what should be done. How much influence did you have over the agreement reached in the Court? (1-4 scale) You felt you had enough control over the way things were run in the court.
Understanding (2-item sub-index, 1-5 scale: strongly agree, disagree, neither disagree or agree, agree, strongly agree; Cronbach's alpha = .793)	You understood what was going on in court. You understood what your rights were during the processing of the case.
Neutrality (3-item sub-index, 1-5 scale: strongly agree, disagree, neither disagree or agree, agree, strongly agree; Cronbach's alpha = .632)	All sides had a fair chance to bring out the facts in the court. You felt that people who committed the same offense were treated the same way by courts. You were disadvantaged in court because of your age, income, sex, race or some other reason.
Dignity/respect (6-item sub-index, 1-5 scale: strongly agree, disagree, neither disagree or agree, agree, strongly agree; Cronbach's alpha = .872)	You felt pushed around in the court case by people with more power than you. During the court you felt pushed into things you did not agree with. You were treated unfairly by the court or the police. People were polite to you in court. You feel that you were treated with respect in the court. How much did you feel the court respected your rights? (1-4 scale)

Table 3-C.2: Sanctions Indices

Index	Item
Certainty of response to drug use (10-item, 1-4 scale: very unlikely, somewhat unlikely, somewhat likely, very likely; Cronbach's alpha = .811)	If Judge/Supervision Officer thought you were using drugs, how likely would they respond: Increase drug testing or tx requirements Increase supervision requirements Community service, writing assignment, jury box Formal warning in writing Informal verbal warning Electronic monitoring Day reporting House arrest/Community control Few days in jail Long time in jail or prison
Perceived undesirability of sanctions (12-item index, 1-3 scale: Not bad at all, somewhat bad, extremely bad; Cronbach's alpha = .836)	How bad would it be to: Be put on house arrest/community control? Be put on electronic monitoring? Have to do community service? Have to take drug tests more often? Be put in jail for 1–3 consecutive nights? Be put in jail for 4+ consecutive nights? Increase your time in tx? Increase the number of AA/NA meetings required? Get a warning from your Supervision Officer? Get a warning from the judge? Be charged with a violation of supervision? To be arrested for a new charge?
Deterrence score: perceived sanction severity	Product of preceding two items.
Understands behaviors that result in sanctions (Yes/No)	Understood which behaviors lead to sanctions.
Sanctions received came as surprise (Yes/No)	Sanctions received came as a surprise. [If had any sanctions.]
Sanctions received were perceived as	Sanctions received were unfair. [If had any sanctions.]

unfair (Yes/No)	

Table 3-C.3: Distributive Justice and Legal Coercion Scales

Index	Item
Distributive Justice Scale	Overall, how do you rate the fairness of the outcome you received? (1-4 scale: very unfair, somewhat unfair, somewhat fair, very fair)
Legal Coercion Scales	Most likely sentence upon drug court failure? (1-4 scale: nothing will happen, probation, jail/prison, something else)
	How bad sentence upon failure from drug court? (1-3 scale: not bad at all, somewhat bad, extremely bad)

Appendix D. Baseline Predictors of Retention at 18 Months

Table 3-D.1. Baseline Predictors of Retention at 18 Months

	Drug Court Retention at 18M
Demographics	
Age	1.020*
Male	0.728+
Race/ethnicity[1]	
Black	1.003
Hispanic	1.483
Other racial group	0.839
Social Ties	
High school degree or GED	1.044
Income (base 10 log of income)	1.071
Employed or enrolled in school	1.390*
Married	0.736
Homeless (any time in 6 months pre-baseline)	0.763
Blood relatives involved with crime or drugs[2]	0.997
Drug Use	
Primary drug of choice[3]	
Marijuana	0.565*
Alcohol	0.672
Cocaine (any form)	0.642*
Average days of use/month (6 months pre-baseline)	1.006
Any residential treatment (6 months pre-baseline)	1.055
Criminal History	
Number of criminal acts (6 months pre-baseline)	0.996
Mental Health	
Depression	0.741+
Anti-social personality disorder	1.229
Narcissistic personality disorder	0.857
Number of cases	936

*+p<.10, * p<.05, ** p<.01, ***p<.001.*

Notes: The coefficients for whether the offender was retained are logistic regression odds ratios.

[1] White is the reference category. "Other racial group" includes Native-American, Alaskan Native, Asian, East Indian, Native Hawaiian, Pacific Islander, and non-Hispanic multi-racial.

[2] The blood relatives measure represents an index of 10 questions, each coded on a 0-10 scale.

[3] The reference category includes primary drugs of heroin, amphetamines, prescription drugs, miscellaneous other drugs, and those who did not claim to have any particular primary drug. All of these categories combined to total 30% of the sample.

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Editors

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