

REQUEST FOR PROPOSALS/QUALIFICATIONS
(RFP/Q)
Rev. 07/11/18

The Administrative Office of the Courts, Twentieth Judicial Circuit for Lee County, Florida is accepting sealed Proposals/Qualifications for the following:

CONTRACT FOR
PROFESSIONAL DRUG LABORATORY SERVICES FOR
ADULT DRUG COURT PARTICIPANTS OF THE CIRCUIT
COURT FOR LEE COUNTY

Copy of RFP/Q:

A copy of the Request for Proposals/Qualifications may be obtained from the Administrative Office of the Courts, Lee County Justice Center, 1700 Monroe Street, Fort Myers, FL., telephone (239) 533-1700, or from the Administrative Office of the Courts' website at <http://www.ca.cjis20.org>.

Proposal Deadline:

All Proposals/Qualifications must be received and date/time stamped by the Administrative Office of the Courts no later than Tuesday, August 7, 2018, 4:00 pm. Proposals received after this deadline will not be accepted. If mailed, the Administrative Office of the Courts accepts no responsibility for ensuring that the proposal is date/time stamped prior to the Proposal Deadline.

Submission: All Proposals/Qualifications must be delivered or mailed/e-mailed to:

Administrative Office of the Courts
Twentieth Judicial Circuit
Lee County Justice Center
Attn: Eric Fishbeck
1700 Monroe Street
Fort Myers, Florida 33901
Email: efishbeck@ca.cjis20.org

Please submit an original and one copy.
FACSIMILIES WILL NOT BE ACCEPTED.

DELIVERIES MUST BE IDENTIFIED WITH THE NOTATION:
RFP/Q #18-002

REQUEST FOR PROPOSALS/QUALIFICATIONS
FOR
PROFESSIONAL DRUG LABORATORY SERVICES
TWENTIETH JUDICIAL CIRCUIT OF FLORIDA FOR LEE COUNTY
#18-002

Part A: NOTICE TO PROPOSERS

NOTICE IS HEREBY GIVEN that sealed proposals marked **RFP/Q #18-002** shall be received at the Administrative Office of the Courts, Lee County Justice Center, 1700 Monroe Street, Fort Myers, FL 33901 (239) 533-1700 no later than Tuesday, August 7, 2018, 4:00 p.m. for the following services:

1. SCOPE OF SERVICES:

The Administrative Office of the Courts (hereinafter "AOC") plan to enter into a contract or contracts with one or more qualified vendors to provide professional drug laboratory services for adult drug court participants for the circuit court for Lee County as needed or as required by law or the Courts. Proposer shall provide such laboratory services on an as needed basis and in accordance with law and Administrative Order 3.15 (revised 04/05/16).

This RFP/Q is solicited by the Administrative Office of the Courts. The AOC will contract with one or more proposers as needed to provide laboratory services to adult drug court participants for the circuit court for Lee County.

2. TERM OF CONTRACT

The initial period of the contract will be for twelve (12) months beginning October 1, 2018 through September 30, 2019, with potential for two (2) one-year extensions.

3. BILLING

Payments will be made on a reimbursement basis to the SELECTED PROVIDER and the SELECTED PROVIDER agrees to accept as full compensation the total amount not to exceed **\$205,500.00**. Payments will be authorized only for work completed and/or services delivered during the term of the contract. Drug laboratory services will be billed directly to the AOC regardless of the participating entity (such as the SAO, PD or a private party).

4. AVAILABILITY OF DOCUMENTS:

The Proposal documents are available from the Administrative Office of the Courts, Lee County Justice Center, 1700 Monroe Street, Fort Myers, Florida 33901, and telephone (239) 533-1700, or from the Administrative Office of the Courts' website at <http://www.ca.cjis20.org>.

5. AOC REPRESENTATIVE:

The AOC Representative who will coordinate the solicitation, evaluation and award of this RFP/Q and serve as the AOC's Contract Administrator is:

Administrative Office of the Courts
Attn: Eric Fishbeck
Lee County Justice Center
1700 Monroe Street
Fort Myers, Florida 33901
Phone: (239) 533-1719
Email: efishbeck@ca.cjis20.org

Questions regarding the specifications and requirements of the RFP/Q should be made IN WRITING to the AOC Representative no later than, Tuesday, July 31, 2018.

6. LOBBYING

Proposers are hereby advised that they are not to lobby for a contract with ANY Court Administration personnel, Judge or Judicial Assistant. Violation of this provision may result in a Proposer's disqualification.

7. PRE-PROPOSAL CONFERENCE:

A pre-proposal conference will be held on Tuesday, July 31, 2018, at 10:00 a.m. at the Administrative Office of the Courts, Lee County Justice Center, 1700 Monroe Street, Fort Myers, Florida 33901, to answer questions regarding the specifications and requirements of this RFP/Q. Prospective vendors must request in advance in order to attend.

AOC will post on the 20th Judicial Circuit website the answers to questions raised during the pre-proposal conference and received in writing on Thursday, August 2, 2018.

All submittals must be made in the official name of the firm or individual under which business is conducted (showing official business address) and must be signed in ink by a person duly authorized to legally bind the person, partnership, company, or corporation submitting the response to this RFP.

Part B: PREPARATION OF PROPOSALS

Proposals will be prepared in accordance with the following:

- A. Please submit the professional drug laboratory services you can provide and how you plan to provide those treatment services to Adult Drug Court Participants.
- B. Please submit your lowest pricing formula for services to be provided. Include calculations for cost per test, as well as the maximum amount of testing to be delivered at the proposed cost.
- C. Proposers will not charge Federal Taxes, nor State of Florida Sales, Excise and Use Taxes in proposal prices, as the AOC is exempt from payment of such taxes.
- D. Proposers shall make all investigations necessary to thoroughly inform themselves regarding the nature of the professional drug laboratory services to be provided, as required by the RFP conditions. No pleas of ignorance by the Proposers of conditions that may hereafter exist as a result of failure or omissions on the part of the Proposer to make prudent examinations and investigations will be accepted as a basis for varying the requirements of the contract or the compensation to vendor.
- E. Any exceptions, substitutions, deletions or deviations from the following specifications shall be explained in detail on a separate page entitled "Exceptions" (see forms at end of RFP package). Providers must show proof that any exceptions are equal and superior to those specified.
- F. Required information to enable a uniform review process:
 1. Letter of Interest: A letter stating the interest in providing these services, signed by the person who will have contract authority over the services and stating the contents of the response are true and accurate.
 2. References: Provide a listing of facilities, agencies, or environments where you have provided similar professional drug laboratory services, along with contact information for each organization, and length of time you have been contracted with each. Include names of key staff involved in rendering the services, and copies of the credentials, resumes, and required Florida licensure.
 3. Documents: Copies of Certificates of Insurance (type and amount as described in Part V, below, page 13).

Forms: (Attached at back of packet):

- Attachment A - No Lobbying Affidavit
- Attachment B - Anti-Collusion Statement & No Gifts Statement
- Attachment C - Public Entity Crime Statement
- Attachment D - Conflict of Interest Disclosure Form
- Attachment E – Immigration Law Certification
- Attachment F - Drug-Free Workplace Certification
- Attachment G - Exceptions (if needed)

Part C: SCOPE OF WORK

1. **Purpose:**

The Twentieth Judicial Circuit of Florida, Administrative Office of the Courts is accepting proposals from professional drug laboratory service providers to deliver laboratory services to participants of the Lee County Felony Drug Court Program. The Lee County Drug Court is a post-adjudicatory drug court made up of felony offenders. The professional drug laboratory service provider participates as a member of a drug court treatment team comprised of a Judge, representatives from Court Administration, the Public Defender's Office, the State Attorney's Office, and Probation. These entities meet on a weekly basis to discuss each client's progress. After the meeting each participant is addressed during a court hearing on their weekly progress or struggles.

2. **Background:**

Adult Felony Drug Court is a multi-phase diversion program offered in lieu of incarceration. Non-violent offenders who have committed crimes related to their substance abuse or dependency, and who qualify, may choose to receive specialized outpatient substance abuse services, stay in recovery and become productive members of society. The program typically takes 15 to 24 months to complete. Certification from Substance Abuse and Mental Health Services Administration (SAMHSA) and/or Clinical Laboratory Improvement Amendments Program (CLIA) is desirable. The SELECTED PROVIDER will agree to collect specimens, analyze and report drug screen results and provide all information to the Lee County Adult Felony Court and its affiliates as requested. The Contractor shall make the following types of drug testing available:

1. Urine
2. Saliva
3. Hair
4. Sweat Patches
5. Alcohol

The Adult Felony Drug Court believes that drug and alcohol testing provides an accurate, timely and comprehensive assessment of unauthorized substance use throughout the term of participation. The vendor contracted to provide the Laboratory services will be responsible to provide adequate, qualified staff to collect the specimens. The collection process must be observed with appropriate (same sex) staff at all times.

SELECTED PROVIDER must deliver testing in strict accordance with the most current versions of, and any subsequent updates to, the Lee County Felony Drug Court Program Operational Handbook and the Lee County Felony Drug Court Program Participant Handbook, which describe the program and treatment phases in detail. Any proposal/application submitted which resulted in this funding award are binding and incorporated as a part of this RFP and any subsequent contract including all conditions and projected levels of service. For federally funded projects, all requirements and conditions as described in the Program Guidelines must also be followed.

3. **Provider Requirements/Proposal Content:**

- a. Each proposal submitted must comprehensively address all RFP requirements in order to avoid rejection.

- b. Each proposal must clearly demonstrate that the proposer is capable of performing the services outlined in this RFP. Include a complete and concise narrative that demonstrates:
 - i. An understanding of the requirements and methodology in providing the service;
 - ii. Hours and locations where services will be performed;
 - iii. A description or outline that includes how the proposer will approach the project;
 - iv. Its working relationship with others;
 - v. Specifics of how the proposer will work with the court and the number of substance abuse tests that the proposer has conducted annually;
 - vi. Any special techniques, strategies and capabilities that help to illuminate the proposer's narrative.
- c. Explanation of the proposer's capacity to successfully operate the proposed project, including identification of all roles and responsibilities needed to develop and operate the project and who will perform the necessary functions.
- d. Resumes for each key staff person who will participate in the program that highlights key and relevant experience.
- e. Depiction of proposer's overall organizational structure and history, which must include a statement as to the form of entity wherein the proposer conducts business and the jurisdiction that the proposer is licensed/incorporated.
- f. Complete cost information which specifies a cost for each type of drug test or each service provision method including personnel costs. Pricing submission for lab-based tests shall include a complete testing price for each type of test including shipping charges if applicable. The laboratory shall be responsible for the supplies to collect samples for drug screening/testing including the electronic chain-of-custody forms/template and other materials necessary for the specimen collection to be completed in accordance with industry standards. This will include all supplies, shipping costs, cost of screening and confirmation of all panels with a presumption positive, cost for initial training for website access to website results and expert court testimony by phone if necessary.
- g. Explanation of accounting systems and internal fiscal controls in place.
- h. Include a minimum of two (2) references for services performed of similar size, scope, and complexity to the requirements listed in this RFP, including the following information:
 - i. Name and location of program(s);
 - ii. Brief description;
 - iii. Name of contact and telephone number;
 - iv. Date of completion if not still an active contract;
 - v. Description of other, relevant programs completed
- i. Copy of current license from any of the following:
 - i. Florida State Board of Health (if the proposer is an out of state company, the resident state's board of health/license agency and/or the Federal Clinical Laboratories Improvement Act (CLIA) Interstate license.

4. The SELECTED PROVIDER shall provide services as follows:

- a. The SELECTED PROVIDER will be required to cooperate with the Drug Court team and to ensure that the Drug Court team receives the most current state-of-the-art, confidential and accurate Consumer Urinalysis/Oral or other substance abuse and alcohol testing services.
- b. The SELECTED PROVIDER will have a staff large enough to accommodate the Felony Drug Court's existing participants (current capacity is 200 clients) and demonstrate the ability to grow with the program. The SELECTED PROVIDER will provide trained laboratory staff to conduct urine testing and will provide all staff certifications, degrees, special qualification and resumes.
- c. Drug testing must be observed by same sex observation at all times.
- d. Testing supplies for in-court drug testing requests must be provided and requested testing during or pre-court may be performed.
- e. Participants will be tested on a frequent and random basis at a minimum of two (2) times per week within a seven (day) period. Accuracy of testing must exceed 90%.

- f. Ability for non-negative/diluted/questionable results or specific requests to be further tested for confirmation of substance.
- g. Communicate testing results to the Drug Court team in a timely manner as established in contract.
- h. Location(s) of testing services must be in Lee County.
- i. Utilize a random contact system (phone, web-based, other) accessible by participants.
- j. The SELECTED PROVIDER will adhere to standards, procedures, and rules for qualifications, certification, regulation, professional conduct, ethics, Florida Statutes, Florida Administrative Code, Florida Rules of Court, Department of Business, the National Association of Drug Court Professionals Adult Drug Court Best Practice Standards, and Professional Regulations or other regulatory body.
- k. Hours of Operation. The SELECTED PROVIDER shall post their hours of operation and this information must be visible to the public. The PROVIDER must operate a minimum of five days per week. Preference for operational hours include evening hours and weekends.
- l. The SELECTED PROVIDER will maintain records, hours and days for which testing services are provided to Drug Court Participants, and report this information to the Court on a monthly basis.
- m. The SELECTED PROVIDER must provide an appointed representative to participate in drug court staff meetings in order to provide input on drug testing protocols, on an as needed basis as requested by the court.
- n. The SELECTED PROVIDER must ensure all drug test results are entered into the designated database within 24 hours.
- o. The SELECTED PROVIDER will give testimony in court hearings related to a drug court participants' involvement in the testing and as to any violations or noncompliance with program rules and requirements.
- p. The SELECTED PROVIDER must provide culturally competent services and gender specific treatment.
- q. The SELECTED PROVIDER must provide on-going staff training and quality control measures
- r. The SELECTED PROVIDER must attend Drug Court program meetings as set by the Court.
- s. The Drug Court understands that there exists no good cause for excluding persons possessing Limited English Proficiency (LEP) from individual or group counseling sessions; therefore, it is preferred that the SELECTED PROVIDER possess, at the time of contract commencement, the ability to provide enabling tools that would equip those in need for full program participation.

Part D: SPECIAL RFP CONDITIONS

- A. It is the Proposer's responsibility to ensure that the Proposal is delivered at the proper date, time and place. Offers by telegram, facsimile or telephone are NOT acceptable. Proposals that are received after the date and time specified will NOT be considered and will be returned unopened.
- B. Proposals will not be considered from Contractors who are currently involved in official financial reorganization or bankruptcy proceedings.
- C. Information: Questions concerning RFP requirements or specifications should be directed in writing to Eric Fishbeck, Twentieth Judicial Circuit of Lee County, efishbeck@ca.cjis20.org. All questions submitted and answers provided will be posted within 48 business hours as a supplement to the RFP on the AOC's website at www.ca.cjis20.org, so as to be available to all Proposers. It is the obligation of all Proposers to check the AOC's website for any questions and answers posted.
- D. Any changes by the AOC to specifications shall be in writing in the form of an addendum posted on the AOC's website at www.ca.cjis20.org and will be furnished to all Proposers who have already submitted or have expressed an intent to submit an RFP prior to the closing date.

- E. RFP Documents will be posted on the AOC website at www.ca.cjis20.org and available to the public.
- F. Contract Period: If a contract is awarded, the initial period will be determined by the AOC based upon the county fiscal year, and may be renewed annually, in writing, if both parties are in agreement, for two (2) additional one-year periods. The initial term of the contract is expected to possess an end-date of September 30, 2019.
- G. Termination of Contract: The AOC reserves the right to immediately terminate the contract with or without cause. The AOC may expressly terminate the contract for unsatisfactory service, deliberate overcharging, or not meeting the terms of the contract. The AOC may also terminate the contract based upon a non-appropriation of sufficient funds.
- H. The Proposers' attention is directed to the fact that all applicable State laws, County ordinances and the rules and regulations of all authorities having jurisdiction over this work shall apply to the RFP throughout, and they will be deemed to be included in the contract the same as though herein written out in full.
- J. Right to Waive and Reject:
 - 1. The AOC, in its absolute discretion, may reject any Proposal that has failed, in the opinion of the AOC, to complete or perform a contracted project in a timely fashion or has failed in any other way, in the opinion of the AOC, to perform a prior contract in a satisfactory manner, and emphasizes this condition to potential Proposers.
 - 2. There is no obligation on the part of the AOC to award the RFP to the lowest Proposer, and the AOC reserves the right to award the RFP to a Proposer submitting a responsive proposal with a resulting negotiated agreement which is most advantageous and in the best interest of the AOC, and to reject any and all Proposals or to waive any irregularity or technicality in Proposals received. The AOC shall be the sole judge of the Proposals and the resulting negotiated agreement that is in its best interest and its decision shall be final.
 - 3. The AOC reserves the right to waive any formalities or reject any and all Proposals, in whole or part, to utilize any applicable state contracts in lieu of or in addition to this RFP and to accept the Proposal that in its judgment will best serve the interest of the AOC.
 - 4. The AOC specifically reserves the right to reject any conditional Proposal and will normally reject those which make it impossible to determine the true amount of the Proposal.
- K. Disqualification of Proposers: Any of the following reasons may be considered as sufficient for the disqualification of a Proposer and the rejection of the Proposal:
 - 1. More than one Proposal for the same work from an individual, firm or corporation under the same or different name.
 - 2. Evidence that the Proposer has a financial interest in the firm of another Proposer for the same work.
 - 3. Evidence of collusion among Proposers. Participants in such collusion will receive no recognition as Proposers for any future work for the AOC until such participant shall have been reinstated as a qualified Proposer.
 - 4. Uncompleted work which in the judgment of the AOC might hinder or prevent the prompt completion of additional work if awarded.

5. Failure to pay or satisfactorily settle all bills due for labor, material or services on former contracts in force at the time of advertisement of proposal.
 6. Default under previous contract.
- L. **Discrimination**: An entity or affiliate who has been placed on the discriminatory vendor list may not submit a proposal on a contract to provide goods or services to a public entity, may not submit a proposal on a contract with a public entity for the construction or repair of a public building or public work, may not submit proposals on leases of real property to a public entity, may not award or perform work as a contractor, supplier, subcontractor, or consultant under contract with any public entity, and may not transact business with any public entity.

Part E: INSURANCE REQUIREMENTS

1. The SELECTED PROVIDER shall not commence any work in connection with this RFP, and any subsequent agreement, until it has obtained all required insurance and such insurance has been approved by the AOC.
2. All insurance policies shall be with reputable insurers licensed to do business in the State of Florida, and shall be maintained through the entire term of the contract.
3. The AOC shall retain the right to reject all insurance contracts that do not meet the requirement of this RFP, and any subsequent agreement. Further, the AOC reserves the right to change these insurance requirements with 60-day notice to the SELECTED PROVIDER.
4. The insurance definition of Insured or Additional Insured shall include Subcontractor, Sub-subcontractor, and any associated or subsidiary companies of the SELECTED PROVIDER, which are involved, and which is a part of the contract.
5. The AOC reserves the right at any time to require the SELECTED PROVIDER to provide certified copies of any insurance policies to document the insurance coverage specified in this RFP, and any subsequent agreement.
6. The designation of the SELECTED PROVIDER shall include any associated or subsidiary company which is involved and is a part of the contract and such, if any associated or subsidiary company is involved in the project, must be named in the Workers' Compensation coverage.
7. All policies shall be written so that the AOC will be notified of cancellation or restrictive amendments at least thirty (30) days prior to the effective date of such cancellation or amendment. Such notice shall be given directly to the AOC Representative.
8. All insurance contracts, except the Workers' Compensation, shall list The AOC as an Additional Insured. The SELECTED PROVIDER shall provide the AOC current Certificates of Insurance for all policies at least ten days before commencing work.

Workers' Compensation Insurance:

- A. The SELECTED PROVIDER shall secure and maintain during the life of this RFP, and any subsequent agreement, Workers' Compensation insurance for all employees employed including supervision, administration and management personnel. In case any work is sublet with the approval of the AOC, the SELECTED PROVIDER shall require the Subcontractor to provide Workers' Compensation insurance for all employees. Evidence of such insurance shall be furnished to the AOC not less than ten (10) days prior to the commencement of any and all subcontracted work.

- B. Such insurance shall comply with the Florida Workers' Compensation Law.
- C. Coverage shall include a waiver or subrogation clause in favor of Administrative Office of the Courts of the Twentieth Judicial Circuit. Also, this endorsement must be indicated on all Certificates of Insurance.

General Liability Insurance:

- 1. The SELECTED PROVIDER shall carry other General Liability insurance of a nature appropriate to the contract and services provided and against all other Bodily Injury, Property Damage and Personal and Advertising Injury exposures.
- 2. The SELECTED PROVIDER shall agree to maintain in force General Liability Insurance coverage for at least two years following acceptance of the contract by the AOC.
- 3. All liability insurance shall be written on an occurrence basis and shall not be written on a claim-made basis. If the insurance is issued with an aggregate limit of liability, the aggregate limit of liability shall apply only to the locations included in this RFP, and any subsequent agreement. If, as the result of any claims or other reasons, the available limits of insurance reduce to less than those stated in the LIMITS OF LIABILITY, the SELECTED PROVIDER shall notify the AOC representative in writing. The SELECTED PROVIDER shall purchase additional liability insurance to maintain the requirements established in this RFP, and any subsequent agreement. Umbrella or Excess Liability insurance can be purchased to meet the Limits of Liability specified in this RFP, and any subsequent agreement.

Professional Liability Insurance: Professional liability insurance with policy limits of or exceeding One Million Dollars (\$1,000,000) is also required under the scope of this RFP.

Limits of Liability: The insurance required shall be written for not less than the following limits unless law requires higher amounts:

<u>COVERAGE</u>	<u>LIMIT</u>
1. Workers Compensation	
a. State	Statutory
b. Employers Liability	\$1 million each accident
2. General Liability Insurance	\$1 million each occurrence (Combined Single Limit)
3. Professional Liability	\$1 million each occurrence (Combined Single Limit)

Notice of Claims or Litigation:

The SELECTED PROVIDER agrees to report any incident or claim that results from performance of this RFP, and any subsequent agreement. Within ten (10) days of the SELECTED PROVIDER'S knowledge, the AOC Representative shall receive written notice describing the incident or claim. In the event such incident or claim involves injury or property damage to a third party, verbal notification shall be given the same day the SELECTED PROVIDER becomes aware of the incident or claim. A detailed written report is to be made within ten (10) days.

Independent Contractor:

The SELECTED PROVIDER will be an independent contractor and not the AOC's employee for all purposes, including, but not limited to, the application of the Fair Labor Standards Act minimum wage and overtime payments, Federal Insurance Contribution Act, the Social Security Act, the Federal Unemployment Tax Act, the provisions of the Internal Revenue Code, Florida revenue and taxation law, Florida Worker's Compensation law and Florida Unemployment Insurance Law. The SELECTED PROVIDER will retain sole and absolute discretion in the judgment of the manner and means of carrying out the SELECTED PROVIDER activities and responsibilities hereunder. The SELECTED PROVIDER agrees that it is a separate and independent enterprise from the public employer, that it has made its own investment in its business, and that it will utilize a high level of skill necessary to perform the work. This RFP, and any subsequent agreement, shall not be construed as creating any joint employment relationship between the SELECTED PROVIDER and AOC, and AOC will not be liable for any obligation incurred by the SELECTED PROVIDER, including, but not limited to, unpaid minimum wages and/or overtime premiums.

Indemnification and Hold Harmless:

To the fullest extent permitted by law, SELECTED PROVIDER shall indemnify and hold harmless THE ADMINISTRATIVE OFFICE OF THE COURTS OF THE TWENTIETH JUDICIAL CIRCUIT, and its employees, judges, and all court staff from liabilities, damages, losses, and costs including but not limited to reasonable attorney fees, to the extent caused by the negligence, recklessness, or intentional wrongful conduct of the SELECTED PROVIDER and other persons employed or utilized by the SELECTED PROVIDER in the performance of this RFP, and any subsequent agreement.

Certificate of Insurance:

- a. All insurance shall include the interest of all entities' names and their respective agents, consultants, servants and employees of each and all other interests as may be reasonably required by the AOC as additional Insured. The coverage afforded the additional Insureds under this policy shall be primary insurance. If the additional Insureds have other insurance that is applicable to the loss, such other insurance shall be on an excess or contingent basis. The amount of the company's liability under this policy shall not be reduced by the existence of such other insurance.
- b. Certificates of insurance, in duplicate, evidencing all required coverage must be submitted to and approved by the AOC prior to the commencement of any of the work. The certificate holder(s) shall be as follows:

Administrative Office of the Courts
Lee Co. Justice Center
1700 Monroe Street
Fort Myers, Florida 33901

- c. All policies shall expressly require 30 days written notice to the AOC at the address set out above, of the cancellations or material alterations of such policies, and the Certificates of Insurance, shall so provide.
- d. All certificates shall be subject to the AOC's approval of adequacy of protection and the satisfactory character of the Insurer.
- e. The Certificates of Insurance shall disclose any and all deductibles or self-insured retentions (SIRs). Deductibles or SIRs in excess of \$10,000 will not be accepted unless specifically approved in writing by the AOC. All deductibles or SIRs, whether approved by the AOC or not, shall be the SELECTED PROVIDER'S full responsibility. In particular, the SELECTED PROVIDER shall afford full coverage as specified herein to entities listed as Additional Insureds.

In no way will the entities listed as additional Insureds be responsible for, pay for, be damaged by, or limited to coverage required by this schedule due to the existence of a deductible or SIR. Specific written approval from the AOC will only be provided upon demonstration that the SELECTED PROVIDER has the financial capability and funds necessary to cover the responsibilities incurred as a result of the deductible or SIR.

- f. In the event of failure of the SELECTED PROVIDER to furnish and maintain said insurance and to furnish satisfactory evidence thereof, the AOC shall have the right (but not the obligation) to take out and maintain insurance on the project. All costs for the coverage will be paid by SELECTED PROVIDER upon presentation of a bill.

General Terms:

Any type of insurance or increase of limits of liability not described above which the SELECTED PROVIDER required for its own protection or on account of statute shall be its own responsibility and at its own expense.

The carrying of the insurance described shall in no way be interpreted as relieving the SELECTED PROVIDER of any responsibility under the contract.

Should the SELECTED PROVIDER engage a subcontractor or sub-subcontractor, if approved by the AOC, the same conditions will apply under this RFP, and any subsequent agreement, to each subcontractor and sub-subcontractor.

The SELECTED PROVIDER will agree to waive all rights of subrogation against the AOC and its consultants and other indemnities of the SELECTED PROVIDER under all the foregoing policies of insurance.

Umbrella Insurance:

The SELECTED PROVIDER shall have the right to meet the liability insurance requirements with the purchase of an umbrella insurance policy. In all instances, the combination of primary and umbrella liability coverage must equal or exceed the minimum liability insurance limits stated in this RFP, and any subsequent agreement.

Part F: ADDITIONAL CONDITIONS

- A. The SELECTED PROVIDER shall furnish all material, equipment, labor, and all other facilities and incidentals necessary for the execution and completion of the work.
- B. Once established by contract, the contract price shall not be increased in the total amount stated without a written change order executed by the AOC, notwithstanding increased quantities or conditions which may be needed to perform Contractor's obligations here under, nor shall the Contractor be entitled to any additional time or payment for time required for the submission and consideration of any such change order request.

PART G: REJECTION OF RFPs

- A. The AOC may reject a proposal as set forth above in Part IV, I, or as follows:
 - 1. The Proposer mistakes or conceals any material fact in the RFP.
 - 2. The Proposal does not strictly conform to the law or requirements of the RFP.
 - 3. The AOC may, however, reject any or all RFPs whenever it is deemed in the best interest of the AOC to do so and may reject any part of an RFP. The AOC may also waive any informality or irregularities in any RFP.

B. RFP Protest Procedure

1. Any Provider that has submitted a formal proposal to the AOC, and who is adversely affected by the decision with respect to the award of the formal proposal, may file with the Trial Court Administrator of the Administrative Office of the Courts of the Twentieth Judicial Circuit at the Lee Co. Justice Center, 1700 Monroe Street, Fort Myers, Florida 33901, a **written protest** no later than forty-eight (48) hours (excluding Saturdays, Sundays, and Legal Holidays) of the decision awarding the Proposal.
2. The “Notice of Intent to File a Protest” document shall be in the form of a letter stating all grounds claimed for the Protest. Failure to do so shall constitute a waiver of all rights to seek any further remedies provided for under this Protest Procedure.
3. The Trial Court Administrator shall submit the protest statement along with his or her own statement in support of the award of the formal RFP to the Chief Judge of the Twentieth Judicial Circuit of Florida for a final determination of the protest.

PART H: MISCELLANEOUS

- A. **No Lobbying:** All respondents are hereby placed on notice that all communication, whether written or oral, with AOC staff or outside individuals working with the AOC in respect to this procurement (with the exception of the Contract/Purchasing personnel designated to receive requests for interpretation or corrections or technical questions) **is prohibited**. These persons shall not be lobbied, either individually or collectively, regarding any request for bid, proposals, qualifications and/or any other solicitations released by the AOC. **To do so is grounds for immediate disqualification from the selection process.** All respondents must submit the attached No Lobbying Affidavit with their submittal stating that they and their subcontractors, sub-consultants and other agents agree to abide by the no lobbying restrictions in order to be considered for this request. Any respondent that does not submit the required No Lobbying Affidavit will be automatically disqualified from further consideration.

NOTE: For the Proposers’ convenience, this certification form is attached and made a part of the procurement package.

- B. **Collusion, Gratuities and Kickbacks:** It shall be unethical for any respondent to collude with any other respondent or offer, give or agree to give any AOC employee or representative (including selection committee members) a gift, gratuity or an offer of employment in connection with any decision, approval, disapproval, recommendation or preparation of any part of the procurement process.

NOTE: For the Proposers’ convenience, this certification form is attached and made a part of the procurement package.

- C. **Modifications:** The AOC reserves the right to modify, alter or change the scope or other aspects of this solicitation.

- D. **Level Playing Field:** The contents of this solicitation are intended to provide a level playing field on which firms or individuals may base their responses.

- E. **Public Entity Crime Affidavit:** As requested by Florida Statute 287.133(2)(a), a person or affiliate who has been placed on the convicted vendor list following a conviction for a Public Entity Crime may not submit a bid on a contract to provide any goods or services to a Public Entity, may not submit a bid on a contract with a Public Entity for the construction or repair of a public building or a public work, may not submit bids on leases of real property to a Public Entity, may not be awarded or

perform work as a contractor, supplier, subcontractor, or consultant under a contract with any Public Entity, and may not transact business with any Public Entity in excess of the threshold amount provided in s. 287.017 for Category Two for a period of 36 months from the date of being placed on the convicted vendor list. Any person must notify the AOC within 30 days after a conviction of a Public Entity crime applicable to that person or to an affiliate of that person.

NOTE: For the Proposers' convenience, this certification form is attached and made a part of the procurement package.

- F. ***Conflict of Interest:*** The award hereunder is subject to the provisions of Chapter 112, Florida Statutes. All respondents must disclose with their submission the name of any officer, director, employee or agent who is also a public officer, employee or an agent of the Twentieth Judicial Circuit, Administrative office of the Court, or any of its departments.

Furthermore, all respondents must disclose the name of any AOC employee or agent who owns, directly or indirectly, an interest of five percent (5%) or more in the firm or any of its parent companies or subsidiaries.

NOTE: For the Proposers' convenience, this certification form is attached and made a part of the procurement package.

- G. ***Immigration Laws:*** The Proposers must comply with all applicable immigration laws in their employment practices.

NOTE: For the Proposers' convenience, this certification form is attached and made a part of the procurement package.

Attachment and Exhibit List:

Attachment A - No Lobbying Affidavit
Attachment B - Anti-Collusion Statement & No Gifts Statement
Attachment C - Public Entity Crime Statement
Attachment D - Conflict of Interest Disclosure Form
Attachment E – Immigration Law Certification
Attachment F - Drug-Free Workplace Certification
Attachment G - Exceptions (if needed)

EXHIBIT A - Adult Felony Drug Court Program Participant Handbook – last revised November 17, 2017

EXHIBIT B - Adult Felony Drug Court Program Operational Manual – last revised November 17, 2017

EXHIBIT C - Florida Adult Drug Court Best Practice Standards – last revised September 29, 2017

**ATTACHMENT A
NO LOBBYING AFFIDAVIT**

RFP No.
STATE OF FLORIDA

This _____ day of _____, 20____, _____

being first duly sworn, deposes and says that he/she is the authorized representative of

(Name of contractor, firm or individual)

Proposer to the attached Request for Bid, Proposal or Qualifications by the Administrative Office of the Courts of the Twentieth Judicial Circuit , and that the Proposer and any of its agents agrees to abide by the Administrative Office of the Court of the Twentieth Judicial Circuit no lobbying restrictions in regard to this solicitation.

Affiant

Sworn to (or affirmed) and subscribed before me this _____ day of _____,
20____, by

_____.

Signature of Notary Public-State of Florida

Print, Type or Stamp Commissioned Name

Personally Known _____ OR Produced Identification _____

Type of Identification Produced _____

RFP No.

**ATTACHMENT B
ANTI-COLLUSION STATEMENT & NO GIFTS STATEMENT**

Date:

Anti-collusion statement: The below-signed Proposer has not divulged to, discussed, or compared his/her Proposal with other Proposer and has not colluded with any other Proposer or parties to a proposal whatever.

No Gift Statement: No premiums, rebates, or gratuities permitted either with, prior to, or after submission of the Proposal. Any such violation will result in rejection of the proposal and removal from the vendor list(s).

Firm Name: _____

By (printed/typed): _____

By (signature): _____

Title: _____

Mailing Address: _____

City, State, Zip: _____

Telephone No.: _____

ATTACHMENT C
SWORN STATEMENT PURSUANT TO SECTION 287.133 (3) (a),
FLORIDA STATUTES, ON PUBLIC ENTITY CRIMES

THIS FORM MUST BE SIGNED AND SWORN TO IN THE PRESENCE OF A NOTARY PUBLIC OR OTHER OFFICIAL AUTHORIZED TO ADMINISTER OATHS.

1. This sworn statement is submitted to the Administrative Office of the Courts of the Twentieth Judicial Circuit of Florida

by: _____
(print individual's name and title)

for: _____
(print name of entity submitting sworn statement)

whose business address is: _____

and (if applicable) its Federal Employer Identification Number (FEIN) is:

_____.

(If the entity has no FEIN, include the Social Security Number of the individual signing this sworn statement: _____-_____-_____.)

2. I understand that a "public entity crime" as defined in Paragraph 287.133(1)(g), Florida Statutes, means a violation of any state or federal law by a person with respect to and directly related to the transaction of business with any public entity or with an agency or political subdivision of any other state or of the United States, including but not limited to, any RFP or contract for goods or services to be provided to any public entity or an agency or political subdivision of any other state or of the United States and involving antitrust, fraud, theft, bribery, collusion, racketeering, conspiracy, or material misrepresentations.

3. I understand that "convicted" or "conviction" as defined in Paragraph 287.133(1)(b), Florida Statutes, means a finding of guilt or a conviction of a public entity crime, with or without an adjudication of guilt, in any federal or state trial court of record relating to charges brought by indictment or information after July 1, 1989, as a result of a jury verdict, non-jury trial, or entry of a plea of guilty or nolo contendere.

4. I understand that an "affiliate" as defined in Paragraph 287.133(1)(a), Florida Statutes, means:

- A. A predecessor or successor of a person convicted of a public entity crime; or
- B. An entity under the control of any natural person who is active in the management of the entity and who has been convicted of a public entity crime. The term "affiliate" includes those officers, directors, executives, partners, shareholders, employees, members, and agents who are active in the management of an affiliate. The ownership by one person of shares constituting a controlling interest in another person, or a pooling of equipment or income among persons when not for fair market value under an arm's length agreement, shall be a prima facie case that one person controls another person. A person who knowingly enters into a joint venture with a person who has been convicted of a public entity crime in Florida during the preceding 36 months shall be considered an affiliate.

5. I understand that a “person” as defined in Paragraph 287.133(1)(e), Florida Statutes, means any natural person or entity organized under the laws of any state or of the United States with the legal power to enter into a binding contract and which RFPs or applies to RFP on contracts for the provision of goods or services let by a public entity, or which otherwise transacts or applies to transact business with a public entity. The term “person” includes those officers, directors, executives, partners, shareholders, employees, members, and agents who are active in management of an entity.

6. Based on information and belief, the statement which I have marked below is true in relation to the entity submitting this sworn statement. (Indicate which statement applies).
 - Neither the entity submitting this sworn statement, nor any of its officers, directors, executives, partners, shareholders, employees, members, or agents who are active in the management of the entity, nor any affiliate of the entity has been charged with and convicted of a public entity crime subsequent to July 1, 1989.

 - The entity submitting this sworn statement, or one or more of its officers, directors, executives, partners, shareholders, employees, members, or agents who are active in the management of the entity, or an affiliate of the entity has been charged with and convicted of a public entity crime subsequent to July 1, 1989.

 - The entity submitting this sworn statement, or one or more of its officers, directors, executives, partners, shareholders, employees, members, or agents who are active in the management of the entity, or an affiliate of the entity has been charged with and convicted of a public entity crime subsequent to July 1, 1989. However, there has been a subsequent proceeding before a Hearing Officer of the State of Florida, Division of Administrative Hearings and the final Order entered by the Hearing Officer determined that it was not in the public interest to place the entity submitting this sworn statement on the convicted vendor list (attach a copy of the final order).

I UNDERSTAND THAT THE SUBMISSION OF THIS FORM TO THE CONTRACTING OFFICER FOR THE PUBLIC ENTITY IDENTIFIED IN PARAGRAPH 1 ABOVE IS FOR THAT PUBLIC ENTITY ONLY AND THAT THIS FORM IS VALID THROUGH DECEMBER 31 OF THE CALENDAR YEAR IN WHICH IT IS FILED. I ALSO UNDERSTAND THAT I AM REQUIRED TO INFORM THE PUBLIC ENTITY PRIOR TO ENTERING INTO A CONTRACT IN EXCESS OF THE THRESHOLD AMOUNT PROVIDED IN SECTION 287.017, FLORIDA STATUTES FOR CATEGORY TWO OF ANY CHANGE IN THE INFORMATION CONTAINED IN THIS FORM.

Signature

Sworn to and subscribed before me this _____ day of _____, 20_____.

Personally known _____ OR Produced Identification _____

_____ Notary Public – State of Florida

Type of Identification _____ My Commission Expires: _____

ATTACHMENT D

RFP No. CONFLICT OF INTEREST DISCLOSURE FORM

For purposes of determining any possible conflict of interest, all Responders must disclose if any Twentieth Judicial Circuit of Florida Administrative Office of the Courts employee(s), elected official(s), or any of its departments is also an owner, corporate officer, agent, employee, etc., of their business.

Indicate either “yes” (a AOC employee, elected official or agent is associated with your business), or “no”. If yes, give person(s) name(s) and position(s) with your business.

YES _____

NO _____

Name(s)

Position(s)

Firm Name: _____

By (Printed): _____

By (Signature): _____

Title: _____

Address: _____

Phone Number: _____

ATTACHMENT E
IMMIGRATION LAW CERTIFICATION
RFP#

The Twentieth Judicial Circuit of Florida Administrative Office of the Courts will not intentionally award AOC contracts to any contractor who knowingly employs unauthorized alien workers, constituting a violation of the employment provisions contained in 8 U.S.C. Section 1324 a(e) (Section 274a(e) of the immigration and nationality act (“INA”)).

The Twentieth Judicial Circuit of Florida Administrative Office of the Courts may consider the employment by any contractor of unauthorized aliens a violation of Section 274A(e) of the INA. Such violation by the recipient of the employment provisions contained in Section 274A(e) of the INA shall be grounds for unilateral cancellation of the contract by AOC.

Respondent attests that it is fully compliant with all applicable immigration laws, specifically relating to the 1986 immigration act and subsequent amendments.

Company Name

Signature

Title

Date

STATE FLORIDA

Sworn to (or affirmed) and subscribed before me this ____ day of _____,
20____, by _____ who is personally known ____ or has produced
_____ as identification.

Notary Public – State of Florida

(stamp)

ATTACHMENT F

RFP No. DRUG-FREE WORKPLACE CERTIFICATION

THE BELOW SIGNED bidder/proposer CERTIFIES that it has implemented a drug-free workplace program. In order to have a drug-free workplace program, a business shall:

1. Publish a statement notifying employees that the unlawful manufacture, distribution, dispensing, possession or use of a controlled substance is prohibited in the work place and specifying the actions that will be taken against employees for violation of such prohibition.
2. Inform employees about the dangers of drug abuse in the workplace, the business's policy of maintaining a drug-free workplace, any available drug counseling, rehabilitation and employee assistance programs, and the penalties that may be imposed upon employees for drug abuse violations.
3. Give each employee engaged in providing the commodities or contractual services that are under quote a copy of the statement specified in subsection 1.
4. In the statement specified in subsection 1, notify the employees that, as a condition of working on the commodities or contractual services that are under quote, the employee will abide by the terms of the statement and will notify the employer of, or pleas of guilty or nolo contendere to, any violation occurring in the workplace no later than five (5) days after such conviction.
5. Impose a sanction on, or require the satisfactory participation in, drug abuse assistance or rehabilitation program if such is available in the employee's community, by an employee who is convicted.
6. Make a good faith effort to continue to maintain a drug-free workplace through implementation of this section.

As the person authorized to sign this statement, I certify that this firm complies fully with the above requirements.

Date: _____ Signature: _____

Company: _____ Name: _____

Address: _____ Title: _____

Phone Number: _____

**ATTACHMENT G
EXCEPTIONS TO RFP**

RFP No.

Each Responder may copy this form, as necessary, to sufficiently list all exceptions and variations from specifications. Please list, as shown, by page and item, if vendor chooses not to supply, or is unavailable, or describe deviation or substitution in detail, if furnished. The AOC shall be the sole judge of a proposed substitution equivalency.

Spec.:	Page:	Item:	Not Available/Explanation:
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TWENTIETH JUDICIAL CIRCUIT LEE COUNTY ADULT FELONY DRUG COURT HANDBOOK



MISSION STATEMENT

*Providing the opportunity for changing and saving lives
through honesty, personal responsibility and recovery.*

Revised: November 17, 2017

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INTRODUCTION TO DRUG COURT

You have been arrested for a drug-related crime and have been identified as a person who may have a drug problem. You may be offered an opportunity to participate in Lee County's Drug Court. This program is designed to help you get off drugs and stay off drugs. Final disposition of your case will be determined by the terms of your Drug Court Contract.

This handbook is designed to answer questions, address concerns and provide over-all information about the Drug Court Program. As a participant, you will be expected to follow the instructions given in Drug Court by the Judge and comply with the treatment and supervision plan developed for you by your treatment team. This handbook will detail what is expected of you as a Drug Court participant and review general program information. All participants are encouraged to share the handbook with family and friends.

PROGRAM DESCRIPTION

The Lee County Drug Court Program is designed as a court supervised, comprehensive treatment program for adults. This is a voluntary program which includes regular court appearances before a designated Drug Court Judge. You will be expected to participate in treatment, including drug testing, individual/group counseling, family counseling and regular attendance at Recovery Support Groups. As a participant, you will be assisted with obtaining education and skill assessments and will be provided referrals for vocational training, education and/or job placement services. It is expected that you will complete the program requirements between 15 and 24 months, depending on your individual progress.

Following arrest and/or formal charges being filed by the Office of the State Attorney, you will first complete a screening to determine if you are clinically appropriate for the Drug Court Program. You and your attorney will receive an explanation of the Drug Court Program so that you can decide whether the sentence being offered, in exchange for the plea to the charges, is in your best interest.

Upon graduation, if the participant is in the program for a substantive charge(s), the State Attorney's Office will dismiss the charge(s). Upon graduation, if the participant has a charge of violation of probation after a prior plea and probation sentence, the violation of probation affidavit will be dismissed, the probation will be terminated and the original conviction that was imposed will remain. Adjudication originally withheld will be upheld upon graduation. If the participant pled to a charge(s) for which the participant has not previously been placed on probation, the participant will be allowed to withdraw the plea of guilty or no contest upon graduation, the sentence will be vacated and the charge(s) will be dismissed by the State Attorney's Office.

Participants wishing to seal or expunge their records may complete an application for certification of eligibility via the Florida Department of Law Enforcement, but are not guaranteed

such. Specific requirements for the application, as well as a list of disqualifying charges and a list of agencies that can obtain sealed and expunged records, can be found on FDLE's site at <http://www.fdle.state.fl.us/expunge>.

Every plea into the Drug Court Program will include the following general terms:

- Random drug testing during the period of probation
- Curfew, except for work or purposes as approved by your Probation Officer
- No possession or consumption of alcohol, drugs, or "mind altering" substances
- Successfully complete the Drug Court Program
- Restitution (if applicable)

Entry into the Drug Court Program is voluntary. However, once you have pled into Drug Court and been sentenced, you may not voluntarily withdraw from the program. While in Drug Court, you will be placed on a minimum of two years state probation or drug offender probation requiring compliance with specific terms and conditions. You will be assigned a probation officer to provide supervision and enforcement of those terms and conditions. You will be required to provide random drug screens.

Successful completion of the program will result in the disposition of your case according to the terms of your drug court contract. Failure of discharge from the program will result in the Violation of Probation. If the participant willfully and substantially fails to comply with all of the requirements of the Drug Court Program, it may be considered a violation of the probation. The participant may be terminated from probation and re-sentenced to incarceration in jail, or prison, pursuant to the Florida Criminal Punishment Code if the violation of probation is proven after hearing. The Judge may also choose to keep the participant in the program and/or sanction the participant with time in jail, community service hours and other sanctions.

The State Attorney's Office will, as directed in Florida Statute 397.334(3)(a), make its recommendation to the Court after having taken into consideration the other factors specifically referenced in the statute. The Court will make the final determination as to acceptance into the Drug Court Program as provided in Florida Statute 397.334(3)(a).

DRUG COURT SUPERVISION

As a Drug Court participant, you will be required to appear in Drug Court on regularly scheduled dates. Missing a court date may result in a warrant being issued for your arrest and remand to custody.

The Drug Court team attends each court session to discuss the participant's progress and makes recommendations to the Drug Court Judge. The Drug Court team consists of representatives from the State Attorney's Office, the Public Defender's office, Pretrial Services, the Department of Corrections and the treatment provider. At each appearance, the Judge will be given a progress report prepared by the treatment provider and/or the probation officer regarding your

test results, attendance and participation. The Judge will ask you questions about your progress and discuss any specific problems you have been experiencing. You will receive encouragement to continue with your progress in the program and work with your treatment team toward success. If you are not doing well, the Judge will discuss this with you and the treatment team to determine further action. If you commit program violations, e.g. positive or missed tests, failure to attend individual or group counseling or Recovery Support Group meetings, failure to report to your Probation Officer, etc., the court may impose sanctions (See Sanctions below). With repeated violations of the program requirements and/or a failure to progress satisfactorily, the court may impose the ultimate sanction of discharge from the program which will lead to a violation of probation.

The imposition of sanctions may also result in the other “natural” consequences such as extended time to complete a phase of the total program; loss of wages due to loss of work; and/or other family, job, or financial hardship.

If you cannot appear in court as scheduled, you must notify your Probation Officer as soon as possible to explain why you cannot appear. If you have any questions regarding your court appearances, you are required to contact your Probation Officer.

Warrants and/or new arrests could result in your termination from the Drug Court Program and a violation of probation. Other violations, which could result in termination, include missing drug tests, demonstrating lack of program participation by failing to cooperate with the treatment, and failure to follow instructions of the Probation Officer. Violence or threats of violence directed at the treatment team or other clients will not be tolerated. All final decisions regarding termination from the program will be made by the Drug Court Judge.

FINANCIAL OBLIGATIONS

As a participant of the Drug Court Program you will be required to pay the following fees:

- Court Costs – Actual costs will be determined by the Judge at the time of sentencing. The Judge will exempt cost of supervision fees and allow the participant to work off the fine and court costs by doing community service with a credit of \$10 for each hour worked.
- Treatment Costs – You will be required to pay for your treatment. The cost will be determined by the treatment provider and paid directly to them.
- Drug Testing Costs – You may be required to pay Drug Testing fees.

TREATMENT PHASES

The Drug Court Treatment Program is a Five Phase, highly structured, treatment program lasting for a minimum of 15 months, depending upon your individual progress. After a plea, you will be assigned to a probation officer and a drug treatment clinician and who will provide an orientation/overview of the Drug Court Program. Your problems and needs will be assessed and an individual treatment plan will be developed.

Each phase consists of specified treatment objectives, therapeutic and rehabilitative activities, all required for advancement into the next phase, which also requires approval by the Drug Court Team. The components and requirements for advancement from each phase are described below.

The plan may also require the performance of community service. If needed, the participant may be required to consult with a doctor or other medical provider for any medical or mental condition. The participant is expected to inform his or her attorney, clinician and the court of any religious beliefs or practices that may serve as a conflict when drug court programs, peer groups and treatment are being considered.

If you relapse or have an unexcused missed drug test during any phase, you may be required to return to an earlier phase as determined by the Drug Court Team. No matter what phase of treatment you are in at time of relapse or an unexcused missed drug test, you must demonstrate six months of continuous sobriety prior to being considered for "Moving-On".

TREATMENT PLANS & COUNSELING

An individualized initial supervision plan will be developed by you and your treatment team following an overall assessment of your problems and needs. The plan will be made available to you and the entire Drug Court Team prior to entry into the program. The plan will act as a guide for your initial treatment phase and within it, you will set goals, select methods for meeting those goals, and develop target dates for achieving those goals. The plan will be maintained by your treatment team and will be updated monthly as you progress through the program. Any member of the Drug Court Team will be provided a copy of any treatment plan or treatment plan update at any time.

Treatment may consist of group therapy, individual therapy, intensive outpatient treatment, residential treatment, and/or referrals to community treatment partners. Your attendance at counseling sessions will be reported to the Drug Court Team as part of your progress report. You must have prior permission from your clinician to be excused from a counseling session.

Medically Assisted Treatment (MAT) will be considered where deemed medically appropriate on a case by case basis.

DRUG TESTING

You will be tested through the entire program. You will be tested randomly at a minimum of twice per week. The Drug Court Team will have access to all drug test results. Missing and or tampering with a drug test may be deemed a positive test and could result in your termination from the program (this includes flushes, diluting, using someone else's urine, or altering your test, etc.). Your creatinine level will also be monitored to ensure that you are not flushing, diluting or altering your test. You may be sanctioned if your creatinine level is less than 20 mg/dL or over 400 mg/dL. Please refer to the Drug Testing Practices Section for more detailed information on drug testing.

****Note:** If you are required to give a drug test on a day that you are also expected to appear in court, you are expected to provide the drug test BEFORE court.

RECOVERY SUPPORT GROUP REQUIREMENTS

Attendance will be required at Recovery Support Group Meetings such as Narcotics, Cocaine and/or Alcoholics Anonymous or another Recovery Support Group, such as Smart Recovery meetings approved by the treatment provider. The frequency of attendance requirement is determined by your progress in the program and your phase level. Attendance is an important part of your recovery process to help familiarize you with the "Recovery" philosophy, and help you develop levels of trust, as well as to earn and create social bonds with other recovering addicts. Your treatment team will provide you with information regarding the time and location of local Recovery Support Group meetings and will also direct you to special interest and recovery events in the community. You will be expected to bring proof of attendance to court.

ATTENDANCE REQUIREMENTS

Attendance at all court appearances, group treatment sessions, drug screens, probation meetings and Recovery Support Group meetings (minimum # per week) is **MANDATORY**. Failure to attend any such event can lead to an immediate sanction or violation of probation. In order to be excused from a mandatory event, you must contact treatment or probation, as appropriate, immediately upon becoming aware of your inability to attend the event. You must provide appropriate proof/documentation of the emergency to treatment or probation, as appropriate, within 48 hours after the emergency has passed.

EDUCATION, VOCATION & EMPLOYMENT PROGRAMS

Recovery from substance addiction means developing self-sufficiency and becoming a productive and responsible member of the community. As you progress in the program, you will be expected to be employed or involved in an educational or vocational training program. Your clinician and your Probation Officer will work to assist you in obtaining an assessment of your needs and skills and will refer you to the proper agency for education, training, and job placement.

If not employed or involved in educational or vocational training, you may be required to perform community service hours at a rate of 20 hours per week.

CASE MANAGEMENT

Upon your entry into the Drug Court Program, your treatment team will assess your housing, transportation, family, and general living needs and when appropriate, refer you to a local, state and/or county agency for assistance.

MEDICAL TREATMENT PROTOCOL

You must provide your treatment provider/lab services with written notification of all prescribed and over-the-counter medications prior to taking a drug test.

When seeking medical treatment, you must do the following:

1. Inform your doctor that you have a substance abuse issue and that you are in drug court.
2. Request the doctor to note that you have informed him/her of this. The doctor needs to put this note on a prescription pad or in letterhead.
3. If the doctor believes a prescription to be medically necessary, have him/her note this as well.
4. Sign a release of information at all medical appointments authorizing the treatment provider to receive your medical treatment records.
5. Inform your treatment provider/lab services of all medications.
6. At a minimum Triage notes, admitting, and discharge records including a diagnosis will be required as well as any medications given or prescribed. The Court may also order you to provide additional records at your own expense.

In urgent medical situations (emergency room, urgent care, last minute appointments or as determined by the court) follow the steps 1 - 6 listed above. You must inform your treatment provider/lab services on the next business day by 9:00 a.m. In addition, you will submit to a urine drug screen at this time.

In emergency situations where you are hospitalized or seen in an emergency room, follow the steps 1 -5 listed above. You must inform your treatment provider/lab services on the next business day by 9:00 a.m. You must provide ALL documentation (including emergency room admission records, not just the discharge documents). In addition, you will submit to a urine drug screen at this time.

MOVING ON

Once you have successfully completed the criteria for each phase (as described in the treatment phases sections) you will eventually become a candidate to “Move On” from the Drug Court Program. We speak of “Moving- On” rather than “Graduation” because the Drug Court Team understands that no addict or alcoholic “graduates” from their addiction, as recovery is a lifelong process. You will be required to discuss your progress toward the goals you initially set, and explain why you believe you have met the criteria for “Moving-On”. Advancement for each phase and successful completion of the program shall be determined by the Drug Court Team. Your family will be invited to join you in court as the Judge congratulates you on successfully completing the Drug Court Program.

DRUG COURT PROGRAM RULES/REQUIREMENTS

Failing to comply with any of these rules may result in imposition of a sanction and/or termination from the Drug Court Program and a violation of probation.

Maintaining a completely drug-free lifestyle is essential in your recovery process. Sobriety is the primary focus of this program. Do not use or possess any drugs, alcohol, or “mind altering” substances, This includes over-the-counter medication/supplements, including all currently known and/or future synthetic and designer drugs, such as Bath Salts, Spice, Kratom, Flakka, etc., as well as mood-altering prescription drugs, such as Benzodiazepines (Valium, Xanax, etc.), Opiates (Tylenol 3, Percocet, Darvocet, etc.). Regarding prescription drugs, you need to follow the same process as stated above in the **Medical Treatment Protocol**:

1. Inform your doctor that you have a substance abuse issue and that you are in drug court.
2. Request the doctor to note that you have informed him/her of this. The doctor needs to put this note on a prescription pad or in letterhead.
3. If the doctor believes a prescription to be medically necessary, have him/her note this as well.
4. Sign a release of information at all medical appointments authorizing the treatment provider to receive your medical treatment records.
5. Inform your treatment provider/lab services of all medications.
6. At a minimum Triage notes, admitting, and discharge records including a diagnosis will be required as well as any medications given or prescribed. The Court may also order you to provide additional records at your own expense.

In urgent medical situations (emergency room, urgent care, last minute appointments or as determined by the court) follow the steps 1 - 6 listed above. You must inform your treatment provider/lab services on the next business day by 9:00 a.m. In addition, you will submit to a urine drug screen at this time.

You must refrain from the use of product or substance that may interfere with or cause a positive drug test. Examples include, but are not limited to: Poppy Seeds, Non-Alcoholic Beer, Vanilla Extract, as well as certain Mouthwash, Toothpaste, Cold Remedies, Hair Products, Inhalants and Cough Syrup.

“WHEN IN DOUBT, LEAVE IT OUT!” If you have any doubt as to whether a product may cause a positive drug test, refrain from use or consult your treatment provider/lab services before using.

1. Report to your Probation Officer as directed: You will meet with your Probation Officer as required to discuss your progress in the program and to ensure you are in compliance with your conditions of probation. Your Probation Officer will discuss with you these reporting procedures during your initial visit.
2. Attend all ordered treatment sessions: These may include individual and/or group counseling, family counseling, educational sessions and Recovery Support Group Meetings. If you are unable to attend any scheduled session, you must contact your treatment team to discuss immediately.
3. Be on time: If you are late, you may not be allowed to attend your counseling session and will be considered non-compliant. Contact your assigned clinician if there is a possibility that you may be late.
4. No threats or violence: Do not make threats toward other participants or staff, or behave in a violent manner. Violent or inappropriate behavior will not be tolerated and will be reported to the court.
5. Inappropriate sexual behavior or harassment: Inappropriate sexual behavior or harassment will not be tolerated and will be reported to the court.
6. Respect others: While in Drug Court or group, remain seated and quiet while others are speaking. Proper attention and respect for everyone in the room will be enforced, for the benefit of all participants and Drug Court Team members. There are to be no side conversations, and absolutely no cell phones will be permitted in the courtroom or in group.
7. Proper attire: As a participant, you will be expected to wear appropriate attire to Drug Court and to group treatment sessions.

Please avoid the following: shorts, flip flops, pants that fall below your waist, anything that depicts illegal or inappropriate activity, any see-through clothing.

DRUG COURT PHASES

PHASE I: Orientation

LENGTH: One Month (out of custody)

In Phase I, you will be assigned to a Probation Officer and a Clinician. They will provide you with an orientation/overview of the Drug Court Program. Your needs will be assessed, and an individualized treatment plan will be developed:

Phase I will include:

- Orientation/Overview of Program
- Initial Assessment and Individual Treatment Plan Development
- Random Laboratory Drug Testing (minimum of two urinalysis per week)
- Minimum of two (2) hours of Group Therapy Sessions per week with a goal of six (hours) as prescribed by the Florida Adult Drug Court Best Practice Standards
- One Recovery Support Group meeting per week
- Report to your Probation Officer as required
- Case Management Services or individual counseling session as required by your treatment plan (at least one per week)
- Formulate Personal Program Goals in conjunction with the Treatment Team
- Clean drug screens
- Curfew: 9:00 p.m. to 6:00 a.m. (or as directed by Probation Officer)
- Weekly Court Appearance as determined by the Drug Court Judge

Advancement Criteria:

- No positive, diluted/adulterated/alterd or missed drug tests for at least 14 consecutive days prior to phase advancement
- No unexcused absences for at least 14 consecutive days prior to phase advancement
- Submit written or recorded statement (a list of topics will be supplied by your clinician)
- Documented required attendance at Recovery Support Group Meetings
- Certification by treatment of appropriate progress with recovery
- Has shown due diligence meeting all financial obligations; otherwise you will be required to meet with financial advisers and probation.

DRUG COURT PHASES

PHASE II: In-Depth Treatment

LENGTH: Four Months

In Phase II, your treatment plan will be updated by you and your clinician to identify your treatment goals and objectives. Counseling and meetings will focus on issues underlying your addiction, relapse prevention techniques, and coping mechanisms for stressful situations.

Phase II will include:

- At least one individual therapy session and one group therapy session per week
- Report to the Probation Officer as required
- Ongoing review and updating of treatment plan
- Random Laboratory Drug Testing (minimum of two per week)
- Case management services as required by your treatment plan
- Be employed or enrolled in educational or vocational courses OR perform required 20 hours of community service/week
- Court appearances every other week, or as directed by Judge
- Obtain a sponsor within 60 days of starting Phase II. Sponsor must have at least 3 years of sobriety
- Documented attendance in a Recovery Support Group (at least 3 per week)
- Curfew: 9:30 p.m. to 6:00 a.m. (or as directed by Probation Officer)

Advancement Criteria:

- No positive, diluted/adulterated/altere d or missed drug tests for at least 60 consecutive days prior to phase advancement
- No unexcused absences for at least 60 consecutive days prior to phase advancement
- Stable employment and/or educational status
- Documented required attendance at Recovery Support Group meetings
- Continue to work with a Recovery Support Sponsor
- Submit written or recorded statement as directed by treatment
- Certification by treatment of appropriate progress with recovery
- Has shown due diligence meeting all financial obligations; otherwise you will be required to meet with financial advisers and probation.

DRUG COURT PHASES

PHASE III: Ongoing Treatment/Relapse Prevention

LENGTH: Four Months

Phase III will address your ongoing recovery needs including maintaining total abstinence from all mind altering substances. The focus will be on daily living skills. This phase is designed to support you in your return to the community as a productive and responsible member.

Phase III will include:

- One group therapy session per week or as directed by treatment
- One individual therapy session per week or as directed by treatment
- Report to the Probation Officer as required
- Ongoing review and updating of treatment plan
- Random Laboratory Drug Testing (minimum of two per week)
- Case management services as required by your treatment plan
- Curfew: 10:00 p.m. to 6:00 a.m. (or as directed by Probation Officer)
- Court appearances every 3 weeks, or as determined by Judge
- Stable employment and/or education status or perform required 20 hours of community service/week
- Continue to work with your sponsor
- Documented attendance in a Recovery Support Group (minimum 4/week)
- Has shown due diligence meeting all financial obligations; otherwise you will be required to meet with financial advisers and probation.

Advancement Criteria:

- No positive, diluted/adulterated/altered or missed drug tests for at least 60 consecutive days prior to phase advancement
- Written or recorded statement as directed by treatment
- No unexcused absences for at least 60 consecutive days prior to phase advancement
- Stable employment and or educational status
- Documented required attendance at Recovery Support Group meetings
- Working with a Recovery Support Sponsor
- Current on treatment payments
- Certification by treatment of appropriate progress with recovery

DRUG COURT PHASES

PHASE IV: Recovery Maintenance

LENGTH: Three Months

In Phase IV the focus is on implementing what you have learned over the last three phases. During this phase you are expected to fine-tune your recovery program and seek additional treatment and/or support as you feel necessary for your continued recovery.

Phase IV will include:

- One group therapy session per week or as directed by treatment
- No unexcused absences
- One individual therapy session per month
- Report to the Probation Officer as required
- Ongoing review and update of treatment plan
- Random Laboratory Drug Testing (minimum of two per week)
- Documented attendance at Recovery Support Groups (4 per week)
- Case management services as required by your treatment plan
- Monthly court appearance as determined by the Drug Court Judge
- Maintain full-time employment and/or educational program(s) or perform required 20 hours of community service/week
- Curfew (if required by Probation Officer)
- Continue working with sponsor
- Has shown due diligence meeting all financial obligations; otherwise you will be required to meet with financial advisers and probation.

Criteria for Moving On:

- No positive, diluted/adulterated/altered or missed drug tests for 6 months
- Stable employment and or educational status
- Documented required attendance at Recovery Support Group meetings
- Continue to work with a Recovery Support Sponsor
- You must be current on treatment payments
- Complete an exit interview and/ or presentation of a confirmed aftercare and relapse prevention plan to the Drug Court Team
- Verbally share your story of “Experience, Strength, and Hope” at your Moving On
- Certification by treatment of appropriate progress with recovery
- Certification by probation of appropriate compliance with probation terms
- Outstanding financial obligations may be used as a factor in the decision for moving on

DRUG COURT PHASES

REGULAR PROBATION: Aftercare

LENGTH: At least Three Months

Upon completion of your Moving On, the focus shifts to continued recovery and reintegration, with community-based supports.

Regular probation will involve:

- Drug Offender probation is converted to regular probation with no curfew
- Report to the Probation Officer as required
- Random Laboratory Drug Testing (at least twice per week)
- Monthly court appearances, or as directed by Judge
- Complete any outstanding terms of probation, including restitution and monetary obligations
- Please note treatment will attempt to contact you for the next 90 days for free aftercare

DRUG COURT PHASES

PHASES	MONTHS	CURFEW	TREATMENT SESSIONS	RECOVERY MEETINGS	COURT
I	1	9:00 PM – 6:00 AM (or as directed by Probation Officer)	Weekly <input type="checkbox"/> Group (2) Minimum <input type="checkbox"/> Individual (1) <input type="checkbox"/> Or as directed by treatment	1 week	Weekly
II	4	9:30 PM – 6:00 AM (or as directed by Probation Officer)	2 Weekly <input type="checkbox"/> Group (1) <input type="checkbox"/> Individual (1) <input type="checkbox"/> Or as directed by treatment Obtain sponsor within 60 days	3 weekly	Every other week
III	4	10:00 PM – 6:00 AM (or as directed by Probation Officer)	3 Weekly <input type="checkbox"/> Group (1) <input type="checkbox"/> Individual (1) <input type="checkbox"/> Or as directed by treatment	4 weekly	Every 3 weeks
IV	3	None (or as directed by Probation Officer)	<input type="checkbox"/> Groups: 1 per week <input type="checkbox"/> Individual: 1 month <input type="checkbox"/> Or as directed by treatment	4 weekly	Monthly
V Regular Probation	<ul style="list-style-type: none"> • LENGTH: at least 3 months • DRUG TESTING: twice/week • DRUG COURT ATTENDANCE: once per month or as directed • NO REQUIRED RECOVERY SUPPORT GROUP MEETINGS • ANY OUTSTANDING SPECIAL CONDITIONS OF PROBATION 				

INCENTIVES AND SANCTIONS MATRIX

Compliance with the requirements and goals of the Drug Court program may earn you certain incentives. Likewise, non-compliance may result in certain sanctions, up to and including termination from Drug Court and a violation of probation being submitted to the court. Incentives and sanctions lie entirely within the discretion of the Drug Court Team.

Some examples are as follows:

RESPONSES TO BEHAVIOR	
ACHIEVEMENTS	INCENTIVES
<ul style="list-style-type: none"> ➤ Attending all Drug Court appearances ➤ Negative drug test results for period of time ➤ Attendance and participation in treatment ➤ Attendance and participation in recovery support meetings ➤ Completion of GED ➤ College enrollment and attendance ➤ New job/Job promotion ➤ Compliance with treatment/supervision plan ➤ Voluntary Speaking Engagements ➤ Phase Advancement ➤ Volunteering at Non-Required Drug Court Community Service Projects ➤ Moving-On Ceremony ➤ Self-Reporting a Relapse 	<ul style="list-style-type: none"> ➤ Recognition and praise by the Drug Court Judge ➤ Leave early from court ➤ Decreased Court appearances ➤ Phase advancement ➤ Extension of Curfew ➤ Overnight out-of-county travel ➤ One night without a curfew ➤ Early Termination of Probation/Moving-On Ceremony ➤ When applicable, State will file a notice of Nolle Prosequi ➤ No jail for certain self-reported relapses as determined by the Drug Court Team
NEGATIVE CHOICES	SANCTIONS
<ul style="list-style-type: none"> ➤ Missed Drug Court appearances ➤ Missed appointment with Probation Officer ➤ Missed recovery support group meetings ➤ Violation of Drug Court Order ➤ Positive drug test ➤ Missed drug test (considered a positive drug test) ➤ Tampered drug test ➤ Missed treatment ➤ Inappropriate behavior at treatment groups and/or treatment facility ➤ New Arrest ➤ Failure to perform Drug Court Sanction(s) ➤ Noncompliance with treatment plan and/or recommendations ➤ Dishonesty with treatment, probation, or the court ➤ Curfew Violation ➤ Inappropriate behavior at court ➤ Submitting fraudulent reaction sheets for recovery support group meetings and reporting a false sobriety date on your weekly treatment reports 	<ul style="list-style-type: none"> ➤ Reprimand from the Judge ➤ Increased Court appearances ➤ Increased drug testing ➤ Daily reporting to Probation ➤ Curfew imposed for longer period of time ➤ LCSO Day Work Program ➤ Community Service Hours ➤ Presentation on a recovery topic at Drug Court ➤ Essay presented to Judge, Probation and/or treatment group ➤ Placement on GPS or SCRAM/Soberlink ➤ Home confinement except for work, treatment, and Drug Court ➤ Jail ➤ Delay in Phase change or regress to a prior Phase ➤ Termination from Drug Court/Imposition of a Florida Sentencing Guideline Score Sheet Sentence ➤ Reside at a sober living home

FACTORS/CONSIDERATIONS IN DETERMINING RESPONSIVE BEHAVIOR:

- Length of time in program
- Prior Violations/Sanctions
- Honesty or Manipulation
- Other factors, of which the Drug Court Team may be aware you are experiencing in your life

DRUG TESTING PRACTICES

SAMSHA (United States Substance Abuse and Mental Health Agency) recommend that laboratory testing procedures adhere to specific methods in analysis. The most common testing method used by reputable and certified laboratories is enzyme immunoassay (EIA). This method (EIA) uses antibodies to detect the presence of drugs and other substances in the urine.

Why the Drug Court Team is providing this information to all UA clients and patients:

Dilutes:

Each day, laboratory testing facilities receive a large number of urine screens that are “diluted”. Dilution is a common method used by some individuals in an attempt to conceal or “throw off” the fact a substance is in the system. Dilution is also known as “water overload” or “adulteration”. Factual evidence from forensic science indicates that dilutions occur only under the following instances: 1) urine substitution, 2) ingestion of fluids or compounds to flush the system, dilute the sample or to interfere with the testing process and 3) direct addition of adulterants to sample itself. This information is important to those of you who are new clients or treatment patients ordered by the court to be screened. Should you unintentionally/intentionally alter the sample provided, consequences may occur. We want you to be informed so that you do not knowingly or unknowingly sabotage your own lab results. The only way to confirm that you did not continue to use a substance is by confirmation testing should adulteration occur with the sample that you provide.

Creatinine Levels:

Creatinine is a measurement used to determine whether a drug test is valid.

Low creatinine: if your sample has a creatinine level of less than 20 mg/dL, this is considered a dilute sample, and you may be sanctioned;

High/Elevated creatinine: This will be considered an attempt to mask dilution/water-loading by taking an over-the-counter supplement. You may be sanctioned if your creatinine level is over 400 mg/dL.

If you produce a urine sample with a creatinine level under 20 mg/dL or over 400 mg/dL , and if you have a medical condition that caused the low or high level, you must furnish the Drug Court Team with written documentation from a medical treatment provider. In that case, you may be required to submit to an alternative test such as an oral swab test, which may be at your expense.

What this means to you:

It is important that all UA clients and patients understand that it is counterproductive to attempt to rid the body of a substance through the use any of the above described methods. We understand that many new UA clients want to rid their body of unwanted substances prior to their first test and that they attempt to flush their system of the substance and do so with good intention. However, the results of this first test may show an inaccurate test result due to adulteration.

Alcohol testing--Monitoring with EtG/Ets (testing for the presence of alcohol):

Ethylglucuronide (EtG) and ethylsulfate (Ets) are metabolites of alcohol that are excreted more slowly from the body than alcohol itself. They are therefore better at picking up drinking and better at documenting abstinence. When being monitored with EtG/Ets, it is important, as in any monitoring situation to be aware of items to avoid so that inadvertent "incidental" exposure does not cause a positive test. In other words, it's important to know what items contain alcohol and to avoid them. With reasonable caution it is rare for "incidental" alcohol exposure to cause a positive test.

It is YOUR responsibility to limit and avoid exposure to the products and substances detailed below as well as any other substance that contains ethyl alcohol. It is YOUR responsibility to read product labels to know what is contained in the products you use and to inspect these products BEFORE you use them.

Terms used to describe alcohol in products that must be avoided include: denatured alcohol, SD alcohol, ethanol or ethyl alcohol. Use of the products detailed below or any other product containing alcohol is a violation of this contract and will NOT be allowed as an excuse for a positive test result.

Mouthwash/Hand Sanitizers: Many of these products contain alcohol and can cause positive tests for alcohol. You are required to read product labels and know whether such a product contains alcohol. Use of alcohol-containing products is not permitted. Non-alcohol mouthwashes and hand sanitizers are readily available and are an acceptable alternative. If you have questions about a particular product, bring it in to discuss with your clinician.

Over-the-counter medications: Do not use alcohol-containing cough syrups or cold preparations (e.g. Nyquil). Nutritional supplements can also contain alcohol and should be avoided. Ethyl alcohol is frequently used in liquid medications as a solvent. Read labels and if the product contains alcohol, don't use it unless you first receive clearance from your clinician or Probation Officer. Non-alcohol containing cough and flu medications are readily available and are acceptable alternatives.

Non-alcohol Beer and wine: These beverages (e.g. O'Doul's, Sharps, etc.) contain enough alcohol

that they can result in a positive test. You are not permitted to ingest these products.

Food and other consumable Products: Flavoring extracts, such as vanilla extract or almond extract, if consumed in excess (e.g. to flavor coffee) can cause a positive test. Some desserts, especially flamed desserts are prepared with large amounts of alcohol and can cause a positive test. Chocolates containing liquid filling can contain alcohol. Some churches use wine or fortified wine for communion, and depending on how much is consumed, can cause a positive test. All of these foods should be avoided.

Breathing Alcohol vapor can cause a Positive Test: Avoid breathing fumes of products containing alcohol, such as alcohol based hand sanitizing gels (e.g. Purell), perfumes or colognes, bug sprays, or other chemicals (lacquers, solvents, or gasohol).

Comments:

We realize that some of you will have questions about this information. If you have questions regarding this matter, please ask a staff member and someone will assist you. If you have questions as to how a diluted or positive screen will impact your legal standing, please contact your attorney for specific information.

Remember: YOU are responsible for what you put in your body

If you find yourself in need of assistance with drug or alcohol use, ask one of the court team members – that is what we do, all you need to do is ask for help.

PRIVACY & DISCLOSURE

Your identity and privacy will be protected consistent with the Florida and Federal law. In response to these regulations, policies and procedures have been developed which guard your confidentiality. You will be asked to sign a General Consent for Release of Confidential Information form authorizing the transfer of information among all named participating agencies.

CONCLUSION

The Drug Court Program has been developed to help you achieve total abstinence from illicit and illegal drugs and all criminal activity. The program is designed to promote self- sufficiency and to return you to the community as a productive and responsible member. The program is voluntary and is your personal choice. The Judge, the court staff and the treatment team are present to guide and assist you, but the final responsibility is yours. You must be motivated to make this change and commit to a drug-free life.

We hope this Handbook has been helpful to you and answered most of your questions. If you have additional questions or concerns about the Drug Court Program, please feel free to ask your treatment team and your attorney.

POLICY AND PROCEDURE MANUAL FOR OPERATION OF THE LEE COUNTY FELONY DRUG COURT PROGRAM



MISSION:

*Rebuilding lives through honesty, personal responsibility
and recovery one day at a time.*

Revised: November 17, 2017

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*“Ability is what you’re capable of doing. Motivation determines what you do.
Attitude determines how well you do it.” – Lou Holtz*

HISTORY OF DRUG COURT

Established in 1989, the Miami-Dade County Drug Court was the first of its kind in the nation. A visionary group of justice professionals decided that the system as it existed was broken and there had to be a better way. The better way included combining drug treatment with the structure and authority of the drug court judge. Working as a team, they were able to effect lasting change in the lifestyle and behavior of Drug Court participants. The Miami-Dade Drug Court sparked a national revolution that has forever changed our justice system. Broward County soon followed, and Florida became a pioneering state in the treatment and court monitoring of drug offenders

In 1994, the Florida Legislature enacted section 948.08(6), Florida Statutes, to provide for dismissal of charges upon successful completion of a drug court program for offenders with no prior felony convictions. This provided a statewide sentencing approach for these offenses, and a “carrot” to encourage offenders to opt into drug court, where they would be held accountable for their actions through intensive monitoring by the court.

In 2001, the Supreme Court Task Force on Treatment-Based Drug Courts proposed legislation that was adopted and enacted as section 397.334, Florida Statutes, which acknowledges the need for, and significant impact of, drug courts in handling substance abusing offenders.

In Lee County, the first administrative order was signed in 2001 and it established the first drug court program. An administrative order was signed by then Chief Judge Cary on September 11, 2007 which began the expansion of drug court to one hundred fifty (150) participants. Currently, the maximum capacity is 200 participants.

In 1999, the Supreme Court Steering Committee on Treatment Based Courts adopted the Ten Key Components. As set forth in Section 397.334 of the Florida Statutes, Florida Drug Courts must adhere to these standards.

THE TEN KEY COMPONENTS

1. Drug courts integrate alcohol and other drug treatment services with justice system case processing.
2. Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants’ due process rights.
3. Eligible participants are identified early and promptly placed in the drug court program.
4. Drug courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services.
5. Abstinence is monitored by frequent alcohol and other drug testing.
6. A coordinated strategy governs drug court responses to participant’s compliance.
7. Ongoing judicial interaction with each drug court participant is essential.
8. Monitoring and evaluation measures the achievement of program goals and gauge effectiveness.

9. Continuing interdisciplinary education promotes effective drug court planning, implementation and operations.
10. Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court program effectiveness.

ADULT DRUG COURT BEST PRACTICE STANDARDS

The Adult Drug Court Best Practice Standards were introduced completing the most comprehensive compilation of research-based, specific, practitioner-focused Drug Court guidance ever produced. The Standards bring to bear over two decades of research on addiction, pharmacology, behavioral health, and criminal justice and include lessons that will not only improve Drug Court, but will help improve the way the entire system responds to offenders living with addiction or mental illness.

I. TARGET POPULATION

Eligibility and exclusion criteria for the Drug Court are predicated on empirical evidence indicating which types of offenders can be treated safely and effectively in Drug Courts. Candidates are evaluated for admission to the Drug Court using evidence-based assessment tools and procedures.

II. HISTORICALLY DISADVANTAGED GROUPS

Citizens who have historically experienced sustained discrimination or reduced social opportunities because of their race, ethnicity, gender, sexual orientation, sexual identity, physical or mental disability, religion, or socioeconomic status receive the same opportunities as other citizens to participate and succeed in the Drug Court.

III. ROLES AND RESPONSIBILITIES OF THE JUDGE

The Drug Court judge stays abreast of current law and research on best practices in Drug Courts, participates regularly in team meetings, interacts frequently and respectfully with participants, and gives due consideration to the input of other team members.

IV. INCENTIVES, SANCTIONS, AND THERAPEUTIC ADJUSTMENTS Consequences for participants' behavior are predictable, fair, consistent, and administered in accordance with evidence-based principles of effective behavior modification.

V. SUBSTANCE ABUSE TREATMENT

Participants receive substance abuse treatment based on a standardized assessment of their treatment needs. Substance abuse treatment is not provided to reward desired behaviors, punish infractions, or serve other non-clinically indicated goals. Treatment providers are trained and supervised to deliver a continuum of evidence-based interventions that are documented in treatment manuals. Each team member will be

responsible for the dissemination of information to their respective agency with regard to confidentiality laws that apply specifically to Drug Court participants. Likewise the sharing of information between team members is a vital part of working together as a team. Team members will also be charged with the education of peer professionals on the program and develop community linkages which enhance the effectiveness of the program. In creating this partnership and uniting in a single goal of addressing an underlying problem affecting our community, we are pledged to enhance communication between the Courts, law enforcement and treatment programs. Through this linkage of services, we expect wider participation and greater effectiveness in addressing drug offenders involved in the criminal justice system.

VI. COMPLEMENTARY TREATMENT AND SOCIAL SERVICES

Participants receive complementary treatment and social services for conditions that co-occur with substance abuse and are likely to interfere with their compliance in Drug Court, increase criminal recidivism, or diminish treatment gains.

VII. DRUG AND ALCOHOL TESTING

Drug and alcohol testing provides an accurate, timely, and comprehensive assessment of unauthorized substance use throughout participants' enrollment in the Drug Court.

VIII. MULTIDISCIPLINARY TEAM

A dedicated multidisciplinary team of professionals manages the day-to-day operations of the Drug Court, including reviewing participant progress during pre-court staff meetings and status hearings, contributing observations and recommendations within team members' respective areas of expertise, and delivering or overseeing the delivery of legal, treatment and supervision services.

IX. CENSUS AND CASELOADS

The Drug Court serves as many eligible individuals as practicable while maintaining continuous fidelity to best practice standards.

X. MONITORING AND EVALUATION

The Drug Court routinely monitors its adherence to best practice standards and employs scientifically valid and reliable procedures to evaluate its effectiveness.

ROLES OF DRUG COURT MEMBERS

Drug Court Judge: As a member of the drug court team, the assigned Judge will preside over the court proceedings and monitor appropriate applications of disciplines, sanctions, and incentives while maintaining the integrity of the court. At the first court appearance, the Judge will explain the defendant's legal rights, program requirements and options. The Judge will require that the defendants appear at regularly scheduled status hearing, in which time the Judge will review, with the defendants, their treatment progress reports. From this information the Judge will have the opportunity to reinforce positive behaviors, identify areas that need continued

improvements, and/or impose appropriate consequences.

Assistant State Attorney: As a member of the drug court team, the assigned Assistant State Attorney acts as “Gate-Keeper” of the program. The Assistant State Attorney is responsible to provide all Drug Court offers and plea agreements terms. The Assistant State Attorney will attend all Drug Court hearings, actively participate in staffing of cases, and address revocations, pleas, and application of sanctions and incentives as they apply to the participant.

State Attorney Liaison/Coordinator: As a member of the drug court team the State Attorney Coordinator will review all potential participants and determine if the offender meets the eligibility criteria. The State Attorney Coordinator/Liaison will attend all drug court hearings and participate in the staffing of cases and assist the team in addressing sanctions, incentives and treatment concerns as they apply to the participant.

Assistant Public Defenders/Defense Counsel: As a member of the drug court team, the Assistant Public Defender or Defense Counsel is responsible to explain and review all offers/documents for participant’s entry. The Assistant Public Defender/Defense Counsel will attend all drug court hearings and actively participate in staffing of cases and will represent participants at revocations, pleas, and application of sanctions and other matters. Among other duties, the defense attorney ensures participants’ constitutional rights are protected and advocates for participants’ stated legal interests.

Public Defender Liaison/Coordinator: As a member of the drug court team, the Public Defender’s Coordinator/ Liaison will meet with potential participants and assist in completing the drug court application process and explain the program requirements. The Public Defender’s Coordinator/Liaison will attend all drug court hearings and participate in staffing of cases to assist the assistant public defender and participant regarding sanctions, incentives, and treatment concerns as they apply to the participant.

Probation Officer: As a member of the drug court team, the Probation Officers will be responsible for implementing the appropriate supervision based on established measures; provide community linkages and referrals to appropriate agencies and monitor compliance with drug court rules and accountability in the home environment of the participant. The Probation Officers will provide staffing reports that will include progress in employment and/or vocational pursuits and compliance with Court mandated fines/fees. The Probation Officer will participate in staffing of cases and interact in a non-adversarial manner to assist the team in addressing sanctions, incentives, and treatment concerns as they apply to the participant.

Pretrial Service Officer/Liaison: As a member of the drug court team, the Pretrial Service Officer/Liaison serves as a multifunction court and team facilitator to ensure efficient case flow and progression for all pending and active drug court cases. The Pretrial Service Coordinator maintains all IJIS/CJIS case data, court events, staffing agendas, court dockets, calendars, and drug court alumni data in order to streamline all pertinent information so that it’s readily available for the team and Judge. As a court employee the Pretrial Service Officer/ Coordinator offers a neutral prospective during team discussions while adhering to handbook guidelines.

Treatment Provider/ Lab Services: As a member of the drug court team, the treatment provider/ lab services will administer substance abuse/dependency screening and assessments utilizing evidenced based validated assessments for each participant; participate in weekly staffings, make treatment recommendations to the Court, and provide drug test collections. Treatment providers will provide individual, family, and group therapy sessions as well as classes on chemical dependency, relapse prevention, Moral Reconciliation Therapy (MRT), life skills or other evidence based treatment modalities. Treatment providers will make available the necessary access to Medication Assisted Treatment when deemed medically necessary. Treatment providers will identify and provide a continuum of care for participants and maintain the integrity of the Court. Treatment providers will ensure that each client's individualized treatment plan and treatment plan changes will be provided electronically to all team members soon as the information is documented and additional information upon request. Treatment provider is to update participant's progress via the IJIS notes tab and must be updated on a weekly basis with all information available no later than 2 days prior to the court docket proceeding. Treatment provider is to notify team immediately if a participant has missed group/appointment/drug test or other behaviors that may lead to a sanction. Treatment provider will establish and maintain communication with all residential programs that participants are attending, and send the residential program a copy of the individualized treatment plan to ensure a steady continuum of care upon completion of the program. Treatment notes will include the following in the shared database, when applicable along with the date for each and any other pertinent treatment related requirement or note:

1. Drug or alcohol screens, what was tested and results
2. Level of engagement in group therapy/ individual sessions
3. General progress and any outstanding issues.

LEE COUNTY FELONY ADULT DRUG COURT ELIGIBILITY CRITERIA

Eligibility is at the discretion of the State Attorney's Office, and is subject to approval by the Drug Court Judge.

The following minimum criteria must be met for consideration:

1. Must be a resident of Lee County.
2. Must be evaluated and found to be an individual with a substance abuse problem who may benefit from a Drug Court Program.
3. Must have a felony.
4. Must not have previously completed or been discharged from Drug Court.
5. In cases where restitution is required, restitution will be capped at \$2000.00.

Note: Cases in which restitution is above the capped limit may still qualify, but participant must agree to one of the following scenarios:

1. Pay amounts above capped limit in full prior to plea.
2. Upon completion of treatment requirement, modify to regular probation until monies are paid in full.

IDENTIFICATION/REFERRAL PROCESS

Step 1.

The Pretrial Services Intake and Investigation Unit will identify potential candidates for diversion programs during the interview process at booking using evidenced based risk instruments. The Drug Court Pretrial Officer will prepare and send a list of those candidates that meet the drug court eligibility criteria to the SAO Coordinator and Public Defender's Office.

Step 2.

Defense/Public Defender Coordinator/Liaison makes direct application to State Attorney Office and provides the client with a drug court handbook. Included in the application packet, the General Consent for Release of Confidential information must be completed.

Step 3.

The SAO Coordinator/Liaison will forward the referral data sheet and signed general consent for release of confidential information for those candidates who have met the legal screening requirement to the Treatment Provider and Pre-Trial Services.

Step 4.

The Pre-Trial Service Officer will open the case in the IJS Drug Court database.

Step 5.

The Treatment Provider will complete the clinical screening within (5) five business days of receipt of referral and email notification of the uploaded clinical information/recommendation. Any participant unable to be contacted within 30 days will automatically be removed from the pending referrals.

Step 6.

The Treatment Provider will input screening/assessment information into the IJS database and provide email notification of the uploaded information within one (1) business day of completion of the screen.

Step 7.

The Assistant State Attorney will review the case along with clinical recommendations and provide an offer (if appropriate) along with all required documents (Pretrial will be notified that an offer has been provided.) The State Attorney's Office will, as directed in Florida Statute 397.334(3)(a), make its recommendation to the Court after having taken into consideration the other factors specifically referenced in the statute. The Court will make the final determination as to acceptance into the Drug Court Program as provided in Florida Statute 397.334(3)(a).

Step 8.

Upon notification that an offer has been accepted, the Pre-Trial Service Officer/Coordinator will provide a court date within twenty-four (24) hours for entry/plea to occur within 2 weeks of the offer.

STAFFING PROCEDURES

A critical component of Drug Court is the use of “drug court staffing”. A staffing is a team meeting held just prior to court to discuss the progress of each participant who will appear in court. The Drug Court Program utilizes a strong team approach which focuses on fairness and accountability. The team relies on accurate reports from the clinicians, Probation Officers and other treatment providers, who provide detailed, up-to-date information on the progress of each client. Additionally, clinicians make recommendations for individual treatment plans and incentives. Each team member must be educated in all aspects of treatment and recovery. The Drug court team is committed to the continual education of its team members.

Team Member Duties: Any team member wishing to address certain participants will provide notification via email or as instructed to add notes to the IJIS system, to be received by the pretrial officer no later than the day prior to staffing. In the event of an un-foreseen circumstance precluding notification on the day prior to staffing, notification to pre-trial must happen immediately.

The treatment provider will bring files to staffing (or have computer access) for all participants scheduled on the staffing agenda and docket and should be prepared to answer treatment related questions from any member of the drug court team.

DOCKET/COURT PROCEDURES

The Drug Court dockets consist of three types of appearances: initial hearings for new participants entering the program; status hearings for the active participants of the program and termination hearings. During the initial court hearings, the individual appears in front of the Judge and pleads to criminal offenses based on a negotiated plea agreement with the State Attorney. At this hearing, the participant is officially admitted and given initial instructions and requirements about the program. Status hearings are regularly scheduled progress hearing where the participants appear in front of the Judge to go over everything that was discussed in the staffing prior to court. Termination hearings include Moving On ceremonies which honors the success of the participant or unsuccessful discharge which results in imposition of sentence based on legal guidelines.

Team Member Duties: The Pretrial Service Officer/Coordinator will prepare a docket for each court date along with the next return dates for the participants appearing in court.

The Pretrial Service Officer/Coordinator will coordinate any docket additions with judicial approval.

The Pretrial Service Officer/Coordinator will make requests for participants to be added to the docket through the Clerk of Court with the full name and case number.

The Pretrial Service Officer/Coordinator will ensure status reports are distributed via email to the drug court team no later than 2:00 p.m. the day prior to court.

The Pretrial Service Officer/Coordinator will announce future court dates for all participants on the docket.

The Clerk of Court will prepare and disseminate the docket for each scheduled court date no later than noon the day prior to court. (Any member of the drug court team may request that the docket be amended when necessary through the pretrial officer).

Assistant Public Defender or other Defense Attorney may advocate for further discussion with the State Attorney about a client's disqualification from the program. In addition, the Assistant Public Defender or other Defense Attorney shall review and sign with participant all documents related to plea/entry of drug court candidate.

Assistant State Attorney shall review and sign all documents related to plea/entry of drug court candidate. Upon graduation, if the participant is in the program for a substantive charge(s), the State Attorney's Office will dismiss the charge(s). Upon graduation, if the participant has a charge of violation of probation after a prior plea and probation sentence, the violation of probation affidavit will be dismissed, the probation will be terminated and the original conviction that was imposed will remain. Adjudication originally withheld will be upheld upon graduation. If the participant pled to a charge(s) for which the participant has not previously been placed on probation, the participant will be allowed to withdraw the plea of guilty or no contest upon graduation, the sentence will be vacated and the charge(s) will be dismissed by the State Attorney's Office.

Treatment/Lab Services shall provide information as to participant's progress via the CJIS/IJIS notes tab and information must be updated on weekly basis with all information available no later than 2 days prior to the court docket. Drug screen results shall be entered via the CJIS/IJIS notes tab on a daily basis.

Treatment shall be prepared to answer all inquiries related to participant's treatment plan and progress. The initial treatment plans must be provided to the drug court team. The treatment provider shall conduct an ASAM Assessment. This assessment shall also be conducted after any relapse and provided in the shared database.

DRUG TESTING

Lee County Drug Court believes that drug and alcohol testing provides an accurate, timely, and comprehensive assessment of unauthorized substance use throughout participants' enrollment in the Drug Court.

Treatment Provider/ Lab Services shall:

1. Perform drug testing on all applicants (out of custody) appearing for clinical screen, the results of which shall be communicated in clinical screening results. Drug screen results shall be entered via the CJIS/IJIS notes tab on a daily basis.
2. The treatment provider who is conducting any clinically based individual or family

treatment shall be a Master's level clinician. Any group sessions should be conducted by a Bachelor's level clinician (preferably with CAP). A Master's level clinician is defined as an individual that holds a Master's in Social Work, Master's in Mental Health Counseling or equivalent.

3. Test on a frequent and random basis at a minimum of two (2) times per week within a seven (day) period. Alternative forms of testing may be required as ordered by the Court.
4. Utilize a call-in phone system accessible by participants.
5. Communicate any change to drug testing hours, technical difficulties related to phone line or lab staffing issues to the Team via email immediately, and no later than twenty-four (24) hours from occurrence.
6. Provide additional hours for drug testing on holidays and weekends as well as extended evening hours up to 7:00 pm as funding permits.
7. Provide trained laboratory staff to conduct urine testing.
8. Observe drug testing at all times.
9. Report any results that are positive, diluted with creatinine level less than 20mg/dl or elevated creatinine above 400 mg/dl via email immediately upon receipt of results but no later than twenty-four (24 hours) from receipt of results.
10. Provide testing supplies for in-court drug testing requests and perform testing during court should the need arise.
11. Upon request by any member of the Team, treatment/ lab services shall notify participant to appear for laboratory testing within 1 hour of the request. Treatment shall immediately thereafter notify Team members via email that the request was made and status of contact (e.g., if direct contact or voicemail). Note: The purpose of the time limitation is to prevent the participant from being able to water-load or consume a flushing agent prior to the test. This requirement just directs treatment to make the contact with the participant. If the participant is legitimately unable to participate in a drug screen within an hour, this is something the Team will consider. See page 18 for other considerations the Team will make when deciding to impose sanctions.

Pretrial shall:

1. Assist with drug testing requests during court.
2. Complete an in-custody urine screen on any participants taken into custody after new law violation or absconding treatment/supervision and will utilize treatment provider's/lab service's chain of custody and testing supplies.

TREATMENT/CASE MANAGEMENT/SUPERVISION SERVICES GENERAL OPERATION FUNCTIONS

Treatment/ Lab Services shall:

1. Interview clients, review records, and confer with other professionals to evaluate the condition of the client.
2. Develop individualized treatment plans with client input to address issues identified in the assessment.
3. Counsel assigned client individually and in group sessions. All counseling services must focus on the goals outlined in the individual's treatment plan.
4. Counsel family members if appropriate to assist family in dealing with and providing

support for the client.

5. Develop working relationships with other treatment service providers.
6. Coordinate activities for clients to promote sober socialization skills.
7. Document in the IJIS note tab all information pertaining to drug testing and treatment progress/concerns on a weekly basis and no later than twenty four (24) hours prior to the scheduled court date.
8. Will coordinate progress reports and verify participation from other treatment providers providing services to participants.
9. Shall contact residential program providers throughout residential placement and for transition planning purpose and shall present transition plan and projected date of release to drug court team no later than forty five days prior to participant's release from program.
10. Shall assist with coordination of services upon transition from residential programs including halfway or sober housing upon release from residential program.
11. Provide linkages in the community for ancillary services.

Department of Correction Probation Officer shall:

1. Monitor and supervise all participants.
2. Conduct field visitations to include participants' residence and/or employment.
3. Enforce curfew orders.
4. Will submit a violation report or warrant to the drug court judge for any participant who violates the conditions of probation and will notify the drug court team of such as soon as possible.

Pretrial Officer/Coordinator shall:

1. Document and update IJIS with all court outcomes including violations, rewards and/or sanctions imposed; work or vocational or educational pursuits; performance of community service hours.
2. Complete a reassignment order by the following business day for all cases that enter the
3. Felony Drug Court Program. If a misdemeanor case is resolved without entering the program, it will not be included on the reassignment order.
4. Add the booking photo to the CJIS/IJIS area when a new participant signs in to the Court.

All Team Members shall:

1. All Drug Court Team members agree to consider the exigent circumstances of any participant in making decisions regarding sanctions, incentives and phase advancement.

APPENDIX A: ASAM ASSESSMENT TEMPLATE DRUG COURT

Date, Time, Location:

Client Name:

Client Background Info: Note client demographics. There should be information about where they grew up, if their parents were together, and other pertinent information to explain who the client is and why they are being evaluated. There should also be indication of age at first use, mental health, family mental health, and reasons they are seeking treatment.

- **Dimension 1 Acute Intoxication and/or Withdrawal Potential:** This should be a narrative that includes an in depth history of their substance use. Include substances used with amount, frequency, and progression of use. It should include last UDS results (if available), last use, with whom and where they used. Note a clinical observation if the person appears to be free of substances. List any current withdrawal symptoms i.e. heart racing, depression, sweating, tremors, nausea, muscle aches, irritability etc. History of withdrawal symptoms, or if they have ever experienced withdrawals. If client is currently undergoing withdrawal are they able to participate in treatment. Post-Acute Withdrawal Syndrome (PAWS) symptoms.
- **Dimension 2 Biomedical Conditions and Complications:** In this section it should be noted if the client has any medical conditions (not including withdrawal or PAWS) that may need to be addressed because it could complicate treatment. Does the client have any chronic conditions that could also complicate treatment? List all medications and why they are prescribed. There should be a history of any medical procedures. Address sleep patterns, chronic illness/diseases, medical conditions **not** related to withdrawal or PAWS, and other factors that may interfere with treatment. If there are any of these issues present it should be noted how they will be addressed or what referrals can be made to address the needs. It should not disqualify a person from entering or staying in treatment.
- **Dimension 3 Emotional, Behavioral, or Cognitive Conditions and Complications:** This is one of the most important sections as it covers mental illness/co-occurring issues that a client may have. It should also cover if the client is a victim of trauma i.e. sexual, physical, mental and any other forms of trauma (not too in depth for the evaluation). It is imperative that mental illnesses are noted in this area, even if self-reported only with no other documentation, to help dictate possible referrals to ensure client's best chance of maintaining abstinence from substances and symptoms of mental illness. Medications past and current with dosage and frequency if possible. It should also reflect if there is a family history of mental illness and/or substance abuse. Any suicidal ideation (if there is any ideation, plan/means should be noted).
- **Dimension 4 Readiness for Change:** Has the client had past treatment episodes, and if the client has successfully completed the treatment, how long they maintained sobriety. Note which "Stage of Change" they are in as evidenced by their statement. It should be noted if the client is amenable to treatment. Ask if the client has been to 12-step meetings/self-help groups. Should note if the client is motivated internally and externally. They should also be asked if they believe their substance use is a major problem in their life. Note sober support systems they have such as family members, employers, and friends that will offer

support to help them maintain sobriety. There should be a scaling question asked on a scale of 1-10 to score their desire to make a change in their life and how motivated they are. Also include short-term and long-term goals.

Dimension 5 Relapse, Continued Use or Continued Problem Potential: Cover mental health and any medical concerns that could pose a potential risk for relapse, and if they are compliant with prescribed medications. Note some triggers that the client may have such as impending divorce, loss of income/job, family stressors, and other biopsychosocial stressors that may increase their risk for relapse. The client's awareness of relapse triggers should be assessed, and if they have adequate coping/refusal skills. Include which assessments were used and what their relapse potential might be. Risk potentials are high risk, medium risk, low risk, and no risk. It is possible for a client to be classified within two risks, there also needs to be an objective "as evidenced by" statement after the risk is given. For example, John Smith is at a medium/high risk for relapse as evidenced by more than two other treatment episodes when he was not able to remain sober, he has a pending divorce with his spouse, and the assessment that was administered scored him as a probable relapse risk without a certain amount of care. This section should note again if the client has strong supports.

- **Dimension 6 Recovery/Living Environment:** Note if the client's current living situation is conducive to their recovery. If they are in custody it should be noted if the living situation that they have available to them upon release is conducive to their recovery. The client should be asked if there are any alcohol/drugs that are in their home, even if it is for a family member. Note if the client has a job or income available to them.
- DSM 5 Diagnostics:** List their substance use disorders and/or co-occurring diagnostics if possible. It should also be noted if the client is an IV user.

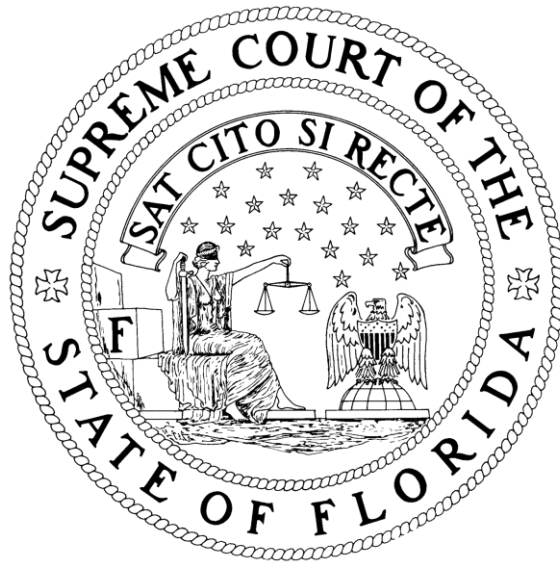
Treatment Recommendations ASAM Level of Care & Therapeutic Interventions: This section should indicate the client's level of care. There should be evidence that offers clinical rationale for the recommendations that are noted in the 6 Dimensions. If there were screening tools used in the assessment those should also be noted in this section. Essentially, this section is justification for the treatment recommendation. Whatever the recommendation is, should be noted on what supports they will receive in treatment and how it will be an intervention for the noted issues within the Dimensions.

Levels of Care:

- 0.5 Early Intervention Assessment and education.
- 1 Outpatient Services Adult: Less than 9 hours of service per week.
- 2.1 Intensive Outpatient Services Adult: More than 9 hours of service per week.
- 2.5 Partial Hospitalization Services 20 or more hours of service per week (Day Treatment).
- 3.1 Clinically Managed Low-intensity Residential Services 24-hour structure with available personnel, at least 5 hours of clinical service per week.
- 3.3 Clinically Managed Population-specific High intensity Residential Services 24-hour care with trained counselors, less intense environment and treatment for those with cognitive and other impairments.

- 3.5 Clinically Managed Medium-intensity Residential Services Clinically Managed High intensity Residential Services 24-hour care with trained counselors.
- 3.7 Medically Monitored High-intensity Inpatient Services Medically Monitored Intensive Inpatient Services 24-hour nursing care with physician availability, 16 hour per day counselor availability.
- 4 Medically Managed Intensive Inpatient Services 24-hour nursing care and daily physician care, counseling available.

The purpose of this assessment is to offer the Drug Court Team a holistic explanation of who the client is and their issues in order to treat them in the most effective manner. This assessment tool should be use on a monthly basis and if a client has a relapse. The monthly updates don't have to be as in depth, but it should update all of the Dimensions to ensure proper interventions. The individualized treatment plan should cover all issues within the Dimensions.



Florida Adult Drug Court Best Practice Standards

June 2017

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Introduction

Since the nation's first drug court was established in 1989 in Miami-Dade County, Florida, the concept of a non-adversarial court-based approach to helping people break the cycle of addiction and improve their lives through treatment and accountability has become a national and international trend in criminal justice. This trend has subsequently led to rigorous research and analysis of drug court practices as well as the development of tools to help drug court practitioners achieve better outcomes for participants. In 1996, *Defining Drug Courts: The Ten Key Components* was published and served for years as the framework for how drug courts should operate. Since then, through continued research and analysis, the National Association of Drug Court Professionals (NADCP) developed the *Adult Drug Court Best Practice Standards*, Vol. I (2013) and Vol. II (2015). The NADCP standards are intended to clearly define the practices that drug courts and problem-solving courts should implement in order to adhere to evidence-based best practices that have been scientifically shown to produce better outcomes, and to maintain fidelity to the drug court model.

The Florida Adult Drug Court Best Practice Standards aim to bring this level of professionalism and fidelity to the drug court model to adult drug courts throughout the state of Florida. The Florida standards are based largely on the research and analysis conducted by NADCP. They have been revised in places to better suit terminology and nuances that are common among adult drug courts in Florida. The research cited by NADCP is included in the form of a Commentary section to emphasize the commitment to implementing and adhering to evidence-based best practices. A References section compiled by NADCP which corresponds to the Commentary is also included. These standards are not necessarily inclusive of every best practice that may exist. Only standards based on reliable and convincing evidence have been included. As new research studies are completed, new standards may be added.

The development of the Florida Adult Drug Court Best Practice Standards could not have been possible without the leadership of Judge Steve Leifman, Chair of the Florida Supreme Court Task Force on Substance Abuse and Mental Health Issues in the Courts, the hard work and dedication of members who served on the Problem-Solving Courts Fidelity Workgroup, and the support of the full Task Force. Judge Melanie May, Chair of the Problem-Solving Courts Fidelity Workgroup, is also recognized for her outstanding leadership and dedication to ensuring this document was rigorously edited and reviewed. Additionally, the ongoing support from the Florida Supreme Court for the work of the Task Force made the development of the standards a reality. Finally, many thanks to staff from the Office of the State Courts Administrator for their work on the standards and support to the Task Force.

State of Florida

Adult Drug Court Best Practice Standards

I. Target Population

Eligibility and exclusion criteria are predicated on empirical evidence of the types of offenders who can be treated safely and effectively. Candidates are evaluated for admission using evidence-based assessment tools and procedures.

A. Eligibility & Exclusion Criteria

1. Eligibility and exclusion criteria are defined objectively and specified in writing in a policy and procedures manual.
2. The drug court team relies on the written objective criteria for participant suitability.
3. Eligibility and exclusion criteria are communicated to potential referral sources including judges, law enforcement, defense attorneys, prosecutors, treatment professionals, and community supervision officers.

B. Risk and Need

1. Drug courts target potential participants who have a substance use disorder and are at risk for reoffending. These individuals are commonly referred to as high-risk and high-need offenders.
2. Drug courts develop alternative tracks with services modified to meet the risk and need levels of its participants.¹

C. Validated Eligibility Assessments

1. Drug courts must use validated risk and assessment tools.
2. Evaluators are trained and proficient in the administration and interpretation of the risk, screening, and assessment tools.

D. Criminal History Disqualifications

1. Current or prior offenses may disqualify potential participants from participation if empirical evidence demonstrates participants cannot be managed safely or effectively.
2. Barring legal prohibitions, potential participants charged with drug dealing or those with violent histories are not automatically excluded.

¹ Refer to section I. part B of the Commentary for more information on alternative tracks in drug court.

E. Clinical Disqualifications

1. If adequate treatment is available, potential participants are not disqualified from participation because of co-occurring mental disorders, medical conditions, or use of legally prescribed psychotropic or addiction medication.
2. A written protocol shall be established for the use of medication assisted treatment.

II. Disadvantaged Groups

Individuals from groups who have experienced discrimination or reduced opportunities because of their race, ethnicity, gender, sexual orientation, sexual identity, physical or mental disability, religion, or socioeconomic status receive the same opportunities as others to participate and succeed in the drug court.

A. Equivalent Access

1. Eligibility criteria for the drug court are nondiscriminatory in intent and impact.
2. Drug courts must monitor and make adjustments if an eligibility requirement has the effect of restricting access for members of a disadvantaged group.

B. Equivalent Retention

1. The drug court regularly monitors whether members of disadvantaged groups complete the program at equivalent rates to other participants.
2. If completion rates are significantly lower for members of a disadvantaged group, the multidisciplinary drug court team should remediate the disparity.

C. Equivalent Treatment

1. Members of disadvantaged groups receive the same levels of care and quality of treatment as other participants with comparable clinical needs.
2. The drug court administers evidence-based treatments that are effective for use with members of disadvantaged groups represented in the drug court population.

D. Equivalent Incentives and Sanctions

1. Members of disadvantaged groups receive the same incentives and sanctions as other participants for comparable achievements or infractions, except when they may cause harm or injury to the participant's physical or mental health.
2. The drug court regularly monitors the delivery of incentives and sanctions to ensure they are administered equivalently to all participants.

E. Equivalent Dispositions

1. Members of disadvantaged groups receive the same legal dispositions as other participants for completing or failing to complete the drug court program.

F. Team Training

1. Multidisciplinary drug court team members shall attend training on recognizing implicit cultural biases, understanding unique needs, and correcting disparate impacts for members of disadvantaged groups.

III. Roles and Responsibilities of the Judge

The drug court judge is up-to-date on current law and best practices in drug courts, participates regularly in team meetings, interacts frequently and respectfully with participants, and gives due consideration to the input of other team members.

A. Professional Training

1. The drug court judge attends training on legal and constitutional issues in drug courts, judicial ethics, evidence-based substance abuse and mental health treatment, behavior modification techniques (i.e. incentives and sanctions), community supervision, and other advances in the drug court field.

B. Length of Term

1. The judge presides over the drug court for no less than two consecutive years to maintain the continuity of the program and ensure use of current drug court policies, procedures, and best practices.

C. Consistent Docket

1. Participants appear before the same judge throughout their participation in drug court.²

D. Participation in Pre-Court Staff Meetings

1. The judge regularly attends pre-court staff meetings during which each participant's progress is reviewed and potential consequences for performance are discussed by the drug court team.

E. Frequency of Status Hearings

1. Participants appear before the judge for status hearings at least every two weeks during the first phase of the program.³
2. The frequency of status hearings may be reduced gradually after participants have achieved abstinence from alcohol and illicit drugs and are routinely engaged in treatment.
3. Status hearings are scheduled every four weeks until participants are in the last phase of the program.

F. Length of Court Interactions

1. Status hearings shall be conducted individually with each participant.
2. Evidence suggests judges should spend at least three minutes interacting with each participant in court.

² Refer to section III. part C of the Commentary for more information.

³ Research suggests that this is especially important for high-risk participants. Refer to section III. part E of the Commentary for more information.

G. Judicial Demeanor

1. The judge offers supportive comments to participants, stresses the importance of their commitment to treatment and recovery, and motivates them to successfully attain their goals.
2. The judge treats each participant with dignity and respect.
3. The judge allows participants a reasonable opportunity to explain their perspectives concerning factual controversies and imposition of sanctions, incentives, and therapeutic adjustments.

H. Judicial Decision-Making

1. The judge makes all final factual determinations and decisions concerning the imposition of incentives and sanctions.
2. The judge makes all decisions after considering input from multi-disciplinary drug court team members, the participant, and defense counsel.
3. The judge considers the input of trained treatment professionals when imposing treatment-related conditions.

IV. Incentives, Sanctions, and Therapeutic Adjustments

Consequences for participants' behavior are predictable, fair, consistent, and administered in accordance with evidence-based principles of effective behavioral modification.

A. Advance Notice

1. Drug court participants are provided with written policies and procedures concerning incentives, sanctions, and treatment interventions before program admission.
2. The policies and procedures provide a clear indication of which behaviors may elicit an incentive, sanction, or therapeutic adjustment; the range of consequences that may be imposed for those behaviors; the criteria for phase advancement, graduation, and termination from the program; and the legal and collateral consequences that may ensue from graduation and termination.
3. The multi-disciplinary drug court team reserves a reasonable degree of discretion to modify a presumptive consequence in light of the circumstances.

B. Opportunity to be Heard

1. Participants are afforded an opportunity to explain their perspective before the imposition of a consequence or therapeutic adjustment.
2. If a participant has difficulty expressing him or herself because of such factors as a language barrier, nervousness, or cognitive limitation, the judge should allow the participant's attorney or legal representative to assist in providing explanations.
3. Participants receive a clear explanation for the imposition or withholding of a particular consequence.

C. Equivalent Consequences

1. Participants receive consequences that are equivalent to those received by other participants in the same phase of the program who are engaged in comparable conduct.
2. Unless necessary to protect the individual from harm, consequences shall be imposed without regard to gender, race, ethnicity, nationality, socioeconomic status, or sexual orientation.

D. Progressive Sanctions

1. A drug court shall have a formal protocol of sanctions, including a protocol for reporting non-compliance, established in writing and included in the courts policies and procedures.
2. For distal goals, the sanctions should progressively increase in severity for successive infractions. For proximal goals, a more severe sanction should be imposed.⁴

⁴ Refer to section IV. part D of the Commentary for more information.

3. There shall be finite time periods for sanctions, including those sanctions involving incarceration or detention which should be considered as the last option.

E. Licit Addictive or Intoxicating Substances

1. Consequences are imposed for the non-medically indicated use of intoxicating or addictive substances including, but not limited to, alcohol, cannabis (marijuana), and medications, regardless of the licit nature of the substance.
2. The multi-disciplinary drug court team relies on expert medical input to determine whether a prescription for an addictive or intoxicating medication is medically necessary and whether alternatives are available.

F. Therapeutic Adjustments

1. Participants do not receive punitive sanctions if they are otherwise compliant with their treatment and supervision requirements, but are not responding to treatment interventions. Reassessment and adjustment of treatment plans may be required.
2. Adjustments to treatment plans are based on the recommendations of trained treatment professionals.

G. Incentivizing Productivity

1. The drug court places as much emphasis on incentives for productive behavior and program compliance as it does on sanctioning non-productive behaviors and program non-compliance.
2. Drug courts should provide a diverse array of incentives to encourage recovery-oriented behaviors, such as abstinence, treatment attendance, and employment.⁵
3. For distal goals, the incentives should be meaningful to the individual and represent the efforts made to achieve each goal.
4. For proximal goals, incentives should be tailored to individual participants and may be used both in and out of the courtroom.
5. The drug court provides new participants with written examples of behaviors that lead to possible incentives that may be awarded.

H. Phase Promotion

1. Phase promotion is predicated on the achievement of realistic and defined behavioral goals.
2. Criteria for phase advancement and graduation include objective evidence that participants are engaged in productive activities; such as, employment, education, or attendance in peer support groups.

⁵ Research indicates that other incentives and services may be necessary and/or appropriate. Refer to section IV. part G of the Commentary for more information.

3. As participants advance through the phases of the program, sanctions for infractions may increase in magnitude, rewards for achievements may decrease, and supervision services may be reduced.
4. Treatment is reduced only if it is clinically determined that such reduction is unlikely to cause a relapse.
5. The frequency of drug and alcohol testing is not reduced until clinically appropriate.
6. The team should develop a remedial plan for any participant that relapses or is inappropriate for transition to another level.

I. Jail Sanctions

1. Jail sanctions are judiciously imposed.
2. Jail sanctions are finite in duration and should not last more than three to five days.
3. Participants are afforded access to counsel and a fair hearing.
4. Generally, periods of incarceration in excess of five days have little therapeutic benefit, should be avoided, and may be detrimental to a participant's progress.

J. Termination

1. Participants who are terminated from the drug court receive a sentence or disposition for the underlying offense that brought them into drug court.
2. Participants are informed in advance of the circumstances under which they may receive an augmented sentence for failing to complete the drug court program.
3. Participants may be terminated from drug court if they are no longer safely manageable in the community or repeatedly fail to comply with treatment or supervision requirements.
4. Participants are not automatically terminated from the drug court for continued substance use unless they are non-compliant or unresponsive to all available treatment alternatives.
5. If a participant is terminated from the drug court because adequate treatment is not available, the participant should not receive an augmented sentence or disposition.

K. Graduation

1. Graduates may avoid a criminal record and/or incarceration and receive a reduced sentence or disposition.
2. Graduates may receive alternative dispositions, including a dismissal of their charges or early termination of their probation.

V. Substance Abuse Treatment

Participants receive substance abuse treatment based on a standardized assessment of their treatment needs. Substance abuse treatment is not provided to reward desired behaviors, punish infractions, or serve other non-clinically indicated goals. Treatment providers are trained and supervised to deliver a continuum of evidence-based interventions.

A. Continuum of Care

1. The drug court offers a continuum of care for substance abuse treatment including detoxification, outpatient, intensive outpatient, day treatment, and residential services.
2. Standardized patient placement criteria govern the level of care provided.
3. Adjustments to the level of care are predicated on each participant's response to treatment and are not tied to the drug court's programmatic phase structure.
4. Participants do not receive punitive sanctions or an augmented sentence if they fail to respond to a level of care that is substantially below or above their assessed treatment needs.

B. Placement in Custody

1. Participants are not involuntarily incarcerated to achieve clinical or social service objectives; such as, obtaining access to detoxification services or sober living.
2. Drug court staff ensure that participants who are taken into custody are placed in substance abuse and other relevant treatment programs within the jail when available.
3. Drug court staff communicate all relevant information concerning the participant's substance use and health to the jail when taken into custody.

C. Team Representation

1. Where feasible, one or two treatment agencies are primarily responsible for managing the delivery of treatment services for participants.
2. Clinically trained representatives from these agencies are core members of the multi-disciplinary drug court team and regularly attend team meetings and status hearings.
3. Drug courts using multiple agencies to provide treatment must establish communication protocols to ensure that accurate and timely information about each participant's progress in treatment is conveyed to the multi-disciplinary drug court team.

D. Treatment Dosage, Duration, and Modality

1. Participants are screened for suitability for group interventions, and group membership is guided by evidence-based selection criteria including participants' gender, trauma histories, and co-occurring psychiatric symptoms.
2. Participants receive a minimum of six hours of group counseling per week during the initial phase of treatment and 200 hours of counseling over nine to twelve months. The drug court allows for flexibility to accommodate individual differences in each participant's response to treatment.
3. Participants meet with a treatment provider or clinical case manager for at least one individual session per week during the first phase of the program. The frequency of individual sessions may be reduced if doing so would be unlikely to precipitate a behavioral setback or relapse.
4. Participants receive an appropriate dosage of substance abuse treatment to achieve long-term sobriety and recovery from addiction.
5. Treatment groups ideally have no more than twelve participants.

E. Evidence-Based Treatments

1. Treatment providers administer cognitive and behavioral treatments that have been demonstrated to improve outcomes for addicted persons involved in the criminal justice system.⁶
2. Treatment providers are proficient at delivering interventions and are supervised to ensure continuous fidelity to treatment models.

F. Medications

1. Participants may be prescribed psychotropic or addiction medications based on medical necessity as determined by a treating physician or nurse practitioner with expertise in addiction psychiatry, addiction medicine, or a closely related field.

G. Provider Training & Credentials

1. Treatment providers are licensed or certified to deliver substance abuse treatment services.
2. Treatment providers have substantial experience working with criminal justice populations.
3. Treatment providers are monitored regularly to ensure continuous fidelity to evidence-based practices.⁷

⁶ Refer to section V. part E of the commentary for information on documented cognitive or cognitive-behavioral treatments.

⁷ Refer to section V. part G of the commentary for more information.

H. Peer Support Groups

1. Participants regularly attend self-help or peer support groups in addition to group and individual counseling.
2. The peer support groups follow a structured model such as 12-step or Smart Recovery.
3. Before participants enter the peer support groups, treatment providers use an evidence-based preparatory intervention, such as 12-step facilitation therapy, to prepare the participants for what to expect in the groups and assist them to gain the most benefit from the groups.
4. Participants should have the option to choose a secular alternative to 12-step peer support groups.

I. Continuing Care

1. Participants complete a final phase of the drug court focusing on relapse prevention and continuing care.
2. Participants prepare a continuing care and relapse prevention plan together with their counselor to ensure they engage in prosocial activities and remain connected with a peer support group after their completion of drug court.
3. Where feasible, for at least the first ninety days after completion of drug court, treatment providers or clinical case managers attempt to contact participants periodically by telephone, mail, e-mail, or similar means to check on their progress, offer advice and encouragement, and provide referrals for additional treatment when indicated.

VI. Additional Treatment and Social Services

Participants receive additional treatment and social services necessary to address co-occurring disorders and other needs, to ensure compliance and successful completion of drug court.

A. Scope of Additional Services

1. The drug court provides or refers participants with co-occurring disorders and needs to treatment and services necessary to enhance their response to substance abuse treatment, decrease criminal recidivism, and maintain long-term treatment gains.
2. Depending on participants' needs, additional services may include mental health counseling and consultation regarding medications, housing assistance, trauma-informed services, criminal thinking interventions, family or interpersonal counseling, parenting skills, vocational or educational services, and medical or dental treatment.
3. Participants receive only those services for which they have an assessed need.

B. Sequence and Timing of Services

1. In all phases, participants are provided access to additional services designed to increase or promote continued compliance with drug court tasks and to reduce recidivism.
2. In the first phase, additional services focus on immediate needs that allow participants to successfully engage in drug court such as stabilization, mental health, housing, and transportation.
3. In the interim phases, participants receive services designed to resolve criminogenic needs; such as, criminal thinking patterns, delinquent peer interactions, and family conflict.
4. In the later phases of drug court, participants receive services designed to maintain treatment gains by enhancing their long-term adaptive functioning; such as, vocational or educational counseling.

C. Case Management⁸

1. Participants meet individually with a case manager or comparable treatment professional at least weekly during the first phase of drug court.
2. The case manager or treatment professional administers a validated assessment instrument to determine whether participants require additional treatment or services, provides or refers participants for such services, and keeps the drug court team apprised of participants' progress.

D. Housing Assistance

1. Where indicated, participants receive assistance in finding safe, stable, and drug-free housing in the first phase of drug court and continuing as necessary throughout their enrollment in the program.

⁸ Refer to section VI. part C of the Commentary for more information.

2. If housing services are unavailable to the drug court, case managers or other staff help participants find safe, stable, and drug free housing.
3. Participants are not excluded from participation in drug court because they lack stable housing.

E. Mental Health Treatment⁹

1. Participants are assessed using a validated instrument for mental disorders.
2. Participants with mental disorders receive mental health services as needed throughout their participation in drug court.
3. Mental disorders and addiction should be treated concurrently using evidence-based interventions.
4. Participants receive psychiatric medication based on the participant's needs as determined by a qualified medical provider.
5. Drug courts do not prohibit admission of persons who have mental disorders or who are taking prescribed psychiatric medications. Participants are not required to discontinue legally prescribed psychiatric medication as a condition of graduating from drug court.

F. Trauma-Informed Services

1. Participants are assessed using a validated instrument for trauma history and symptoms; such as, but not limited to, post traumatic stress disorder (PTSD).
2. Participants with a history of trauma receive evidence-based treatment services.¹⁰
3. Trauma-informed services are provided in gender-specific groups and/or individual counseling sessions.
4. All drug court team members receive formal training related to trauma-informed services.

G. Criminal Thinking Interventions

1. Participants receive an evidence-based criminal thinking intervention, as needed, after they are stabilized.
2. Staff members are trained to administer a standardized and validated cognitive-behavioral criminal-thinking intervention; such as, Moral Reconciliation Therapy, the "Thinking for a Change" program, or the "Reasoning & Rehabilitation" program.

⁹ Refer to section VI. part E of the Commentary for a more detailed description of mental health treatment services.

¹⁰ Refer to section VI. part F of the Commentary for more information on evidence-based treatment interventions for post traumatic stress disorders.

H. Family and Interpersonal Counseling

1. When feasible, at least one reliable family member, friend, or daily acquaintance is enlisted to provide firsthand observations about a participant's conduct outside of the program.
2. After participants are stabilized clinically, they receive evidence-based, cognitive-behavioral interventions that focus on areas such as cognitive restructuring, communications skills, problem-solving, and relapse prevention.¹¹

I. Educational and Vocational Services

1. Participants receive educational and vocational services as needed throughout drug court.
2. Drug courts encourage participants to have a stable job or be enrolled in a vocational or educational program.

J. Medical and Dental Treatment¹²

1. Participants should be referred for medical or dental treatment as needed.
2. Assessment of trauma history and symptoms should also include Traumatic Brain Injury (TBI).

K. Prevention of Health-Risk Behaviors

1. Participants complete a brief evidence-based educational curriculum describing concrete measures they can take to reduce their exposure to sexually transmitted and other communicable diseases.

L. Overdose Prevention and Reversal

1. Participants complete a brief evidence-based educational curriculum describing concrete measures to prevent or reverse drug overdose.

¹¹ Refer to section VI. part H of the Commentary for more information.

¹² Refer to section VI. part J of the Commentary for more information.

VII. Drug and Alcohol Testing

Drug and alcohol testing provides an accurate, timely, and comprehensive assessment of unauthorized substance use throughout a participant's participation in the drug court.

A. Frequent Testing

1. Drug and alcohol testing is performed frequently to ensure substance use is detected quickly and reliably.
2. Drug and alcohol testing is performed at least twice per week for the duration of intensive phases of drug court treatment.
3. Tests that measure substance use over extended periods of time, such as ankle monitors, are applied for at least ninety consecutive days followed by urine or other intermittent testing methods.
4. Breathalyzers or oral fluid tests are utilized spontaneously when recent substance use is suspected or when substance use is more likely to occur; such as, during weekends or holidays.

B. Random Testing

1. The schedule of drug and alcohol testing is random and unpredictable. The probability of being tested on weekends and holidays is the same as on other days.
2. Participants are required to be tested as soon as practicable after being notified that a test has been scheduled.
3. Urine specimens are delivered no more than eight hours after being notified that a urine test has been scheduled.
4. For tests with short detection windows, such as oral fluid tests, specimens are delivered no more than four hours after being notified that a test was scheduled.

C. Duration of Testing

1. Drug and alcohol testing continues throughout the course of drug court participation to determine whether relapse occurs as other treatment and supervision services are adjusted.

D. Breadth of Testing

1. Specimens are tested for all unauthorized substances that are suspected to be used by the drug court participant.
2. Randomly selected specimens are tested periodically for a broader range of substances to detect new substances of abuse that might be emerging in the drug court population.

E. Witnessed Collection

1. Collection of test specimens is witnessed directly by a gender appropriate person, who has been trained to prevent tampering and substitution of fraudulent specimens.
2. Barring exigent circumstances, participants are not permitted to undergo independent drug or alcohol testing in lieu of being tested by trained personnel assigned to, or authorized by, the drug court.

F. Valid Specimens

1. Test specimens are examined routinely for dilution and adulteration.

G. Accurate and Reliable Testing Procedures

1. The drug court uses scientifically valid and reliable testing procedures and establishes a chain of custody for each specimen.
2. If a participant denies substance use in response to a positive screening test, a portion of the same specimen is subjected to confirmatory analysis using gas chromatography/mass spectrometry (GC/MS), liquid chromatography/mass spectrometry (LC/MS), or a similarly calibrated test.
3. Drug or metabolite concentrations falling below industry-or manufacturer-recommended cutoffs are not interpreted as evidence of new substance use or changes in participants' substance use patterns unless such a determination is based on specialized staff expertise in analyzing toxicology results.

H. Rapid Results

1. Test results, including the results of confirmation testing, are available to the drug court team within forty-eight hours of specimen collection.

I. Participant Contract

1. Upon entering the drug court, participants receive a clear and comprehensive explanation of their rights and responsibilities related to drug and alcohol testing. This information is described in a participant contract or handbook and reviewed periodically with participants to ensure they remain cognizant of their obligations.

VIII. Multidisciplinary Team

A multidisciplinary team participates in the operation of the drug court, reviews participant's progress, provides observations, makes recommendations, and delivers legal, treatment, and supervision services.

A. Team Composition

1. The multi-disciplinary drug court team includes, but is not limited to, a judge or judicial officer, program coordinator, prosecutor, defense counsel, treatment representative, additional service providers, community supervision officer, and law enforcement officer.

B. Pre-Court Staff Meetings

1. Team members consistently attend pre-court staff meetings to review a participant's progress, determine appropriate actions to improve outcomes, and prepare for status hearings in court.
2. Pre-court staff meetings are presumptively closed to participants and the public unless the court has a good reason for a participant to attend discussions related to that participant's case.

C. Team Communication and Decision-Making

1. Team members share information as necessary to assess a participant's progress in treatment and compliance with drug court conditions.
2. Partner agencies execute memoranda of understanding (MOUs) specifying what information will be shared among team members.
3. Participants provide voluntary and informed consent permitting team members to share specified information.
4. Defense counsel will advise the participant and drug court team members of information to be shared with the drug court team.
5. The court considers input from all team members before making decisions that affect the participant. The court explains the basis for its decisions to team members and participants.

D. Status Hearings

1. Team members attend status hearings on a consistent basis.
2. During the status hearings, team members contribute relevant information and recommendations when requested by the judge, or as necessary to improve outcomes, or to protect participant's legal interests.

E. Team Training

1. All drug court team members are trained in best practices prior to working in the drug court. Drug court teams should observe established drug courts that employ best practices.
2. Team members receive annual continuing education to gain up-to-date knowledge about best practices in drug court.
3. New staff hires receive a formal orientation training on the drug court model and best practices as soon as feasible.

IX. Census and Caseloads

The drug court serves as many eligible individuals as practicable while maintaining continuous fidelity to best practice standards.

A. Drug Court Census

1. The drug court does not impose arbitrary restrictions on the number of participants it serves.
2. The drug court census is predicated on local need, obtainable resources, and the program's ability to apply best practices.
3. When the census reaches 125 active participants, program operations are monitored carefully to ensure they remain consistent with best practice standards.

B. Supervision Caseloads

1. Probation officers should not maintain caseloads greater than 50 active participants.
2. Supervision includes monitoring participant performance, applying effective behavioral consequences, and reporting compliance information during pre-court staff meetings and status hearings.

C. Clinical Caseloads

1. Caseloads for clinicians must permit sufficient opportunities to assess participant needs and deliver adequate and effective dosages of substance abuse treatment and indicated additional services.
2. Program operations are monitored carefully to ensure adequate services are delivered when caseloads exceed the following thresholds:
 - 50 active participants for clinicians providing clinical case management.
 - 40 active participants for clinicians providing individual therapy or counseling.
 - 30 active participants for clinicians providing both clinical case management and individual therapy or counseling.
3. To ensure quality of services, treatment process groups or skills-based groups typically include no more than 12 participants.

X. Monitoring and Evaluation

The drug court routinely monitors its adherence to best practice standards and employs scientifically valid and reliable procedures to evaluate its effectiveness.

A. Adherence to Best Practices

1. The drug court monitors its adherence to best practice standards on at least an annual basis, develops a remedial action plan and timetable to rectify deficiencies, and examines the success of the remedial actions.
2. Outcome evaluations describe the effectiveness of the drug court in the context of its adherence to best practices.

B. In-Program Outcomes

1. The drug court continually monitors participant outcomes, including attendance at scheduled appointments, drug and alcohol test results, lengths of stay¹³, educational/vocational goal achievements, and in-program technical violations and new arrests.
2. The drug court annually monitors retention and graduation rates.

C. Criminal Recidivism

1. Where such information is available, new arrests, new convictions, and new incarcerations are monitored for at least three years following each participant's entry into drug court.
2. Offenses are categorized according to the level and nature of the crime involved.

D. Independent Evaluations

1. A skilled and independent evaluator examines the drug court's adherence to best practices and participant outcomes at least every five years.
2. The drug court develops a remedial action plan and timetable to implement recommendations from the evaluator.

E. Disadvantaged Groups

1. The drug court continually monitors admission rates, services delivered, and outcomes achieved for members of disadvantaged groups who are represented in the drug court program.

¹³ Lengths of stay is defined as the number of days from entry to discharge or the participant's last in-person contact with staff. Refer to section X. part B of the commentary for more information.

2. The drug court develops a remedial action plan and timetable to correct disparities and examines the success of the remedial actions.

F. Electronic Database

1. Information relating to the services provided and participant's in-program performance is entered into an electronic database on a timely basis. Staff members record information concerning the provision of services and in-program outcomes within forty-eight hours of the respective events.
2. Staff are provided statistical summaries from the database with real-time participant information.

G. Intent-to-Treat Analyses

1. Outcomes are examined for all eligible participants who entered the drug court regardless of whether they graduated, withdrew, or were terminated from the program.

H. Comparison Groups

1. Outcomes for drug court participants are compared to those of an unbiased and equivalent comparison group.
2. Individuals in the comparison group satisfy legal and clinical eligibility criteria for participation in the drug court, but did not enter the drug court for reasons having no relationship to their outcomes.
3. Comparison groups do not include individuals who refused to enter the drug court, withdrew or were terminated from the drug court, or were denied entry to the drug court because of their legal charges, criminal history, or clinical assessment results.

I. Time at Risk¹⁴

1. Whenever feasible, outcomes for drug court participants and the comparison group are examined over an equivalent time period that begins with a similar start date.
2. Statistical controls are used to account for any differences between drug court participants and comparison groups "at risk" for various outcomes of interest (e.g., criminal recidivism, substance use). These differences may occur, for example, when persons are incarcerated or detained in a residential facility.

¹⁴ Refer to section X. part I for more information on "Time at Risk" in the context of evaluation.

Appendix A

State of Florida

Adult Drug Court Best Practice Standards

Commentary

This commentary was borrowed from the National Association of Drug Court Professionals (NADCP) Adult Drug Court Best Practice Standards, Vol. I, (2013) and Vol. II, (2015). The NADCP commentary is included here to provide the foundation of research, analysis, and evidence-based practices on which the standards are based. Some terminology has been adapted for use with the Florida Adult Drug Court Best Practice Standards. Significant differences between the NADCP Standards and Florida Standards are noted where appropriate.

I. Target Population

A. Eligibility and Exclusion Criteria

Studies have found that the admissions process in many drug courts included informal or subjective selection criteria, multiple gatekeepers, and numerous opportunities for candidates to be rejected from the programs (Belenko et al., 2011). Removing subjective eligibility restrictions and applying evidence-based selection criteria significantly increases the effectiveness and cost-effectiveness of drug courts by allowing them to serve the most appropriate target population (Bhati et al., 2008; Sevigny et al., 2013).

Some drug courts may screen candidates for their *suitability* for the program based on the team’s subjective impressions of the offender’s motivation for change or readiness for treatment. Suitability determinations have been found to have no impact on drug court graduation rates or postprogram recidivism (Carey & Perkins, 2008; Rossman et al., 2011). Because they have the potential to exclude individuals from drug courts for reasons that are empirically invalid, subjective suitability determinations should be avoided.

B. Risk and Need

A substantial body of research indicates which types of offenders are most in need of the full range of interventions embodied in the *Ten Key Components of Drug Courts* (NADCP, 1997). These are the offenders who are (1) addicted to or dependent on illicit drugs or alcohol and (2) at high risk for criminal recidivism or failure in less intensive rehabilitative dispositions. Drug courts that focus their efforts on these individuals—commonly referred to as high-risk/high-need offenders—reduce crime approximately twice as much as those serving less serious offenders (Cissner et al., 2013; Fielding et al., 2002; Lowenkamp et al., 2005) and return approximately 50% greater cost savings to their communities (Bhati et al., 2008; Carey et al., 2008, 2012; Downey & Roman, 2010).

It may not always be feasible for drug courts to target high-risk and high-need offenders. To gain the cooperation of prosecutors or other stakeholders, some drug courts may need to begin by treating less serious offenders and then expand their eligibility criteria after they have proven the safety and effectiveness of their programs. In addition, some drug courts may not have statutory authorization or adequate resources to treat high-risk or high-need offenders. Under such circumstances, research indicates the programs should modify their services to provide a lower intensity of supervision, substance abuse treatment, or both. Otherwise, the programs risk

wasting resources or making outcomes worse for some of their participants (Lowenkamp & Latessa, 2004). Providing substance abuse treatment for nonaddicted substance abusers can lead to higher rates of reoffending or substance abuse or a greater likelihood of these individuals eventually becoming addicted (Lovins et al., 2007; Lowenkamp & Latessa, 2005; Szalavitz, 2010; Wexler et al., 2004). In particular, mixing participants with different risk or need levels together in treatment groups or residential facilities can make outcomes worse for the low-risk or low-need participants by exposing them to antisocial peers or interfering with their engagement in productive activities, such as work or school (DeMatteo et al., 2006; Lowenkamp & Latessa, 2004; McCord, 2003; Petrosino et al., 2000). A free publication from the NDCI provides evidence-based recommendations for developing alternative tracks in drug courts for low-risk and low-need participants.

Some evidence suggests drug courts may have better outcomes if they target offenders either on a pre- or postadjudication basis and do not mix these populations (Shaffer, 2006). Other studies have found no differences in outcomes regardless of whether these populations were served alone or in combination (Carey et al., 2012). It is premature to conclude whether it is appropriate to mix pre- and postadjudication populations in drug courts; however, drug courts must be mindful of the fact that the populations may differ significantly in terms of their risk or need levels. They should not be treated in the same counseling groups or residential facilities if their treatment needs or criminal propensities are significantly different.

C. Validated Eligibility Assessments

Standardized assessment tools are significantly more reliable and valid than professional judgment for predicting success in correctional supervision and matching offenders to appropriate treatment and supervision services (Andrews et al., 2006; Miller & Shutt, 2001; Wormith & Goldstone, 1984). Drug courts that employ standardized assessment tools to determine candidates' eligibility for the program have significantly better outcomes than drug courts that do not use standardized tools (Shaffer, 2010).

Eligibility assessments should be performed along the dimensions of both risk and need to match offenders to appropriate levels of criminal justice supervision and treatment services, respectively (Andrews & Bonta, 2010; Casey et al., 2011; Marlowe, 2009). Most substance abuse screening tools are not sufficient for this purpose because they do not accurately differentiate substance dependence or addiction from lesser degrees of substance abuse or substance involvement (Greenfield & Hennessy, 2008; Stewart, 2009). A structured psychiatric interview is typically required to make a valid diagnosis of substance dependence or addiction and thus to ensure that a drug court is serving the target population. Appendix A provides information on how to obtain risk and need assessment tools that have been validated for use with addicted individuals in substance abuse treatment or the criminal justice system.

D. Criminal History Disqualifications

Some drug courts serve only individuals charged with drug-possession offenses or may disqualify offenders who are charged with or have a history of a serious felony. Research reveals, however, that drug courts yielded nearly twice the cost savings when they served addicted individuals charged with felony theft and property crimes (Carey et al., 2008, 2012). Drug courts that served only drug-possession cases typically offset crimes that did not involve high victimization or incarceration costs, such as petty theft, drug possession, trespassing, and traffic offenses (Downey & Roman, 2010). As a result, the investment costs of the programs were not recouped by the modest cost savings that were achieved from reduced recidivism. The most cost-effective drug courts focused their efforts on reducing serious felony offenses that are most costly to their communities.

Mixed outcomes have been reported for violent offenders in drug courts. Several studies found that participants who were charged with violent crimes or had histories of violence performed as well or better than nonviolent participants in drug courts (Carey et al., 2008, 2012; Saum & Hiller, 2008; Saum et al., 2001). However, two meta-analyses reported significantly smaller effects for drug courts that admitted violent offenders (Mitchell et al., 2012; Shaffer, 2010). The most likely explanation for this discrepancy is that some of the drug courts might

not have provided adequate services to meet the need and risk levels of violent offenders. If adequate treatment and supervision are available, there is no empirical justification for routinely excluding violent offenders from participation in drug courts.

Although research is sparse on this point, there also appears to be no justification for routinely excluding individuals charged with drug dealing from participation in drug courts, providing they are drug addicted. Evidence suggests such individuals can perform as well (Marlowe et al., 2008) or better (Cissner et al., 2013) than other participants in drug court programs. An important factor to consider in this regard is whether the offender was dealing drugs to support an addiction or solely for purposes of financial gain. If drug dealing serves to support an addiction, the participant might be a good candidate for a drug court.

E. Clinical Disqualifications

Appellate cases in some jurisdictions permit drug courts to exclude offenders who require more intensive psychiatric or medical services than the program is capable of delivering (Meyer, 2011). Assuming, however, that adequate services are available, there is no empirical justification for excluding addicted offenders with co-occurring mental health or medical problems from participation in drug courts. A national study of twenty-three adult drug courts, called the Multisite Adult Drug Court Evaluation (MADCE), found that drug courts were equivalently effective for a wide range of participants regardless of their mental health conditions (Rempel et al., 2012; Zweig et al., 2012). Another study of approximately seventy drug courts found that programs that excluded offenders with serious mental health issues were significantly less cost-effective and had no better impact on recidivism than drug courts that did not exclude such individuals (Carey et al., 2012). Because mentally ill offenders are likely to cycle in and out of the criminal justice system and to utilize expensive emergency room and crisis-management resources, intervening with these individuals in drug courts (assuming they are drug addicted and at high risk for treatment failure) has the potential to produce substantial cost savings (Rossman et al., 2012; Skeem et al., 2011).

It is unclear how severe the mental health problems were in the above-referenced studies because psychiatric diagnoses were not reported. A Mental Health Court, Co-Occurring Disorder Court or other psychiatric specialty program might be preferable to a drug court for treating an individual with a major psychiatric disorder, such as a psychotic or bipolar disorder. Research does not provide a clear indication of how to make this determination. The best course of action is to carefully assess offenders along the dimensions of risk and need and match them to the most suitable programs that are available in their community. It is not justifiable to have an across-the-board exclusion from drug court for addicted offenders who are suffering from mental health problems or conditions.

Finally, numerous controlled studies have reported significantly better outcomes when addicted offenders received medically assisted treatments including opioid antagonist medications such as naltrexone, opioid agonist medications such as methadone, and partial agonist medications such as buprenorphine (Chandler et al., 2009; Finigan et al., 2011; National Institute of Drug Abuse, 2006). Therefore, a valid prescription for such medications should not serve as the basis for a blanket exclusion from a drug court (Parrino, 2002). A unanimous resolution of the NADCP Board of Directors provides that drug courts should engage in a fact-sensitive inquiry in each case to determine whether and under what circumstances to permit the use of medically assisted treatments. This inquiry should be guided in large measure by input from physicians with expertise in addiction psychiatry or addiction medicine [see also Standard V, Substance Abuse Treatment].

II. Disadvantaged Groups

Drug courts are first and foremost courts, and the fundamental principles of due process and equal protection apply to their operations (Meyer, 2011). Drug courts have an affirmative legal and ethical obligation to provide equal access to their services and equivalent treatment for all citizens.

In June of 2010, the Board of Directors of the NADCP passed a unanimous resolution (hereafter minority resolution) directing Drug courts to examine whether unfair disparities exist in their programs for racial or ethnic minority participants; and if so, to take reasonable corrective measures to eliminate those disparities (NADCP, 2010). The minority resolution places an affirmative obligation on drug courts to continually monitor whether minority participants have equal access to the programs, receive equivalent services in the programs, and successfully complete the programs at rates equivalent to nonminorities. It further instructs drug courts to adopt evidence-based assessment tools and clinical interventions, where they exist, that are valid and effective for use with minority participants and requires staff members to attend up-to-date training events on the provision of culturally sensitive and culturally proficient services.

The NADCP minority resolution focuses on racial and ethnic minority participants for two reasons. First, these groups are *suspect classes* pursuant to constitutional law and therefore receive heightened scrutiny and protections from the courts. Second, most of the available research on disproportionate impacts in drug courts has focused on African-American and Hispanic or Latino individuals because these individuals were represented in sufficient numbers in the studies for the evaluators to conduct separate analyses on their behalf. Nevertheless, the same principles of fundamental fairness apply to all historically disadvantaged groups that have experienced sustained periods of discrimination or reduced social opportunities. As a practical matter, drug courts can only be required to take remedial actions based on characteristics of participants that are readily observable or have been brought to the attention of the court. Such observable characteristics will typically include participants' gender, race or ethnicity.

A. Equivalent Access

Evidence suggests African-American and Hispanic or Latino citizens may be underrepresented by approximately 3% to 7% in drug courts. National studies have estimated that approximately 21% of drug court participants are African-American and 10% are Hispanic or Latino (Bureau of Justice Assistance, 2012; Huddleston & Marlowe, 2011). In contrast, approximately 28% of arrestees and probationers were African-American and approximately 13% of probationers were Hispanic or Latino. Additional research is needed to examine the representation of other historically disadvantaged groups in drug courts. Some commentators have suggested that unduly restrictive eligibility criteria might be partly responsible for the lower representation of minority persons in drug courts (Belenko et al., 2011; O'Hear, 2009). It has been suggested, for example, that African-Americans or Hispanics may be more likely than Caucasians to have prior felony convictions or other entries in their criminal records that disqualify them from participation in drug court (National Association of Criminal Defense Lawyers [NACDL], 2009; O'Hear, 2009). Although there is no empirical evidence to confirm this hypothesis, drug courts must ensure that their eligibility criteria do not unnecessarily exclude minorities or members of other historically disadvantaged groups. If an eligibility criterion has the unintended impact of differentially restricting access to the drug court for such persons, then extra assurances are required that the criterion is necessary for the program to achieve effective outcomes or protect public safety. If less restrictive adjustments can be made to an eligibility requirement to increase the representation of members of a historically disadvantaged group without jeopardizing public safety or efficacy, the drug court is obligated to make those adjustments. Although an unintended discriminatory impact may not always be constitutionally objectionable (*Washington v. Davis*, 1976), it is nevertheless inconsistent with best practices in drug courts and with the NADCP minority resolution.

Drug courts cannot assume that the assessment tools they use to determine candidates' eligibility for the program—which are often validated on samples comprising predominantly Caucasian males—are valid for use with minorities, females, or members of other demographic subgroups (Burlew et al., 2011; Huey & Polo, 2008). Studies have found that women and racial or ethnic minorities interpreted test items differently than other test respondents, making the test items less valid for the women or minorities (Carle, 2009; Perez & Wish, 2011; Wu

et al., 2010). Therefore, where available, drug courts have a responsibility to select tools that have been validated for use with members of historically disadvantaged groups that are represented among the candidates for the program. If such tools do not exist, then at a minimum the drug court should elicit feedback from the participants about the clarity, relevance, and cultural sensitivity of the tools it is using. Ideally, the drug court should engage an evaluator to empirically validate the tools among the candidates for the program.

The Alcohol and Drug Abuse Institute Library at the University of Washington has an online catalog of screening and assessment tools created for use in substance abuse treatment. Each instrument can be searched for research studies, if any, that have examined its validity and reliability among women and racial or ethnic minorities.

B. Equivalent Retention

Numerous studies have reported that a significantly smaller percentage of African-American or Hispanic participants graduated successfully from drug court as compared to non-Hispanic Caucasians (Finigan, 2009; Marlowe, 2013). In several of the studies, the magnitude of the discrepancy was as high as 25% to 40% (Belenko, 2001; Sechrest & Shicor, 2001; Wiest et al., 2007). These findings are not universal, however. A smaller but growing number of evaluations has found no differences in outcomes or even superior outcomes for racial minorities as compared to Caucasians (Brown, 2011; Cissner et al., 2013; Fulkerson, 2012; Saum et al., 2001; Somers et al., 2012; Vito & Tewksbury, 1998). Nevertheless, African-Americans appear less likely to succeed in a plurality of drug courts as compared to their nonracial minority peers.

To the extent such disparities exist, evidence suggests they might not be a function of race or ethnicity per se, but rather might be explained by broader societal burdens that are often borne disproportionately by minorities, such as lesser educational or employment opportunities or a greater infiltration of crack cocaine into some minority communities (Belenko, 2001; Dannerbeck et al., 2006; Fosados, et al., 2007; Hartley & Phillips, 2001; Miller & Shutt, 2001). When evaluators accounted statistically for these confounding factors, the influence of race or ethnicity disappeared (Dannerbeck et al., 2006). Interviews and focus groups conducted with racial minority participants have suggested that drug courts may be paying insufficient attention to employment and educational problems that are experienced disproportionately by minority participants (Cresswell & Deschenes, 2001; DeVall & Lanier, 2012; Gallagher, 2013; Leukefeld et al., 2007).

These findings require drug courts to determine whether racial or ethnic minorities or members of other historically disadvantaged groups are experiencing poorer outcomes in their programs as compared to other participants and to investigate and remediate any disparities that are detected. One low-cost and effective strategy is to confidentially survey participants and staff members about their perceptions of disparate treatment and outcomes in the program (Casey et al., 2012; Sentencing Project, 2008). Programs that continually solicit feedback about their performance in the areas of cultural competence and cultural sensitivity learn creative ways to address the needs of their participants and produce better outcomes as a result (Szapocznik et al., 2007). Drug courts are further encouraged to engage independent evaluators to objectively identify areas requiring improvement to meet the needs of minorities and members of other historically disadvantaged groups (Carey et al., 2012; Rubio et al., 2008).

C. Equivalent Treatment

Racial and ethnic minorities often receive lesser quality treatment than nonminorities in the criminal justice system (Brocato, 2013; Janku & Yan, 2009; Fosados et al., 2007; Guerrero et al., 2013; Huey & Polo, 2008; Lawson & Lawson, 2013; Marsh et al., 2009; Schmidt et al., 2006). A commonly cited example of this phenomenon relates to California Proposition 36, the Substance Abuse and Crime Prevention Act of 2000, a statewide diversion initiative for nonviolent drug possession offenders. A several-year study of Proposition 36 (Nicosia et al., 2012; Integrated Substance Abuse Programs, 2007) found that Hispanic participants were significantly less likely than Caucasians to be placed in residential treatment for similar patterns of drug abuse, and African-Americans were less likely to receive medically assisted treatment for addiction. To date, no empirical studies have determined whether there are such disparities in the quality of treatment in drug courts. The NADCP minority resolution directs drug courts to remain vigilant to potential differences in the quality or intensity of services provided to minority participants and to institute corrective measures where indicated.

Drug courts must also ensure that the treatments they provide are valid and effective for members of historically disadvantaged groups in their programs. Because women and racial minorities are often underrepresented in clinical trials of addiction treatments, the treatments are frequently less beneficial for these individuals (Burlew et al., 2011; Calsyn et al., 2009). The Substance Abuse and Mental Health Services Administration (SAMHSA) maintains an internet directory of evidence-based treatments called the National Registry of Evidence-Based Programs and Practices (NREPP). The NREPP Web site may be searched specifically for interventions that have been evaluated among substantial numbers of racial and ethnic minority participants, women, and members of some other historically disadvantaged groups.

A small but growing number of treatments have been tailored specifically to meet the needs of women or racial minority participants in drug courts. In one study, outcomes were improved significantly for young African-American male participants when an experienced African-American clinician delivered a curriculum that addressed issues commonly confronting these young men, such as negative racial stereotypes (Vito & Tewksbury, 1998). Efforts are underway to examine the intervention used in that study—habilitation, empowerment & accountability therapy (HEAT)—in a controlled experimental study.

Studies indicate the success of culturally tailored treatments depends largely on the training and skills of the clinicians delivering the services (Castro et al., 2010; Hwang, 2006). Unless the clinicians attend comprehensive training workshops and receive ongoing supervision on how to competently deliver the interventions, outcomes are unlikely to improve for women and minority participants.

D. Equivalent Incentives and Sanctions

Some commentators have questioned whether racial or ethnic minority participants are sanctioned more severely than nonminorities in drug courts for comparable infractions. Anecdotal observations have been cited to support this concern (NACDL, 2009) and minority participants in at least one focus group did report feeling more likely than other participants to be ridiculed or laughed at during court sessions in response to violations (Gallagher, 2013). No empirical study, however, has borne out the assertion. To the contrary, what little research has been conducted suggests drug courts and other problem-solving courts appear to administer sanctions in a racially and ethnically even-handed manner (Arabia et al., 2008; Callahan et al., 2013; Frazer, 2006; Guastaferrro & Daigle, 2012; Jeffries & Bond, 2012). Considerably more research is required to study this important issue in a systematic manner and in a representative range of drug courts. The NADCP minority resolution places an affirmative obligation on drug courts to continually monitor whether sanctions and incentives are being applied equivalently for minority participants and to take corrective actions if discrepancies are detected.

E. Equivalent Dispositions

Concerns have similarly been expressed that racial or ethnic minority participants might be sentenced more harshly than nonminorities for failing to complete drug court (Drug Policy Alliance, 2011; Justice Policy Institute, 2011; O’Hear, 2009). This is an important matter because, as discussed previously, minorities may be more likely than nonminorities to be terminated from drug courts. Although the matter is far from settled, evidence from at least one study suggests that participants who were terminated from drug court did receive harsher sentences than traditionally adjudicated defendants who were charged with comparable offenses (Bowers, 2008). There is no evidence, however, to indicate whether this practice differentially impacts minorities or members of other historically disadvantaged groups. In fact, one study in Australia found that indigenous minority drug court participants were *less* likely than nonminorities to be sentenced to prison (Jeffries & Bond, 2012). Nevertheless, due process and equal protection require drug courts to remain vigilant to the possibility of sentencing disparities in their programs and to take corrective actions where indicated.

F. Team Training

One of the most significant predictors of positive outcomes for racial and ethnic minority participants in substance abuse treatment is culturally sensitive attitudes on the part of the treatment staff, especially managers and

supervisors (Ely & Thomas, 2001; Guerrero, 2010). When managerial staff value diversity and respect their clients' cultural backgrounds, the clients are retained significantly longer in treatment and services are delivered more efficiently (Guerrero & Andrews, 2011). Cultural-sensitivity training can enhance counselors' and supervisors' beliefs about the importance of diversity and the need to understand their clients' cultural backgrounds and influences (Cabaj, 2008; Westermeyer, & Dickerson, 2008).

Effective cultural-sensitivity curricula focus, in part, on identifying and examining the (often implicit or unconscious) biases that may be held by staff members about their clients (Greenwald & Banaji, 1995; Kang, 2005). Although the issue of implicit bias has not been studied in drug courts, it has been shown to negatively affect judicial decision-making in traditional criminal courts (Marsh, 2009; Rachlinski et al., 2009; Seamone, 2009). Cultural-sensitivity training can assist court staff to recognize and resolve prejudicial thoughts or beliefs they might hold but might not be aware of.

Merely sensitizing court staff to cultural concerns is not sufficient. Drug courts need to go considerably further and teach staff concrete strategies to correct any problems that are identified and remediate disparities in services and outcomes. This includes teaching staff members how to apply research-based performance-monitoring procedures to identify and rectify disparate impacts (Casey et al., 2012; Rubio et al., 2008; Yu et al., 2009). One goal of cultural-sensitivity training is to underscore the importance of recognizing implicit bias; however, unless drug courts focus equally on finding concrete and feasible solutions to biases that are identified, little positive change is likely to occur.

III. Roles and Responsibilities of the Judge

A. Professional Training

All team members in drug courts should attend annual training workshops on best practices in drug courts. The importance of training is emphasized specifically for judges because research indicates the judge exerts a unique and substantial impact on outcomes in drug courts (Carey et al., 2012; Jones, 2013; Jones & Kemp, 2013; Marlowe et al., 2006; Zweig et al., 2012).

Judges in drug courts have a professional obligation to remain abreast of legal, ethical and constitutional requirements related to drug court practices (Meyer, 2011; Meyer & Tauber, 2011). In addition, outcomes are significantly better when the drug court judge attends annual training conferences on evidence-based practices in substance abuse and mental health treatment and community supervision (Carey et al., 2008, 2012; Shaffer, 2010). A national study of twenty-three adult drug courts, called the Multisite Adult Drug Court Evaluation (MADCE), found that drug courts produced significantly greater reductions in crime and substance abuse when the judges were rated by independent observers as being knowledgeable about substance abuse treatment (Zweig et al., 2012). Similarly, a statewide study in New York reported significantly better outcomes when drug court judges were perceived by the participants as being open to learning about the disease of addiction (Farole & Cissner, 2007).

The increasing availability of webinars and other distance-learning programs has made it considerably more affordable and feasible for judges to stay abreast of evidence-based practices. Organizations including the NDCI, Center for Court Innovation, National Center for State Courts, and American University offer, free of charge, live and videotaped webinars on various topics related to best practices in drug courts. Appendix B provides further information about these webinars.

B. Length of Term

A study of approximately seventy drug courts found nearly three times greater cost savings and significantly lower recidivism when the judges presided over the drug courts for at least two consecutive years (Carey et al., 2008, 2012). Significantly greater reductions in crime were also found when the judges were assigned to the drug courts on a voluntary basis and their term on the drug court bench was indefinite in duration (Carey et al., 2012). Evidence suggests many drug court judges are significantly less effective at reducing crime during their first year on the drug court bench than during ensuing years (Finigan et al., 2007). Presumably, this is because judges, like most professionals, require time and experience to learn how to perform their jobs effectively. For this reason, annually rotating assignments appear to be contraindicated for judges in drug courts.

C. Consistent Docket

Drug courts that rotated their judicial assignments or required participants to appear before alternating judges had the poorest outcomes in several research studies (Finigan et al., 2007; National Institute of Justice, 2006). Participants in drug courts commonly lead chaotic lives, and they often require substantial structure and consistency in order to change their maladaptive behaviors. Unstable staffing patterns, especially when they involve the central figure of the judge, are apt to exacerbate rather than ameliorate the disorganization in participants' lives.

D. Participation in Pre-Court Staff Meetings

Studies have found that outcomes were significantly better in drug courts where the judges regularly attended pre-court staff meetings (Carey et al., 2008, 2012). Pre-court staff meetings are where team members share their observations and impressions about each participant's performance in the program and propose consequences for the judge to consider (McPherson & Sauder, 2013). The judge's presence at the staff meetings ensures that each team member's perspective is taken into consideration when important decisions are made in the case.

Observational studies suggest that when judges do not attend pre-court staff meetings, they are less likely to be adequately informed or prepared when they interact with the participants during court hearings (Baker, 2012; Portillo et al., 2013).

E. Frequency of Status Hearings

A substantial body of experimental and quasi-experimental research establishes the importance of scheduling status hearings no less frequently than every two weeks (biweekly) during the first phase of a drug court. In a series of experiments, researchers randomly assigned drug court participants to either appear before the judge every two weeks for status hearings or to be supervised by their clinical case managers and brought into court only in response to repetitive rule violations. The results revealed that high-risk participants had significantly better counseling attendance, drug abstinence, and graduation rates when they were required to appear before the judge every two weeks (Festinger et al., 2002). This finding was replicated in misdemeanor and felony drug courts serving urban and rural communities (Jones, 2013; Marlowe et al., 2004a, 2004b). It was subsequently confirmed in prospective matching studies in which the participants were assigned at entry to biweekly hearings if they were determined to be high risk (Marlowe et al., 2006, 2007, 2008, 2009, 2012).

Similarly, a meta-analysis involving ninety-two adult drug courts (Mitchell et al., 2012) and another study of nearly seventy drug courts (Carey et al., 2012) found significantly better outcomes for drug courts that scheduled status hearings every two weeks during the first phase of the program. Scheduling status hearings at least once per month until the last phase of the program was also associated with significantly better outcomes and nearly three times greater cost savings (Carey et al., 2008, 2012).

F. Length of Court Interactions

In a study of nearly seventy adult drug courts, outcomes were significantly better when the judges spent an average of at least three minutes, and as much as seven minutes, interacting with the participants during court sessions (Carey et al., 2008, 2012). Shorter interactions may not allow the judge sufficient time to gauge each participant's performance in the program, intervene on the participant's behalf, impress upon the participant the importance of compliance with treatment, or communicate that the participant's efforts are recognized and valued by staff.

G. Judicial Demeanor

Studies have consistently found that drug court participants perceived the quality of their interactions with the judge to be among the most influential factors for success in the program (Farole & Cissner, 2007; Goldkamp et al., 2002; Jones & Kemp, 2013; National Institute of Justice, 2006; Satel, 1998; Saum et al., 2002; Turner et al., 1999). The MADCE study found that significantly greater reductions in crime and substance use were produced by judges who were rated by independent observers as being more respectful, fair, attentive, enthusiastic, consistent and caring in their interactions with the participants in court (Zweig et al., 2012). Similarly, a statewide study in New York reported significantly better outcomes for judges who were perceived by the participants as being fair, sympathetic, caring, concerned, understanding and open to learning about the disease of addiction (Farole & Cissner, 2007). In contrast, outcomes were significantly poorer for judges who were perceived as being arbitrary, jumping to conclusions, or not giving participants an opportunity to explain their sides of the controversies (Farole & Cissner, 2007; Zweig et al., 2012). Program evaluations have similarly reported that supportive comments from the judge were associated with significantly better outcomes in drug courts (Senjo & Leip, 2001) whereas stigmatizing, hostile, or shaming comments from the judge were associated with significantly poorer outcomes (Miethe et al., 2000).

These findings are consistent with a body of research on procedural fairness or procedural justice. The results of those studies indicated that criminal defendants and other litigants were more likely to have successful outcomes and favorable attitudes towards the court system when they were treated with respect by the judge, given an opportunity to explain their sides of the controversies, and perceived the judge as being unbiased and benevolent

in intent (Burke, 2010; Burke & Leben, 2007; Frazer, 2006). This in no way prevents judges from holding participants accountable for their actions, or from issuing stern warnings or punitive sanctions when they are called for. The dispositive issue is not the outcome of the judge's decision, but rather how the decision was reached and how the participant was treated during the interaction.

H. Judicial Decision Making

Due process and judicial ethics require judges to exercise independent discretion when resolving factual controversies, administering sanctions or incentives that affect a participant's fundamental liberty interests, or ordering the conditions of supervision (Meyer, 2011). A drug court judge may not delegate these responsibilities to other members of the drug court team. For example, it is not permissible for a drug court team to vote on what consequences to impose on a participant unless the judge considers the results of the vote to be merely advisory. Judges are, however, required to consider probative evidence or relevant information when making these determinations. Because judges are not trained to make clinical diagnoses or select treatment interventions, they ordinarily require expert input from treatment professionals to make treatment-related decisions. The collaborative nature of the drug court model brings together experts from several professional disciplines, including substance abuse treatment, to share their knowledge and observations with the judge, thus enabling the judge to make rational and informed decisions (Hora & Stalcup, 2008).

IV. Incentives, Sanctions, and Therapeutic Adjustments

A. Advance Notice

Numerous studies reported significantly better outcomes when drug courts developed a coordinated sanctioning strategy that was communicated in advance to team members and participants. A national study of twenty-three adult drug courts, called the Multisite Adult Drug Court Evaluation (MADCE), found significantly better outcomes for drug courts that had a written schedule of predictable sanctions that was shared with participants and staff members (Zweig et al., 2012). Another study of approximately forty-five drug courts found 72% greater cost savings for drug courts that shared their sanctioning regimen with all team members (Carey et al., 2008a, 2012). A meta-analysis of approximately sixty studies involving seventy drug courts found significantly better outcomes for drug courts that had a formal and predictable system of sanctions (Shaffer, 2010). Finally, statewide studies of eighty-six adult drug courts in New York (Cissner et al., 2013) and twelve adult drug courts in Virginia (Cheesman & Kunkel, 2012) found significantly better outcomes for drug courts that provided participants with written sanctioning guidelines and followed the procedures in the guidelines.

Meta-analyses of voucher-based positive reinforcement programs have similarly reported superior outcomes for programs that communicated their policies and procedures to participants and staff members (Griffith et al., 1999; Lussier et al., 2006). To be most effective, drug courts should describe to participants the expectations for earning positive reinforcement and the manner in which rewards will be administered (Burdon et al., 2001; Stitzer, 2008).

Evidence from the MADCE also suggests that drug courts should remind participants frequently about what is expected of them in the program and the likely consequences of success or failure (Zweig et al., 2012). Significantly higher retention rates were produced in another study when staff members in drug courts consistently reminded participants about their responsibilities in treatment and the consequences that would ensue from graduation or termination (Young & Belenko, 2002).

Drug courts should not, however, apply a rigid template when administering sanctions and incentives. Two of the above studies reported significantly better outcomes when the drug court team reserved a reasonable degree of discretion to modify a presumptive consequence in light of the facts presented in each case (Carey et al., 2012; Zweig et al., 2012). This empirical finding is consistent with legal and ethical requirements that drug court judges must exercise independent discretion when resolving factual controversies and imposing punitive consequences [See Standard III, Roles and Responsibilities of the Judge].

Because certainty is a critical factor in behavior modification programs (Marlowe & Kirby, 1999), discretion should generally be limited to modifying the magnitude of the consequence as opposed to withholding a consequence altogether. Drug courts that intermittently failed to impose sanctions for infractions had significantly poorer outcomes in at least one large statewide study (Cissner et al., 2013). Withholding a consequence is appropriate only if subsequent information suggests an infraction or achievement did not in fact occur. For example, a sanction should be withheld if a participant's absence from treatment had been excused in advance by staff.

B. Opportunity to be Heard

A substantial body of research on procedural justice or procedural fairness reveals that criminal defendants are most likely to react favorably to an adverse judgment or punitive sanction if they believe fair procedures were followed in reaching the decision. The best outcomes were achieved when defendants were (1) given a reasonable opportunity to explain their side of the dispute, (2) treated in an equivalent manner to similar people in similar circumstances and (3) accorded respect and dignity throughout the process (Burke & Leben, 2007; Frazer, 2006; Tyler, 2007).

In the MADCE study, outcomes were significantly better when participants perceived the judge as fair and when independent observers rated the judge's interactions with the participants as respectful, fair, consistent, and predictable (Rossman et al., 2011). In contrast, outcomes were significantly poorer for judges who were rated as being arbitrary or not giving participants an opportunity to explain their side of the controversy (Farole & Cissner, 2007; Rossman et al., 2011). Stigmatizing, hostile, and shaming comments from the judge have also been associated with significantly poorer outcomes in drug courts (Gallagher, 2013; Miethe et al., 2000).

C. Equivalent Consequences

See Commentary B above.

D. Progressive Sanctions

Sanctions are less effective at low and high magnitudes than in the intermediate range (Marlowe & Kirby, 1999; Marlowe & Wong, 2008). Sanctions that are weak in magnitude can cause *habituation* in which the individual becomes accustomed, and thus less responsive, to punishment. Sanctions that are severe in magnitude can lead to *ceiling effects* in which the program runs out of sanctions before treatment has had a chance to take effect. The most effective drug courts develop a wide and creative range of intermediate- magnitude sanctions that can be ratcheted upward or downward in response to participants' behaviors (Marlowe, 2007). The NDCI publishes, free of charge, lists of sanctions and incentives of varying magnitudes that have been collected from hundreds of drug courts around the country.

Significantly better outcomes are achieved when the sanctions for failing to meet difficult goals increase progressively in magnitude over successive infractions (Harrell & Roman, 2001; Harrell et al., 1999; Hawken & Kleiman, 2009; Kilmer et al., 2012; National Institute on Drug Abuse, 2006). Providing gradually escalating sanctions for difficult goals gives treatment a chance to take effect and prepares participants to meet steadily increasing responsibilities in the program. In contrast, applying high- magnitude sanctions for failing to meet easy goals avoids habituation (Marlowe, 2011).

E. Licit Additive or Intoxicating Substances

Consequences should be imposed for the nonmedically indicated use of intoxicating and addictive substances, including alcohol, cannabis (marijuana), and prescription medications, regardless of the licit or illicit status of the substance. Ingestion of alcohol and cannabis gives rise to further criminal activity (Bennett et al., 2008; Boden et al., 2013; Friedman et al., 2001; Pedersen & Skardhamar, 2010; Reynolds et al., 2011), precipitates relapse to other drugs of abuse (Aharonovich et al., 2005), increases the likelihood that participants will fail out of drug courts (Sechrest & Shicor, 2001), and reduces the efficacy of rewards and sanctions that are used in drug courts to improve participants' behaviors (Lane et al., 2004; Thompson et al., 2012). Permitting the continued use of these substances is contrary to evidence-based practices in substance abuse treatment and interferes with the central goals of a drug court. The use of any addictive or intoxicating substance should be authorized only if it is determined by competent medical evidence to be medically indicated, if safe and effective alternative treatments are not reasonably available, and if the participant is carefully monitored by a physician with training in addiction psychiatry or addiction medicine. There is a serious risk of morbidity, mortality, or illegal diversion of medications when addiction medications are prescribed by general medical practitioners for addicted patients (Bazazi et al., 2011; Bohnert et al., 2011; Daniulaityte et al., 2012; Johanson et al., 2012).

F. Therapeutic Adjustments

Individuals who are addicted to alcohol or other drugs commonly experience severe cravings to use the substance and may suffer from painful or uncomfortable withdrawal symptoms when they discontinue use (American Psychiatric Association, 2000; American Society of Addiction Medicine, 2011). These symptoms often reflect neurological or neurochemical impairment in the brain (Baler & Volkow, 2006; Dackis & O'Brien, 2005; NIDA, 2006). If a drug court imposes substantial sanctions for substance use early in treatment, the team is likely to run

out of sanctions and reach a ceiling effect before treatment has had a chance to take effect. Therefore, drug courts should ordinarily adjust participants' treatment requirements in response to positive drug tests during the early phases of the program. Participants might, for example, require medication, residential treatment, or motivational-enhancement therapy to improve their commitment to abstinence (Chandler et al., 2009). Because judges are not trained to make such decisions, they must rely on the expertise of duly trained clinicians when adjusting treatment conditions [see also Standard III, Roles and Responsibilities of the Judge]. After participants have received adequate treatment and have stabilized, it becomes appropriate to apply progressively escalating sanctions for illicit drug or alcohol use.

The question might arise about what to do for a participant who is complying with most of his or her obligations in the program, but is continuing to abuse substances over an extended period. If multiple adjustments to the treatment plan have been inadequate to initiate abstinence, it is possible the participant might not be amenable to the treatments that are available in the drug court. Under such circumstances, it may become necessary to discharge the participant; however, the participant should not be punished or receive an augmented sentence for trying, but failing, to respond to treatment (see subsection K below). Alternatively, the team might discover that the participant was willfully failing to apply him or herself in treatment. Under those circumstances, it would be appropriate to apply punitive sanctions for the willful failure to comply with treatment.

G. Incentivizing Productivity

Drug courts achieve significantly better outcomes when they focus as much on incentivizing productive behaviors as they do on reducing undesirable behaviors. In the MADCE, significantly better outcomes were achieved by drug courts that offered higher and more consistent levels of praise and positive incentives from the judge (Zweig et al., 2012). Several other studies found that a 4:1 ratio of incentives to sanctions was associated with significantly better outcomes among drug offenders (Gendreau, 1996; Senjo & Leip, 2001; Wodahl et al., 2011). Support for the 4:1 ratio must be viewed with caution because it was derived from post hoc (after the fact) correlations rather than from controlled studies. By design, sanctions are imposed for poor performance and incentives are provided for good performance; therefore, a greater proportion of incentives might not have caused better outcomes, but rather better outcomes might have elicited a greater proportion of incentives. Nevertheless, although this correlation does not prove causality, it does suggest that drug courts are more likely to be successful if they make positive incentives readily available to their participants.

It is essential to recognize that punishment and positive reinforcement serve different, but complementary, functions. Punishment is used to reduce undesirable behaviors, such as substance abuse and crime, whereas positive reinforcement is used to increase desirable behaviors, such as treatment attendance and employment. Therefore, they are most likely to be effective when administered in combination (DeFulio et al., 2013). The effects of punishment typically last only as long as the sanctions are forthcoming, and undesirable behaviors often return precipitously after the sanctions are withdrawn (Marlowe & Kirby, 1999; Marlowe & Wong, 2008). For this reason, drug courts that rely exclusively on punishment to reduce drug abuse and crime will rarely produce lasting gains after graduation.

Treatment gains are most likely to be sustained if positive reinforcement is used to increase participant involvement in productive activities, such as employment or recreation, which can compete against drug abuse and crime after graduation. Studies have revealed that drug courts achieved significantly greater reductions in recidivism and greater cost savings when they required their participants to have a job, enroll in school, or live in sober housing as a condition of graduation from the program (Carey et al., 2012). How high a drug court should set the bar for graduation depends on the level of functioning of its participants. For seriously impaired participants, finding a safe place to live might be the most that can reasonably be expected after only a year or so of treatment. Other participants, however, might be capable of obtaining a job or a GED after a year. At a minimum, drug courts must ensure that their participants are engaged in a sufficient level of prosocial activities to keep them stable and abstinent after they have left the structure of the drug court program. The community reinforcement approach (CRA; Budney et al., 1998; Godley & Godley, 2008) is one example of an evidence-

based counseling intervention that drug courts can use to incentivize participant involvement in prosocial activities.

H. Phase Promotion

Drug courts have significantly better outcomes when they have a clearly defined phase structure and concrete behavioral requirements for advancement through the phases (Carey et al., 2012; Shaffer, 2006; Wolfer, 2006). The purpose of phase advancement is to reward participants for their accomplishments and put them on notice that the expectations for their behavior have been raised accordingly (Marlowe, 2011). Therefore, phase advancement should be predicated on the achievement of clinically important milestones that mark substantial progress towards recovery. Phase advancement should not be based simply on the length of time that participants have been enrolled in the program.

As participants make progress in treatment, they become better equipped to resist illicit drugs and alcohol and to engage in productive activities. Therefore, as they move through the phases of the program, the consequences for infractions should increase accordingly and supervision services may be reduced. Because addiction is a chronic and relapsing medical condition (McLellan et al., 2000), treatment must be reduced only if it is determined clinically that doing so would be unlikely to precipitate a relapse. Finally, a basic tenet of behavior modification provides that the effects of treatment should be assessed continually until all components of the intervention have been withdrawn (Rusch & Kazdin, 1981). Therefore, drug and alcohol testing should be the last supervisory obligation that is lifted to ensure relapse does not occur as other treatment and supervision services are withdrawn.

Reducing treatment or supervision before participants have been stabilized sufficiently puts the participants at serious risk for relapse or other behavioral setbacks. A relapse occurring soon after a phase promotion is often a sign that services were reduced too abruptly. The appropriate course of action is to return the participant temporarily to the preceding phase and plan for a more effective phase transition. Returning the participant to the beginning of the first phase of treatment is usually not appropriate because this may exacerbate what is referred to as the *abstinence violation effect* (AVE) (Marlatt, 1985). When addicted individuals experience a lapse after an extended period of abstinence, they may conclude, wrongly, that they have accomplished nothing in treatment and will never be successful at recovery. This counterproductive all-or-nothing thinking may put them at further risk for a full relapse or for dropping out of treatment (Collins & Lapp, 1991; Marlatt & Witkiewitz, 2005; Stephens et al., 1994). Returning the participant to the first phase of treatment could be misinterpreted as corroborating this erroneous thinking. The goal of the drug court should be to counteract the AVE and help the participant learn from the experience and avoid making the same mistake again.

I. Jail Sanctions

The certainty and immediacy of sanctions are far more influential to outcomes than the magnitude or severity of the sanctions (Harrell & Roman, 2001; Marlowe et al., 2005; Nagin & Pogarsky, 2011). As was noted earlier, sanctions that are too high in magnitude can lead to ceiling effects in which outcomes may become stagnant or may even be made worse.

Drug courts are significantly more effective and cost-effective when they use jail sanctions sparingly (Carey et al., 2008b; Hepburn & Harvey, 2007). Research in drug courts indicates that jail sanctions produce diminishing returns after approximately three to five days (Carey et al., 2012; Hawken & Kleiman, 2009). A multisite study found that drug courts that had a policy of applying jail sanctions of longer than one week were associated with increased recidivism and negative cost-benefits (Carey et al., 2012). Drug courts that relied on jail sanctions of longer than two weeks were two and a half times less effective at reducing crime and 45% less cost-effective than drug courts that tended to impose shorter jail sanctions.

Because jail sanctions involve the loss of a fundamental liberty interest, drug courts must ensure that participants receive a fair hearing on the matter (Meyer, 2011). Given that many controversies in drug courts involve uncomplicated questions of fact, such as whether a drug test was positive or whether the participant missed a

treatment session, truncated hearings can often be held on the same day and provide adequate procedural due process protections.

J. Termination

Participants may be terminated from the drug court if they pose an immediate risk to public safety, are unwilling or unable to engage in treatment, or are too impaired to benefit from the treatments that are available in their community. If none of these conditions are met, then in most cases the most effective course of action will be to adjust a nonresponsive participant's treatment or supervision requirements or apply escalating sanctions.

Drug courts have significantly poorer outcomes and are considerably less cost-effective when they terminate participants for drug or alcohol use. In a multisite study, drug courts that had a policy of terminating participants for positive drug tests or new arrests for drug possession offenses had 50% higher criminal recidivism and 48% lower cost savings than drug courts that responded to new drug use by increasing treatment or applying sanctions of lesser severity (Carey et al., 2012). The results of another meta-analysis similarly revealed significantly poorer outcomes for drug courts that had a policy of terminating participants for positive drug tests (Shaffer, 2010). Because termination from drug court for continued substance use is costly and does not improve outcomes, participants should be terminated only when necessary to protect public safety or if continued efforts at treatment are unlikely to be successful.

If a participant is terminated from drug court because adequate treatment was unavailable to meet his or her clinical needs, fairness dictates the participant should receive credit for the efforts in the program and should not receive an augmented sentence or disposition for the unsuccessful termination. To do otherwise is likely to dissuade addicted offenders and their defense attorneys from choosing the drug court option. Defense attorneys are understandably reluctant to advise their clients to enter drug court when there is a serious risk their client could receive an enhanced sentence despite his or her best efforts in treatment (Bowers, 2007; Justice Policy Institute, 2011; National Association of Criminal Defense Lawyers, 2009).

(Note: The following commentary originally applied to NADCP Standard IV, Part L, Consequences of Graduation and Termination. This standard was revised and incorporated into Florida Standard IV, Part J, Termination.)

Studies consistently find that drug courts have better outcomes when they exert *leverage* over their participants, meaning the participants can avoid a serious sentence or disposition if they complete the program (Cissner et al., 2013; Goldkamp et al., 2001; Longshore et al., 2001; Mitchell et al., 2012; Rempel & DeStefano, 2001; Rossman et al., 2011; Shaffer, 2010; Young & Belenko, 2002). Conversely, outcomes are typically poor if minimal consequences are enacted for withdrawing from or failing to complete the program (Cissner et al., 2013; Burns & Peyrot, 2008; Carey et al., 2008b; Gottfredson et al., 2003; Rempel & DeStefano, 2001; Rossman et al., 2011; Young & Belenko, 2002). If it is the policy of a drug court to resume traditional legal proceedings as if terminated participants had never attempted drug court, the odds are substantially diminished that the program will be successful.

Legal precedent and empirical research offer little guidance for deciding when to impose more than the presumptive sentence for the underlying offense if an offender fails a diversion program such as a drug court. At a minimum, participants and their legal counsel must be informed of the possibility that an augmented sentence could be imposed when they execute a waiver to enter the drug court (Meyer, 2011). Drug courts should make every effort to spell out in the waiver agreement what factors the judge is likely to take into account when deciding whether to augment the presumptive sentence if a participant is terminated or withdraws from the program.

K. Graduation

See Commentary J above.

V. Substance Abuse Treatment

A. Continuum of Care

Outcomes are significantly better in drug courts that offer a continuum of care for substance abuse treatment which includes residential treatment and recovery housing in addition to outpatient treatment (Carey et al., 2012; Koob et al., 2011; McKee, 2010). Participants who are placed initially in residential treatment should be stepped down gradually to day treatment or intensive outpatient treatment and subsequently to outpatient treatment (Krebs et al., 2009). Moving patients directly from residential treatment to a low frequency of standard outpatient treatment has been associated with poor outcomes in substance abuse treatment studies (McKay, 2009a; Weiss et al., 2008). Broadly speaking, standard outpatient treatment is typically less than nine hours per week of services, intensive outpatient treatment is typically between nine and nineteen hours, and day treatment is typically over twenty hours but does not include overnight stays (Mee-Lee & Gastfriend, 2008).

Significantly better results are achieved when substance abuse patients are assigned to a level of care based on a standardized assessment of their treatment needs as opposed to relying on professional judgment or discretion (Andrews & Bonta, 2010; Babor & Del Boca, 2002; Karno & Longabaugh, 2007; Vieira et al., 2009). The most commonly used placement criteria are the *American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders* (ASAM-PPC; Mee-Lee et al., 2001). Studies have confirmed that patients who received the indicated level of care according to the ASAM-PPC had significantly higher treatment completion rates and fewer instances of relapse to substance use than patients who received a lower level of care than was indicated by the ASAM-PPC (for example, patients who received outpatient treatment when the ASAM-PPC indicated a need for residential treatment; De Leon et al., 2010; Gastfriend et al., 2000; Gregoire, 2000; Magura et al., 2003; Mee-Lee & Gastfriend, 2008). Patients who received a higher level of care than was indicated by the ASAM-PPC had equivalent or worse outcomes than those receiving the indicated level of care, and the programs were rarely cost-effective (Magura et al., 2003).

In the criminal justice system, mismatching offenders to a higher level of care than they require has been associated frequently with negative or iatrogenic effects in which outcomes were made worse. In several studies, offenders who received residential treatment when a lower level of care would have sufficed had significantly higher rates of treatment failure and criminal recidivism than offenders with comparable needs who were assigned to outpatient treatment (Lovins et al., 2007; Lowenkamp & Latessa, 2005; Wexler et al., 2004). The negative impact of receiving an excessive level of care appears to be most pronounced for offenders below the age of twenty-five years, perhaps because youthful offenders are more vulnerable to antisocial peer influences (DeMatteo et al., 2006; Lowenkamp & Latessa, 2004; McCord, 2003; Petrosino et al., 2000; Szalavitz, 2010). Particular caution is required, therefore, to ensure younger drug court participants are not placed erroneously into residential substance abuse treatment.

As was discussed earlier, evidence suggests racial and ethnic minority offenders may be more likely than nonminorities to receive a lower level of care than is warranted from their assessment results (Integrated Substance Abuse Programs, 2007; Janku & Yan, 2009). To prevent this from occurring in drug courts, a unanimous resolution of the NADCP Board of Directors requires drug courts to monitor whether minorities and members of other historically disadvantaged groups are receiving services equivalent to other participants in the program and to take remedial measures, where indicated, to correct any discrepancies [see Standard II, Historically Disadvantaged Groups].

Some drug courts may begin all participants in the same level of care, or may routinely taper down the level of care as participants move through the phases of the program. The research cited above shows clearly that such practices are not justified on the bases of clinical necessity or cost. Participants should not be assigned to a level of care without first confirming through a standardized and validated assessment that their clinical needs warrant that level of care.

If a drug court is unable to provide adequate levels of care to meet the needs of addicted individuals, then the program might consider adjusting its eligibility criteria to serve a less clinically disordered population, such as offenders who abuse but are not addicted to drugs or alcohol. At a minimum, participants should not be punished for failing to respond to a level of care that research indicates is insufficient to meet their treatment needs. If a participant is terminated from drug court for failing to respond to an inadequate level of treatment, fairness dictates the participant should receive credit for his or her efforts in the program and should not receive an augmented sentence or disposition for the unsuccessful termination. To do otherwise is likely to dissuade addicted offenders and their defense attorneys from choosing the drug court option. As was noted earlier, evidence suggests defense attorneys are reluctant to advise their clients to enter drug court when there is a serious chance the client could receive an enhanced sentence despite his or her best efforts in treatment (Bowers, 2007; Justice Policy Institute, 2011; National Association of Criminal Defense Lawyers, 2009).

B. Placement in Custody

Relying on in-custody substance abuse treatment can reduce the cost-effectiveness of a drug court by as much as 45% (Carey et al., 2012). Most studies have reported minimal gains from providing substance abuse treatment within jails or prisons (Pearson & Lipton, 1999; Pelissier et al., 2007; Wilson & Davis, 2006). Although specific types of in-custody programs, such as therapeutic communities (TCs), have been shown to improve outcomes for jail or prison inmates (Mitchell et al., 2007), most of the benefits of those programs were attributable to the fact that they increased the likelihood the offenders would complete outpatient treatment after their release from custody (Bahr et al., 2012; Martin et al., 1999; Wexler et al., 1999). The long-term benefits of the TCs were accounted for primarily by the offender's subsequent exposure to community-based treatment. Once an offender has engaged in community-based treatment, rarely will there be a clinical rationale for transferring him or her to in-custody treatment. Placing a participant in custody might be appropriate to protect public safety or to punish willful infractions such as intentionally failing to attend treatment sessions; however, in-custody treatment will rarely serve the goals of treatment effectiveness or cost-effectiveness.

Some drug courts may place participants in jail as a means of providing detoxification services or to keep them "off the streets" when adequate treatment is unavailable in the community. Although this practice may be necessary in rare instances to protect participants from immediate self-harm, it is inconsistent with best practices, unduly costly, and unlikely to produce lasting benefits. As soon as a treatment slot becomes available, the participant should be released immediately from custody and transferred to the appropriate level of care in the community.

C. Team Representation

Outcomes are significantly better in drug courts that rely on one or two primary treatment agencies to manage the provision of treatment services for participants (Carey et al., 2008, 2012; Shaffer, 2006; Wilson et al., 2006). Criminal recidivism may be reduced by as much as two fold when representatives from these primary agencies are core members of the drug court team and regularly attend staff meetings and court hearings (Carey et al., 2012). This arrangement helps to ensure that timely information about participants' progress in treatment is communicated to the drug court team and treatment-related issues are taken into consideration when decisions are reached in staff meetings and status hearings.

For practical reasons, large numbers of treatment providers cannot attend staff meetings and court hearings on a routine basis. Therefore, for drug courts that are affiliated with large numbers of treatment agencies, communication protocols must be established to ensure timely treatment information is reported to the drug court team. Clinical case managers from the primary treatment agencies are often responsible for ensuring that this process runs efficiently and timely information is conveyed to fellow team members. Particularly when drug courts are affiliated with large numbers of treatment providers, outcomes may be enhanced by having those

treatment providers communicate frequently with the court via e-mail or similar electronic means (Carey et al., 2012).

D. Treatment Dosage, Duration, and Modality

The success of drug courts is attributable, in part, to the fact that they significantly increase participant exposure to substance abuse treatment (Gottfredson et al., 2007; Lindquist et al., 2009). The longer participants remain in treatment and the more sessions they attend, the better their outcomes (Banks & Gottfredson, 2003; Gottfredson et al., 2007; Gottfredson et al., 2008; Peters et al., 2002; Shaffer, 2010; Taxman & Bouffard, 2005). The best outcomes are achieved when addicted offenders complete a course of treatment extending over approximately nine to twelve months (270 to 360 days; Peters et al., 2002; Huebner & Cobbina, 2007). On average, participants will require approximately six to ten hours of counseling per week during the first phase of the program (Landenberger & Lipsey, 2005) and 200 hours of counseling over the course of treatment (Bourgon & Armstrong, 2005; Sperber et al., 2013). The most effective drug courts publish general guidelines concerning the anticipated length and dosage of treatment; however, they retain sufficient flexibility to accommodate individual differences in each participant's response to treatment (Carey et al., 2012).

(Note: The following commentary originally applied to NADCP Standard V, Part E, Treatment Modalities. This standard was revised and incorporated into Florida Standard V, Part D. Treatment Dosage, Duration and Modality.)

Outcomes are significantly better in drug courts that require participants to meet with a treatment provider or clinical case manager for at least one individual session per week during the first phase of the program (Carey et al., 2012; Rossman et al., 2011). Most participants are unstable clinically and in a state of crisis when they first enter a drug court. Group sessions may not provide sufficient time and opportunities to address each participant's clinical and social service needs. Individual sessions reduce the likelihood that participants will fall through the cracks during the early stages of treatment when they are most vulnerable to cravings, withdrawal symptoms, and relapse.

Group counseling may also improve outcomes in drug courts, but only if the groups apply evidence-based practices and participants are screened for their suitability for group-based services. Research indicates counseling groups are most effective with six to twelve participants and two facilitators (Brabender, 2002; Sobell & Sobell, 2011; Velasquez et al., 2001; Yalom, 2005). Groups with more than twelve members have fewer verbal interactions, spend insufficient time addressing individual members' concerns, are more likely to fragment into disruptive cliques or subgroups, and are more likely to be dominated by antisocial, forceful or aggressive members (Brabender, 2002; Yalom, 2005). Groups with fewer than four members commonly experience excessive attrition and instability (Yalom, 2005). If a drug court cannot form stable groups with at least four members, relying on individual counseling rather than groups to deliver treatment services may be preferable.

For groups that are treating externalizing or acting-out behaviors, such as crime and substance abuse, two facilitators are often needed to monitor and control the group interactions (Sobell & Sobell, 2011). The main facilitator can direct the format and flow of the sessions, while the cofacilitator may set limits on disruptive participants, review participants' homework assignments, or take part in role-plays such as illustrating effective drug-refusal strategies. Although the main facilitator should be a trained and certified treatment professional, the cofacilitator may be a trainee or recent hire to the program. Using trainees or inexperienced staff members as cofacilitators can reduce the costs of having two facilitators and provides an excellent training opportunity for the new staff members.

Evidence reveals group interventions may be contraindicated for certain types of participants, such as those suffering from serious brain injury, paranoia, sociopathy, major depression, or traumatic disorders (Yalom, 2005). Individuals with these characteristics may need to be treated on an individual basis or in specialized groups that can focus on their unique needs and vulnerabilities (Drake et al., 2008; Ross, 2008). Better outcomes have been

achieved, for example, in drug courts (Messina et al., 2012; Liang & Long, 2013) and other substance abuse treatment programs (Grella, 2008; Mills et al., 2012) that developed specialized groups for women with trauma histories. Researchers have identified substantial percentages of drug court participants who may require specialized group services for comorbid mental illness (Mendoza et al., 2013; Peters, 2008; Peters et al., 2012) or trauma histories (Sartor et al., 2012).

Not all substance abuse treatment participants may benefit from group counseling. Interviews with participants who were terminated from drug courts found that many of them attributed their failure, in part, to their dissatisfaction with group-based services (Fulkerson et al., 2012). This theme has arisen frequently in focus groups with young, African-American, male drug court participants (Gallagher, 2013). Although there is no proof that dissatisfaction with group counseling was the actual cause of these individuals' failure in the programs, the findings do suggest that drug courts should consider whether participants are suited for group-based services and prepare them for what to expect in the groups before assigning them to the interventions.

E. Evidence-Based Treatments

A substantial body of research spanning several decades reveals that outcomes from correctional rehabilitation are significantly better when (1) offenders receive behavioral or cognitive-behavioral counseling interventions, (2) the interventions are carefully documented in treatment manuals, (3) treatment providers are trained to deliver the interventions reliably according to the manual, and (4) fidelity to the treatment model is maintained through continuous supervision of the treatment providers (Andrews et al., 1990; Andrews & Bonta, 2010; Gendreau, 1996; Hollins, 1999; Landenberger & Lipsey, 2005; Lowenkamp et al., 2006; Lowenkamp et al., 2010; Smith et al., 2009). Adherence to these principles has been associated with significantly better outcomes in drug courts (Gutierrez & Bourgon, 2012) and in other drug abuse treatment programs (Prendergast et al., 2013).

Behavioral treatments reward offenders for desirable behaviors and sanction them for undesirable behaviors. The systematic application of graduated incentives and sanctions in drug courts is an example of a behavior therapy technique (Defulio et al., 2013; Marlowe & Wong, 2008). Cognitive-behavioral therapies (CBT) take an active problem-solving approach to managing drug- and alcohol-related problems. Common CBT techniques include correcting participants' irrational thoughts related to substance abuse (e.g., "I will never amount to anything anyway, so why bother?"), identifying participants' triggers or risk factors for drug use, scheduling participants' daily activities to avoid coming into contact with their triggers, helping participants to manage cravings and other negative affects without recourse to substance abuse, and teaching participants effective problem-solving techniques and drug-refusal strategies.

Examples of manualized CBT curricula that have been proven to reduce criminal recidivism among offenders include Moral Reconciliation Therapy (MRT), Reasoning and Rehabilitation (R&R), Thinking for a Change (T4C), relapse prevention therapy (RPT) and the Matrix Model (Cullen et al., 2012; Dowden et al., 2003; Ferguson & Wormith, 2012; Landenberger & Lipsey, 2005; Lipsey et al., 2001; Lowenkamp et al., 2009; Marinelli-Casey et al., 2008; Milkman & Wanberg, 2007; Pearson et al., 2002; Wilson et al., 2005). Some of these CBT curricula were developed to address criminal offending generally and were not developed specifically to treat substance abuse or addiction. However, the Matrix Model and RPT were developed for the treatment of addiction and MRT has been adapted successfully to treat drug-abusing offenders (Bahr et al., 2012; Wanberg & Milkman, 2006) and drug court participants (Cheesman & Kunkel, 2012; Heck, 2008; Kirchner & Goodman, 2007). The Substance Abuse and Mental Health Services Administration (SAMHSA) maintains an Internet directory of evidence-based treatments called the *National Registry of Evidence-Based Programs and Practices* (NREPP). Drug court professionals can search the NREPP Web site, free of charge, to identify substance abuse treatments that have been demonstrated to improve outcomes for addicted offenders.

Outcomes from CBT are enhanced significantly when counselors are trained to deliver the curriculum in a reliable manner as specified in the manual (Goldstein et al., 2013; Southam-Gerow & McLeod, 2013). A minimum of three days of preimplementation training, periodic booster sessions, and monthly individualized supervision and

feedback are required for probation officers and treatment providers to administer evidence-based practices reliably (Bourgon et al., 2010; Edmunds et al., 2013; Robinson et al., 2012; Schoenwald et al., 2013). In addition, outcomes are better when counselors give homework assignments to the participants that reinforce the material covered in the sessions (Kazantzis et al., 2000; McDonald & Morgan, 2013). Examples of homework assignments include having participants keep a journal of their thoughts and feelings related to substance abuse, requiring participants to develop and follow through with a preplanned activity schedule, or having them write an essay on a drug-related topic (Sobell & Sobell, 2011).

F. Medications

Medically assisted treatment (MAT) can significantly improve outcomes for addicted offenders (Chandler et al., 2009; National Center on Addiction & Substance Abuse, 2012; National Institute on Drug Abuse, 2006). Buprenorphine or methadone maintenance administered prior to and immediately after release from jail or prison has been shown to significantly increase opiate-addicted inmates' engagement in treatment; reduce illicit opiate use; reduce rearrests, technical parole violations, and reincarceration rates; and reduce mortality and hepatitis C infections (Dolan et al., 2005; Gordon et al., 2008; Havnes et al., 2012; Kinlock et al., 2008; Magura et al., 2009). These medications are referred to as agonists or partial agonists because they stimulate the central nervous system (CNS) in a similar manner to illicit drugs. Because they can be addictive and may produce euphoria in nontolerant individuals, they may be resisted by some criminal justice professionals. Positive outcomes have also been reported for antagonist medications, such as naltrexone, which are nonaddictive and nonintoxicating. Naltrexone blocks the effects of opiates and partially blocks the effects of alcohol without producing psychoactive effects of its own. Studies have reported significant reductions in heroin use and rearrest rates for opiate-addicted probationers and parolees who received naltrexone (Cornish et al., 1997; Coviello et al., 2012; O'Brien & Cornish, 2006). In addition, at least two small-scale studies reported better outcomes in DWI Drug Courts or DWI probation programs for alcohol-dependent participants who received an injectable form of naltrexone called Vivitrol (Finigan et al., 2011; Lapham & McMillan, 2011).

A recent national survey found that nearly half of drug courts do not use medications in their programs (Matusow et al., 2013). One of the primary barriers to using medications was reportedly a lack of awareness of or familiarity with medical treatments. For this reason, the NADCP Board of Directors issued a unanimous resolution directing drug courts to learn the facts about MAT and obtain expert consultation from duly trained addiction psychiatrists or addiction physicians. Drug courts should ordinarily discourage their participants from obtaining addictive or intoxicating medications from general medical practitioners, because this practice can pose an unacceptable risk of morbidity, mortality, or illegal diversion of the medications (Bazazi et al., 2011; Bohnert et al., 2011; Daniulaityte et al., 2012; Johanson et al., 2012).

G. Provider Training & Credentials

Treatment providers are significantly more likely to administer evidence-based assessments and interventions when they are professionally credentialed and have an advanced educational degree in a field directly related to substance abuse treatment (Kerwin et al., 2006; McLellan et al., 2003; National Center on Addiction & Substance Abuse, 2012; Olmstead et al., 2012). Studies have found that clinicians with higher levels of education and clinical certification were more likely to hold favorable views toward the adoption of evidence-based practices (Arfken et al., 2005) and to deliver culturally competent treatments (Howard, 2003). A large-scale study found that clinically certified professionals significantly outperformed noncertified staff members in conducting standardized clinical assessments (Titus et al., 2012). Clinicians are also more likely to endorse treatment philosophies favorable to client outcomes if they are educated about the neuroscience of addiction (Steenbergh et al., 2012).

As was previously discussed, treatment providers must be supervised regularly to ensure continuous fidelity to evidence-based treatments. Providers are better able to administer evidence-based practices when they receive three days of preimplementation training, periodic booster trainings, and monthly individualized supervision and

feedback (Bourgon et al., 2010; Edmunds et al., 2013; Robinson et al., 2012). Finally, research suggests treatment providers are more likely to be effective if they have substantial experience working with criminal offenders and are accustomed to functioning in a criminal justice environment (Lutze & van Wormer, 2007).

H. Peer Support Groups

Participation in self-help or peer-support groups is consistently associated with better long-term outcomes following a substance abuse treatment episode (Kelly et al., 2006; Moos & Timko, 2008; Witbrodt et al., 2012). Contrary to some beliefs, individuals who are court mandated to attend self-help groups perform as well or better than nonmandated individuals (Humphreys et al., 1998). The critical variable appears to be how long the participants were exposed to the self-help interventions and not their original level of intrinsic motivation (Moos & Timko, 2008). Many people (more than 40%) drop out prematurely from self-help groups, in part because they are unmotivated or insufficiently motivated to maintain sobriety (Kelly & Moos, 2003). Therefore, drug courts need to find effective ways to leverage continued participant involvement in self-help groups.

Simply attending self-help groups is not sufficient to achieve successful outcomes. Sustained benefits are more likely to be attained if participants engage in recovery-relevant activities such as developing a sober- support social network (Kelly et al., 2011a), engaging in spiritual practices (Kelly et al., 2011b; Robinson et al., 2011), and learning effective coping skills from fellow group members (Kelly et al., 2009). Because it is very difficult for drug courts to mandate and monitor compliance with these types of recovery activities, they must find other means of encouraging and reinforcing participant engagement in recovery- related exercises. Evidence-based interventions have been developed, documented in treatment manuals, and proven to improve participant engagement in self-help groups and recovery activities. Examples of validated interventions include 12-step facilitation therapy (Ries et al., 2008), which teaches participants about what to expect and how to gain the most benefits from 12-step meetings. In addition, *intensive referrals* improve outcomes by assertively linking participants with support-group volunteers who may escort them to the groups, answer any questions they might have, and provide them with support and camaraderie (Timko & DeBenedetti, 2007).

I. Continuing Care

Vulnerability to relapse remains high for at least three to six months after completion of substance abuse treatment (Marlatt, 1985; McKay, 2005). One year after treatment, an average of 40% to 60% of treatment graduates will have relapsed to substance abuse (McLellan et al., 2000). Therefore, preparation for aftercare or continuing care is a critical component of drug courts.

In one multisite study, drug courts that included a formal phase focusing on relapse prevention and aftercare preparation had more than three times greater cost-benefits and significantly greater reductions in recidivism than those that offered minimal services during the last phase of the program or neglected aftercare preparation (Carey et al., 2008). Drug courts that required their participants to plan for engaging in prosocial activities after graduation, such as employment or schooling, were found to be more effective and significantly more cost effective than those that did not plan for postgraduation activities (Carey et al., 2012). Another study found that drug-abusing probationers who received aftercare services were nearly three times more likely to be abstinent from all drugs of abuse after six months than those who did not receive aftercare services (Brown et al, 2001).

As was described earlier, RPT is a manualized, cognitive-behavioral counseling intervention that has been demonstrated to extend the effects of substance abuse treatment (Dowden et al., 2003; Dutra et al, 2008). Participants in RPT learn to identify their personal triggers or risk factors for relapse, take measures to avoid coming into contact with those triggers, and rehearse strategies to deal with high-risk situations that arise unavoidably. Drug courts that teach formal RPT skills are likely to significantly extend the effects of their program beyond graduation (Carey et al., 2012).

Studies have also examined ways to remain in contact with participants after they have been discharged from a treatment program. For example, researchers have extended the benefits of substance abuse treatment by making periodic telephone calls to participants (McKay, 2009a), although not all studies have reported success with this approach (McKay et al., 2013). In addition, treatment benefits have been extended by inviting participants back to the program for brief recovery management check-ups (Scott & Dennis, 2012), providing assertive case management involving periodic home visits (Godley et al., 2006), and reinforcing participants with praise or small gifts for continuing to attend aftercare sessions (Lash et al., 2004). The aftercare strategies that have been successful typically continued for at least 90 days and had trained counselors, nurses, or case managers contact the participants briefly to check on their progress, probe for potential warning signs of an impending relapse, offer advice and encouragement, and make suitable referrals if a return to treatment appeared warranted (McKay, 2009b).

Although some of these measures might be cost-prohibitive for many drug courts, and participants might be reluctant to remain engaged with the criminal justice system after graduation, research suggests brief telephone calls, letters, or e-mails can be helpful in extending the effects of a drug court at minimal cost to the program and with minimal inconvenience to the participants. Anecdotal reports from drug court graduates and staff members have also suggested that involving graduates in alumni groups might be another promising, yet understudied, method for extending the benefits of drug courts (Burek, 2011; McLean, 2012).

VI. Additional Treatment and Social Services

A. Scope of Additional Services

Drug court participants frequently have needs for treatment and social services that extend well beyond substance abuse treatment. National and statewide studies have found that substantial proportions of drug court participants suffered from a serious co-occurring mental health or medical disorder, were chronically unemployed, had low educational achievement, were homeless, or had experienced physical or sexual abuse or other trauma (see Table 1).

TABLE 1		COMPLEMENTARY NEEDS IDENTIFIED IN NATIONAL AND STATEWIDE STUDIES OF DRUG COURTS	
Complementary Need		Percentage of Participants	
Any mental health problem/disorder		63%	
Major depression		16%–39%	
Posttraumatic stress disorder (PTSD)		10%	
Anxiety disorder other than PTSD		9%	
Bipolar disorder		8%	
Chronic medical condition		26%	
Unemployed		54%–72%	
Less than a high school diploma or GED		32%–38%	
Homeless		11%–47%	
Abuse or trauma history		27%–29%	

Sources: Cissner et al. (2013); Green & Rempel (2012); Peters et al. (2012).

Drug courts are more effective and cost-effective when they offer complementary treatment and social services to address these co-occurring needs. A multisite study of approximately seventy drug courts found that programs were significantly more effective at reducing crime when they offered mental health treatment, family counseling, and parenting classes and were marginally more effective when they offered medical and dental services (Carey et al., 2012). The same study determined that drug courts were more cost-effective when they helped participants find a job, enroll in an educational program, or obtain sober and supportive housing. Similarly, a statewide study of eighty-six drug courts in New York found that programs were significantly more effective at reducing crime when they assessed participants for trauma and other mental health treatment needs, and delivered mental health, medical, vocational, or educational services where indicated (Cissner et al., 2013).

Studies do not, however, support a practice of delivering the same complementary services to all participants. Drug courts that required all participants to receive educational or employment services were determined in one meta-analysis to be less effective at reducing crime than drug courts that matched these services to the assessed needs of the participants (Shaffer, 2006). Requiring participants to receive unnecessary services wastes time and resources and can make outcomes worse by placing excessive demands on participants and interfering with the time they have available to engage in productive activities (Gutierrez & Bourgon, 2012; Lowenkamp et al., 2006; Prendergast et al., 2013; Smith et al., 2009; Vieira et al., 2009; Viglione et al., 2015). Evidence also suggests participants may become resentful, despondent, or anxious if they are sanctioned for failing to meet excessive or unwarranted demands, a phenomenon referred to as learned helplessness or ratio burden (Seligman, 1975). Under such circumstances, behavior fails to improve, and participants may leave treatment prematurely (Marlowe & Wong, 2008). If a drug court team cannot articulate a sound rationale for requiring a participant to receive a given service, then the team should reconsider requiring that service.

B. Sequence and Timing of Services

Timing is critical to the successful delivery of complementary treatment and social services. Outcomes are significantly better when rehabilitation programs address complementary needs in a specific sequence. This finding has important implications for designing the phase structure in a drug court. The first phase of drug court should focus primarily on resolving conditions that are likely to interfere with retention or compliance in treatment (responsivity needs). This process may include meeting participants' basic housing needs, stabilizing mental health symptoms if present, and ameliorating acute psychological or physiological symptoms of addiction, such as cravings, anhedonia, or withdrawal. Subsequently, the interim phases of drug court should focus on resolving needs that increase the likelihood of criminal recidivism and substance abuse (criminogenic needs). This process includes initiating sustained abstinence from drugs and alcohol, addressing dysfunctional or antisocial thought patterns, eliminating delinquent peer associations, and reducing family conflict. Finally, later phases of drug court should address remaining needs that are likely to undermine the maintenance of treatment gains (maintenance needs). This process may include providing vocational or educational assistance, parent training, or other interventions designed to enhance participants' activities of daily living (ADL) skills.

Responsivity Needs. When participants first enter drug court, one of the most pressing goals is to ensure that they remain in treatment and comply with other reporting obligations. This objective requires drug courts to resolve symptoms or conditions that are likely to interfere with attendance or engagement in treatment. Such conditions are commonly referred to as responsivity needs because they interfere with a person's response to rehabilitation efforts (Andrews & Bonta, 2010; Smith et al., 2009). Although responsivity needs do not necessarily cause or exacerbate crime, they nevertheless must be addressed early in treatment to prevent participants from failing or dropping out of treatment prematurely (Hubbard & Pealer, 2009; Karno & Longabaugh, 2007).

Responsivity needs that are commonly encountered in drug courts include severe mental illness and homelessness or unstable housing (Cissner et al., 2013; Green & Rempel, 2012; Peters et al., 2012). Although these conditions usually do not cause crime (Andrews & Bonta, 2010; Bonta et al., 1998; Gendreau et al., 1996), they have a marked tendency to undermine the effectiveness of drug courts and other correctional rehabilitation programs (Gray & Saum, 2005; Hickert et al., 2009; Johnson et al., 2011; Mendoza et al., 2013; Young & Belenko, 2002). To avoid premature termination from drug court, these responsivity needs must be addressed, when present, beginning in the first phase of treatment and continuing as needed throughout participants' enrollment in the program.

Criminogenic Needs. Criminogenic needs refer to disorders or conditions that cause or exacerbate crime (Andrews & Bonta, 2010). Drug and alcohol dependence are highly criminogenic needs (Bennett et al., 2008; Walters, 2015), which explains why they are the primary focus of most interventions in drug courts. Other criminogenic needs that are encountered frequently in drug courts include criminal-thinking patterns, impulsivity, family conflict, and delinquent peer affiliations (Green & Rempel, 2012; Hickert et al., 2009; Jones et al., 2015).

Studies have reported improved outcomes when drug courts provided services to address these criminogenic needs. For example, superior outcomes have been reported when drug court participants learned to apply effective and prosocial decision-making skills, such as learning to think before they act, to consider the potential consequences of their actions, and to recognize their own role in interpersonal conflicts (Cheesman & Kunkel, 2012; Heck, 2008; Kirchner & Goodman, 2007; Lowenkamp et al., 2009; Vito & Tewksbury, 1998). Similarly, studies found that crime and substance abuse declined significantly when drug court participants spent less time interacting with delinquent peers, spent more time interacting with prosocial peers and relatives, and reported fewer conflicts with family members (Green & Rempel, 2012; Hickert et al., 2009; Shaeffer et al., 2010; Wooditch et al., 2013).

Maintenance Needs. Some needs, such as poor job skills, illiteracy, or low self-esteem, are often the result of living a nonproductive or antisocial lifestyle rather than the cause of that lifestyle (Hickert et al., 2009; Wooditch et al., 2013). Treating such noncriminogenic needs before one treats criminogenic needs is associated with

increased criminal recidivism, treatment failure, and other undesirable outcomes (Andrews & Bonta, 2010; Andrews et al., 1990; Smith et al., 2009; Vieira et al., 2009). Nevertheless, if these needs are ignored over the long term, they are likely to interfere with the maintenance of treatment gains. Improvements in certain maintenance needs, such as improved educational achievement or job skills, predict better long-term persistence of treatment effects (Leukefeld et al., 2007).

The important point is that improvements in maintenance needs rarely occur until after the more pressing responsivity and criminogenic needs have been resolved. Participants are unlikely, for example, to improve their job performance until after they have stopped experiencing debilitating symptoms of addiction or mental illness, stopped associating with delinquent peers, and relinquished self-centered attitudes and impulsive behaviors (Guastafarro, 2012; Samenow, 2014). After participants are stabilized clinically and have achieved a reasonable period of sobriety, maintenance services designed to enhance their adaptive functioning and ADL skills help to ensure the gains are sustained. Outcomes are also significantly better when continued involvement in maintenance activities after discharge is a requirement for graduation and a component of each participant's continuing-care plan (Carey et al., 2012).

C. Case Management

Studies consistently find that drug courts are more effective and cost-effective when participants meet individually with a clinical case manager or comparable treatment professional at least weekly during the first phase of the program (Carey et al., 2012; Cissner et al., 2013; Zweig et al., 2012). As described previously, drug courts must identify a range of complementary needs among participants, refer participants for indicated services, and ensure the services are delivered in an effective sequence. To do otherwise risks wasting resources and making outcomes worse for some participants. These complicated tasks require input from a professionally trained clinical case manager or clinician who is competent to perform clinical and social service assessments, understands how services should be sequenced and matched to participant needs, and is skilled at monitoring and reporting on participant progress (Monchick et al., 2006; Rodriguez, 2011).

Typically, clinical case managers are addiction counselors, social workers, or psychologists who have received specialized training to assess participant needs, broker referrals for indicated services, coordinate care between partner agencies, and report progress information to other interested professionals (Monchick et al., 2006; Rodriguez, 2011). In some drug courts, probation officers or other criminal justice professionals may serve as court case managers, to be distinguished from clinical case managers. Typically, court case managers administer brief screening instruments designed to identify participants requiring more in-depth clinical assessments. Participants scoring above established thresholds on the screening instruments are referred for further evaluation by a clinically trained treatment professional.

Broadly speaking, there are four basic models of clinical case management (Hesse et al., 2007; Rapp et al., 2014):

- *Brokerage Model*—The least intensive form of case management, the brokerage model involves assessing participants and linking them to indicated services.
- *Generalist or Clinician Model*—In the most common form of case management, the Generalist case manager assesses participant needs and delivers some or all of the indicated services.
- *Assertive Community Treatment (ACT) Model*—The most intensive form of case management, the ACT Model provides around-the-clock access to a multidisciplinary team of professionals that delivers wrap-around services in the community designed to meet an array of treatment and social-service needs.
- *Strengths-Based Model*—A strengths-based philosophy may be applied in the context of any of the above models. It focuses on leveraging participants' natural resources and encouraging participants to take an active role in setting treatment goals and selecting treatment options.

Meta-analyses reveal that all four case management models significantly increase referrals for indicated services and retain participants longer in treatment; however, they have relatively small effects on substance abuse, crime, and other long-term outcomes (Hesse et al., 2007; Rapp et al., 2014). Whether a program produces long-term improvements depends ultimately on the quality and quantity of treatment and social services that are delivered. No evidence suggests any one case management model is superior to another; however, the models were developed for different types of programs serving individuals with different clinical and social service profiles. The generalist model was developed primarily for use in outpatient treatment settings where a primary therapist commonly delivers or coordinates the delivery of various components of a participant's care. Although few drug court studies have provided a clear description of the case management services that were provided, the generalist model appears to be used most frequently in adult drug courts (Carey et al., 2012; Cissner et al., 2013; Zweig et al., 2012).

The brokerage model was developed for participants who are served by more than one agency or system. For example, some substance abuse treatment programs may lack the required expertise to deliver mental health treatment or vocational rehabilitation. As a result, participants must be referred to another agency for a portion of their care. A clinical case manager is required to broker the referral, reconcile conflicting demands that may be placed on participants by different agencies, and report on participant progress to the drug court team.

A specific model of case management, called Treatment Accountability for Safer Communities or Treatment Alternatives to Street Crime (TASC), was designed to bridge gaps between the substance abuse, mental health, and criminal justice systems. TASC programs typically apply a brokerage or generalist model depending on whether treatment is available within the criminal justice system or must be brokered through another system or agency. Evidence is convincing that TASC programs increase participants' access to services and retention in treatment; however, impacts on substance abuse and crime have been mixed (Anglin et al., 1999; Ventura & Lambert, 2004). As was already noted, the key to successful outcomes depends on the quality and quantity of treatment and social services that are delivered (Clark et al., 2013; Cook, 2002; Rodriguez, 2011). Outcomes are more consistently favorable when TASC case management is delivered in conjunction with intensive evidence-based treatment as in drug courts (Monchick et al., 2006). Therefore, training on the TASC model or a comparable case management model is important for staff members providing clinical case management services in drug courts.

Finally, the ACT model was developed for use with seriously impaired individuals who have a wide range of mental health and social service needs (McLellan et al., 1998, 1999). This intensive model of case management has been applied successfully in the context of a mental health court (Braude, 2005) and a community court serving persons with serious and persistent mental illness or social service needs (Somers et al., 2014). Training on the ACT model of case management is advisable for drug courts serving seriously impaired individuals suffering from co-occurring mental illness, chronic homelessness, or other severe functional impairments.

Regardless of which model of case management is applied, outcomes are superior when case managers administer reliable and valid needs-assessment instruments (Andrews & Bonta, 2010; Andrews et al., 2006). [Appendix C provides examples of validated instruments designed to assess clinical and criminogenic needs among persons in substance abuse treatment and the criminal justice system.] Whether needs assessments should be administered repeatedly during the course of treatment is an open question. Although evidence suggests changes in need scores correlate with progress in treatment (Greiner et al., 2015; Serin et al., 2013; Vose et al., 2013; Wooditch et al., 2013), little guidance is available to determine when or how to alter treatment conditions in light of changing scores (Serin et al., 2013). Until such guidance is available, drug courts are advised to rely on objective indices of participant progress, such as drug test results and treatment attendance rates, to make decisions about adjusting treatment and social services.

On a final note, a critical function of case management is linking participants to public benefits and other subsidies to which they are legally entitled. For example, under the Affordable Care Act (ACA), drug court participants may be eligible for medical or mental health care benefits pursuant to Medicaid expansion or newly created

health-insurance exchanges (Frescoln, 2014). Court case managers or clinical case managers must leverage these financial resources and enroll participants for eligible benefits to meet participants' needs for substance abuse treatment and other complementary services.

D. Housing Assistance

Participants are unlikely to succeed in treatment if they do not have a safe, stable, and drug-free place to live (Morse et al., 2015; Quirouette et al., 2015). No study was identified that has examined the impact of housing assistance on drug court outcomes. However, studies in similar contexts have reported improved outcomes when housing assistance was provided for parolees reentering the community after prison (Clark, 2014; Lutze et al., 2014), in community courts for persons suffering from serious and persistent mental illness (Kilmer & Sussell, 2014; Lee et al., 2013), and in programs serving homeless military veterans (Elbogen et al., 2013; Winn et al., 2014).

Some drug courts may have a policy of denying entry to persons who do not have a stable place of residence. Such a policy is likely to have the unintended effect of excluding the highest-risk and highest-need individuals—those who need drug court the most—from participation in drug court (Morse et al., 2015; Quirouette et al., 2015). The preferable course of action is to provide housing assistance, where indicated, beginning in the first phase of drug court and continuing as needed throughout participants' enrollment in the program. If professional housing services are not available to a drug court, then clinical case managers or other staff members should make every effort to help participants find safe and stable housing with prosocial and drug-free relatives, friends, or other suitable individuals.

E. Mental Health Treatment

Approximately two-thirds of drug court participants report serious mental health symptoms and roughly one-quarter have a diagnosed Axis I psychiatric disorder, most commonly major depression, bipolar disorder, PTSD, or other anxiety disorder (Cissner et al., 2013; Green & Rempel, 2012; Peters et al., 2012). Mental illness, by itself, is ordinarily not a criminogenic need (Bonta et al., 1998; Elbogen & Johnson, 2009; Gendreau et al., 1996; Peterson et al., 2014; Phillips et al., 2005; Prins et al., 2014); however, it is a responsivity need that can interfere significantly with the effectiveness of drug courts and other rehabilitation programs (Gray & Saum, 2005; Hickert et al., 2009; Johnson et al., 2011; Manchak et al., 2014; Mendoza et al., 2013; Ritsher et al., 2002; Young & Belenko, 2002). Moreover, when mental illness is combined with substance abuse, the odds of recidivism increase significantly—although the magnitude of this effect is smaller than for most other criminogenic risk factors, such as a participant's criminal history or association with delinquent peers (Andrews & Bonta, 2010; Peters et al., 2015; Rezanoff et al., 2013).

Mental illness and substance abuse may co-occur in a given case for several reasons. Substance abuse may trigger or exacerbate mental illness, mentally ill individuals may abuse substances in a misguided effort to self-medicate psychiatric symptoms, or the two disorders may emerge independently in a person who has a generalized vulnerability to stress-related illness (Ross, 2008). Causality aside, treating either disorder alone without treating both disorders simultaneously is rarely, if ever, successful. Addiction and mental illness are reciprocally aggravating conditions, meaning that continued symptoms of one disorder are likely to precipitate relapse in the other disorder (Chandler et al., 2004; Drake et al., 2008). For example, a formerly depressed person who continues to abuse drugs is likely to experience a resurgence of depressive symptoms. Conversely, a person recovering from addiction who continues to suffer from depression is at risk for relapsing to drug abuse. For this reason, best practice standards for drug courts and other treatment programs require mental illness and addiction to be treated concurrently as opposed to consecutively (Drake et al., 2004; Kushner et al., 2014; Mueser et al., 2003; Osher et al., 2012; Peters, 2008; Steadman et al., 2013). Whenever possible, both disorders should be treated in the same facility by the same professional(s) using an integrated treatment model that focuses on the mutually aggravating effects of the two conditions. The Substance Abuse and Mental Health Services Administration (SAMHSA, 2010)

has published therapist toolkits to assist in delivering evidence-based integrated treatments for co-occurring substance-use and mental health disorders.

Participants should also have unhindered access to medical providers qualified to prescribe and monitor response to psychiatric medications (Kushner et al, 2014; Steadman et al., 2013). In one study, drug court participants who were prescribed psychiatric medications were seven times more likely to graduate successfully from the program than participants with psychiatric symptoms who did not receive psychiatric medications (Gray & Saum, 2005). Thus, for drug courts to deny participants access to psychiatric medication or require them to discontinue legally prescribed psychiatric medication as a condition of entering or graduating from drug court is not appropriate [see also Standard I, Target Population, and Standard V, Substance Abuse Treatment]. A participant should only be denied psychiatric medication if the decision is based on expert medical evidence from a qualified physician who has examined the participant and is adequately informed about the facts of the case (Peters & Osher, 2004; Steadman et al., 2013).

F. Trauma-Informed Services

More than one-quarter of drug court participants report having been physically or sexually abused in their lifetime or having experienced another serious traumatic event, such as a life-threatening car accident or work-related injury (Cissner et al., 2013; Green & Rempel, 2012). Among female drug court participants, studies have found that more than 80% experienced a serious traumatic event in their lifetime, more than half were in need of trauma-related services, and over a third met diagnostic criteria for PTSD (Messina et al., 2012; Powell et al., 2012; Sartor et al., 2012).

Unlike most types of mental illness which are typically noncriminogenic, individuals in the criminal justice system who have PTSD are approximately one and a half times more likely to reoffend than those without PTSD (Sadeh & McNiel, 2015). Moreover, as is true for many forms of mental illness, individuals with PTSD are significantly more likely to drop out or to be discharged prematurely from substance abuse treatment than individuals without PTSD (Mills et al., 2012; Read et al., 2004; Saladin et al., 2014). For these reasons, addressing trauma-related symptoms beginning in the first phase of drug court and continuing as necessary throughout participants' enrollment in the program is essential.

Most research on treatment of PTSD and other trauma-related syndromes has been conducted with military veterans or women in gender-specific treatment programs. For persons suffering from a diagnosed PTSD, evidence-based treatments are manualized, standardized, and cognitive-behavioral in orientation (Benish et al., 2008). Effective interventions focus on the following objectives (Benish et al., 2008; Bisson et al., 2007; Bradley et al., 2005; Mills et al., 2012):

- Creating a safe and dependable therapeutic relationship between the participant and therapist
- Helping participants deal with anger, anxiety, and other negative emotions without lashing out or engaging in avoidance behaviors such as substance abuse
- Assisting participants to construct a coherent “narrative” or understanding of the traumatic events that points toward productive actions (For example, many trauma victims believe they were to blame for past traumas or are helpless to prevent future traumas. Helping participants absolve themselves of guilt for past events and learn effective behavioral strategies to avoid future retraumatization is far more productive.)
- Exposing participants, in tolerable dosages, to memories or images of the event in a manner that gradually desensitizes them to associated feelings of panic and anxiety

Web sites providing additional information about evidence-based treatments for PTSD are listed in Appendix D.

In a randomized controlled experiment, female drug court participants with trauma histories who received manualized cognitive-behavioral PTSD treatments—Helping Women Recover (Covington, 2008) or Beyond

Trauma (Covington, 2003)—in gender-specific groups were more likely to graduate from drug court, were less likely to receive a jail sanction in the program, and reported more than twice the reduction in PTSD symptoms than participants with trauma histories who did not receive PTSD treatment (Messina et al., 2012). In another study, female drug court participants who received similar interventions—trauma- focused cognitive-behavioral therapy or abuse-focused cognitive-behavioral therapy—reported substantial reductions in substance use and mental health symptoms as well as improvements in housing and employment (Powell et al., 2012). Given the design of these studies, separating the effects of the PTSD treatments from the effects of the gender-specific groups is not possible. Studies have reported superior outcomes when women in the criminal justice system received various types of substance abuse treatment in female-only groups (Grella, 2008; Kissin et al., 2013; Liang & Long, 2013; Morse et al., 2013). Given the current state of knowledge, the best practice is to deliver trauma-related services for women in female- only groups because this combination of services clearly enhances outcomes for these participants.

Not all individuals who experience trauma will develop PTSD or require PTSD treatment, nor can drug courts assume that past trauma was the cause of a participant’s substance abuse problem or criminal history (Saladin et al., 2014). In some cases, trauma is the result rather than the cause of a participant’s substance abuse problem or criminal involvement. Persons who engage in substance abuse or crime often expose themselves repeatedly to the potential for trauma; therefore, treating trauma symptoms without paying equivalent attention to substance abuse and other criminogenic needs is unlikely to produce sustainable improvements.

Although some participants with trauma histories do not require formal PTSD treatment, all staff members, including court personnel and other criminal justice professionals, need to be *trauma-informed* for all participants (Bath, 2008). Staff members should remain cognizant of how their actions may be perceived by persons who have serious problems with trust, are paranoid or unduly suspicious of others’ motives, or have been betrayed, sometimes repeatedly, by important persons in their lives. Safety, predictability and reliability are critical for treating such individuals. Several practice recommendations should be borne in mind (Bath, 2008; Covington, 2003; Elliott et al., 2005; Liang & Long, 2013):

- Staff members should strive continually to avoid inadvertently retraumatizing participants. For example, responding angrily to participant infractions, ignoring participants’ fears or concerns, maintaining a chaotic or noisy group-counseling environment, or performing urine drug testing in a public or disrespectful manner may reawaken feelings of shame, fear, guilt, or panic in formerly traumatized individuals.
- Staff should remain true to their word, including following policies and procedures as described in the program manual and applying incentives and sanctions as agreed. Too much flexibility, no matter how well-intentioned, may seem unfair and unpredictable to persons who have fallen victim to unexpected dangers in the past.
- Staff should provide clear instructions in advance to participants concerning behaviors that are expected and prohibited in the program. Individuals with trauma histories need to understand the rules and to be prepared for what will occur in the event of an accomplishment or infraction.
- Staff should start and end counseling sessions, court hearings, and other appointments on time, at the agreed-upon location, and according to an agreed-upon structure and format. If participants cannot rely on staff to follow a basic itinerary, relying on those same staff persons for trustworthy support, feedback, and counseling may prove difficult for participants.
- Participants with PTSD or severe trauma-related symptoms, such as panic or dissociation (feeling detached from one’s surroundings), may not be suitable candidates for group interventions, especially in the early stages of treatment (Yalom & Leszcz, 2005). Such individuals may need to be treated on an individual basis or in small groups with carefully selected group members who are nonthreatening and nonpredatory. As was noted earlier, female participants with trauma histories are especially well suited for gender-specific groups (Liang & Long, 2013; Messina et al., 2012).

- Participants with histories of childhood-onset abuse or neglect may be at risk for developing a severe personality disorder such as borderline personality disorder. These individuals may have considerable difficulty trusting others, controlling overwhelming feelings of anger or depression, and containing their impulses. Manualized cognitive-behavioral treatments, such as dialectical behavior therapy (Linehan, 1996), have been shown to improve outcomes in these difficult cases (Dimeff & Koerner, 2007; Linehan et al., 1999). These complicated treatments require specialized training and continuous supervision to help staff deal with uncomfortable and confusing reactions that are commonly engendered in these challenging cases.

G. Criminal Thinking Interventions

As stated earlier, criminal-thinking patterns are observed frequently among drug court participants (Jones et al., 2015) and may contribute to program failure (responsivity need) and criminal recidivism (criminogenic need) (Gendreau et al., 1996; Helmond et al., 2015; Knight et al., 2006; Walters, 2003). Some drug court participants have considerable difficulty seeing other people's perspectives, recognizing their role in interpersonal conflicts, or anticipating consequences before they act. Moreover, they may hold counterproductive attitudes or values, such as assuming that all people are untrustworthy and motivated to manipulate or dominate others. Given such antisocial sentiments, these participants are often viewed as suspicious or manipulative in character, get into repeated conflicts with others, and fail to learn from negative social interactions.

Several manualized cognitive-behavioral interventions address criminal-thinking patterns among individuals addicted to drugs or charged with crimes. Evidence-based curricula demonstrating improved outcomes in drug court and similar programs include but are not limited to Moral Reconciliation Therapy (Cheesman & Kunkel, 2012; Heck, 2008; Kirchner & Goodman, 2007), Thinking for a Change (Lowenkamp et al., 2009), and Reasoning & Rehabilitation (Cullen et al., 2012; Tong & Farrington, 2006). Other curricula focused specifically on the needs of men in the criminal justice system, such as Habilitation, Empowerment and Accountability Therapy (Turpin & Wheeler, 2012; Vito & Tewksbury, 1998) and Helping Men Recover (Covington et al., 2011), are undergoing development and effectiveness testing in drug courts. Additional information about evidence-based criminal-thinking interventions is provided in Appendix D.

Studies have not determined when delivering criminal-thinking interventions is most beneficial. Clinical experience suggests the most beneficial time to introduce these interventions is after participants are stabilized in treatment and no longer experiencing acutely debilitating symptoms such as cravings, withdrawal, or anhedonia (Milkman & Wanberg, 2007). Until participants are no longer in acute distress, expecting them to benefit from a cognitive-behavioral intervention that requires them to maintain consistent attention and cognitive endurance is unrealistic. Participants should be stabilized clinically before a drug court can reasonably expect them to think flexibly about the motivations for their behaviors and the potential ramifications of continuing in their current behavioral patterns.

H. Family and Interpersonal Counseling

Reductions in substance abuse and crime go hand in hand with reduced family conflict, fewer interactions with delinquent relatives and peers, and increased interactions with sober and prosocial individuals (Berg & Huebner, 2011; Fergusson et al., 2002; Knight & Simpson, 1996; Wooditch et al., 2013; Wright & Cullen, 2004). These findings hold true in drug courts as they do in most correctional rehabilitation programs (Green & Rempel, 2012; Hickert et al., 2009).

Most studies of family treatments in drug courts have been conducted in the context of Family Drug Courts or Juvenile Drug Courts. Results have demonstrated consistently superior outcomes when manualized, cognitive-behavioral family interventions were added to the drug court curriculum, including Strengthening Families and Celebrating Families! (Brook et al., 2015) and modified versions of multidimensional family therapy (Dakof et al., 2009, 2010, 2015), multisystemic therapy (Henggeler et al., 2006), and functional family therapy (Datchi &

Sexton, 2013). [Further information about these and other evidence-based family treatments is provided in Appendix D.] Each of these treatments focuses on lessening familial conflict, reducing interactions with drug-using and antisocial peers and relatives, improving communication skills, and enhancing problem-solving skills. In the beginning of treatment, prosocial and drug-free family members, friends, or daily acquaintances are trained by staff to monitor participant behavior reliably, reinforce prosocial activities, respond appropriately and helpfully to problematic behaviors, reduce tension and conflict, and deescalate confrontations. As therapy progresses, treatment focuses on teaching all parties effective communication and problem-solving skills.

Studies have not determined when delivering family or interpersonal counseling in drug courts is most beneficial. Given the powerful association between family functioning and criminal justice outcomes, these services should be delivered as soon as practicable. Outcomes in substance abuse treatment are significantly better when at least one reliable and prosocial family member, friend, or close acquaintance is enlisted early in treatment to help the participant arrive on time for appointments and comply with other obligations in the program, such as following a curfew, adhering to prescribed medications, and avoiding forbidden locations like bars (Meyers et al., 1998; Roozen et al., 2010). The same individual may be enlisted to provide helpful observations to staff about the participant's conduct outside of treatment (Kirby et al., 1999). After participants are stabilized clinically, family interventions should focus on improving communication skills, altering maladaptive interactions, reinforcing prosocial behaviors, and reducing interpersonal conflicts.

I. Educational and Vocational Services

Approximately one-half to three-quarters of drug court participants have poor work histories or low educational achievement (Cissner et al., 2013; Deschenes et al., 2009; Green & Rempel, 2012; Hickert et al., 2009; Leukefeld et al., 2007). Being unemployed or having less than a high school diploma or general educational development (GED) certificate predicts poor outcomes in drug courts (DeVall & Lanier, 2012; Gallagher, 2013b; Gallagher et al., 2015; Mateyoke-Scrivener et al., 2004; Peters et al., 1999; Roll et al., 2005; Shannon et al., 2015) as it does in most other substance abuse treatment (Keefer, 2013) and correctional rehabilitation programs (Berg & Huebner, 2011; Wright & Cullen, 2004).

Unfortunately, few vocational or educational interventions have been successful at reducing crime (Aos et al., 2006; Cook et al., 2014; Farabee et al., 2014; Wilson et al., 2000) or substance abuse (Lidz et al., 2004; Magura et al., 2004; Platt, 1995). Disappointing results have commonly been attributable to poor quality and timing of the interventions. Many vocational programs amount to little more than job-placement services, which alert participants to job openings, place them in a job, or help them conduct a job search. Placing high-risk and high-need individuals in a job is unlikely to be successful if they continue to crave drugs or alcohol, experience serious mental health symptoms, associate with delinquent peers, or respond angrily or impulsively when they are criticized or receive negative feedback from others (Coviello et al., 2004; Lidz et al., 2004; Magura et al., 2004; Platt, 1995; Samenow, 2014). Improvements in education and employment rarely occur until after participants are stabilized clinically, cease interacting with delinquent peers, and learn to deal with frustration in a reasonably effective and mature manner.

At least two studies in drug courts have reported improved outcomes when unemployed or underemployed participants received a manualized, cognitive-behavioral vocational intervention. The effective interventions taught participants not only how to find a job, but also how to keep the job by behaving responsibly and dependably and how to land a better or higher-paying job in the future by continually honing their skills and productivity (Deschenes et al., 2009; Leukefeld et al., 2007). Comparable studies in drug abuse treatment reported improved outcomes when participants learned to interact effectively with coworkers and employers and resolve interpersonal conflicts on the job (Platt et al., 1993; Platt, 1995).

Studies have not determined when administering vocational or educational interventions is most beneficial. For high-risk and high-need individuals, these services are best introduced late in the course of drug court after participants have secured safe and stable housing, their addiction and mental health symptoms have resolved

substantially, they have completed a criminal-thinking intervention, and they are spending most or all of their time interacting with prosocial, sober, and supportive peers (Magura et al., 2004; Platt, 1995). For many high-risk and high-need participants, this preparatory process may require at least six months of treatment, and twelve months may be needed for individuals with serious substance use disorders or mental illness (Gottfredson et al., 2007; Peters et al., 2002).

J. Medical and Dental Treatment

Approximately one-quarter of drug court participants suffer from chronic medical or dental conditions that cause them serious discomfort, require ongoing medical attention, or interfere with their daily functioning (Green & Rempel, 2012). Medical and dental problems are typically maintenance needs, meaning they are most often a result rather than the cause of substance abuse and crime but can interfere with the maintenance of treatment gains. (An obvious exception is participants who become addicted to prescription medications during the course of medical or dental treatment.) Evidence suggests providing medical or dental treatment can improve outcomes for some drug court participants (Carey et al., 2012). Moreover, for humanitarian reasons, treating pain or discomfort regardless of the impact on criminal justice outcomes is always important.

No study has determined when addressing medical or dental concerns in drug courts is most appropriate. Needless to say, conditions that are life-threatening or may cause long-term disability should be treated immediately. However, waiting until later phases of drug court to treat nonessential or nonacute conditions that are exacerbated or maintained by substance abuse may be prudent. Outcomes may be better if medical or dental services are delivered after participants have achieved sobriety and relinquished other antisocial behaviors. For example, participants who abuse methamphetamine often have serious dental problems (American Dental Association, n.d.). If these dental problems are not causing acute distress, it might be appropriate to wait until the participant has stopped using methamphetamine before attempting dental repairs. Continued substance abuse risks undoing dental efforts and may cause a participant to discontinue dental treatment prematurely. A more efficient use of resources may be to address nonessential dental or medical treatment in a late phase of drug court or as part of a participant's continuing-care plan so as to maintain and extend the drug court's beneficial effects. A logical first step is to refer participants for routine medical and dental checkups to establish relationships with health care providers and begin a long-term process of preventive and routine medical and dental care.

K. Prevention of Health-Risk Behaviors

Alarming high percentages of drug court participants engage in behaviors which put them at serious risk for contracting human immunodeficiency virus (HIV) and other sexually transmitted diseases (STDs). In some studies, approximately 50% to 85% of drug court participants reported engaging in frequent unprotected sex with multiple sex partners (Festinger et al., 2012; Robertson et al., 2012; Tolou-Shams et al., 2012). Drug court participants were found in one study to lack basic knowledge about simple self-protective measures they can take to reduce their health-risk exposure, such as using condoms and cleaning injection needles (Robertson et al., 2012).

A recent systematic review identified several brief educational interventions that are proven to reduce HIV risk behaviors among drug-addicted persons in the criminal justice system (Underhill et al., 2014). [Additional resources for identifying effective health-risk prevention programs are provided in Appendix D.] Most effective interventions are brief and inexpensive to administer, and some can be delivered via computer or videotape with minimal burden on staff. The criminal justice system is a major vector for the spread of HIV, STDs, and other serious communicable diseases (Belenko et al., 2004; Spaulding et al., 2009). Impacts on crime and substance abuse aside, drug courts have a responsibility to reduce the chances that participants will contract a life-threatening or incurable illness, especially in light of the fact that effective interventions can be delivered at minimal cost and burden to the program.

L. Overdose Prevention and Reversal

Unintentional overdose deaths from illicit and prescribed opiates have more than tripled in the past fifteen years (Meyer et al., 2014). Individuals addicted to opiates are at especially high risk for overdose death following release from jail or prison because tolerance to opiates decreases substantially during periods of incarceration (Dolan et al., 2005; Strang, 2015; Strang et al., 2014).

Drug courts should educate participants, their family members, and close acquaintances about simple precautions they can take to avoid or reverse a life-threatening drug overdose. At a minimum, this should include providing emergency phone numbers and other contact information to use in the event of an overdose or similar medical emergency.

As permitted by law, drug courts should also support local efforts to train drug court personnel, probation officers, law enforcement, and other persons likely to be first responders to an overdose on the safe and effective administration of overdose-reversal medications such as naloxone hydrochloride (naloxone or Narcan). Naloxone is nonaddictive, nonintoxicating, poses a minimal risk of medical side effects, and can be administered intranasally by nonmedically trained laypersons (Barton et al., 2002; Kim et al., 2009). The Centers for Disease Control and Prevention (2012) estimates that more than 10,000 potentially fatal opiate overdoses have been reversed by naloxone administered by nonmedical laypersons. Studies in the U.S. and Scotland confirm that educating at-risk persons and their significant others about ways to prevent or reverse overdose, including the use of naloxone, significantly reduces overdose deaths (National Institute on Drug Abuse, 2014; Strang, 2015).

State laws vary in terms of who may administer naloxone. Some states shield professional first responders and nonprofessional Good Samaritans from criminal or civil liability if they administer naloxone or render comparable medical aid in the event of a drug overdose (Strang et al., 2006). Other states restrict administration of naloxone to licensed medical providers, trained law enforcement personnel, or other professional first responders.

Some drug court professionals may fear this practice could give the unintended message to participants that continued drug use is acceptable or anticipated. On the contrary, educating participants about drug overdose delivers a clear message about the potentially fatal consequences of continued drug abuse. Moreover, drug-abstinent participants may find themselves in the position of needing to save the life of a nonsobber family member or acquaintance. Preparing participants to respond effectively in such circumstances delivers the prosocial message that they have a responsibility to help their fellow citizens.

VII. Drug and Alcohol Testing

Certainty is one of the most influential factors for success in a behavior modification program (Harrell & Roman, 2001; Marlowe & Kirby, 1999). Outcomes improve significantly when detection of substance use is likely (Kilmer et al., 2012; Marques et al., 2014; Schuler et al., 2014), and participants receive incentives for abstinence and sanctions or treatment adjustments for positive test results (Hawken & Kleiman, 2009; Marlowe et al., 2005). Therefore, the success of any drug court will depend, in part, on the reliable monitoring of substance use. If a drug court does not have accurate and timely information about whether participants are maintaining abstinence from alcohol and other drugs, the team has no way to apply incentives or sanctions correctly or to adjust treatment and supervision services accordingly. Drug and alcohol testing also serves other important therapeutic aims, such as helping to confirm clinicians' diagnostic impressions, providing objective feedback to participants about their progress or lack thereof in treatment, and assisting clinicians to challenge and resolve participant denial about the severity of their problems (American Society of Addiction Medicine (ASAM), 2010, 2013; DuPont & Selavka, 2008; DuPont et al., 2014; Srebnik et al., 2014).

Participants cannot be relied upon to self-disclose substance use accurately (Hunt et al., 2015). Studies consistently find that between 25% and 75% of participants in substance abuse treatment deny recent substance use when biological testing reveals a positive result (Auerbach, 2007; Harris et al., 2008; Hindin et al., 1994; Magura & Kang, 1997; Morral et al., 2000; Peters et al., 2015; Tassiopoulos et al., 2004). The accuracy of self-reporting is particularly low among individuals involved in the criminal justice system, presumably because they are likely to receive sanctions for substance use (Harrison, 1997; Peters et al., 2015). Although some clinicians may assume that the accuracy of self-report increases during the course of treatment, contrary evidence suggests participants may be *less* likely to acknowledge substance use after they have been enrolled in treatment for a period of time or have completed treatment (Wish et al., 1997). The longer participants are in treatment, the more staff come to expect and insist upon abstinence. For this reason, participants find it increasingly difficult to admit to substance abuse after they have been enrolled in treatment for several months (Davis et al., 2014; Nirenberg et al., 2013).

Best practices for conducting drug and alcohol testing vary considerably depending on whether a test is administered intermittently as opposed to continually, the length of the test's detection window, and the range of substances the test is capable of detecting. Some tests, such as urine or oral fluid tests, must be administered repeatedly, whereas others, such as sweat patches or ankle monitors, can measure substance use over extended periods of time. Most drug metabolites are detectable in urine for approximately two to four days, but are detectable in oral fluid for an average of twenty-four hours and in breath or blood for less than twelve hours (Auerbach, 2007; Cary, 2011; DuPont et al., 2014). Some tests, such as breathalyzers, can only assess for alcohol use, whereas urine tests can assess for a wide range of substances. These factors influence how the tests must be used to obtain useful results.

Urine testing is, by far, the most common methodology used in drug courts and probation programs. This is because urine is typically available in copious amounts, is relatively simple to collect, does not require elaborate sample preparation procedures, is inexpensive to analyze, and can be examined for many substances (Cary, 2011). Most studies, to date, have examined best practices for conducting urine testing with offenders; however, recent studies have begun to examine other testing methods in drug courts, including sweat patches and ankle monitors.

A. Frequent Testing

The more frequently drug courts and probation programs perform urine drug testing, the better their outcomes in terms of higher graduation rates and lower drug use and criminal recidivism (Banks & Gottfredson, 2003; Gottfredson et al., 2007; Griffith et al., 2000; Harrell et al., 1998; Hawken & Kleiman, 2009; Kinlock et al., 2013; National Institute on Drug Abuse, 2006). In focus groups, drug court participants consistently identified frequent drug and alcohol testing as being among the most influential factors for success in the program (Gallagher et al., 2015; Goldkamp et al., 2002; Saum et al., 2002; Turner et al., 1999; Wolfer, 2006).

The most effective drug courts perform urine drug testing at least twice per week for the first several months of the program (Carey et al., 2008). In a multisite study of approximately seventy drug courts, programs performing urine testing at least twice per week in the first phase produced 38% greater reductions in crime and were 61%

more cost-effective than programs performing urine testing less frequently (Carey et al., 2012). Because the metabolites of most drugs of abuse are detectable in urine for approximately two to four days, testing less frequently leaves an unacceptable time gap during which participants can abuse substances and evade detection, thus leading to significantly poorer outcomes (Stitzer & Kellogg, 2008).

Recent studies have examined the impact of other testing methods in drug courts. The Secure Continuous Remote Alcohol Monitor (SCRAM) is an ankle device that can detect alcohol in sweat and transmits a wireless signal to a remote monitoring station. Preliminary evidence suggests the use of a SCRAM may deter alcohol consumption and alcohol-impaired driving among recidivist driving-while-impaired (DWI) offenders if it is worn for at least ninety consecutive days (Flango & Cheesman, 2009; Tison et al., 2015). Another study found that adding sweat patches to urine testing did not improve outcomes in a drug court (Kleinpeter et al., 2010). However, that study did not examine the influence of sweat patches alone or as compared against urine testing. The study merely found that the addition of sweat patches did not improve outcomes beyond what was already being achieved from frequent urine drug testing.

Ethyl glucuronide (EtG) and ethyl sulfate (EtS) are metabolites of alcohol that can be detected in urine for longer periods of time than ethanol. The use of EtG or EtS can extend the time window for detecting alcohol consumption from several hours to several days (Cary, 2011). A recent randomized, controlled trial reported that participants completed the first two phases of a drug court significantly sooner when they were subjected to weekly EtG and EtS testing (Gibbs & Wakefield, 2014). The EtG and EtS testing enabled the drug court to respond more rapidly and reliably to instances of alcohol use, thus producing more efficient results. Importantly, EtG and EtS testing was determined in the same study to be superior to standard ethanol testing for detecting alcohol use occurring over weekends. Because some drug courts may not perform drug or alcohol testing on weekends, weekday tests capable of detecting weekend substance use are crucial.

As was noted previously, some drug or alcohol tests have short detection windows of twelve to twenty-four hours. This makes them generally unsuitable for use as the primary testing method in drug courts. Such tests can be used effectively, however, for spot-testing when recent use is suspected or during high-risk times, such as weekends or holidays. Evidence also suggests these tests can deter substance use effectively if they are administered on a daily basis. A statewide study in South Dakota found that daily breathalyzer testing significantly reduced failures to appear and rearrest rates among DWI offenders released on bail (Kilmer et al., 2012). In that study, daily breathalyzer testing appears to have been sufficient to deter alcohol consumption in the majority of cases without the need for additional services.

B. Random Testing

Drug and alcohol testing is most effective when performed on a random basis (ASAM, 2013; ASAM, 2010; Auerbach, 2007; Carver, 2004; Cary, 2011; Harrell & Kleiman, 2002; McIntire et al., 2007). If participants know in advance when they will be tested, they can adjust the timing of their usage or take other countermeasures, such as excessive fluid consumption, to defraud the tests (McIntire & Lessenger, 2007). Random drug testing elicits significantly higher percentages of positive tests than prescheduled testing, suggesting that many participants can evade detection if they have advance notice about when testing will occur (Harrison, 1997).

Random testing means the odds of being tested are the same on any given day of the week, including weekends and holidays. For example, if a participant is scheduled to be drug tested two times per week, then the odds of being tested should be two in seven (28%) on every day of the week. For this reason, drug courts should not schedule their testing regimens in seven-day or weekly blocks, which is a common practice. Assume, for example, that a participant is randomly selected for drug testing on Monday and Wednesday of a given week. If testing is scheduled in weekly blocks, then the odds of that same participant being selected again for testing on Thursday will be zero. In behavioral terms, this is referred to as a *respite* from detection, which can lead to increased drug or alcohol use owing to the absence of negative consequences (Marlowe & Wong, 2008).

The odds of being tested for drugs and alcohol should be the same on weekends and holidays as on any other day of the week (Marlowe, 2012). Weekends and holidays are high-risk times for drug and alcohol use (Kirby et al., 1995; Marlatt & Gordon, 1985). Providing a respite from detection during high-risk times reduces the randomness of testing and undermines the central aims of a drug-testing program (ASAM, 2013).

Limiting the time delay between notification of an impending drug or alcohol test and collection of the test specimen is essential (ASAM, 2013). If participants can delay provision of a specimen for even a day or two, they can rely on natural elimination processes to reduce drug and metabolite concentrations below cutoff levels. For participants who live in close proximity to the testing facility and do not have confirmed scheduling conflicts, drug courts can reasonably expect samples to be delivered within a few hours of notification that a test has been scheduled (Cary, 2011). Barring exigent circumstances, participants should be required to deliver a urine specimen no more than eight hours after being notified that a urine test has been scheduled (Auerbach, 2007). This practice should give most participants ample time to meet their daily obligations and travel to the sample collection site, while also reducing the likelihood that metabolite concentrations will fall below cutoff levels. For tests with short detection windows of less than twenty-four hours, such as oral fluid tests, participants should be required to deliver a specimen no more than four hours after being notified that a test has been scheduled.

C. Duration of Testing

A basic tenet of behavior modification provides that the effects of any intervention should be assessed continually until all components of the intervention are completed (Rusch & Kazdin, 1981). This is the only way to know whether a participant is likely to relapse or regress after the program ends.

Drug courts commonly decrease the intensity of treatment and supervision as participants make progress in the program. For example, the frequency of court hearings or case management sessions is commonly reduced as participants advance through successive phases. With a reduction of services comes the ever-present risk of relapse or other behavioral setback; therefore, drug and alcohol testing should continue uninterrupted to reveal any relapse as other components of the participants' treatment regimens are adjusted (Cary, 2011; Marlowe, 2011, 2012). Although research has not addressed the issue, logic dictates maintaining the frequency of drug and alcohol testing until participants are engaged in what will ultimately be their continuing-care or aftercare plan. This practice provides the greatest assurance that participants are likely to remain abstinent after program graduation.

D. Breadth of Testing

Drug courts must test for the full range of substances that are likely to be used by participants in the program. Participants can easily evade detection of their substance use on many standard test panels—such as the National Institute on Drug Abuse five-panel test (NIDA-5) or a standard eight-panel test—simply by switching to other drugs of abuse that have similar psychoactive effects but are not detected by the test (ASAM, 2013). For example, heroin users can avoid detection by many standard test panels if they switch to pharmaceutical opioids, such as oxycodone or buprenorphine (Wish et al., 2012). Similarly, marijuana users can avoid detection by using synthetic cannabinoids, such as K2 or Spice, which were developed for the specific purpose of avoiding detection (Cary, 2014; Castaneto et al., 2014). Studies confirm that some marijuana users do switch to synthetic cannabinoids to evade detection by drug tests and then return to marijuana use after the testing regimen has been discontinued (Perrone et al., 2013). Because new substances of abuse are constantly being sought out by offenders to cheat drug tests, drug courts should select test specimens randomly and frequently and examine them for a wide range of potential drugs of abuse that might be emerging in their population (ASAM, 2013).

E. Witnessed Collection

Drug court participants and probationers acknowledge engaging in widespread efforts to defraud drug and alcohol tests. These efforts include, but are not limited to, consuming excessive water to dilute the sample (dilution),

adulterating the sample with chemicals intended to mask a positive result (adulteration), and substituting another person's urine or a look-alike sample that is not urine, such as apple juice (substitution) (Cary, 2011; McIntire & Lessenger, 2007). Collectively, these efforts are referred to as tampering. In focus groups, drug court participants reported being aware of several individuals in their program who tampered with drug tests on more than one occasion without being detected by staff (Goldkamp et al., 2002).

The most effective way to avoid tampering is to ensure that sample collection is witnessed directly by a trained and experienced staff person (ASAM, 2013; Cary, 2011). If substitution or adulteration is suspected, a new sample should be collected immediately under closely monitored conditions (McIntire et al., 2007). Staff members should be trained in how to implement countermeasures to avoid tampered test specimens. Examples of such countermeasures include searching participants' clothing for chemical adulterants or fraudulent samples, requiring participants to leave outerwear outside of the test-collection room, and putting colored dye in the sink and toilet to prevent water from being used to dilute test specimens (McIntire & Lessenger, 2007).

If substitution or other efforts at tampering are suspected for a urine specimen, it may be useful to obtain an oral fluid specimen immediately as a secondary measure of substance use. Generally speaking, observing the collection of oral fluid closely is easier than for the collection of urine, and oral fluid tests are less susceptible to dilution than urine tests (Heltsley et al., 2012; Sample et al., 2010). However, because oral fluid testing has a shorter detection window than urine testing, a negative oral fluid test would not necessarily rule out recent drug use or the possibility of a tampered urine test.

Because specialized training is required to minimize tampering of test specimens, under most circumstances participants should be precluded from undergoing drug and alcohol testing by independent sources. In exigent circumstances, such as when participants live a long distance from the test collection site, the drug court might designate independent professionals or laboratories to perform drug and alcohol testing. As a condition of approval, these professionals should be required to complete formal training on the proper collection, handling, and analyses of drug and alcohol test samples among drug court participants or comparable criminal justice populations. Drug courts are also required to follow generally accepted chain-of-custody procedures when handling test specimens (ASAM, 2013; Cary, 2011; Meyer, 2011). Therefore, if independent professionals or laboratories perform drug and alcohol testing, they must be trained carefully to follow proper chain-of-custody procedures.

F. Valid Specimens

Several low-cost analyses can be performed to detect adulterated or diluted test specimens (McIntire et al., 2007). The temperature of each urine specimen should be examined immediately upon collection to ensure it is consistent with an expected human body temperature. An unusual temperature might suggest the sample cooled down because it was collected at an earlier point in time, or was mixed with water that was too cold or too hot to be consistent with body temperature. Under normal conditions, urine specimens should be between 900 and 1000 F within four minutes of collection, and a lower or higher temperature likely indicates a deliberate effort at deception (ASAM, 2013; Tsai et al., 1998).

Urine specimens should also be tested for creatinine and specific gravity. Creatinine is a metabolic product of muscle contraction that is excreted in urine at a relatively constant rate. A creatinine level below 20 mg/dL is rare and is a reliable indicator of an intentional effort at dilution or excessive fluid consumption barring unusual medical or metabolic conditions (ASAM, 2013; Cary, 2011; Jones & Karlsson, 2005; Katz et al., 2007). Specific gravity reflects the amount of solid substances that are dissolved in urine. The greater the specific gravity, the more concentrated the urine; and the lower the specific gravity, the closer its consistency to water. The normal range of specific gravity for urine is 1.003 to 1.030, and a specific gravity of 1.000 is essentially water. Some experts believe a specific gravity below 1.003 reflects a diluted sample (Katz et al., 2007). Although this analysis, by itself, may not be sufficient to prove excessive fluid consumption, dilution is likely to have occurred if the specific gravity is low and accompanies other evidence of tampering or invalidity, such as a low creatinine level

or temperature. Several commercially available test strips, such as Adultacheck and Intect, have also been shown to reliably detect dilution or adulteration of urine test samples (Dasgupta et al., 2004; Mikkelsen & Ash, 1988).

G. Accurate and Reliable Testing Procedures

To be admissible as evidence in a legal proceeding, drug and alcohol test results must be derived from scientifically valid and reliable methods (Meyer, 2011). Appellate courts have recognized the scientific validity of several commonly used methods for analyzing urine, including gas chromatography/mass spectrometry (GC/MS), liquid chromatography/tandem mass spectrometry (LC/MS/MS), the enzyme multiple immunoassay technique (EMIT), and some sweat, oral fluid, hair, and ankle-monitor tests (Meyer, 2011).

Tests such as GC/MS and LC/MS/MS are referred to as instrumented tests, laboratory-based tests, or confirmation tests. These tests have a higher degree of scientific precision than immunoassay tests, point of collection tests (POCT), or screening tests, such as on-site test cups or instant test strips. If a participant denies substance use in the face of a positive screening test, courts will typically require, and toxicology experts recommend, performing confirmation testing using GC/MS or a similar instrumented technique (ASAM, 2013; Cary, 2011). Confirmation with an instrumented test virtually eliminates the odds of a false-positive result, assuming the sample was collected and stored properly (Auerbach, 2007; Peat, 1988). Drug courts commonly require participants to pay the cost of confirmation tests if the initial screening result is confirmed (Cary, 2011; Meyer, 2011). Confirmation testing should be performed on a portion of the original test specimen. If confirmation testing is performed on a different specimen that was collected at a later point in time, a conflicting result might not reflect a failure to confirm but rather differences in the detection windows for the tests or the metabolic processes of the participant.

Drug courts must follow generally accepted chain-of-custody procedures when handling test specimens (ASAM, 2013; Cary, 2011; Meyer, 2011). They need to establish a reliable paper trail identifying each professional who handled the specimen from collection through laboratory analysis to reporting of the results. Establishing a proper chain of custody requires sufficient labeling and security measures to provide confidence the specimen belongs to the individual identified on the record and the specimen was transported and stored according to generally accepted laboratory procedures and manufacturer recommendations.

Some drug courts interpret changes in quantitative levels of drug metabolites as evidence that new substance use has occurred or a participant's substance use pattern has changed. Unless a drug court has access to an expert trained in toxicology, pharmacology, or a related discipline, such practices should be avoided. Quantitative metabolite levels can vary considerably based on a number of factors, including the total fluid content in urine or blood (Cary, 2004; Schwilke et al., 2010). Moderate changes in participants' fluid intake or fluid retention could lead drug courts to miscalculate substance use patterns. Most drug and alcohol tests used in drug courts were designed to be *qualitative*, meaning they were designed to determine whether a drug or drug metabolite is present at levels above a prespecified concentration level. The cutoff concentration level is calculated empirically to maximize the true-positive rate, true-negative rate, or classification rate. When drug courts engage in quantitative analyses, they are effectively altering the cut-off score and making the results less accurate.

Some drug courts have difficulty interpreting positive cannabinoid (marijuana) test results. Because cannabinoids are lipid-soluble (i.e., bind to fat molecules), they may be excreted more slowly than other substances of abuse. This has caused confusion about when a positive cannabinoid result may be interpreted as evidence of new use as opposed to residual use from an earlier episode. A participant is highly unlikely to produce a cannabinoid-positive urine result above 50 ng/mL after more than ten days following cessation of chronic usage or for more than three to four days following a single-use event (Cary, 2005). Therefore, a drug court would be justified in considering the first two weeks of enrollment to be a grace period during which there would be no sanctions for positive cannabinoid test results. However, subsequent positive tests may be interpreted as evidence of new cannabis use and dealt with accordingly. Moreover, once a participant has produced two consecutive cannabinoid-negative urine specimens (called an *abstinence baseline*), a subsequent cannabinoid-positive test may be interpreted as new use (Cary, 2005). Some drug courts or laboratories may employ a lower cutoff level of 20

ng/mL for cannabis metabolites. Using this lower cutoff, thirty days is sufficient to establish a presumptive abstinence baseline even for chronic users (Cary, 2005); in the majority of cases, twenty-one days should be sufficient.

Some participants may attempt to attribute a positive cannabinoid test to passive inhalation or second-hand smoke. This excuse should not be credited. The likelihood of passive inhalation triggering a positive cannabinoid test is negligible (Cone et al., 2014; Law et al., 1984; Katz et al., 2007; Niedbala et al., 2005). Moreover, because drug court participants are usually prohibited from associating with people who are engaged in substance use, passive inhalation may be viewed as a violation of this central prohibition, thus meriting an additional sanction (Marlowe, 2011).

H. Rapid Results

In addition to certainty, timing is one of the most influential factors for success in a behavior modification program (Harrell & Roman, 2001; Marlowe & Kirby, 1999). The sooner sanctions are delivered after an infraction and incentives delivered after an achievement, the better the results. Because sanctions and incentives are imposed routinely on the basis of drug and alcohol test results, the drug court team needs test results before participants appear for status hearings.

A study of approximately seventy drug courts reported significantly greater reductions in criminal recidivism and significantly greater cost benefits when the teams received drug and alcohol test results within forty-eight hours of sample collection (Carey et al., 2012). Drug courts that received test results within forty-eight hours were 73% more effective at reducing crime and 68% more cost-effective than drug courts receiving test results after longer delays. Ordinarily, negative test results should take no longer than one business day to produce, and positive results should require no more than two days if confirmation testing is requested (Cary, 2011; Robinson & Jones, 2000).

I. Participant Contract

Outcomes are significantly better when drug courts specify their policies and procedures clearly in a participant manual or handbook (Carey et al., 2012). Criminal defendants are significantly more likely to react favorably to an adverse judgment if they were given advance notice about how such judgments would be made (Burke & Leben, 2007; Frazer, 2006; Tyler, 2007). Drug courts can enhance participants' perceptions of fairness substantially and reduce avoidable delays from contested drug and alcohol tests by describing their testing procedures and requirements in a participant contract or handbook.

Below are examples of provisions that should be included in a participant contract to address many of the best practices discussed above. For participants with limited educational histories, the language may need to be simplified and the requirements explained orally. Repeat the information periodically to ensure participants understand their rights and obligations.

- Drug and alcohol testing will be performed frequently and on a random basis throughout your enrollment in the drug court.
- Drug and alcohol testing will be performed on weekends and holidays.
- Drug and alcohol testing will be performed by a laboratory or program approved by the drug court.
- Because cannabinoids (a byproduct of marijuana) may persist in the body for several days, marijuana users have a two-week grace period following enrollment during which no sanctions will be given for positive cannabinoid test results. However, after two weeks positive cannabinoid tests will be presumed to reflect new marijuana use. Participants bear the burden of establishing a convincing alternative explanation for such results. After you have had two consecutive cannabinoid-negative urine specimens, the drug court will presume that subsequent positive cannabinoid results reflect new use.

- You must arrive at the testing facility as soon as possible after being notified that a test has been scheduled. You will be sanctioned for an unexcused failure to arrive within eight hours of being notified that a urine test has been scheduled or within four hours for tests that have short detection windows, such as breath or oral fluid tests.
- A staff person will directly observe the collection of test specimens. The staff person will be the same gender as you unless you, your defense attorney or your therapist request otherwise.
- Failure to provide a test specimen or providing an insufficient volume of fluid for analysis is an infraction of the rules of the program and will be sanctioned accordingly. You will be given a sufficient time (up to one hour) to deliver a urine specimen and allowed to drink up to one cup of water in the presence of staff.
- You may not drink any fluid excessively before testing and must avoid environmental contaminants, over-the-counter medications, or foods that can reduce the accuracy of the tests. Potential contaminants that you need to avoid are [provide list of contaminants].
- You may be subjected to immediate spot testing if the drug court has reason to suspect recent use or during high-risk times such as weekends or holidays.
- You have the right to challenge the results of a screening test and to request proof that an adequate chain of custody was established for your specimen. The drug court will rely on the results of an instrumented or laboratory-based test in confirming whether substance use has occurred. You may be charged the cost of the confirmation test if a screening test is confirmed.
- You will be sanctioned for providing diluted, adulterated, or substituted test specimens. Urine specimens below 90° F, above 100° F, or that have a creatinine level below 20 mg/dL will be presumed to be diluted or fraudulent. Participants bear the burden of establishing a convincing alternative explanation for such results. Under such circumstances, you may receive two sanctions, one for the substance use and one for the effort at deception.
- You will be sanctioned for using synthetic substances such as K2 or Spice that are designed to avoid detection by standard drug tests. Switching to a new substance of abuse (for example, switching from heroin to an unauthorized prescription opioid) will be presumed to be an effort to defraud the drug test. You may receive two sanctions in such circumstances, one for the substance use and one for the effort at deception.
- You will be sanctioned for associating with other people who are engaged in substance use or for exposing yourself to passive inhalation or secondhand smoke.

VIII. Multidisciplinary Team

A. Team Composition

Studies reveal the composition of the drug court team has a substantial influence on outcomes. Drug courts produce significantly greater reductions in criminal recidivism and are significantly more cost-effective when the following professionals are dedicated members of the drug court team and participate regularly in pre-court staff meetings and status hearings (Carey et al., 2008, 2012; Cissner et al., 2013; Rossman et al., 2011; Shaffer, 2010):

- *Judge*—Typically a trial court judge leads the drug court team; however, in some jurisdictions a nonjudicial officer such as a magistrate or commissioner may preside over the drug court. Nonjudicial officers usually report directly to a judge and require judicial authorization for actions that affect participants' liberty interests such as jail sanctions or discharge from the program. No study has compared outcomes between judges and nonjudicial officers.
- *Program Coordinator*—Typically a court administrator or clerk serves as the coordinator for the drug court program; however, some drug courts may employ a senior probation officer, case manager, or clinician as the coordinator. Among many other duties, the coordinator is responsible for maintaining accurate and timely records and documentation for the program, overseeing fiscal and contractual obligations, facilitating communication between team members and partner agencies, ensuring policies and procedures are followed, overseeing collection of performance and outcome data, scheduling court sessions and staff meetings, and orienting new hires.
- *Prosecutor*—Typically an assistant district attorney serves on the team. Among other duties, the prosecutor advocates on behalf of public safety, victim interests, and holding participants accountable for meeting their obligations in the program. The prosecutor may also help to resolve other pending legal cases that impact participants' legal status or eligibility for drug court.
- *Defense Attorney*—Typically an assistant public defender or private defense attorney specializing in drug court cases serves on the team. Among other duties, the defense attorney ensures participants' constitutional rights are protected and advocates for participants' stated legal interests. Defendants are usually represented by a public defender or private defense attorney in proceedings leading up to their entry into drug court. After entry, participants may retain their previous defense counsel, provide informed consent to be represented by a defense representative serving on the drug court team, or consent to be represented jointly by private defense counsel and the defense representative. In cases of joint representation, the defense representative typically handles most day-to-day issues relating to drug court participation, but private counsel may step in if the participant faces a potential jail sanction or discharge from the program (Freeman-Wilson et al., 2003; Tobin, 2012).
- In postconviction drug courts, participation in the program is a condition of probation or part of a criminal sentence. Ordinarily, participants are not entitled to defense representation at the postconviction stage unless they face a potential jail sanction or revocation of probation (Meyer, 2011a). Nevertheless, postconviction drug courts should include a defense representative on their team because studies indicate defense involvement improves outcomes significantly (Carey et al., 2012; Cissner et al., 2013; National Association of Drug Court Professionals [NADCP], 2009). Evidence suggests participants may be more likely to perceive drug court procedures as fair when a dedicated defense attorney represents their interests in team meetings and status hearings (Frazer, 2006), and greater perceptions of fairness are consistently associated with better outcomes in drug courts and other problem-solving courts (Berman & Gold, 2012; Burke, 2010; Gottfredson et al., 2007; Rossman et al., 2011).
- Some drug courts require participants to waive defense representation as a condition of entry. Although no case has addressed this issue squarely in the context of drug court, the weight of legal authority suggests defendants and probationers are entitled to withdraw such waivers and reassert their right to counsel at critical stages in the proceedings such as when they face a potential jail sanction or probation revocation (McKaskle v. Wiggins, 1984; Menefield v. Borg, 1989; Robinson v. Ignacio, 2004; State v. Pitts, 2014). Regardless of the legality of such waivers, defense representation should be encouraged

- rather than discouraged in drug courts because doing so is associated with significantly better outcomes and ensures participants' due process rights are protected (Hora & Stalcup, 2008; NADCP, 2009).
- *Community Supervision Officer*—Typically a probation officer or pretrial services officer serves on the team; however, some drug courts may rely on law enforcement or specially trained case managers or social service professionals to provide community supervision. Duties of the community supervision officer may include performing drug and alcohol testing, conducting home or employment visits, enforcing curfews and travel restrictions, and delivering cognitive-behavioral interventions designed to improve participants' problem-solving skills and alter dysfunctional criminal-thinking patterns (Harberts, 2011).
 - *Treatment Representative*—Typically an addiction counselor, social worker, psychologist, or clinical case manager serves on the team. In many drug courts, participants can be referred to multiple treatment agencies or providers for substance abuse treatment and other complementary services such as mental health counseling or vocational rehabilitation. Because it is unwieldy to have multiple providers attend pre-court staff meetings and status hearings, many drug courts will designate one or two treatment professionals to serve as treatment representatives on the drug court team (Carey et al., 2012). The treatment representatives receive clinical information from programs treating drug court participants, report that information to the drug court team, and contribute clinical knowledge and expertise during team deliberations.
 - *Law Enforcement Officer*—Typically a police officer, deputy sheriff, highway patrol officer, or jail official serves on the team. Law enforcement is often the eyes and ears of drug court on the street, observing participant behavior and interacting with participants in the community. Law enforcement may also assist with home and employment visits, and serves as a liaison between the drug court and the police department, sheriff's office, jail, and correctional system.

Drug courts may include other community representatives on their team as well, such as peer mentors, vocational advisors, or sponsors from the self-help recovery community. Studies have not examined the impact of including such persons on the drug court team; however, anecdotal reports suggest this practice can enhance team decision making and effectiveness (Taylor, 2014). As a condition of federal grant funding and funding from many states, drug courts may also be required to include an evaluator on their team beginning in the planning stages for the program and continuing during implementation. This practice helps to ensure drug courts collect reliable performance data to report to grant-making authorities and is generally advisable for all drug courts to ensure good-quality program monitoring and evaluation [see Standard X, Monitoring and Evaluation]. Finally, drug courts may be advised to include a nurse or physician on their team if they treat substantial numbers of participants requiring medication-assisted treatment or suffering from co-occurring medical or mental health disorders.

B. Pre-Court Staff Meetings

The drug court model requires drug courts to hold pre-court staff meetings—commonly referred to as *staffings* or *case reviews*—to review participant progress, develop a plan to improve outcomes, and prepare for status hearings in court (Hardin & Fox, 2011; NADCP, 1997; Roper & Lessenger, 2007). Not every participant is discussed in every meeting; however, staffings are held frequently enough (typically weekly or at the same frequency as status hearings) to ensure the team has an opportunity to consider the needs of each case.

Consistent attendance by all team members at staffings is associated with significantly better outcomes (Carey et al., 2012; Cissner et al., 2013; Rossman et al., 2011; Shaffer, 2010). A multisite study of approximately seventy drug courts found that programs were 50% more effective at reducing recidivism when all team members—the judge, prosecutor, defense representative, program coordinator, treatment representative, law-enforcement representative, and community supervision officer—attended staffings on a consistent basis (Carey et al., 2008, 2012). Drug courts were nearly twice as cost-effective when defense counsel attended staffings consistently, and were more than twice as effective at reducing recidivism when the program coordinator, treatment representative, and law enforcement representative attended staffings consistently (Carey et al., 2012).

In most drug courts, staffings are presumptively closed. Discussions are not transcribed or recorded and the meeting is not open to the public or to participants unless the court has a good reason to allow a participant to attend discussions related to his or her case. Few appellate opinions have addressed the constitutionality or legality of closing staffings. In a recent opinion, the Washington State Supreme Court— which traditionally holds a very dim view of off-the-record proceedings—ruled that staffings may be presumptively closed at the discretion of the drug court judge (*State of Washington v. Sykes*, 2014). The Court analogized staffings to *pre-court conferences* in which attorneys commonly meet with the judge in chambers to clarify what legal issues are under contention, determine which facts are in dispute, and address other practical or collateral matters necessary to achieve a fair and efficient resolution of the case, such as scheduling witnesses or issuing discovery orders. In line with this reasoning, staffings may be closed so long as no final decisions are reached concerning disputed facts or legal issues in the case, and the judge recites in open court what decisions, if any, were made during the staffing. A closed staffing may not result in a binding order or factual conclusion related to a contested matter (Meyer, 2011a). Contested matters must be addressed and resolved in open court during status hearings or related due process hearings such as termination hearings or probation violation hearings.

Studies have not determined whether closed staffings produce more favorable outcomes than open staffings. The rationale for closing staffings derives largely from empirical studies and ethical analyses conducted in the context of psychotherapy progress notes and case conferences. For example, the Health Insurance Portability and Accountability Act (HIPAA) of 1996 grants broad access for patients to their health records, yet provides a lone exception for psychotherapy progress notes (45 C.F.R. §§ 164.508(a)(2) & 164.524; U.S. Dept. of Health & Human Services [U.S. DHHS], 2003; *Wooten v. Duane Reade*, 2009). Psychotherapy notes receive heightened protection against patient access, in part, because they often contain sensitive information provided by collateral sources, such as family members and friends (U.S. DHHS, 2003). If participants could gain access to this information, collateral sources might not be forthright in providing sensitive information about matters which are critical for delivering effective treatment, such as providing accurate histories of participants' substance abuse patterns, criminality, or related conduct (Stasiewicz et al., 2008). Studies have also reported that patients can be harmed psychologically by receiving unfettered access to their therapists' diagnostic impressions and conclusions (Lajeunesse & Lussier, 2010; Ross & Lin, 2003; Sergeant, 1986; Short, 1986; Westin, 1977). Sensitive clinical information must be communicated to patients in a cautious, empathic, and understandable manner to avoid causing psychological distress, embarrassment, confusion, or other untoward reactions (McFarlane et al., 1980; Miller et al., 1987).

Participant attendance at staffings might also inhibit free flow of information among staff, which is necessary to achieve productive aims. Treatment representatives, for example, may be reluctant to discuss their concerns about a participant's prognosis in front of the participant. Probation officers might similarly be reticent to recommend sanctions for participants in response to infractions. It is one thing for sanctions to be imposed by the team as a whole, but quite another for an individual staff member to be identified as the person who first proposed the sanction. Closed staffings allow team members to freely consider alternative courses of action that may or may not be adopted ultimately by the team.

Although staffings are presumptively closed, the judge and team may conclude they have a good reason for a participant to attend discussions related to that participant's case. For example, the team might wish to discuss highly sensitive matters with a participant in private, such as a history of childhood sexual abuse or positive HIV test result. Drug courts are encouraged to include participants in staffings when clinically indicated or necessary to protect a participant from serious harm resulting from public disclosure of highly sensitive treatment information.

C. Team Communication and Decision-Making

(Note: The following commentary originally applied to NADCP Standard VIII, Part D, Sharing Information. This standard was revised and incorporated into Florida Standard VIII, Part C. Team Communication and Decision Making.)

Participants and staff rate communication among team members as one of the most important factors for success in drug courts (Frazer, 2006; Gallagher et al., 2015; Lloyd et al., 2014). Participants complain frequently that they are forced to repeat the same information to different professionals and to comply with excessive and inconsistent mandates stemming from different agencies (Goldkamp et al., 2002; Saum et al., 2002; Turner et al., 1999). Ongoing communication among staff ensures participants receive consistent messages, reduces unwarranted burdens on participants, and prevents participants from falling through the cracks or eluding responsibility for their actions by providing different information selectively to different team members.

Contrary to some misconceptions, the HIPAA and other applicable confidentiality statutes (e.g., Confidentiality of Substance Abuse Patient Records, 42 C.F.R. Part 2) do *not* prohibit treatment professionals or criminal justice professionals from sharing information related to substance abuse and mental health treatment (Matz, 2014; Meyer, 2011b). Rather, these statutes control how and under what circumstances such information may be disclosed (U.S. DHHS, 2003). Treatment professionals are generally permitted to share confidential treatment information with criminal justice professionals pursuant to a voluntary, informed, and competent waiver of a patient's confidentiality and privacy rights (45 C.F.R.164.502(a)) or pursuant to a court order (45 C.F.R. §164.512(e)).

The scope of the disclosure must be limited to the minimum information necessary to achieve the intended aims of the disclosure (45 C.F.R. §§164.502(b) & 164.514(d)). In drug courts, team members may ordinarily share information pursuant to a valid waiver to the degree necessary to ensure that participants are progressing adequately in treatment and complying with other conditions of the program (Meyer, 2011b). At a minimum, the following data elements are required by all drug court team members to appraise participant progress and compliance or noncompliance with the conditions of drug court:

- Assessment results pertaining to a participant's eligibility for drug court and treatment and supervision needs.
- Attendance at scheduled appointments.
- Drug and alcohol test results, including efforts to defraud or invalidate said tests.
- Attainment of treatment plan goals, such as completion of a required counseling regimen.
- Evidence of symptom resolution, such as reductions in drug cravings or withdrawal symptoms.
- Evidence of treatment-related attitudinal improvements, such as increased insight or motivation for change.
- Attainment of drug court phase requirements, such as obtaining and maintaining employment or enrolling in an educational program.
- Compliance with electronic monitoring, home curfews, travel limitations, and geographic or association restrictions.
- Adherence to legally prescribed and authorized medically assisted treatments.
- Procurement of unauthorized prescriptions for addictive or intoxicating medications.
- Commission of or arrests for new offenses.
- Menacing, threatening, or disruptive behavior directed at staff members, participants or other persons.

To be legally valid, an informed consent document must specify what data elements may be shared, with whom, and for what authorized period of time (Meyer, 2011b). Therefore, the above data elements and any other information that may be shared among team members should be listed in releases of information or confidentiality waivers executed by drug court participants (Meyer, 2011b). If the scope of the disclosure is not enumerated clearly, then the waiver may not be knowing or informed—and thus may be legally invalid. Consent documents

must also indicate which professionals are authorized to receive the information, what steps participants must take to revoke consent, and when the consent expires. Expiration of consent may be predicated upon a specific event, such as discharge from drug court, as opposed to a specific date or time frame (Meyer, 2011b). Finally, recipients of confidential information must be put on notice that they are only permitted to redisclose information to additional parties under carefully specified and approved conditions. MOUs between partner agencies—referred to as business associate contracts pursuant to HIPAA—must state clearly that confidential information may not be redisclosed to additional parties outside of the drug court without the express written permission of the participant and may not be used to prosecute new charges against the participant.

Assuming a participant has executed a valid waiver of his or her privacy and confidentiality rights, drug court team members are permitted, and indeed may be required, to share covered information in the course of performing their professional duties. Confidentiality and privacy rights belong to the participant, not to staff, and may be waived freely and voluntarily in exchange for receiving anticipated benefits, such as gaining access to effective treatment or avoiding a criminal record or jail sentence (Melton et al., 2007). Failing to abide by a valid confidentiality waiver could, under some circumstances, be a breach of a staff person's professional responsibilities to the participant.

Staff persons also have ethical obligations to other drug court team members. If a staff person knowingly withholds relevant information about a participant from other team members, this omission could inadvertently interfere with the participant's treatment goals, endanger public safety, or undermine the functioning of the drug court team. All agencies involved in the administration of a drug court should, therefore, execute MOUs specifying what data elements will be shared among team members (Harden & Fox, 2011). The data elements listed above might be included in such MOUs to clarify the obligations of each professional on the team.

If a staff person questions the validity or legality of a consent waiver, that staff person should raise this concern with the drug court team and make it clear that he or she may withhold relevant progress information until the matter is resolved. This course of action puts the drug court team on notice that important information may not be forthcoming and reduces the likelihood that mistaken actions will be taken based on erroneous or incomplete information.

Controversy surrounds the question of whether defense representatives should report infractions by participants to the drug court team. In most instances, infractions come to the attention of the team from sources other than defense counsel, such as positive drug tests or progress reports from treatment providers or probation officers. In some instances, however, participants may self-disclose infractions to defense representatives which would otherwise go undetected by the program.

Some defense experts advise against disclosing such communications because doing so may violate the attorney's ethical duty to advocate for the participant's stated legal interests, which are to be distinguished from the participant's *best* interests (Boldt, 1998; National Association of Criminal Defense Lawyers [NACDL], 2009). Other defense experts take the contrary position that withholding such information may undermine the defense representative's trustworthiness and credibility with the team. If team members know or suspect that defense counsel is shielding important information from them, they may discount recommendations from that defense expert as one-sided or nonobjective or may withhold information of their own (Tobin, 2012). In the absence of empirical evidence or legal precedent to guide the decision, defense representatives should make clear their position and the rationale for that position to participants and team members from the outset of each case (Freeman-Wilson et al., 2003). Participants have a right to know whether some confidences shared with defense representatives may be disclosed to other staff members, and team members have a right to know whether some information may not be available to them for decision making.

(Note: The following commentary originally applied to NADCP Standard VIII, Part D, Team Communication and Decision Making. This standard was revised and incorporated as Florida Standard VIII, Part C. Team Communication and Decision Making.)

Before the advent of drug courts, studies of *courtroom workgroups* raised concerns about relying on multidisciplinary teams to manage criminal and civil cases. In response to overwhelming court dockets in the 1980s, some jurisdictions appointed teams of professionals—commonly including a judge, defense attorney, prosecutor, court clerk, probation officer, and bailiff—to process certain types of cases more efficiently, such as drug possession cases and child maltreatment cases. Observational studies revealed these workgroups tended to routinize their procedures to speed case processing, often at the expense of applying evidence-based practices or adapting dispositions to the needs and risk levels of litigants (Haynes et al., 2010; Knepper & Barton, 1997; Lipetz, 1980). Teaming up as a group did not necessarily improve outcomes and in some cases may have undermined litigants’ due process rights. Drug courts must not, in the interest of expediency, allow assembly-line procedures or groupthink mindsets to interfere with their adherence to due process and best practices.

Drug courts are properly characterized as nonadversarial programs, meaning participants waive some, but not all, adversarial trial rights as a condition of entry, including the right to a speedy trial and to refuse to provide self-incriminating information (Hora & Stalcup, 2008; NADCP, 1997). Moreover, unlike traditional adversarial proceedings, the drug court judge speaks directly to participants rather than through legal counsel and takes an active role in supervising cases. The term nonadversarial does *not*, however, imply that team members relinquish their professional roles or responsibilities (Holland, 2010; Hora & Stalcup, 2008). Prosecutors continue to advocate on behalf of public safety, victim interests, and participant accountability; defense counsel continue to advocate for participants’ legal rights; and treatment providers continue to advocate for effective and humane treatment (Freeman-Wilson et al., 2003; Holland, 2010; Tobin, 2012). In other words, the term *nonadversarial* does not have the same meaning as *nonadvocacy*. The principal distinction in drug courts is that advocacy occurs primarily in staffings as opposed to court hearings, reserving the greater share of court time for intervening with participants rather than arbitrating uncontested facts or legal issues (Christie, 2014; Portillo et al., 2013).

How drug court teams make decisions in this nonadversarial climate has constitutional implications. Due process and judicial ethics require drug court judges to exercise independent discretion when resolving factual controversies, ordering conditions of treatment and supervision, and administering sanctions and incentives that affect participants’ liberty interests (Hora & Stalcup, 2008; Meyer, 2011c; Meyer & Tauber, 2011). The judge may not delegate these decisions to the drug court team or acquiesce to majority rule [see Standard III, Roles and Responsibilities of the Judge]. The judge must, however, consider arguments from all sides of a controversy (typically from the defense and prosecution) before rendering a decision and must hear evidence from scientific experts if the subject matter of the controversy is beyond the common knowledge of laypersons (Hora & Stalcup, 2008; Meyer, 2011a). Information relating to addiction science and substance abuse treatment is typically beyond the knowledge of laypersons; therefore, this information must usually be introduced or explained by a qualified expert (e.g., Federal Rule of Evidence 702, 2015).

In drug courts, the multidisciplinary team serves essentially as a panel of “expert witnesses” providing legal and scientific expertise for the judge (Bean, 2002; Hora & Stalcup, 2008). Team members have an obligation to contribute relevant observations and insights and to offer suitable recommendations based on their professional knowledge, experience, and training. A team member who remains silent in staffings or defers habitually to group consensus is violating his or her professional obligations to participants and to the administration of justice (Freeman-Wilson et al., 2003; Holland, 2010; NACDL, 2009; Tobin, 2012). The judge may ultimately overrule a team member’s assertions, but this fact does not absolve the team member from articulating and justifying an informed opinion.

Studies have identified effective communication strategies that can enhance team decision making in drug courts. For example, researchers have improved team decision-making skills in several drug courts using the NIATx (Network for the Improvement of Addiction Treatment) Organizational Improvement Model (Melnick et al., 2014a, 2014b; Wexler et al., 2012). The NIATx model seeks to create a climate of psychological safety by teaching team members to articulate divergent views in a manner that is likely to be heeded by fellow team members. Examples of NIATx techniques include the following (Melnick et al., 2014b):

- *Avoid Ego-Centered Communications*—Focus statements on the substantive issue at hand rather than attempting to be “right” or win an argument.
- *Avoid Downward Communication*—Ensure that all team members, regardless of status or authority, have an equal opportunity to speak.
- *Practice Attentive Listening*—Hear all aspects of a team member’s statements before thinking about or forming a response.
- *Reinforce Others’ Statements*—Express appreciation for a team member’s input before making counterarguments or changing the subject.
- *Find Common Ground*—Acknowledge areas of agreement among team members before making counterarguments.
- *Reframe Statements Neutrally*—Restate a position in a manner that minimizes counterproductive affect such as anger or frustration.
- *Ensure Inclusiveness*—Ensure that all team members weigh in on subjects within their area of expertise or experience.
- *Show Understanding*—Restate others’ positions to demonstrate accurate understanding.
- *Engage in Empathic Listening*—Imagine oneself in other team members’ positions to understand issues from their perspective.
- *Sum Up*—The judge should recap the various arguments and positions, assure the team that all positions were considered carefully, and explain his or her rationale for reaching a conclusion or tabling the matter pending further information.

Preliminary studies in more than ten drug courts found that training drug court teams on the NIATx model enhanced team communication skills (Melnick et al., 2014b), increased staff job satisfaction (Melnick et al., 2014a), and improved program efficiency, leading to higher admission rates, shorter wait times for treatment, and reduced no-show rates at scheduled appointments (Wexler et al., 2012).

D. Status Hearings

Status hearings are critical components of drug courts (NADCP, 1997). In status hearings, participants interact with all team members in the same proceeding, the judge speaks personally with each participant, and incentives, sanctions and treatment adjustments are administered in accordance with participants’ progress or lack thereof in treatment (Roper & Lessenger, 2007). A substantial body of research establishes convincingly that better outcomes are achieved when status hearings are held biweekly (every two weeks) or more frequently at least during the first phase of drug court (Carey et al., 2012; Cissner et al., 2013; Festinger et al., 2002; Jones, 2013; Marlowe et al., 2006, 2007; Mitchell et al., 2012; Rossman et al., 2011).

Studies further reveal that consistent attendance by all team members at status hearings is associated with significantly better outcomes. A study of approximately seventy drug courts found that programs were 35% more cost-effective and 35% more effective at reducing crime when all team members—the judge, program coordinator, defense representative, prosecutor, probation officer, treatment representative, and law enforcement representative—attended status hearings regularly (Carey et al., 2012). When a treatment representative attended status hearings regularly, drug courts were nearly twice as effective at reducing crime and 80% more cost-effective, and when a representative from law enforcement attended hearings regularly, drug courts were over 80% more effective at reducing crime and 60% more cost-effective (Carey et al., 2008, 2012).

Although the judge typically controls most of the interactions during status hearings, observational studies reveal that other team members play an important role as well. Team members may report on participant progress, share their observations of participants, fill in missing information for the judge, offer praise and encouragement to participants, challenge inaccurate statements by participants, or make recommendations for suitable consequences to impose (Baker, 2013; Christie, 2014; Mackinem & Higgins, 2008; McPherson & Sauder, 2013; Portillo et al.,

2013; Roper & Lessenger, 2007). Colloquially referred to as *courtroom as theater*, these interactions are often planned in advance during staffings to illustrate treatment-relevant concepts, prevent participants from fomenting disagreement among staff members, and demonstrate unity of purpose for the team as a whole (Satel, 1998; Tauber, 2011). In focus groups, participants rated interactions among staff during court sessions as informative and helpful to improving their performance (Goldkamp et al., 2002).

E. Team Training

Drug courts represent a fundamentally new way of treating persons charged with drug-related offenses (Roper & Lessenger, 2007). Specialized knowledge and skills are required to implement these multifaceted programs effectively (Carey et al., 2012; Shaffer, 2010; Van Wormer, 2010). To be successful in their new roles, staff members require at least a journeyman's knowledge of best practices in a wide range of areas, including substance abuse and mental health treatment, complementary treatment and social services, behavior modification, community supervision, and drug and alcohol testing. Staff must also learn to perform their duties in a multidisciplinary environment, consistent with constitutional due process and the ethical mandates of their respective professions. These skills and knowledge sets are not taught in traditional law school, graduate school, or most continuing education programs (Berman & Feinblatt, 2005; Holland, 2010). Ongoing specialized training and supervision are needed for staff to achieve the goals of drug court and conduct themselves in an ethical, professional, and effective manner.

Preimplementation Trainings—In preimplementation trainings, staff meet for several days as a team to, among other things, develop a mission statement and goals and objectives for their program, learn from expert faculty about best practices in drug courts, and develop effective policies and procedures to govern their day-to-day operations (Hardin & Fox, 2011). A multisite study found that drug courts were nearly two and a half times more cost-effective and over 50% more effective at reducing recidivism when the teams participated in formal training prior to implementation (Carey et al., 2008, 2012). Drug courts that did not receive preimplementation training produced outcomes that were negligibly different from traditional criminal justice approaches (Carey et al., 2008).

Continuing Education Workshops—Continuing education workshops are commonly delivered as part of national, regional, or state drug court training conferences or in stand-alone seminars. These workshops provide experienced drug court professionals with up-to-date knowledge about new research findings on best practices in drug courts. Studies consistently find that annual attendance by staff at training workshops is associated with significantly better outcomes. A multisite study involving more than sixty drug courts found that annual attendance at training conferences was the greatest predictor of program effectiveness (Shaffer, 2006, 2010). Another large-scale study found that regular participation in continuing education workshops was the greatest predictor of a program's adherence to the drug court model (Van Wormer, 2010). After taking continuing education into account, no other variable was independently or incrementally associated with adherence to the drug court model. This finding suggests that adherence to best practices may be mediated primarily through staff participation in continuing education workshops. The same study determined that regular attendance in continuing education workshops was also associated with better collaboration among drug court team members, increased job satisfaction by staff, greater perceived benefits of drug court, greater optimism about the effects of substance abuse treatment, and better perceived coordination between the criminal justice system and other social service and treatment systems (Van Wormer, 2010).

Tutorials for New Staff—Within five years, 30% to 60% of drug courts experience substantial turnover in key staff positions (Van Wormer, 2010). The highest turnover rates, commonly exceeding 50%, are among substance abuse and mental health treatment providers (Lutze & Van Wormer, 2007; McLellan et al., 2003; Taxman & Bouffard, 2003; Van Wormer, 2010). Evidence further reveals that staff turnover correlates significantly with downward drift in the quality of the services provided, meaning that services diverge increasingly from the drug court model as more staff positions turn over (Van Wormer, 2010).

Research has determined that drug courts are more effective when they provide introductory tutorials for new hires. A multisite study of approximately seventy drug courts found that programs were over 50% more effective at reducing recidivism when they routinely provided formal orientation training for new staff (Carey et al., 2012). Typically, the tutorials provide a “*Reader’s Digest*” orientation to the Ten Key Components of Drug Courts (NADCP, 1997) and a synopsis of best practices associated with each component. The tutorials are not intended to take the place of formal continuing education workshops, but serve rather as a stopgap measure to prevent acute disruption in services and degradation of outcomes. To maintain effective outcomes over time, recent hires should attend formal training workshops as soon as practicable after assuming their new positions. Given the powerful influence of staff training on drug court outcomes (Carey et al., 2012; Shaffer, 2006, 2010; Van Wormer, 2010), a firm commitment to ongoing professional education is key to maintaining the success and integrity of drug courts.

IX. Census and Caseloads

A. Drug Court Census

Drug courts serve fewer than 10% of adults in the criminal justice system in need of their services (Bhati et al., 2008; Huddleston & Marlowe, 2011). An important goal for the drug court field is to take drug courts to scale and serve every drug-addicted person in the criminal justice system who meets evidence-based eligibility criteria for the programs (Fox & Berman, 2002). Putting arbitrary restrictions on the size of the drug court census unnecessarily reduces the program's impact on public health and public safety.

Not all drug courts, however, may have adequate resources to increase capacity while maintaining fidelity to best practices. Surveys of judges and other criminal justice professionals consistently identify insufficient personnel and other resources as the principal barrier preventing drug courts from expanding to serve more people (Center for Court Innovation, n.d.; Farole, 2006, 2009; Farole et al., 2005; Huddleston & Marlowe, 2011). Resource limitations may put some drug courts in the challenging position of needing to choose between diluting their services to treat more people or turning away deserving individuals.

Evidence suggests expanding drug court capacity without sufficient resources can interfere with adherence to best practices. A multisite study of approximately seventy drug courts found a significant inverse correlation between the size of the drug court census and effects on criminal recidivism (Carey et al., 2008, 2012a). On average, programs evidenced a steep decline in effectiveness when the census exceeded approximately 125 participants. Drug courts with fewer than 125 participants were over five times more effective at reducing recidivism than drug courts with more than 125 participants (Carey et al., 2012a).

Further analyses uncovered a likely explanation for this finding: drug courts with more than 125 participants were less likely to follow best practices than drug courts with fewer participants. Specifically, when the census exceeded 125 participants, the following was observed (Carey et al., 2012b):

- Judges spent approximately half as much time interacting with participants in court.
- Team members were less likely to attend pre-court staff meetings.
- Treatment and law enforcement representatives were less likely to attend status hearings.
- Drug and alcohol testing occurred less frequently.
- Treatment agencies were less likely to communicate with the court about participant performance via email or other electronic means.
- Participants were treated by a large number of treatment agencies with divergent practices and expectations.
- Team members were less likely to receive training on drug court best practices.

These findings are merely correlations and do not prove that a large census produces poor outcomes. Most drug courts in the study were staffed by a single judge and a small team of roughly four to five other professionals overseeing a single court docket. Drug courts can serve far more than 125 participants with effective results if the programs have sufficient personnel and resources to accommodate larger numbers of individuals. In fact, studies have reported positive outcomes for well-resourced drug courts serving more than 400 participants (Carey et al., 2012a; Cissner et al., 2013; Marlowe et al., 2008; Shaffer, 2010).

Nevertheless, the above results raise a red flag that as the census increases, drug courts may have greater difficulty delivering the quantity and quality of services required to achieve effective results. Therefore, when the drug court census reaches 125 active participants, this milestone should trigger a careful reexamination of the program's adherence to best practices. For example, staff should monitor drug court operations to ensure the judge is spending at least three minutes interacting with each participant in court [see Standard III, Roles and Responsibilities of the Judge], drug and alcohol testing is being performed randomly at least twice per week [see Standard VII, Drug and Alcohol Testing], team members are attending pre-court staff meetings and status hearings on a consistent basis [see Standard III and Standard VIII, Multidisciplinary Team], and team members

are receiving up-to-date training on best practices [see Standards III and VIII]. If the results of this reexamination suggest some operations are drifting away from best practices, the team should develop a remedial action plan and timetable to rectify the deficiencies and evaluate the success of the remedial actions. For example, the drug court might need to hire additional staff to ensure it has manageable participant-to-staff caseloads, schedule status hearings on more days of the week, purchase more drug and alcohol tests, or schedule more continuing-education workshops for staff.

Studies have not determined whether censuses greater than 125 participants should trigger additional reexaminations of adherence to best practices. Until research addresses this question, at a minimum drug courts are advised to reexamine adherence to best practices when the census increases by successive increments of 125 participants.

B. Supervision Caseloads

In most drug courts, probation officers or pretrial services officers are responsible for supervising participants in the community; however, some drug courts may rely on law enforcement or specially trained court case managers to provide community supervision. Duties of the supervision officer may include performing drug and alcohol testing, conducting home and employment visits, enforcing curfews and geographic restrictions, and delivering cognitive-behavioral interventions designed to improve participants' problem-solving skills or alter dysfunctional criminal-thinking patterns (Harberts, 2011).

No study has examined the influence of supervision caseloads in drug courts. However, many studies have examined supervision caseloads in the context of adult probation. Early studies found that small probation caseloads were paradoxically associated with *increased* rates of technical violations and arrests for new offenses (Gendreau et al., 2000a; Petersilia, 1999; Turner et al., 1992). This counterintuitive finding was attributable to increased surveillance of the probationers coupled with a failure to apply evidence-based practices. Smaller caseloads led to greater detection of infractions, but most infractions received excessively punitive responses, such as probation revocations, rather than evidence-based treatment or gradually escalating incentives and sanctions (Andrews et al., 1990; Gendreau et al., 2000b; Hollin, 1999).

Recent studies have reported improved outcomes when reduced probation caseloads were combined with evidence-based cognitive-behavioral counseling, motivational interviewing, or gradually escalating incentives and sanctions (Jalbert & Rhodes, 2012; Jalbert et al., 2010, 2011; Paparozzi & Gendreau, 2005; Pearson & Harper, 1990; Worrall et al., 2004). Results of these newer studies confirm that detecting infractions alone is insufficient to improve outcomes. To achieve positive results, probation officers must respond to infractions and achievements by delivering effective behavioral contingencies (incentives and sanctions) and ensuring probationers receive effective and adequate evidence-based treatment and social services (Center for Effective Public Policy, 2014; Paparozzi & Hinzman, 2005; Skeem & Manchak, 2008).

Identifying optimal probation caseloads has been a challenging task. In 1990, the American Probation and Parole Association (APPA, 1991) issued caseload guidelines derived from expert consensus. The 1990 guidelines recommended caseloads of 30:1 for high-risk probationers who have a substantial likelihood of failing on probation or committing a new offense (Table 2). In 2006, the APPA guidelines were amended, in part, to add a new category for intensive supervised probation (ISP). ISP was designed for probationers who are both high risk and high need, meaning they pose a substantial risk of failing on probation and also have serious treatment or social-service needs (Petersilia, 1999). Because ISP and drug courts are both intended for high-risk and high-need individuals, recommendations for ISP may be particularly instructive for drug court best practices. Based on expert consensus, the 2006 APPA amendments recommended caseloads of 20:1 for high-risk and high-need probationers on ISP, and increased the recommended caseloads to 50:1 for moderate- and high-risk probationers who do not have serious treatment or social- service needs (Byrne, 2012; DeMichele, 2007).

TABLE 2 Probationer Risk and Need Level	APPA* RECOMMENDED CASELOADS	
	1990 Guidelines	2006 Guidelines
ISP:† high risk and high need	NR§	20:1
High risk	30:1	50:1
Moderate risk	60:1	50:1
Low risk	120:1	200:1

*American Probation and Parole Association

Sources: APPA (1991); Byrne (2012); DeMichele (2007)

†Intensive supervised probation

§Not reported

Recent studies examined the effects of adhering to the 2006 APPA guidelines. A randomized experiment compared the services received and outcomes achieved when probation officers had reduced caseloads of approximately 50:1 for moderate and high-risk probationers as compared to typical probation caseloads of approximately 100:1 (Jalbert & Rhodes, 2012). Results confirmed that probationers on 50:1 caseloads received significantly more probation office sessions, field visits, employer contacts, telephone check-ins, and substance abuse and mental health treatment (Jalbert & Rhodes, 2012). As a consequence of receiving more services, they also had significantly better probation outcomes, including fewer positive drug tests and other technical violations (Jalbert & Rhodes, 2012). Probation officers with caseloads substantially above 50:1 had considerable difficulty accomplishing their core missions of monitoring probationers closely and reducing technical violations.

Another quasi-experimental study examined the effects of reducing caseloads from 50:1 to 30:1 for high-risk and high-need probationers on ISP (Jalbert et al., 2010). A 30:1 caseload is greater than the APPA recommended guideline of 20:1 for ISP, but is considerably smaller than typical probation caseloads of 100:1 (Bonta et al., 2008; Paparozzi & Hinzman, 2005) and recommended caseloads of 50:1 for most high-risk probationers (Byrne, 2012). Results confirmed that probationers on 30:1 caseloads had more frequent and longer contacts with their probation officers, and received more specialized services designed to reduce their risk to public safety, including behavior therapy, domestic-violence counseling, spousal-batterer interventions, and sex-offender treatment (Jalbert et al., 2010). Most striking, probationers on 30:1 caseloads had significantly lower recidivism rates lasting for at least two and a half years, including fewer new arrests for drug, property, and violent crimes (Jalbert et al., 2010).

Taken together, the weight of scientific evidence (Jalbert & Rhodes, 2012; Jalbert et al., 2011) and expert consensus (APPA, 1991; Byrne, 2012; DeMichele, 2007) suggests supervision officers are unlikely to manage high-risk cases effectively and reduce technical violations when their caseloads exceed 50:1. Supervision officers in drug courts are unlikely to accomplish their core functions of monitoring participants accurately, applying effective behavioral consequences, and sharing important compliance information with drug court team members if their caseloads exceed this critical threshold.

Research in ISP programs suggests long-term reductions in criminal recidivism are most likely to be achieved for high-risk and high-need participants when caseloads stay at or below 30:1 (Jalbert et al., 2010). Whether 30:1 caseloads are required similarly for drug courts is an open question. Drug courts include several components not encompassed by ISP, which may enhance the influence of supervision officers. For example, drug court participants are supervised and treated by a multidisciplinary team of professionals and attend status hearings in court on a frequent basis. Larger caseloads may be manageable for supervision officers in light of these additional service elements. Until research resolves the issue, drug courts are advised to monitor their operations carefully when caseloads for supervision officers exceed 30:1; caseloads should never exceed a 50:1 ratio. Assurance is needed that supervision officers can monitor participant performance effectively, contribute critical observations and information during pre-court staff meetings and status hearings, and complete other assigned duties such as performing drug and alcohol testing, conducting field visits, and delivering cognitive-behavioral criminal-thinking interventions.

Bear in mind these caseload guidelines assume the supervision officer is assigned principally to drug court and is not burdened substantially with other professional obligations. Smaller caseloads may be required if supervision officers are also managing caseloads outside of drug court or if they have supplementary administrative or managerial duties in addition to supervising drug court participants.

C. Clinical Caseloads

In drug courts, addiction counselors, social workers, psychologists, or clinical case managers are typically responsible for assessing participant needs, delivering or overseeing the delivery of treatment services, charting treatment progress, and reporting progress information to the drug court team (Lutze & Van Wormer, 2007; Shaffer, 2010; Van Wormer, 2010). Outcomes are significantly better in drug courts when participants meet individually with one of these clinicians on a weekly basis for at least the first phase of the program [see Standard V, Substance Abuse Treatment and Standard VI, Complementary Treatment and Social Services].

National studies of outpatient individual substance abuse treatment consistently find that the size of clinician caseloads is inversely correlated with patient outcomes and clinician job performance (Hser et al., 2001; McCaughrin & Price, 1992; Stewart et al., 2004; Vocisano et al., 2004; Woodward et al., 2006). As caseloads increase, patients receive fewer services, patients are more likely to abuse illicit substances, clinicians are more likely to behave punitively toward patients, and clinicians are more likely to report significant job burnout and dissatisfaction (King et al., 2004; Stewart et al., 2004). Comparable studies are lacking for residential substance abuse treatment and for group clinicians who deliver services to several participants simultaneously.

Determining appropriate caseloads for clinicians in drug courts depends largely on their role and the scope of their responsibilities:

- **Clinical Case Management Role**—Some clinicians in drug courts serve principally as clinical case managers, assessing participant needs, brokering referrals for services, and reporting progress information to the drug court team (Monchick et al., 2006). They may also represent treatment concerns during pre-court staff meetings and status hearings.
- **Treatment Provider Role**—Some clinicians serve principally as treatment providers, administering individual therapy or counseling and perhaps facilitating or cofacilitating group interventions (Cissner et al., 2013; Zweig et al., 2012). They may also provide or refer participants for indicated complementary services, such as mental health treatment or vocational counseling.
- **Combined Clinical Case Management and Treatment Provider Roles**—Some clinicians serve both clinical case management and treatment provider functions. In addition to providing individual therapy or counseling, they are responsible for assessing participant needs, referring participants for complementary services, coordinating care between multiple service providers, reporting progress to the drug court team, and representing treatment concerns during pre-court staff meetings and status hearings (Braude, 2005; Monchick et al., 2006).

National practitioner organizations have published broad caseload guidelines based in part on these professional roles and responsibilities (Case Management Society of America & National Association of Social Workers, 2008; North Carolina Administrative Office of the Courts, 2010; Rodriguez, 2011). These guidelines have not been validated empirically in terms of their effects on outcomes. Rather, they are derived from expert consensus about heavy caseloads that are likely too large to deliver adequate services or that contribute to staff burnout and job dissatisfaction. The guidelines focus exclusively on individual counseling and clinical case management. Comparable guidelines for group counselors have not been published. Table 3 summarizes the consensus conclusions.

TABLE 3	CASELOAD GUIDELINES DERIVED FROM EXPERT CONSENSUS	
Principal Role and Responsibilities	Caseload	Reference
Clinical case management	50:1 to 75:1	Rodriguez (2011)
Individual therapy or counseling	40:1 to 50:1	CMSA* & NASW† (2008) Hromco et al. (2003)
Combination of clinical case management and individual therapy or counseling	30:1	CMSA & NASW (2008) NCAOC§ (2010)

*Case Management Society of America

†National Association of Social Workers

§North Carolina Administrative Office of the Courts

To reiterate, these guidelines are derived from expert consensus and have not been validated against outcomes. Moreover, professional roles and responsibilities are rarely so clearly delineated in day-to-day drug court operations. Clinicians in drug courts may provide clinical case management for some participants and therapy or counseling for others, may have a mixture of individual and group treatment responsibilities, and may have other nonclinical duties, such as drug and alcohol testing, that reduce the time they have available for clinical assessment, treatment, or case management. Caseload expectations need to be adjusted in light of actual job responsibilities.

Nevertheless, these guidelines should serve as broad milestones to alert drug courts to the possibility of clinician overload and the need to audit their operations to ensure adequate services are being delivered. Because drug courts serve high-risk and high-need individuals, programs are advised to reexamine adherence to best practices when clinician caseloads reach the lowest ratios reported in Table 3. For example, when clinical case management caseloads exceed 50:1, individual counseling caseloads exceed 40:1, or combined caseloads exceed 30:1, staff should monitor drug court operations to ensure participants are being assessed appropriately for risk and need [see Standard I, Target Population], participants are meeting individually with a clinician on a weekly basis for at least the first phase of treatment [see Standard V, Substance Abuse Treatment and Standard VI, Complementary Treatment and Social Services], participants are receiving at least 200 hours of cognitive-behavioral treatment [see Standard V], and clinicians are providing reliable and timely progress information to the drug court team [see Standard VIII, Multidisciplinary Team]. Drug courts are unlikely to achieve the goals of rehabilitating participants and reducing crime if clinicians are spread too thin to assess and meet participants' service needs.

X. Monitoring and Evaluation

A. Adherence to Best Practices

Adherence to best practices is generally poor in most sectors of the criminal justice and substance abuse treatment systems (Friedmann et al., 2007; Henderson et al., 2007; McLellan et al., 2003; Taxman et al., 2007). Programs infrequently deliver services that are proven to be effective and commonly deliver services which have not been subjected to careful scientific scrutiny. Over time, the quality and quantity of the services provided may decline precipitously (Etheridge et al., 1995; Van Wormer, 2010). The best way for a drug court to guard against these prevailing destructive pressures is to monitor its operations routinely, compare its performance to established benchmarks, and seek to align itself continually with best practices. Not knowing whether one's drug court is in compliance with best practices makes it highly unlikely that needed improvements will be recognized and implemented; therefore, evaluating a drug court's adherence to best practice standards is, itself, a best practice.

Studies reveal that drug courts are significantly more likely to deliver effective services and produce positive outcomes when they hold themselves accountable for meeting empirically validated benchmarks for success. A multisite study involving approximately seventy drug courts found that programs had more than twice the impact on crime and were more than twice as cost-effective when they monitored their operations on a consistent basis, reviewed the findings as a team, and modified their policies and procedures accordingly (Carey et al., 2008, 2012).

Like many complex service organizations, drug courts are highly susceptible to *drift*, in which the quality of their services may decline appreciably over time (Van Wormer, 2010). Management strategies such as continuous performance improvement (CPI), continuous quality improvement (CQI), and managing for results (MFR) are designed to avoid drift and enhance a program's adoption of best practices. Each of these management strategies emphasizes continual self-monitoring and rapid-cycle testing. This process involves collecting real-time information about a program's operations and outcomes, feeding that information back to key staff members and decision makers on a routine basis, and implementing and evaluating remedial action plans where indicated. Research consistently shows that continual self-monitoring and rapid-cycle testing are critical elements for improving outcomes and increasing adoption of best practices in the health care and criminal justice systems (Damschroder et al., 2009; Rudes et al., 2013; Taxman & Belenko, 2013). These strategies are essential for programs that require cross collaboration and interdisciplinary communication among multiple service agencies, including drug courts (Bryson et al., 2006; Wexler et al., 2012).

Studies have not determined how frequently programs should review performance information and implement and evaluate self-corrective measures. Common practice among successful organizations is to collect performance data continually and meet at least annually as a team to review the information and take self-corrective measures (Carey et al., 2012; Rudes et al., 2013; Taxman & Belenko, 2013).

Reporting outcomes from drug courts without placing those findings into context by describing the quality of the programs is no longer enough. Meta-analyses (Aos et al., 2006; Latimer et al., 2006; Lowenkamp et al., 2005; Mitchell et al., 2012; Shaffer, 2010; Wilson et al., 2006) and large-scale multisite studies (Rossman et al., 2011) have already clearly established that drug courts reduce crime by approximately 8% to 14% on average. These averages, derived from evaluations of more than 100 drug courts, mask a great deal of variability between programs. Some drug courts reduce crime by more than 50%, others have no impact on crime, and still others increase crime rates in their communities (Carey et al., 2012; Carey & Waller, 2011; Cissner et al., 2013; Downey & Roman, 2010; Government Accountability Office, 2011; Mitchell et al., 2012; Shaffer, 2010). The important question is no longer whether drug courts can work, but rather how they work and what services contribute to better outcomes (Marlowe et al., 2006). Understanding what distinguishes effective drug courts from ineffective and harmful drug courts is now an essential goal for the field. Unless evaluators describe each drug court's adherence to best practices, there is no way to place that program's outcomes in context or interpret the significance of the findings.

B. In-Program Outcomes

One of the primary aims of a drug court is to rehabilitate seriously addicted individuals, which means that retaining participants in treatment, reducing drug and alcohol use, and helping participants to complete treatment successfully are important indicators of short-term progress. However, policymakers, the public, and other stakeholders are likely to judge the merits of a drug court by how well it reduces crime, incarceration rates, and taxpayer expenditures. Therefore, drug courts need to measure in-program outcomes that not only reflect clinical progress, but are also significant predictors of postprogram criminal recidivism and other long-term outcomes.

At minimal cost and effort, drug courts can evaluate short-term outcomes while participants are enrolled in the program. These short-term outcomes provide significant information about participants' clinical progress and the likely long-term impacts of the drug court on public health and public safety. Studies have consistently determined that postprogram recidivism is reduced significantly when participants attend more frequent treatment and probation sessions, provide fewer drug-positive urine tests, remain in the program for longer periods of time, have fewer in-program technical violations and arrests for new crimes, and satisfy other conditions for graduation (Gifford et al., 2014; Gottfredson et al., 2007, 2008; Huebner & Cobbina, 2007; Jones & Kemp, 2011; Peters et al., 2002). Drug courts should, therefore, monitor and report on these in-program outcomes routinely during the course of their operations.

Several resources are available to help drug courts define and calculate performance measures of in-program outcomes (Berman et al., 2007; Heck, 2006; Marlowe, in press; Peters, 1996; Rubio et al., 2008a). In 2006, NADCP convened leading drug court researchers and evaluators to form the National Research Advisory Committee (NRAC). One goal of this committee was to define a core data set of in-program performance measures for adult drug courts (Heck, 2006). NRAC selected measures that are simple and inexpensive to track and evaluate and proven to predict long-term outcomes. These performance measures include the following:

- *Retention*—the number of participants who completed the drug court divided by the number who entered the program
- *Sobriety*—the number of negative drug and alcohol tests divided by the total number of tests performed
- *Recidivism*—the number of participants arrested for a new crime divided by the number who entered the program, and the number of participants adjudicated officially for a technical violation divided by the number who entered the program
- *Units of Service*—the numbers of treatment sessions, probation sessions, and court hearings attended
- *Length of Stay*—the number of days from entry to discharge or the participant's last in-person contact with staff

Longer lists of performance measures addressing a wide range of outcomes in drug courts and other problem-solving courts have been published by expert organizations including the National Center for State Courts (Rubio et al., 2008a; Waters et al., 2010), the Center for Court Innovation (Rempel, 2006, 2007), American University (Peters, 1996), the Organization of American States (Marlowe, in press), the National Center for DWI Courts (Marlowe, 2010), and the National Institute of Justice (NIJ, 2010). Drug courts are advised to consult these and other resources for further information on how to calculate and interpret additional performance measures for their evaluations.

C. Criminal Recidivism

For many policymakers and members of the public, reducing criminal recidivism is one of the primary aims of a drug court. Recidivism is defined as any return to criminal activity after the participant entered the drug court. Recidivism does not include crimes that occurred before the participant entered drug court even if those crimes are charged or prosecuted after entry.

Recidivism is measured most commonly by new arrests, new convictions, or new incarcerations occurring over a two- or three-year period (Carey et al., 2012; King & Elderbroom, 2014; Rempel, 2006). For example, the Bureau of Justice Statistics (BJS) tracks new arrests, convictions, and incarcerations occurring within three years of the date that state and federal inmates are released from jail or prison (Durose et al., 2014).

Based on scientific considerations, evaluators should follow participants for at least three years, and ideally up to five years, from the date of entry into the drug court or from the date of the arrest or technical violation that made the individual eligible for drug court. The date of entry should be the *latest* start date for the evaluation because that is when the drug court becomes capable of influencing participant behavior directly.

Starting from the date of arrest or technical violation takes into account the potential impact of delays in admitting participants to drug court. The sooner participants enter drug court after an arrest or probation violation, the better the results (Carey et al., 2008, 2012); therefore, evaluators may wish to examine how delayed entry affects outcomes. However, because drug courts cannot always control what transpires before participants enter the drug court program, attributing to the drug court any recidivism occurring before entry may not fairly represent the drug court's effects on recidivism. Starting from the date of entry ensures recidivism may be attributed fairly to the effects of the drug court. No one answer fully addresses the issues surrounding selection of a start date for evaluation; therefore, evaluators should state clearly what start date was selected and the rationale for choosing that start date.

Rates of criminal recidivism among drug-involved offenders become relatively stable after approximately three to five years (King & Elderbroom, 2014). After three years, statistically significant between-group differences in recidivism are likely to remain significant going forward (e.g., Knight et al., 1999; Martin et al., 1999; Wexler et al., 1999). For example, if drug court participants have significantly lower rearrest rates than comparison group subjects after three years, this difference is likely (although not guaranteed) to remain significant after an additional two years (DeVall et al., 2015). After five years, recidivism rates tend to reach a plateau, meaning that most (but not all) participants who will recidivate have likely done so by then (e.g., Gossop et al., 2005; Inciardi et al., 2004; Olson & Lurigio, 2014).

Importantly, these findings do not suggest drug courts must wait three to five years before reporting recidivism outcomes. Recidivism occurring during enrollment and shortly after discharge from drug court may be of considerable interest to practitioners, policymakers, and other stakeholders. However, implying that recidivism rates occurring within the first two years are likely to reflect the long-term effects of a drug court is inappropriate. Evaluators should state clearly that such recidivism rates are preliminary and likely to increase over time.

No one basis exists for deciding whether new arrests, new convictions, or new incarcerations are likely to be the most valid or informative indicator of recidivism. As discussed below, each measure has advantages and disadvantages that the evaluator must take into account. Because no one measure is clearly superior to another, whenever possible evaluators are advised to report all three measures of recidivism, discuss the implications and limitations of each, or indicate why a particular measure is not being reported.

Analyzing new arrests as a measure of criminal recidivism provides at least two advantages. First, arrests are often substantially closer in time to the alleged offense than convictions. Resolving a criminal case and determining guilt or innocence may take months or years. Evaluators can usually report arrest outcomes in much less time than waiting for lengthy legal proceedings to resolve. Second, criminal cases are often dismissed or pled down to a lesser charge for reasons having little to do with factual guilt, such as insufficient evidence or plea bargains. As a result, the absence of a conviction or conviction on a lesser charge may not reflect the offense that occurred.

However, some individuals are arrested for crimes they did not commit. This fact may lead to an overestimation of the true level of criminal recidivism. Relying on conviction data rather than arrest data may provide greater assurances that the crimes did, in fact, occur.

Incarceration has substantial cost impacts that may far exceed those of arrests and convictions. A day in jail or prison can cost between five and twenty times more than a day on probation or in community-based treatment (Belenko et al., 2005; Zarkin et al., 2012). Evaluators typically distinguish between incarceration that occurred while participants were enrolled in the drug court and incarceration that occurred after discharge. In-program incarceration often reflects brief jail sanctions that may be imposed for misconduct in the program, whereas postprogram incarceration typically reflects pretrial detention for new charges, sentences for new charges, or (for terminated participants) sentencing on the original charge that led to participation in drug court. In cost evaluations, in-program jail sanctions are typically counted as an investment cost for the drug court whereas postprogram detention is typically counted as an outcome cost (Carey et al., 2012).

Evaluators must also consider the timeliness and accuracy of information contained in criminal justice databases. In some jurisdictions, arrest data may be recorded in a more timely and faithful manner than conviction or incarceration data. Evaluators must familiarize themselves with how and when information is entered into national, state, and local criminal justice records and should describe clearly in their evaluation reports any limitations that may relate to the accuracy or timeliness of the data.

Self-report information could potentially provide the most accurate assessment of criminal recidivism because it does not require detection or prosecution by law enforcement. Because many crimes are unreported by victims and undetected by the authorities (Truman & Langton, 2014), arrest and conviction data may underestimate true levels of criminal activity. For obvious reasons, however, individuals cannot be relied upon to acknowledge their crimes unless they receive strict assurances that the information will be kept confidential and will not be used against them in a criminal proceeding. Drug courts will typically be required to hire an independent evaluator who has no connection to the court or criminal justice system to confidentially survey participants. This method is likely to be prohibitively costly for many drug courts, which explains why it has rarely been employed with the notable exception of one highly funded national study (Rossman et al., 2011).

Whether measured by arrests, convictions, or incarcerations, categorizing recidivism according to the level (i.e., felony, misdemeanor, or summary offense) and nature (e.g., drug offenses, property and theft offenses, violent offenses, technical violations, prostitution, and traffic offenses) of the crimes involved is highly informative and necessary. Different categories of crime can have very different implications for public safety and cost. For example, violent offenses may have serious victimization costs and may result in substantial jail or prison sentences, whereas drug possession may not involve an identifiable victim and is more likely to receive a less costly probation sentence (Zarkin et al., 2012).

As a final note, not all drug courts have reasonable access to data on new arrests, convictions, or incarcerations occurring after participants have been discharged from the program. In some jurisdictions, these records may be in the possession of other executive agencies, such as the police department or department of corrections, and the Drug Court may not be entitled to the information. Under such circumstances, drug courts should make every effort to negotiate access to the data, but of course, drug courts cannot be held accountable for reporting information beyond their reach.

D. Independent Evaluations

In addition to monitoring their own performance, drug courts benefit greatly from having an independent evaluator examine their program and issue recommendations to improve their adherence to best practices. Drug courts that engaged an independent evaluator and implemented at least some of the evaluator's recommendations were determined in one multisite study to be twice as cost-effective and nearly twice as effective at reducing crime as drug courts that did not engage an independent evaluator (Carey et al., 2008, 2012).

Drug courts benefit from an independent evaluation for several reasons. Every program has blind spots that prevent staff from recognizing their own shortcomings. Some team members, such as the judge, may have more social influence or power than others, making it difficult for some team members to call attention to problems in court or during team meetings. Drug courts also operate in a political environment and staff may be hesitant to criticize local practices for fear of reprisal. An independent evaluator from another jurisdiction can usually offer frank criticisms of current practices with less fear of repercussions (Heck & Thanner, 2006).

Although most drug courts are capable of keeping descriptive statistics about their program, considerably more expertise is required to perform *inferential analyses*, which compare Drug court outcomes to those of a comparison group. Controlling statistically for preexisting group differences that could bias one's results is often necessary. For example, if drug court participants had fewer previous convictions than comparison subjects before entering the study, better outcomes for the drug court might simply reflect the fact that it treated a less severe population. Evaluators must take numerous scientific matters into consideration and may need to apply several levels of statistical corrections to produce valid and reliable results.

Studies also reveal that participant perceptions are often highly predictive of outcomes in drug courts. For example, perceptions concerning the procedural fairness of the program (Burke, 2010; McIvor, 2009), the manner in which incentives and sanctions are delivered (Goldkamp et al., 2002; Harrell & Roman, 2001; Marlowe et al., 2005), and the quality of the treatment services provided (Turner et al., 1999) are often predictive of recidivism and correlate significantly with adherence to best practices. Needless to say, participants are more likely to be forthright with an independent evaluator about their perceptions of the drug court than with staff members who control their fate in the criminal justice system.

Studies have not determined how frequently drug courts should be evaluated by an independent investigator. Generally speaking, a new evaluation should be performed whenever a program or the environment within which it operates changes substantially. Staff turnover and evidence of drift from the intended model are critical events that call for a new evaluation (Yeaton & Camberg, 1997). Evidence suggests that staff turnover and model drift occur within five-year intervals in drug courts. Within five years, between roughly 30% and 60% of drug courts experience substantial turnover in key staff positions (Van Wormer, 2010). The highest turnover rates, commonly exceeding 50%, are among substance abuse and mental health treatment providers (Lutze & Van Wormer, 2007; McLellan et al., 2003; Taxman & Bouffard, 2003; Van Wormer, 2010). Evidence further reveals that staff turnover correlates significantly with drift in the quality of the services provided (Van Wormer, 2010). Therefore, five years is a reasonable outside estimate of how frequently drug courts should be evaluated independently. If resources allow, drug courts should engage independent evaluators at more frequent intervals to detect drift readily and prevent services from worsening with time.

Drug courts need to select competent evaluators. The first step in selecting a competent evaluator is to request recommendations from other drug courts and national organizations that are familiar with drug court operations and research. Senior staff at NADCP and NDCI are familiar with the evaluation literature and the skill sets of dozens of evaluators nationally. When selecting an evaluator, review prior evaluation reports, especially those involving drug courts or other problem-solving courts. If prior evaluations failed to follow the practices described herein, consider selecting another evaluator who has demonstrated expertise in applying best practices related to drug court program evaluations. One of the most important questions to consider when reviewing prior evaluations is whether the report recommended concrete actions the drug court could take to enhance its adherence to best practices and improve its outcomes. The most effective evaluators are aware of the literature on best practices, measure drug court practices against established performance benchmarks, and promote useful strategies to improve each program's operations and results.

Many drug courts do not have sufficient resources to hire independent evaluators. One way to address this problem is to contact local colleges or universities to determine whether graduate or undergraduate students may be interested in evaluating the drug court as part of a thesis, dissertation, or capstone project. Because such projects require close supervision from senior academic faculty, the drug court can receive high-level research expertise

at minimal or no cost. Moreover, students are likely to be highly motivated to complete the evaluation successfully because their academic degree and standing depends on it.

E. Disadvantaged Groups

The term *historically disadvantaged groups* refers to socio-demographic groups that have historically experienced sustained discrimination or reduced social opportunities due to their race, ethnicity, gender, sexual orientation, sexual identity, physical or mental disability, religion, or socioeconomic status. Best practices for ensuring equivalent treatment of historically disadvantaged groups in drug courts are described in Standard II, Historically Disadvantaged Groups.

Evidence suggests racial and ethnic minority individuals are underrepresented in some drug courts and may have lower graduation rates than other participants [see Commentary in Standard II, Historically Disadvantaged Groups]. Drug courts have an affirmative obligation to determine whether racial and ethnic minority individuals and members of other historically disadvantaged groups are being disproportionately burdened or excluded from their programs; and if so, to take reasonable corrective measures to rectify the problem and evaluate the success of the corrective actions [see Standard II]. Not knowing whether one's drug court is disproportionately burdening disadvantaged groups is itself a violation of best practice standards (Marlowe, 2013).

Studies have not determined how frequently drug courts should review performance information for members of historically disadvantaged groups. Consistent with the general literature on CPI, CQI and MFR, the drug court team should review performance information at least annually and implement and evaluate self-corrective measures on a rapid-cycle basis (Rudes et al., 2013; Wexler et al., 2012).

A number of resources are available to help drug courts identify and rectify disparate impacts for historically disadvantaged groups (e.g., Casey et al., 2012; Rubio et al., 2008b; Yu et al., 2009). Seasoned evaluators and university faculty are likely to be familiar with this literature and to know how to perform these types of analyses. Many analyses, such as comparing graduation rates between different racial groups, are relatively simple and straightforward to perform. Other analyses, such as determining whether disadvantaged groups have equivalent access to drug court, are considerably more difficult. Many drug courts may not have adequate information about the relevant arrestee population to determine whether disadvantaged groups are gaining access to the drug court at equivalent rates. For example, information might not be available to determine what proportion of racial-minority arrestees have serious drug problems and are therefore eligible for participation in drug court. The primary challenge for such drug courts may be to gain better access to a wider range of information on the arrestee population, and as a practical matter, such analyses may be beyond the ability and expertise of some programs to accomplish.

F. Electronic Database

Paper files have minimal value for conducting program evaluations. Evaluators are typically required to extract information from handwritten notes and progress reports that are difficult to read, contain contradictory information, and have numerous missing entries. As a consequence, many evaluations are completed months or years after the fact when the results may no longer reflect what is occurring in the program. Such evaluations often contain so many gaps or caveats in the data that the conclusions which may be drawn are tentative at best.

Drug courts are approximately 65% more cost-effective when they enter standardized information concerning their services and outcomes into an electronic management information system (MIS), which is capable of generating automated summary reports (Carey et al., 2008, 2012). The cost of purchasing an MIS is offset many times over by providing greater efficiencies in operations and yielding the type of performance feedback that is necessary to continually improve and fine-tune one's drug court program.

Appendix E provides examples of MISs that have been developed for use in drug court evaluations. Some of the older and less sophisticated systems can be obtained free of charge. For example, the Buffalo System (so named because it was developed in a drug court in Buffalo, New York) is a Microsoft Access database that can be obtained at no cost by contacting NADCP. Newer systems must be purchased or licensed, but are more likely to be web-based and can be accessed simultaneously by multiple users and agencies. Allowing multiple agencies to use the same MIS, each with its own secured and encrypted access, can spread the cost of the system across several budgets. Newer systems are also more likely to have preprogrammed analytic reports that provide important summary information for staff at the push of a button. Finally, newer systems are more likely to include a data-extraction tool. A data-extraction tool allows information to be imported readily into a statistical program, such as SAS or SPSS, which skilled evaluators then can use to conduct sophisticated statistical analyses.

(Note: The following commentary originally applied to NADCP Standard X, Part G, Timely and Reliable Data Entry. This standard was revised and incorporated into Florida Standard X, Part F. Electronic Database.)

The biggest threat to a valid program evaluation is poor data entry by staff. The adage “garbage in/garbage out” is particularly apt in this regard. If staff members do not accurately record what occurred, no amount of scientific expertise or sophisticated statistical adjustments can produce valid findings.

The best time to record information about services and events is when they occur. For example, staff members should enter attendance information into an MIS or written log during court hearings and treatment sessions. This is referred to as *real-time recording*. The typical staff person in a drug court is responsible for dozens of participants and each participant has multiple obligations in the program, such as appearing at court hearings, attending treatment sessions, and delivering urine specimens. Only the rare staff person can recall accurately what events transpired or should have transpired days or weeks in the past. Attempting to reconstruct events from memory is likely to introduce unacceptable error into a program evaluation.

Data should ordinarily be recorded within no more than forty-eight hours of the respective events. Medicare, for instance, requires physicians to document services within a “reasonable time frame,” defined as twenty-four to forty-eight hours (Pelaia, n.d.). After forty-eight hours, errors in data entry have been shown to increase significantly. After one week, information is so likely to be inaccurate that it may be better to leave the data as missing than attempt to fill in gaps from faulty memory (Marlowe, 2010).

Staff members who are persistently tardy when entering data pose a serious threat to the integrity of a drug court. Not only are evaluation results unlikely to be accurate, but those same staff persons are unlikely to be delivering appropriate services. Good-quality treatment and supervision require staff to monitor participant behavior vigilantly, record performance information in a timely and actionable fashion, and adjust services and consequences accordingly. Failing to record performance information in a timely and reliable manner undermines the quality and effectiveness of a drug court and seriously jeopardizes participant care.

G. Intent-to-Treat Analyses

A serious error in some drug court evaluations is to examine outcomes only for participants who graduated successfully from the program. The logic for performing such an analysis is understandable. Evaluators are often interested in learning what happens to individuals who received all of the services the program has to offer. If individuals who dropped out or were terminated prematurely from the drug court are included in the analyses, the results will be influenced by persons who did not receive all of the intended services.

Although this reasoning might seem logical, it is scientifically flawed (Heck, 2006; Heck & Rousell, 2007; Marlowe, 2010, in press; Peters, 1996; Rempel, 2006, 2007). Outcomes must be examined for all eligible individuals who participated in the drug court regardless of whether they graduated, were terminated, or withdrew from the program. This is referred to as an *intent-to-treat analysis* because it examines outcomes for all individuals whom the program initially set out to treat. Reporting outcomes for graduates alone is not appropriate because such an analysis unfairly and falsely inflates the apparent success of the program. For example, individuals who graduated from the drug court are more likely than terminated participants to have entered the program with less

severe drug or alcohol problems, less severe criminal propensities, higher motivation for change, or better social supports. As a result, they might have been less likely to commit future offenses or relapse to substance abuse regardless of the services they received in drug court.

This issue is particularly important when outcomes are contrasted against those of a comparison sample, such as probationers. Selecting the most successful drug court cases and comparing their outcomes to all of the probationers unfairly skews the results in favor of the drug court. It is akin to selecting the A+ students from one classroom, comparing their scores on a test to those of all of the students in a second classroom, and then concluding the first class had a better teacher. Such a comparison would clearly be slanted unfairly in favor of the first teacher.

This is not to suggest that outcomes for graduates are of no interest. Drug courts may, indeed, want to know what happens to individuals who receive all of the services in the program. This, however, should be a *secondary analysis* that is performed after the intent-to-treat analysis has shown positive results. If it is first determined that the drug court achieved significantly improved outcomes on an intent-to-treat basis, it may then be appropriate to proceed further and determine whether outcomes were even better for the graduates. If the intent-to-treat analysis is not significant, then it is not acceptable to move on to evaluate outcomes for graduates alone.

Importantly, if secondary analyses are performed on drug court graduates, then the comparison sample should also comprise successful completers. For example, outcomes for drug court graduates should be compared to those of probationers who satisfied the conditions of probation. Comparing outcomes for drug court graduates to all probationers, including probation failures, would unfairly favor the drug court.

The only exception to an intent-to-treat analysis is for what are sometimes referred to as *neutral discharges*. Some drug courts assign a neutral discharge to participants who are withdrawn from the program for reasons beyond the control of the participant and the program. A neutral discharge is assigned most commonly when the drug court discovers a participant was admitted to the program erroneously. For example, a participant might need to be withdrawn from drug court if he or she had a prior conviction that precluded eligibility for the drug court or resided in a judicial district that was not within the jurisdictional boundaries of the drug court. A neutral discharge may also be assigned to participants who are withdrawn from the program because they enlisted in the military or moved out of the jurisdiction with the court's permission. A neutral discharge should never be assigned to cases in which termination was related to a participant's performance in drug court.

H. Comparison Groups

The mere fact that individuals perform well after participating in drug court does not prove the drug court was responsible for their favorable outcomes. Those same individuals might have functioned just as well if they had never entered drug court. To examine the important question of causality, the performance of drug court participants must be compared against that of an equivalent and unbiased comparison group. Comparing what happened in the drug court to what would most likely have happened if the drug court did not exist is referred to as testing the *counterfactual hypothesis*, or the possibility that the drug court was ineffective (Popper, 1959).

Some comparison groups are reasonably unbiased and can yield a fair and accurate assessment of what would most likely have occurred without the drug court. Others, however, may be systematically biased in such a manner as to make the drug court look better or worse than it deserves. This may lead to the unwarranted conclusion that the drug court was effective or ineffective when, in fact, the reverse could be true.

Random Assignment—The strongest inference of causality may be reached when eligible individuals are randomly assigned either to the drug court or to a comparison group. Random assignment provides the greatest assurance that the groups started out with an equal chance of success; therefore, better outcomes for one group can be confidently attributed to the effects of the program (Campbell & Stanley, 1963; Farrington, 2003; Farrington & Welsh, 2005; National Research Council, 2001; Telep et al., 2015). Even when an evaluator employs random

assignment, there is still the possibility (albeit a greatly diminished possibility) that the groups differed on important dimensions from the outset. This possibility requires the evaluator to perform a confirmation of the randomization procedure. The evaluator will need to check for preexisting differences between the groups that could have affected the results. If the groups differed significantly on variables that are correlated with outcomes (such as the severity of participants' criminal histories or drug problems), the evaluator might employ statistical procedures to adjust for those differences and obtain defensible results.

As a practical matter, conducting random assignment is often very difficult in drug courts. Some staff members may have ethical objections against denying potentially effective services to eligible individuals. Moreover, some drug courts may have difficulty filling their slots and may not wish to turn away eligible individuals. The evaluator will also need to gain approval and buy-in for random assignment from numerous professionals and agencies, including the court, prosecution, and defense counsel. Finally, random assignment usually requires implementation of ethical safeguards (National Research Council, 2001). For example, participants may need to provide informed consent to random assignment, and an independent ethics review board may need to oversee the safety and fairness of the study. Local colleges and universities often have institutional review boards (IRBs) or data and safety monitoring boards (DSMBs) which have the authority and expertise to provide ethical oversight for randomized studies.

Random assignment poses far fewer challenges if a drug court has insufficient capacity to treat many individuals who would otherwise be eligible for its services. If many eligible people must be turned away, then it would arguably be fairest to select participants randomly rather than allow staff members to pick and choose who gets into the program. Under such circumstances, random assignment may provide the best protection against unfair discrimination and unconscious bias (National Research Council, 2001). In fact, a number of drug court studies have used random assignment successfully in light of insufficient program capacity (e.g., Gottfredson et al., 2003; Jones, 2011; Turner et al., 1999).

Quasi-Experimental Comparison Group—In many drug courts, engaging in random assignment is simply impractical. The next best approach is to use a quasi-experimental comparison group (Campbell & Stanley, 1963). This refers to individuals who were eligible for the drug court but did not enter for reasons that are unlikely to have influenced their outcomes. Perhaps the best example is individuals who were eligible for and willing to enter the drug court, but were denied access because there were no empty slots available. This is referred to as a *wait-list comparison group*. The mere happenstance that the drug court was full is unlikely to have led to the systematic exclusion of individuals who had more severe problems or poorer prognoses to begin with, and therefore is unlikely to bias the results.

Less optimal, but still potentially acceptable, quasi-experimental comparison groups include individuals who would have been eligible for the drug court but were arrested in the year or so before the drug court was established, or were arrested in an immediately adjacent county that does not have a drug court (Heck, 2006; Heck & Roussell, 2007; Marlowe, 2010, in press; Peters, 1996). Because these individuals were arrested at an earlier point in time or in a different geographic region than the drug court participants, such comparison groups might still be different enough from the drug court group to bias the results. For example, socioeconomic conditions might differ significantly between neighboring communities, or law enforcement practices might change from year to year. The likelihood of this occurring, however, is usually not substantial and these may be the only practical comparison conditions that can be used for many drug court evaluations.

When using a quasi-experimental comparison group, the evaluator must check for preexisting differences between the groups that could have affected the results (Campbell & Stanley, 1963). For example, the comparison individuals may have had more serious criminal histories than the drug court participants to begin with. This, in turn, might have put them at greater risk for criminal recidivism. If so, then superior outcomes for the drug court participants might not have been due to the effects of the drug court, but rather to the fact that it treated a less severe population. A skilled evaluator can use a number of statistical procedures to adjust for such differences and potentially obtain scientifically defensible results.

Matched Comparison Group—Evaluators do not always have a quasi-experimental comparison group at their disposal. Under such circumstances, they may be required to construct a comparison group out of a large and heterogeneous pool of offenders. For example, an evaluator might need to select comparison subjects from a statewide probation database. Many of those probationers would not have been eligible for drug court, or are dissimilar to drug court participants on characteristics that are likely to have influenced their outcomes. For example, some of the probationers might not have had serious drug problems, or might have been charged with offenses that would have excluded them from participation in drug court. The evaluator must, therefore, select a subset of individuals from the entire probation pool that are similar to the drug court participants on characteristics that are known to affect outcomes. For example, the evaluator might pair each drug court participant with a probationer who has the same or similar criminal history, demographic characteristics, and substance use diagnosis (Heck, 2006; Marlowe, 2010, in press). Because the evaluator will choose only those probationers who are similar to the drug court participants on multiple characteristics, it is necessary to start out with a large sample of potential candidates from which to select comparable individuals.

The success of any matching strategy will depend largely on whether the evaluator has adequate information about the comparison candidates to make valid matches (Campbell & Stanley, 1963). If data are not available on such important variables as the probationers' criminal histories or substance abuse problems, evaluators and drug courts will not be able to place confidence in the validity of the matches. Simply matching the groups on variables that are easy to measure and readily available, such as gender or race, is not sufficient because the groups might differ on other important dimensions that were not taken into account.

Propensity Score Analysis—An evaluator may also use an advanced statistical procedure called a propensity score analysis to mathematically adjust for differences between the drug court and comparison groups. This procedure calculates the statistical probability that an individual with a given set of characteristics would be in the drug court group as opposed to the comparison group—in other words, the relative similarity of that individual to one group as opposed to the other (Dehejia & Wahba, 2002). The analysis then mathematically adjusts for this relative similarity when comparing outcomes. Advanced statistical expertise is required to implement and interpret this complicated procedure.

As with any statistical adjustment, the success of a propensity score analysis will depend on whether the evaluator has adequate information about the comparison subjects to make valid adjustments. If data are not available on such important variables as the comparison subjects' criminal histories or substance abuse problems, evaluators and drug courts will not be able to place confidence in the adjustments (Peikes et al., 2008). Again, merely adjusting the scores based on easily measured variables, such as gender or race, is not sufficient because the groups might differ on other important dimensions that were never taken into account.

Invalid Comparison Groups—Several comparison groups have been used in drug court evaluations that quite likely produced seriously biased results. Comparing outcomes from a drug court to those of individuals who refused to enter the drug court, were denied access to the drug court because of their clinical or criminal histories, dropped out of the drug court, or were terminated prematurely from the drug court is rarely, if ever, justified (Heck, 2006; Heck & Thanner, 2006; Marlowe, 2010, in press; Peters, 1996). The probability is unacceptably high that such persons had poorer prognoses or more severe problems to begin with. For example, they very likely had more serious criminal or substance abuse histories, lower motivation for change, or lesser social supports. Given the high likelihood that these individuals were seriously disadvantaged from the outset, statistical adjustments cannot be relied upon to overcome the differences (Campbell & Stanley, 1963).

I. Time at Risk

For an evaluation to be valid, drug court and comparison participants must have the same time at risk, meaning the same opportunity to engage in substance abuse, crime, and other behaviors of interest to the evaluation. If, for example, an evaluator measured criminal recidivism over a period of twelve months for drug court participants, but over a period of twenty-four months for the comparison group, this would give an unfair advantage to the

drug court participants. The comparison group participants would have twelve additional months in which to commit new crimes or other infractions.

Ensuring an equivalent time at risk requires the evaluator to begin the analyses from a comparable start date for both groups. As was mentioned earlier, drug court evaluations typically use the date of entry into drug court or the date of the arrest or technical violation that made the individual eligible for drug court as the start date for analyses. If the comparison group is comprised of probationers, comparable start dates might be the date the individual was placed on probation or the date of the arrest that led to a probation sentence.

If the time at risk differs significantly between groups, the evaluator might be able to compensate for this problem by adjusting statistically for time at risk in outcome comparisons. For example, the evaluator might enter time at risk as a covariate in the statistical analyses. A *covariate* is a variable that is entered first into a statistical model. The independent effect of the variable of interest (in this case, being treated in a drug court) is then examined after first taking the effect of the covariate into account. This procedure would indicate whether drug court participants had better outcomes after first taking into account the influence of their shorter time at risk. The use of covariates is not always successful, however, and the best course of action is to ensure the groups have equivalent follow-up windows.

A related issue is referred to as *time at liberty*. Time at liberty and time at risk are similar in that both affect a participant's opportunity to reoffend or engage in other behaviors of interest to the evaluation. The difference is that time at liberty relates to whether restrictive conditions were placed on the participant. The most obvious restrictive conditions involve physical barriers to freedom, such as incarceration or placement in a residential treatment facility. These physical barriers severely restrict a participant's ability to use drugs, commit new offenses, obtain a job, or engage in other behaviors of interest to evaluators.

A potential error in drug court evaluations is to neglect time at liberty when performing outcome comparisons. In some jurisdictions, for example, individuals who do not enter drug court may be more likely to receive a jail sentence. If they are jailed for a portion of the follow-up period, they might have fewer opportunities to reoffend or use drugs than drug court participants who are treated in the community. The evaluator might conclude, erroneously, that drug court caused participants to reoffend or use drugs more often, when in fact they simply had more time at liberty to do so. Under such circumstances, the evaluator would need to adjust statistically for participants' time at liberty in the outcome analyses. For example, the evaluator might need to enter time at liberty as a covariate in the statistical models. This would indicate whether drug court participants had better outcomes after first taking into account their longer time at liberty. As was noted earlier, such adjustments are not always successful and drug courts will require expert consultation to ensure the analyses are carried out appropriately.

Note that evaluators are not always advised to adjust for time at liberty. In cost analyses, for example, the time participants spend in jail or a residential treatment facility is an important outcome in its own right and should be valued accordingly from a fiscal standpoint. Deciding whether to adjust for time at liberty, like many evaluation-related decisions, requires scientific expertise and careful consideration of the aims of the study. For such analyses, drug courts are strongly advised to obtain expert statistical and scientific consultation.

Appendix B

State of Florida

Adult Drug Court Best Practice Standards

References

This references list was borrowed from the National Association of Drug Court Professionals (NADCP) Adult Drug Court Best Practice Standards, Vol. I, (2013) and Vol. II, (2015). The references were compiled by NADCP and correspond to the Commentary included in this document.

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