



*Nebraska Veterans Treatment
Courts
Best-Practice Standards*



NEBRASKA SUPREME COURT

ADMINISTRATIVE OFFICE OF THE COURTS AND PROBATION

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Introduction

In 2012, the Nebraska Problem-Solving Court Leadership Group developed a strategic plan to identify the goals and policies required to ensure Nebraska’s problem-solving courts operate effectively and efficiently. The establishment of statewide standards is central to this effort, expanding the capacity of the courts and ensuring the establishment of best practices and quality assurance. The Nebraska Administrative Office of the Courts and Probation was awarded a grant from the Bureau of Justice Assistance in 2013 to support the development of the standards and facilitate the implementation of the standards by providing a supporting information infrastructure along with statewide training and technical assistance to DUI and drug court teams.

The development of the proposed standards was a collaborative effort among practitioners from all of the Nebraska Drug and DUI courts, the Nebraska Administrative Office of the Courts and Probation, and the National Center for State Courts. The development of the draft standards was completed over the course of two separate meetings held in December 2013 and July 2014. An extensive review of the National Association of Drug Court Professionals’ (NADCP) Adult Drug Court Best Practice Standards was conducted and, along with other research findings, served as the foundation for the *Nebraska Adult Drug Court and DUI Court Best Practice Standards* approved by the Nebraska Supreme Court in June 2015.

In April 2016, the Nebraska Legislature and Governor approved legislation broadening the definitions of problem-solving courts in Nebraska, and providing appropriations to establish Nebraska’s first Veterans Treatment Court. In response, the Nebraska Supreme Court Problem-Solving Court Committee appointed a Veterans Treatment Court Subcommittee to establish an implementation plan that includes the development of a set of best-practice standards for veterans treatment courts. It was agreed that the *Nebraska Adult Drug Court and DUI Court Best Practice Standards* would serve as the foundation for the *Nebraska Veterans Treatment Courts Best Practice Standards*.

Because research related to veterans treatment courts is in its infancy, and the makeup of participants in veterans treatment courts may or may not differ from those in drug courts, it cannot be assumed that all drug court best-practices apply to veterans treatment courts. Thus, additional guidance was sought from the National Center for State Courts. Most of the standards found in this document have been identified as being applicable across both drug courts and veterans treatment courts and are presumed to be best-practices, despite the absence of research specific to veterans treatment courts. Standards identified with 3 asterisks (***) **have not** been determined to be applicable across program types and should be viewed only as guidelines. These standards will be modified at such time as additional research becomes available.

I. The Veterans Treatment Court Team

A. PROGRAM PLANNING AND OVERSIGHT*¹

Initial planning and implementation shall be conducted by representatives from a wide range of agencies and disciplines. The steering committee or advisory board shall represent all aspects of the criminal justice system, treatment and ancillary service providers, funding entities, and the community at large. All programs shall have a written procedure for modifying program policies and procedures.

B. TEAM COMPOSITION*

The Veterans Treatment Court team shall include a judge, prosecutor, defense counsel, probation-based coordinator, probation-based community supervision, Veterans Affairs representative, veteran mentor coordinator, law enforcement, treatment provider(s), and other ancillary service providers. Every effort shall be made to assign members to the team for significant periods of time in order to maximize adherence to program tenets and to promote stability of the team.

C. PRE-COURT STAFFING MEETINGS*

All team members shall attend pre-court staffing meetings and shall be afforded the opportunity to provide information and professional perspectives regarding program participants' progress and recommendations for modifications to individual case plans, as well as sanctions and incentives.

D. COURT STATUS HEARINGS*

All team members shall attend court status hearings to demonstrate the collaborative nature of the program to veterans. Additionally, appearance by all team members enables a swift response when new information is presented to the court.

E. COMMUNICATION*

Programs shall have written formal and informal procedures for information communication among team members that outline the frequency, and timely and accurate dissemination of information. Team members shall regularly communicate with each other and the judge outside of pre-court staffing meetings. All team members shall follow confidentiality policy and procedure for all instances and means of communication.

¹ Items marked with one asterisk (*) indicate items identified as reasonably easy to implement under the present conditions at most sites. Items with two asterisks (**) indicate items identified as more aspirational in nature that would potentially require two to five years and additional training or policy/practice changes in order for some sites to comply with the standard. Items marked with three asterisks (***) are standards that, in the absence of research, may or may not apply to VTC's.

F. INITIAL AND CONTINUING EDUCATION*

All programs shall have a written orientation plan for new team members. All team members shall attend on-going education not less than every three years regarding veterans treatment court tenets and operations to ensure adherence to the veterans treatment court model and to maximize team collaboration (as opposed to operating from the traditional criminal justice perspective). All Veterans Treatment Court team members, including court personnel and other criminal justice professionals, shall receive formal training on delivering trauma-informed services.

G. ROLES AND RESPONSIBILITIES*

Team member roles and responsibilities shall be detailed in formal written agreements (e.g. Memoranda of Agreement/Understanding) among partner agencies/organizations and the court. Written protocols shall be in place to ensure the appropriate resolution of conflict among team members.

H. SUPERVISION CASELOADS*

Supervision caseloads shall not exceed fifty active participants per supervision officer. When supervision caseloads exceed thirty active participants per supervision officer, program operations shall be monitored carefully to ensure supervision officers can evaluate participant performance accurately, share significant observations with team members, and complete other supervisory duties as assigned.

Supporting Evidence ---

The supporting evidence is based on the National Adult Drug Court Standards developed by the National Association of Drug Court Professionals, (2013), p.34-40; and (2015), p.38-58.

A. Program Planning and Oversight:

Engaging the community in the planning and implementation of a new program such as a drug court has been consistently identified as essential to successful implementation (Fixsen, et al., 2005). Implementation literature across different domains (including business, education, and criminal justice) consistently cites the importance of “stakeholder involvement” and “buy in” throughout the implementation process (Fixsen, et. al., 2005). Rogers (2002) identified communication, a clear theory of change that makes the case for the intended changes (in this case, implementing the drug court model), and the development of champions who can consistently advocate as key to implementation. Adelman and Taylor (2003), in the context of education, described some early stages of preparation for adopting innovations that include developing a “big picture” context for the planned program or intervention (How is the problem currently addressed? How will the planned intervention add value to current efforts?), mobilizing interest, consensus, and support among key stakeholders, identifying champions, and clarifying how the functions of the intervention (drug court) can be institutionalized through existing, modified, or new resources. A 2010 national survey of drug court professionals (judges, prosecutors, defense attorneys, drug court coordinators, treatment providers, probation officers, law enforcement officers and others) found that focusing on procedures and consistently monitoring fidelity to the drug court model can prevent team and program drift (Van Wormer, 2010).

B. Team Composition

Several drug court evaluations have demonstrated that a key component of drug court success is inclusion of a diverse array of stakeholders, including a judge, prosecutor, defense counsel, coordinator, community supervisor, law enforcement officer, and treatment provider, in the drug court team (Carey et al, 2005; Carey et al, 2008). In a study of sixty nine drug courts, courts that included law enforcement on the drug court team had 87% greater reductions in recidivism and 44% increase in cost savings compared to courts that did not (Carey et al., 2012). More details on the benefits of diverse teams are covered in sections C and D below.

C. Pre-court Staffing Meetings

The Carey et al. (2012) study of 69 drug courts included key informant interviews, site visits, focus groups and document reviews. It assessed the impact of attending staff meetings on recidivism and cost savings. The study found that compared to courts that did not, courts in which staff meetings were attended by the defense attorney showed a 20% reduction in recidivism and 93% increase in cost savings; those attended by a coordinator showed a 58% reduction in recidivism and 41% increase in cost savings, those attended by law enforcement showed a 67% reduction in recidivism and 42% increase in cost savings, and those attended by a representative from treatment showed 105% reduction in recidivism. In courts where staff meetings were attended by the judge, both attorneys, a treatment representative, program coordinator, and a probation officer, recidivism was reduced by 50% and cost savings increased by 20%.

D. Court Status Hearings

The same Carey et al. (2012) study assessed the impact of drug court staff member attendance at status hearings. They found that, compared to courts that did not, courts in which status hearings were attended by a representative from treatment showed a 100% reduction in recidivism and an 81% increase in cost savings while those attended by law enforcement showed an 83% increase in recidivism reduction and a 64% increase in costs savings. In courts where status hearing were attended by the judge, both attorneys, a treatment representative, probation officer, and coordinator, showed a 35% increase in recidivism reduction and a 36% increase in cost savings.

E. Communication

Communication plays an important role in many aspects of effective drug courts (Carey et al., 2008, Wolfe et al., 2004). Carey et al. (2012) evaluated the impact of communicating via email in their assessment of 69 drug courts. They found that programs with communication protocols (email in this instance) had a 119% greater reduction in recidivism and a 39% increase in cost savings. Additionally, research in interdisciplinary collaboration highlights the role of communication in enhancing collaboration on interdisciplinary teams (Stokols et al., 2008).

F. Initial and Continuing Education

An evaluation of 18 drug courts included comparisons of business-as-usual courts to drug courts in which all staff were trained and drug courts in which not all staff were trained (Carey et al., 2008). Drug courts in which all staff were trained showed a 41% improvement in outcome cost savings over business-as-usual courts, while drug courts in which not all staff were trained only showed an 8% savings over business-as-usual courts. In drug courts where all staff were trained, the graduation rate was 63% compared to 40% for drug courts where not all staff were trained.

Carey et al. (2012) assessed 69 drug courts and found that drug courts that trained staff before program implementation showed a 55% greater reduction in recidivism and 238% greater cost savings than those that did not. In her survey of 295 drug court staff, Van Wormer (2010) found that continuing education is essential to fighting “team drift”. Other research demonstrates that training can improve implementation (Latessa & Lownkamp, 2006, Melde et al., 2006; Rhine et al., 2006; Murphy & Lutze 2009). Participants in drug court who exhibit trauma-related symptoms require specific, trauma-

informed services beginning in the first phase of drug court and continuing as necessary throughout the participant's enrollment in the program. Even though all participants with trauma histories may not require formal post-traumatic stress disorder (PTSD) treatment, each staff member, including court personnel and criminal justice professionals, should be trauma-informed for all participants (Bath, 2008).

G. Roles and Responsibilities

In their assessment of team decision-making across three sites, Crea et al. (2009) suggest that fidelity to the decision-making models is critical, and that fidelity can be enhanced with clear role definitions. The team drift literature points to the need for clear definitions of roles and ongoing education to keep programs focused on their mission (Van Wormer, 2010).

H. Supervision Caseloads

The American Parole and Probation Association (APPA) introduced caseload guidelines in 2006, including guidelines regarding intensive supervised probation (ISP). ISP is designed for probationers that are both high-risk and high-needs, and as such are at a higher risk of failing probation and having serious social service and treatment needs (Petersilia, 1999). Drug courts are similar to ISP in that they are intended for high-risk, high-need individuals. Therefore, the APPA caseload recommendations are instructive for drug courts. The APPA recommends caseloads of 50:1 for moderate-risk and high-risk probationers without serious social-service or treatment needs, and caseloads of 20:1 for high-risk, high-need probationers (Byrne, 2012; DeMichele, 2007). A randomized experiment confirmed that probationers on a 50:1 caseload received more services, including substance abuse and mental health treatment, probation office sessions, telephone check-ins, employer contacts, and field visits than probationers supervised by officers with higher caseloads (Jalbert & Rhodes, 2012). As a result of receiving more services, probationers on a 50:1 caseload had better probation outcomes, including fewer positive drug tests as well of fewer technical violations (Jalbert & Rhodes, 2012). Probation officers with caseloads substantially above the 50:1 recommendation had difficulty monitoring probationers closely and reducing technical violations.

References:

- Adelman, H. S., & Taylor, L. (2003). On sustainability of project innovations as systemic change. *Journal of Educational and Psychological Consultation*, 14(1), 1-25.
- Bath, H. (2008). The three pillars of trauma-informed care. *Reclaiming Children and Youth*, 17(3), 17–21.
- Byrne, J.M. (2012). New directions in community supervision: Should we target high risk offenders, high risk times, and high risk locations? *European Journal of Probation*, 4(2), 77–101.
- Carey, S.M., Crumpton, D., Finegan, M.W., & Waller, M. (2005). *California drug courts: A methodology for determining costs and benefits phase II: Testing the methodology*. Portland, OR: NPC Research. Retrieved from http://www.courts.ca.gov/documents/drug_court_phase_II.pdf
- Carey, S.M., & Perkins, T. (2008). *Methamphetamine users in Missouri drug courts: Program elements associated with success* (Final report). Submitted to the Missouri Office of the State Court Administrator.
- Carey, S.M., Mackin, J.R., & Finigan, M.W. (2012). What works? The ten key components of drug court: Research-based best practices. *Drug Court Review*, 7(1), 6–42.
- DeMichele, M.T. (2007). Probation and parole's growing caseloads and workload allocation: Strategies for managerial decision making. Lexington, KY: *American Probation & Parole Association*. Available at <http://www.appanet.org/eweb/docs/appa/pubs/SMDM.pdf>

- Fixsen, D., Naoom, S., Blase, K., Friedman, R., & Wallace, F. (2005). *Implementation research: A synthesis of the literature*. Tampa, FL: University of South Florida, Louis de la Parte Florida Mental Health Institute, The National Implementation Research Network.
- Hollin, C.R. (1999). Treatment programs for offenders: Meta-analysis, “what works,” and beyond. *International Journal of Law and Psychiatry*, 22(3-4), 361–372.
- Jalbert, S.K., & Rhodes, W. (2012). Reduced caseloads improve probation outcomes. *Journal of Crime and Justice*, 35(2), 221–238.
- Landenberger, N.A., & Lipsey, M.W. (2005). The positive effects of cognitive-behavioral programs for offenders: A meta-analysis of factors associated with effective treatment. *Journal of Experimental Criminology*, 1, 451–476.
- Latessa, E.J., & Lowenkamp, C.T. (2006). What works in reducing recidivism? *University of St. Thomas Law Journal*, 3(3), 521–535.
- Lowenkamp, C.T., Latessa, E.J., & Smith, P. (2006). Does correctional program quality really matter? The impact of adhering to the principles of effective intervention 2006. *Criminology & Public Policy*, 5(3), 575–594.
- Lowenkamp C.T., Flores, A.W., Holsinger, A.M., Makarios, M.D., & Latessa, E.J. (2010). Intensive supervision programs: Does program philosophy and the principles of effective intervention matter? *Journal of Criminal Justice*, 38, 368–375.
- Lutze, Faith E., & van Wormer, J.G. (2007). The nexus between drug and alcohol treatment program integrity and drug court effectiveness: Policy recommendations for pursuing success. *Criminal Justice Policy Review*, 18(3), 226–245.
- Melde, C., Esbensen, F.-A., & Tusinski, K. (2006). Addressing program fidelity using onsite observations and program provider descriptions of program delivery. *Evaluation Review*, 30(6), 714–740.
- Murphy, D., & Lutze, F. (2009). Police-probation partnerships: Professional identity and the sharing of coercive power. *Journal of Criminal Justice*, 37, 65–76.
- Petersilia, J. (1999). A decade of experimenting with intermediate sanctions: What have we learned? *Justice Research and Policy*, 1(1), 9–23.
- Rhine, E.E., Mawhorr, T. L., & Parks, E.C. (2006). Implementation: The bane of effective correctional programs. *Criminology & Public Policy*, 5(2), 347–358.
- Rogers, R. W. (2002). *White Paper – The power of realization*, from <http://www.ddiworld.com/research/publications>.
- Smith, P., Gendreau, P., & Swartz, K. (2009). Validating the principles of effective intervention: A systematic review of the contributions of meta-analysis in the field of corrections. *Victims and Offenders*, 4, 148–169.
- Stokols, D., Hall, K.L., Taylor, B.K., & Moser, R.P. (2008). The science of team science: Overview of the field and introduction to the supplement. *American Journal of Preventative Medicine*, 35(2S), S77–S88
- Van Wormer, J.G. (2010). *Understanding operational dynamics of drug courts* (Unpublished doctoral dissertation). Washington State University, Pullman, WA.
- Wolfe, E.L., Guydish, J., Woods, W., & Tajima, B. (2004) Perspectives on the drug court model across systems: A process Evaluation. *Journal of Psychoactive Drugs*, 36(3), 379–386.

II. Target Population, Eligibility, Referral, Entry, and Orientation

A. OBJECTIVE ELIGIBILITY AND EXCLUSION CRITERIA**

Eligibility and exclusion criteria shall be defined objectively, specified in writing, and communicated to potential referral sources including judges, law enforcement, defense attorneys, prosecutors, treatment professionals, and community supervision officers. The Veterans Treatment Court team shall not apply personal impressions to determine veterans' suitability for the program.

B. HIGH-RISK AND HIGH-NEED VETERANS/****

The Veterans Treatment Court shall target veterans for admission who have indicators of substance use, mental health, or co-occurring disorders and are at substantial risk for reoffending or failing to complete a less intensive intervention, such as standard probation or pretrial supervision. These individuals are commonly referred to as high-risk and high-need individuals. If a veterans treatment court chooses to serve target populations in addition to high-risk and high-need defendants, the program shall develop alternative tracks with services that are modified to meet the risk and need levels of its participants. If a veterans treatment court develops alternative tracks, it shall not mix participants with different risk or need levels in the same counseling groups, residential treatment milieu, or housing unit.

C. VALIDATED ELIGIBILITY ASSESSMENTS/****

Candidates for the Veterans Treatment Court shall be assessed for eligibility using validated risk assessment and clinical evaluation tools prior to program entry. The risk assessment tools shall be demonstrated empirically to predict criminal recidivism or failure on community supervision and shall be equivalently predictive for women and racial or ethnic minority groups that are represented in the local arrestee population. The clinical evaluation shall evaluate the formal diagnostic symptoms of substance use and/or mental health disorders. Staff whom conduct screening and assessment shall be trained and proficient in the *Standardized Model for the Delivery of Substance Use Services*, administration of the assessment tools, and interpretation of the results.

D. TRAUMA-INFORMED SERVICES**

Participants shall be assessed using a validated instrument for trauma history, trauma-related symptoms, and post-traumatic stress disorder (PTSD).

E. IDENTIFY AND CONSIDER RESPONSIVITY FACTORS*

Veterans treatment courts shall identify and base case management plans on the characteristics of participants that may impact their ability to respond to treatment goals when making referrals for services.

F. CRIMINAL HISTORY DISQUALIFICATIONS**

Except as hereinafter stated, and barring legal prohibitions, current offense or criminal history shall not presumptively exclude candidates from participation in veterans treatment court. Any eligibility or admission policy or procedure approved by the Supreme Court and in effect at the time of the adoption of this standard which contains written criteria for a judicially monitored evaluation of the candidate's current offense or criminal history shall be deemed to meet this standard.

G. CLINICAL DISQUALIFICATIONS **

Candidates shall not be automatically disqualified from participation in the Veterans Treatment Court because of co-occurring mental health or medical conditions or because they have been legally prescribed psychotropic or addiction medication.

Supporting Evidence

The supporting evidence is based on the National Adult Drug Court Standards developed by the National Association of Drug Court Professionals, (2013), p.6 – 10, 13; and (2015) p.59-73.

A. Objective Eligibility and Exclusion Criteria

Research shows that subjective eligibility criteria, including suitability determinations based on defendant motivation for change or readiness for treatment, have no impact on graduation or post-program recidivism rates (Carey & Perkins, 2008; Rossman et al., 2011). Standardized assessment tools are significantly more reliable and valid than professional judgment for predicting success in correctional supervision and matching participants to appropriate treatment and supervision services (Andrews et al., 2006; Bhati et al., 2008; Miller & Shutt, 2001; Sevigny et al., 2013; Shaffer, 2010; Wormith & Goldstone, 1984;).

B. High-Risk and High-Need Participants

A substantial body of research shows that drug courts that focus on high-risk/high-need defendants² reduce crime approximately twice as much as those serving less serious defendants (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). However, research suggests that courts that do serve lower-risk or need cases should provide a lower intensity of programming to this group, to avoid wasting resources or making outcomes worse (Lowenkamp & Latessa, 2004). Providing substance abuse treatment for non-addicted 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). If a program serves participants with different risk or need levels, participants should be served in different treatment groups and residential facilities to avoid making outcomes worse for the lower-risk or 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).

² Those 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.

Researchers recently created a five-question screening tool to identify military veterans who may be at risk of violence. The Violence Screening and Assessment of Needs (VIO-SCAN) is published in the online *American Journal of Psychiatry*. In addition to a history of anger associated with post-traumatic stress disorder (PTSD), the questionnaire probes veterans' history of violence and arrests, alcohol misuse, combat experience, and financial instability. The risk factors are evidence-based and geared to provide an overall picture of a veteran's risk of violence.

<http://ajp.psychiatryonline.org/data/Journals/AJP/0/appi.ajp.2014.13101316.pdf>

C. Validated Eligibility Assessments

Drug and DUI courts should use validated assessment tools to assess risk and need. Research suggests that standardized assessment tools are significantly more reliable and valid than professional judgment for predicting success in correctional supervision and matching defendants 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 defendants 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) nor do they assess risk for reoffending. Assessment tools used to determine candidates' eligibility for programs—which are often validated on samples of predominantly Caucasian males—should not be assumed to be valid for use with minorities, females, or members of other demographic subgroups (Burlew et al., 2011). Studies have found that women and racial or ethnic minorities interpreted assessment items differently than other test respondents, making the test items less valid for these groups (Carle, 2009; Perez & Wish, 2011; Wu et al., 2010).

D. Trauma-Informed Services

Veterans are particularly susceptible to PTSD due to exposure to traumatic events during military service. The rates of PTSD vary depending upon era of service. A 2008 RAND study estimates that 300,000 service members will be returning from OEF/OIF deployment with PTSD or a major depressive disorder (Tanielian & Jaycox, 2008). An estimate for current prevalence of PTSD among veterans from OEF/OIF who were assessed with the Posttraumatic Stress Disorder Checklist (PCL)5 indicate a 13.8 percent diagnosis. Studies also note an increased risk of PTSD as time after deployment increases (Tanielian & Jaycox, 2008). In a study conducted from 1995-1997, 12.1 percent of Gulf War Veterans assessed with the PCL assessment tool were assessed as having PTSD (Kang, Natelson, Lee, & Murphy, 2003). A study conducted in 1986-1988 indicates that “15.2% of males and 8.1% of females” who served in Vietnam had diagnoses of PTSD at the time of the study (Kulka et al., 1988). Additionally, rates of traumatic exposure are particularly high for incarcerated veterans. In one study of 129 incarcerated veterans, 87 percent reported at least one trauma during their military service (Saxon, Davis, Sloan, McKnight, McFall, & Kivlahan, 2001).

Evidence-based treatments for individuals diagnosed with PTSD are manualized, standardized, and cognitive-behavioral in orientation (Benish et al., 2008). Best practices for effective intervention focus on objectives including: creating a safe and dependable therapeutic relationship between participant and therapist; encouraging participants to cope with negative emotions without resorting to avoidance behaviors such as substance abuse; helping participants construct a “narrative” of their traumatic histories to facilitate a productive and healthy understanding of the traumatic events and to prevent future retraumatization; and gradually exposing participants to memories and images of the event in order to reduce feelings of panic and anxiety associated with the event (Benish et al., 2008; Bisson et al., 2007; Bradley et al., 2005; Mills et al., 2012).

E. Criminal History Disqualifications

Research on criminal history disqualification focuses on disqualifying defendants who have been charged with, or have a history of, committing three classes of offenses: 1. felony theft and property crimes; 2. violent crimes; and 3. drug dealing. Research shows that not only are drug courts effective in reducing recidivism among individuals charged with felony theft and property crimes, but courts that serve these populations yielded almost twice the cost savings compared to those that did not (Carey et al., 2008, 2012). The additional costs savings were attributed to the fact that cost-savings associated with reduced recidivism for these more serious offenses were greater than those associated with reduced recidivism associated with simple drug possession cases (Downey & Roman, 2010). Research on defendants with a history of violent crime in drug courts show more mixed results. Some studies find they perform as well or better than nonviolent participants (Carey et al., 2008, 2012; Saum & Hiller, 2008; Saum et al., 2001) but two meta-analyses demonstrated that drug courts which include defendant charged with violent crimes are significantly less effective than those that do not (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 defendants. Less research has been conducted on the inclusion of individuals charged with drug dealing. Existing studies suggested that these individuals can perform as well (Marlowe et al., 2008) or better (Cissner et al., 2013) than other participants in drug court programs.

A British study of Iraq and Afghanistan returning soldiers found that in those under 30 y/o, 20% had a conviction for violent offences compared with 6.7% of civilians the same age.

<http://www.ptsupdate.com/violence-veterans-fact-fiction/>

F. Clinical Disqualifications

Assuming that adequate services are available, there is no empirical justification for excluding addicted defendants with co-occurring mental health or medical problems from participation in drug courts. Mental illness, in and of itself, is not recognized as being criminogenic (Skeem and Petersen, 2012). A national study of twenty-three adult drug courts found that drug courts were equivalently effective for a wide range of participants regardless of their mental health conditions (Rempel et al., 2012; Rossman et al., 2011; Zweig et al., 2012). Another study of approximately seventy drug courts found that programs that excluded defendants 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 individuals are likely to cycle in and out of the criminal justice system and use 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).

A valid prescription for medication to treat drug addiction should not serve as the basis for a blanket exclusion from a drug court (Parrino, 2002). Numerous controlled studies have reported significantly better outcomes when addicted participants 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).

References:

- Andrews, D.A., Bonta, J., & Wormith, J.S. (2006). The recent past and near future of risk and/or need assessment. *Crime & Delinquency*, 52(1), 7–27.
- Andrews, D.A., & Bonta, J. (2010). *The Psychology of Criminal Conduct* (5th ed.). New Providence, NJ: Anderson.

- Benish, S.G., Imel, Z.E., & Wampold, B.E. (2008). The relative efficacy of bona fide psychotherapies for treating post-traumatic stress disorder: A meta-analysis of direct comparisons. *Clinical Psychology Review, 28*(5), 746–758.
- Bhati, A.S., Roman, J.K., & Chalfin, A. (2008). *To treat or not to treat: Evidence on the prospects of expanding treatment to drug-involved offenders*. Washington, DC: Urban Institute.
- Bisson, J.I., Ehlers, A., Matthews, R., Pilling, S., Richards, D., & Turner, S. (2007). Psychological treatments for chronic posttraumatic stress disorder: Systematic review and meta-analysis. *British Journal of Psychiatry, 190*, 97–104. doi:10.1192/bjp.bp.106.021402.
- Bradley, R., Greene, J., Russ, E., Dutra, L., & Westen, D. (2005). A multidimensional meta-analysis of psychotherapy for PTSD. *American Journal of Psychiatry, 162*(2), 214–227.
- Burlew, A.K., Weekes, J.C., Montgomery, L., Feaster, D.J., Robbins, M.S., Rosa, C.L., Wu, L. (2011). Conducting research with racial/ethnic minorities: Methodological lessons from the NIDA Clinical Trials Network. *American Journal of Drug & Alcohol Abuse, 37*(5), 324–332.
- Carey, S.M., & Perkins, T. (2008). *Methamphetamine users in Missouri drug courts: Program elements associated with success* (Final report). Submitted to the Missouri Office of the State Court Administrator.
- Carey, S.M., Mackin, J.R., & Finigan, M.W. (2012). What works? The ten key components of drug court: Research-based best practices. *Drug Court Review, 7*(1), 6–42.
- Carle, A.C. (2009). Assessing the adequacy of self-reported alcohol abuse measurement across time and ethnicity: Cross-cultural equivalence across Hispanics and Caucasians in 1992, nonequivalence in 2001–2002. *BioMed Central Public Health, 9*(60). Retrieved from <http://www.biomedcentral.com/1471-2458/9/60>
- Casey, P.M., Warren, R.K., & Elek, J.K. (2011). *Using offender risk and needs assessment information at sentencing*. Williamsburg, VA: National Center for State Courts. Retrieved from <http://ncsc.contentdm.oclc.org/cgi-bin/showfile.exe?CISOROOT=/criminal&CISOPTR=196>
- Chandler, R.K., Fletcher, B.W., & Volkow, N.D. (2009). Treating drug abuse and addiction in the criminal justice system: Improving public health and safety. *Journal of the American Medical Association, 301*(2), 183–190.
- Cissner, A., Rempel, M., Franklin, A.W., Roman, J.K., Bieler, S., Cohen, R., & Cadoret, C.R. (2013). *A statewide evaluation of New York's adult drug courts: Testing which policies work best*. Paper presented at the New York Association of Drug Treatment Court Professionals Training. Retrieved from <http://www.nyadtcp.org/userfiles/file/presentation/The%202012%20New%20York%20State%20Drug%20Court%20Evaluation.pdf>
- DeMatteo, D.S., Marlowe, D.B., & Festinger, D.S. (2006). Secondary prevention services for clients who are low risk in drug court: A conceptual model. *Crime & Delinquency, 52*(1), 114–134.
- Downey, P.M., & Roman, J.K. (2010). *A Bayesian meta-analysis of drug court cost-effectiveness*. Washington, DC: Urban Institute.
- Fielding, J.E., Tye, G., Ogawa, P.L., Imam, I.J., & Long, A.M. (2002). Los Angeles County drug court programs: Initial results. *Journal of Substance Abuse Treatment, 23*(3), 217–224.
- Finigan, M.W., Perkins, T., Zold-Kilbourn, P., Parks, J., & Stringer, M. (2011). Preliminary evaluation of extended-release naltrexone in Michigan and Missouri drug courts. *Journal of Substance Abuse Treatment, 41*(3), 288–293.
- Green, M., & Rempel, M. (2012). Beyond crime and drug use: Do adult drug courts produce other psychosocial benefits? *Journal of Drug Issues, 42*(2), 156–177.
- Greenfield, S.F., & Hennessy, G. (2008). Assessment of the patient. In M. Galanter & H.D. Kleber (Eds.). *Textbook of substance abuse treatment* (4th ed., pp. 55–78). Washington, DC: American Psychiatric Publishing.
- Kang, H.K., Natelson, B.H., Mahan, C.M., Lee, K.Y., & Murphy, F.M. (2003). Post-traumatic stress disorder and chronic fatigue syndrome-like illness among Gulf War Veterans: A population-based survey of 30,000 veterans. *American Journal of Epidemiology, 157*(2), 141–148. Retrieved from <http://aje.oxfordjournals.org/>

- Kulka, R.A., Schlenger, W.E., Fairbank, J.A., Hough, R.L., Jordan, B.K., Marmar, C.R., & Weiss, D.S. (1988). Contractual report of findings from the National Vietnam Veterans Readjustment Study: Volume II: Tables of Findings. North Carolina: Research Triangle Park.
- Lovins, L.B., Lowenkamp, C.T., Latessa, E.J., & Smith, P. (2007). Application of the risk principle to female offenders. *Journal of Contemporary Criminal Justice*, 23(4), 383–398.
- Lowenkamp, C.T., & Latessa, E.J. (2004). Understanding the risk principle: How and why correctional interventions can harm low-risk offenders. *Topics in Community Corrections*, 2004, 3–8.
- Lowenkamp, C.T., & Latessa, E.J. (2005). Increasing the effectiveness of correctional programming through the risk principle: Identifying offenders for residential placement. *Criminology & Public Policy*, 4(2), 263–290.
- Marlowe, D.B. (2009). Evidence-based sentencing for drug offenders: An analysis of prognostic risks and criminogenic needs. *Chapman Journal of Criminal Justice*, 1(1), 167–201.
- Marlowe, D.B., Festinger, D.S., Dugosh, K.L., Arabia, P.L., & Kirby, K.C. (2008). An effectiveness trial of contingency management in a felony pre-adjudication drug court. *Journal of Applied Behavior Analysis*, 41(4), 565–577.
- Mitchell, O., Wilson, D.B., Eggers, A., & MacKenzie, D.L. (2012). Assessing the effectiveness of drug courts on recidivism: A meta-analytic review of traditional and nontraditional drug courts. *Journal of Criminal Justice*, 40(1), 60–71.
- McCord, J. (2003). Cures that harm: Unanticipated outcomes of crime prevention programs. *Annals of the American Academy of Political & Social Science*, 587(1), 16–30.
- Miller, J.M., & Shutt, J.E. (2001). Considering the need for empirically grounded drug court screening mechanisms. *Journal of Drug Issues*, 31(1), 91–106.
- Mills, K.L., Teesson, M., Back, S.E., Brady, K.T., Baker, A.L., Hopwood, S., Ewer, P.L. (2012). Integrated exposure-based therapy for co-occurring posttraumatic stress disorder and substance dependence: A randomized controlled trial. *Journal of the American Medical Association*, 308(7), 690–699.
- National Association of Drug Court Professionals. (2013) *Adult drug court best practice standards* (Volume 1). Alexandria, VA.
- National Institute on Drug Abuse. (2006). *Principles of drug abuse treatment for criminal justice populations* (NIH Pub. No. 06-5316). Bethesda, MD.
- Parrino, M.W., & McNicholas, L. (2002). Methadone maintenance and other pharmacotherapeutic interventions in the treatment of opioid dependence. *NDCI Drug Court Practitioner Fact Sheet*, 3(1), 1–4.
- Perez, D.M., & Wish, E.D. (2011). Gender differences in the validity of the Substance Abuse Subtle Screening Inventory–3 (SASSI-3) with a criminal justice population. *International Journal of Offender Therapy & Comparative Criminology*, 55(3), 476–491.
- Petrosino, A., Turpin-Petrosino, C., & Finckenauer, J.O. (2000). Well-meaning programs can have harmful effects! Lessons from experiments of programs such as Scared Straight. *Crime & Delinquency*, 46(3), 354–379.
- Rempel, M., Green, M., & Kralstein, D. (2012). The impact of adult drug courts on crime and incarceration. *Journal of Experimental Criminology*, 8(3), 165–192.
- Rossman, S.B., Rempel, M., Roman, J.K., Zweig, J.M., Lindquist, C.H., Green, M., Farole, D.J. (2011). *The multisite adult drug court evaluation: The impact of drug court* (Volume 4). Washington, DC: Urban Institute Justice Policy Center. Retrieved from <https://www.ncjrs.gov/pdffiles1/nij/grants/237112.pdf>
- Rossman, S.B., Willison, J.B., Mallik-Kane, K., Kim, K., Debus-Sherrill, S., & Downey, P.M. (2012). *Criminal justice interventions for offenders with mental illness: Evaluation of mental health courts in Bronx and Brooklyn, New York*. Washington, DC: Urban Institute.
- Saxon, A. J., Davis, T. M., Sloan, K. L., McKnight, K. M., McFall, M. E., & Kivlahan, D. R. (2001). Trauma, symptoms of posttraumatic stress disorder, and associated problems among incarcerated veterans. *Psychiatric Services*, 52, 959–964.

- Saum, C.A., & Hiller, M.L. (2008). Should violent offenders be excluded from drug court participation? An examination of the recidivism of violent and nonviolent drug court participants. *Criminal Justice Review*, 33(3), 291–307.
- Saum, C.A., Scarpitti, F.R., & Robbins, C.A. (2001). Violent offenders in drug court. *Journal of Drug Issues*, 31(1), 107–128.
- Shaffer, D.K. (2010). Looking inside the black box of drug courts: A meta-analytic review. *Justice Quarterly*, 28(3), 493–521.
- Sevigny, E. L., Pollack, H. A., & Reuter, P. (2013). Can drug courts help to reduce prison and jail populations? *Annals of the American Academy of Political & Social Science*, 647, 190-212.
- Stewart, S.H. (2009). Dependence and diagnosis. In P.M. Miller (Ed.), *Evidence-based addiction treatment* (pp. 77–88). New York, NY: Elsevier.
- Skeem, J., & Peterson, J. (2012). Identifying, treating, and reducing risk for offenders with mental illness. In J. Petersilia & K. Reitz (Eds), *Handbook on Sentencing and Corrections* (521-543). New York: Oxford University Press.
- Skeem, J.J., Manchak, S., & Peterson, J.K. (2011). Correctional policy for offenders with mental illness: Creating a new paradigm for recidivism reduction. *Law & Human Behavior*, 35(2), 110–126.
- Szalavitz, M. (2010, July 16). Does teen drug rehab cure addiction or create it? *Time Magazine: On-Line*. Retrieved from <http://time.com/time/printout/0,8816,2003160,00.html>
- Tanielian, T. & Jaycox, L.H. (Eds.). (2008). *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery* (MG-720-CCF, pp.492). Santa Monica, Calif.: *RAND Corporation*. Retrieved from <http://veterans.rand.org>.
- Wexler, H.K., Melnick, G., & Cao, Y. (2004). Risk and prison substance abuse treatment outcomes: A replication and challenge. *The Prison Journal*, 84(1), 106–120.
- Wormith, J.S., & Goldstone, C.S. (1984). The clinical and statistical prediction of recidivism. *Criminal Justice & Behavior*, 11(1), 3–34.
- Wu, L.T., Pan, J.J., Blazer, D.G., Tai, B., Stitzer, M.L., & Woody, G.E. (2010). Using a latent variable approach to inform gender and racial/ethnic differences in cocaine dependence: A National Drug Abuse Treatment Clinical Trials Network Study. *Journal of Substance Abuse Treatment*, 38(Suppl. 1), S70–S79.
- Zweig, J.M., Lindquist, C., Downey, P.M., Roman, J., & Rossman, S.B. (2012). Drug court policies and practices: How program implementation affects offender substance use and criminal behavior outcomes. *Drug Court Review*, 7(1), 43–79.

III. Program Structure

A. PROGRAM CAPACITY*

High capacity programs shall develop a plan to ensure that the veterans treatment court model and services are provided to all participants consistent with evidence-based practices. When the census reaches 125 active participants, program operations shall be monitored carefully to ensure they remain consistent with best practice standards. If evidence suggests some operations are drifting away from best practices, the team shall develop a remedial action plan and timetable to rectify the deficiencies and evaluate the success of the remedial actions.

B. PROGRAM ENTRY*

Programs shall minimize the time between the precipitating event (arrest or probation violation) and entrance into the Veterans Treatment Court and the time between the Veterans Treatment Court entry and first treatment episode.

C. GRADUATION, TERMINATION, AND PROGRAM DURATION*

1. **BENEFITS OF PROGRAM PARTICIPATION***- Benefits of program participation shall be clearly articulated in a written document and participants shall be made aware of these benefits prior to program entry. Veterans treatment court programs shall dismiss, withhold enhancement,³ or reduce charges or motions to revoke probation upon successful completion.³
2. **CONSEQUENCES FOR UNSUCCESSFUL PROGRAM EXIT***- Participants shall be given written notice of the potential consequence for failure to complete the Veterans Treatment Court program prior to program entry.
3. **PROGRAM LENGTH*/*****- Program length shall be long enough to allow participants to initiate and maintain recovery and mental health; develop coping and relapse prevention skills; and transition to and maintain compliance with an aftercare plan.
4. **PROGRAM PROGRESSION STRUCTURE*/*****- Programs shall adopt the *Veterans Treatment Court Progression Plan* which defines how participants are expected to progress during participation in the program. Progress through the *Veterans Treatment Court Progression Plan* shall be predicated on the achievement of realistic and defined behavioral objectives.. As participants advance through the program, sanctions for infractions may increase in magnitude, rewards for achievements may decrease, and supervision services may be reduced. Treatment shall be reduced only if it is clinically determined that a reduction in treatment is unlikely to precipitate a relapse to substance use or mental health instability.

³ Nebraska's DWI courts are post-sentence and, therefore, dismissal of charges or motions to revoke probation apply to drug courts and veterans treatment courts only.

5. GRADUATION REQUIREMENTS*/*** - Participants shall meet specified graduation requirements in order to “successfully complete” the Veterans Treatment Court program. Programs shall define graduation requirements to include those that focus on long-term success. These requirements should be an extension of the participants’ progress in the program and shall incorporate a written post-program plan that focuses on skills to maintain the behavioral changes each participant accomplished during program participation. This written plan should be implemented prior to program exit to allow the participant to practice learned behaviors and skills during participation.

A. PERIOD OF TIME CLEAN AND SOBER PRIOR TO PROGRAM EXIT*/*-**

For those veterans whose primary diagnosis is a substance use disorder, a minimum of 90 days of continuous sobriety shall be required prior to graduation; however, each veterans treatment court may establish its own minimum standard that exceeds the established minimum.

B. STABLE AND PRO-SOCIAL ACTIVITIES AND ENVIRONMENT*- Programs shall require participants to be involved in pro-social activities prior to graduation. Programs shall require participants to reside in a pro-social living environment prior to graduation. Participants, who are able, shall be required to have employment or be enrolled in an educational program prior to graduation.

C. WRITTEN SUSTAINED SUCCESS PLAN*- Programs shall work with the participant to develop a written long-term success plan that is implemented prior to graduation. Programs should require participants to demonstrate ability to comply with the sustained success plan in preparation for transition out of the program. If a participant is unable to follow the sustained success plan while still engaged in the program, the plan shall be modified to ensure the plan can be followed by the participant after program exit.

Supporting Evidence

The supporting evidence is based on the National Adult Drug Court Standards developed by the National Association of Drug Court Professionals, (2013), p.19-24, 40-51; and (2015), p.51-58.

A. Program Capacity

Recidivism reduction declines significantly as program size increases. A study of 69 drug courts found that programs with less than 125 participants had over five times the reduction in recidivism compared to those with 125 or more participants (Carey et al, 2012). Research also suggests that to avoid the decrease in positive outcomes associated with a larger number of participants, larger programs should regularly monitor their practices to ensure that they maintain fidelity to the drug court model and to best practices (Carey et al, 2012). It is unnecessary for drug courts to place arbitrary restrictions on program size, and it should be a goal of the drug court field to serve every drug addicted person in the criminal justice system who meets evidence based eligibility criteria for the programs (Fox & Berman, 2002). However, many drug courts are not equipped with the resources to increase capacity and continue to deliver quality services. A study of approximately seventy drug courts found a significant inverse relationship between the size of the drug court census and the effects on criminal recidivism (Carey et al., 2008, 2012a). Programs evidenced a steep decline in effectiveness when the census exceeded 125 participants, and drug courts with fewer than 125 participants were five times more effective in

reducing recidivism than drug courts with more than 125 participants (Carey et al., 2012b). Staff should monitor drug court operations, and if some operations are drifting away from best practices, a remedial action plan should be implemented to rectify the deficiencies, such as hiring additional staff, purchasing more drug and alcohol tests, providing continuing education for staff, or scheduling status hearings on more days of the week.

B. Program Entry

Carey et al. (2012) also found that programs in which the time between arrest and program entry was 50 days or less had a 63% greater reduction in recidivism when compared to programs in which the time between arrest and program entry was longer. A study of 18 drug courts found that a shorter time between arrest and entry into the program was associated with lower recidivism rates and greater cost savings (Carey et al., 2008).

SAMHSA's *Treatment Improvement Protocol 44* (Center for Substance Abuse Treatment, 2005) recommends providing screening and assessment at the earliest point possible and moving defendants into treatment as soon as possible.

C. Graduation, Duration, Program Participation

1. Benefits of Program Participation AND 2. Consequences for Unsuccessful Program Exit

A national study of twenty-three adult drug courts, the NIJ-Multisite Adult Drug Court Evaluation (MADCE), finds better outcomes for courts that provide participants with a written schedule of rewards for participation and sanctions for non-compliance prior to beginning participation (Rossman et al., 2011). The same study found that programs in which clients perceived that courts had a higher degree of leverage over them (e.g. that they were being closely monitored and that the consequences of noncompliance would be negative) prevented more crimes than those with a low degree of leverage (Rossman et al., 2011).

A meta-analysis of approximately sixty studies including seventy drug courts examined the relationship between recidivism and the type of reward associated with graduation (Shaffer, 2006). Shaffer (2006) found that drug courts are more effective at reducing recidivism when graduation leads to charges and/or motions to revoke probation being dismissed than when it is linked to avoiding a sanction.

3. Program Length

The MADCE study found that it is important to provide substance abuse treatment of sufficient duration to allow participants to alter their behavior and attitudes (Rossman et al., 2011). In a meta-analysis including 60 studies covering 76 distinct drug courts and 6 aggregated drug court programs, programs that lasted 8-16 months were significantly more effective in reducing recidivism than programs that were shorter or longer (Shaffer, 2006). In a study of 69 drug courts, programs that were 12 months or longer had a 57% greater reduction in recidivism than shorter programs (Carey et al., 2012). As Marlowe, Dematteo, and Festinger (2003) point out, 12 months in substance treatment is required to reduce the probability of relapse by 50 percent. As they point out, twelve months of drug treatment appears to be the “median point” on the dose-response curve; that is, approximately 50% of clients who complete twelve months or more of drug abuse treatment remain abstinent for an additional year following completion of treatment.

4. Program Progression Structure

Several studies have found that using a written schedule of graduated sanctions and incentives is most effective in producing positive outcomes (Cissner & Rempel, 2005; Harrell et al., 2000; Rossman et al, 2011). In a meta-analysis of adult drug courts including 92 studies, Mitchell et al (2012) specifically examined multi-phase programs and found that programs with more than three phases had a larger reduction in drug recidivism than programs with fewer phases.

5. Graduation Requirements

a. Period of Time Clean and Sober Prior to Program Exit

In a study of 69 drug courts, programs in which participants were required to have at least 90 days of negative drug tests prior to successfully exiting the program had 164% greater reduction in recidivism and 50% greater cost savings than programs that required fewer days clean (Carey et al., 2012).

b. Stable and Pro-social Activities and Environment

Carey et al. (2012) also found that programs which require participants to have sober housing prior to graduation have 48% greater cost savings than programs which do not. In addition, programs which require participants to have a job or be in school prior to graduation have an 83% greater cost-savings than programs that do not. Andrews and Bonta (2010), when defining their new widely-applied *Risk-Needs-Responsivity (RNR)* model identified “prosocial recreational activities” as a criminogenic need that, if not met, is associated, if weakly, with recidivism.

c. Written Sustained Recovery Plan

The provision of after care services is associated with reduced recidivism (Van Voorhis & Hurst, 2000). In a random-assignment study of 453 veterans receiving substance abuse treatment, Seigal et al. (2002) found that engagement in aftercare with continued supervision and case management after completing treatment significantly reduced negative behavior.

References:

- Andrews, D. A., & Bonta, J. (2010). *The psychology of criminal conduct* (5th ed.). Newark, NJ: LexisNexis/Matthew Bender
- Carey, S.M., & Perkins, T. (2008). *Methamphetamine users in Missouri Drug Courts: Program elements associated with success* (Final report). Submitted to the Missouri Office of the State Court Administrator.
- Carey, S.M., Finigan, M.W., & Pukstas, K. (2008). Exploring the key components of drug courts: A comparative study of 18 adult drug courts on practices, outcomes and costs. Portland, OR: NPC Research. Available at http://www.npcresearch.com/Files/NIJ_Cross-site_Final_Report_0308.pdf.
- Carey, S.M., Mackin, J.R., & Finigan, M.W. (2012). What works? The ten key components of drug court: Research-based best practices. *Drug Court Review*, 7(1), 6–42.
- Center for Substance Abuse Treatment. (2005). *Substance Abuse Treatment for Adults in the Criminal Justice System*. Treatment Improvement Protocol (TIP) Series 44. DHHS Publication No. (SMA) 05-4056. Rockville, MD: Substance Abuse and Mental Health Services Administration.
- Cissner, A., Rempel, M., Franklin, A.W., Roman, J.K., Bieler, S., Cohen, R., & Cadoret, C.R. (2013). *A statewide evaluation of New York’s adult drug courts: Testing which policies work best*. Paper presented at the New York Association of Drug Treatment Court Professionals Training. Available at <http://www.nyadtcp.org/userfiles/file/presentation/The%202012%20New%20York%20State%20Drug%20Court%20Evaluation.pdf>.
- Fox, A., & Berman, G. (2002). Going to scale: A conversation about the future of drug courts. *Court Review*, 39(3), 4–13.
- Harrell, A.; Cavanagh, S. and Roman, J. (2000). Evaluation of the D.C. Superior Court Drug Intervention Programs. *Research in Brief*. National Institute of Justice, Washington, DC.
- Marlowe, D. B., DeMatteo, D. S., & Festinger, D. S. (2003). A sober assessment of drug courts. *Federal Sentencing Reporter*, 16, 153-157.

- Mitchell, O.; Wilson, D.B.; Eggers, A.; MacKenzie, D. L. (2012). Assessing the effectiveness of drug courts on recidivism: A meta-analysis of traditional and non-traditional drug courts. *Journal of Criminal Justice*, 40: 60-71.
- Rossman, S.B., Rempel, M., Roman, J.K., Zweig, J.M., Lindquist, C.H., Green, M., Downey, P.M., Yahner, J., Bhati, A.S., & Farole, D.J. (2011). *The multisite adult drug court evaluation: The impact of drug courts, vol. 4*. Washington, DC: Urban Institute Justice Policy Center. Available at <https://www.ncjrs.gov/pdffiles1/nij/grants/237112.pdf>.
- Seigal, H.A.; Li, Li; Rapp, R.C. (2002). Case management as therapeutic enhancement. *Journal of Addictive Diseases*, 21(4): 37-46.
- Shaffer, D.K. (2006) *Reconsidering Drug Court Effectiveness: A Meta-analytic review*. (unpublished doctoral dissertation). University of Cincinnati, Cincinnati, OH.
- Van Voorhis, P. & G. Hurst (2000). Treating substance abuse in offender populations. In P. Van Voorhis, M. Braswell, M., & D. Lester (eds.) *Correctional Counseling and Rehabilitation*, 4th Edition, Cincinnati: Anderson, pp. 265-288.

IV. Treatment

A. CONTINUUM OF CARE*/***

For those whose primary diagnosis is a substance use disorder, veterans treatment courts shall offer a continuum of care for substance use treatment consistent with the *Standardized Model for the Delivery of Substance Use Services*. The *Standardized Model for the Delivery of Substance Use Services* shall govern the level of care that is provided. For those who have been identified with a mental health disorder, veterans treatment courts shall offer a continuum of care for treatment consistent with mental health disorders as found within the Diagnostic and Statistical Manual of Mental Disorders (DSM-5). Treatment for individuals with co-occurring disorders will apply standard and criteria from both the *Standardized Model for the Delivery of Substance Use Services* and the DSM-5, as applicable. Adjustments to the level of care shall be predicated on each participant's needs and response to treatment and are not tied to the veterans treatment court's programmatic structure.

B. IN-CUSTODY TREATMENT*

Participants shall not be incarcerated to achieve clinical or social service objectives. The court shall not be prohibited from utilizing incarceration for reasons of public safety or preventing harm to self or others.

C. TEAM REPRESENTATION/**/*****

One or two treatment agencies/representatives shall be primarily responsible for managing the delivery of treatment services to veterans treatment court participants. Clinically trained representatives from these agencies shall be core members of the Veterans Treatment Court team and regularly attend team meetings and status hearings.

D. GROUP TREATMENT DOSAGE AND DURATION/**/*****

Veterans treatment courts shall prioritize referrals to services for those needs associated with an increased risk to reoffend and incorporate compliance with these services into the veterans treatment court requirements. The veterans treatment courts shall match the dosage, duration and intensity of services to the veteran's level of criminogenic risk and need as determined by a validated assessment instrument. For those whose primary diagnosis is a substance use disorder, a sufficient dosage and duration of substance use treatment to achieve long-term sobriety and recovery from addiction shall be provided. High risk, high need participants shall receive six to ten hours of counseling per week during the initial phase of treatment and approximately 200 hours of counseling over nine to twelve months; however, the Veterans Treatment Court shall allow for flexibility to accommodate individual differences in each veteran's response to treatment.

E. TREATMENT MODALITIES/****

In addition to group substance use treatment, high risk, high needs participants shall meet with a treatment provider or clinical case manager for at least one individual treatment 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. All participants shall be screened for their suitability for group interventions. Group participation shall be guided by evidence-based selection criteria including participants' gender, trauma history and co-occurring psychiatric symptoms. Treatment groups optimally have no more than twelve participants and at least two leaders or facilitators. Caseloads for clinicians shall provide sufficient opportunities to assess participant needs and deliver adequate and effective dosages of substance use treatment and indicated complementary services. Program operations shall be 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

F. EVIDENCE-BASED TREATMENT/****

Treatment providers shall administer behavioral or cognitive-behavioral treatment programs that are documented in manuals and have been demonstrated to improve outcomes for persons with substance use problems involved in the criminal justice system. Treatment providers shall be proficient at delivering the interventions and shall be supervised regularly to ensure continuous fidelity to the treatment models.

G. IDENTIFY SERVICES IN THE COMMUNITY TO TARGET PARTICIPANT NEEDS*

Veterans treatment courts shall develop a continuum of ancillary services to target the criminogenic needs and responsivity factors of veterans treatment court participants. Ancillary services may include services such as job skills training, family therapy, mental health treatment, trauma treatment and/or housing assistance.

H. ASSESS CHANGES IN PARTICIPANTS' NEEDS AND RESPONSIVITY FACTORS*

Veterans treatment courts shall assess and document changes in needs in conjunction with responsivity factors at regular intervals using a validated assessment tool. The Veterans Treatment Court shall revise case plans to respond to changes in participants' needs and responsivity factors.

I. MEDICATION ASSISTED TREATMENT**

Participants may use prescribed psychotropic or addiction medications, based on medical necessity, when prescribed by a treating physician with expertise in addiction psychiatry or addiction medicine, in collaboration with the Veterans Treatment Court team.

J. PROVIDER TRAINING AND CREDENTIALS*/**

Treatment providers shall be a registered service provider with the Nebraska Office of Probation Administration, have substantial experience working with criminal justice populations, and be supervised regularly to ensure continuous fidelity to evidence-based practices.

K. PEER SUPPORT GROUPS*

Participants shall attend self-help or peer support groups in addition to professional counseling. Additionally, veterans treatment court participants shall have access to a veteran mentor who acts as an ally; a resource to interact with participants, assisting with navigation of the court, treatment and VA systems.

L. TRAUMA-INFORMED SERVICES*/**

Veterans with PTSD shall receive an evidence-based intervention that teaches them how to manage distress without resorting to substance use or other avoidance behaviors, desensitizes them gradually to symptoms of panic and anxiety, and encourages them to engage in productive actions that reduce the risk of retraumatization. Veterans with PTSD or severe trauma-related symptoms shall be evaluated for their suitability for group interventions and are treated on an individual basis or in small groups when necessary to manage panic, dissociation, or severe anxiety.

M. CRIMINAL THINKING INTERVENTIONS*/***

Participants shall receive an evidence-based criminal-thinking intervention after they are stabilized clinically and are no longer experiencing acute symptoms of substance use or mental health distress such as cravings, withdrawal, or depression. Staff members shall be 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.

N. OVERDOSE PREVENTION AND REFERRAL*/***

Those individuals whose primary diagnosis is a substance use disorder, shall complete a brief evidence-based educational curriculum describing concrete measures they can take to prevent or reverse drug overdose.

The supporting evidence is based on the National Adult Drug Court Standards developed by the National Association of Drug Court Professionals (2013) p.38 – 49; and (2015) p.5-25.

A. Continuum of Care

Veterans involved in the criminal justice system, particularly those that are incarcerated, have high rates of PTSD, substance use, mental health disorders and other criminal risk factors. Combat exposure has been linked to increased aggression, violence, and anti-social behavior, which may in turn increase risk for incarceration (Greenberg, Rosenheck, & Desai, 2007). Incarcerated veterans may be more likely to have experienced severe combat exposure during their service than non-incarcerated veterans (Greenberg et al., 2007). In a sample of 30,000 incarcerated veterans, 79 percent had a mental health disorder (Tsai, Rosenheck, Kaspro, & McGuire, 2014). Veterans with PTSD and substance misuse also experience higher arrest rates (Elbogen, Johnson, Wagner, Newton, & Beckham, 2012). Incarcerated veterans from Operation Enduring Freedom, Operation Iraqi Freedom, and Operation New Dawn present combat-related PTSD three times more than other incarcerated veteran populations (Tsai, Rosenheck, Kaspro, & McGuire, 2013). VTCs will be faced with the complex cases these veterans present to the system, often in combination.

Outcomes are significantly better in drug courts that offer a continuum of care including residential treatment and recovery, housing, and 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 treatment⁴ (Krebs et al., 2009). Moving participants 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).

Significantly better results are achieved when substance abuse participants 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). Studies have confirmed that participants who received the indicated level of care according to the *American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders*⁵ (ASAM-PPC) had significantly higher treatment completion rates and fewer instances of relapse to substance use than participants who received a lower level of care than was indicated (De Leon et al., 2010; Gastfriend et al., 2000; Gregoire, 2000; Magura et al., 2003; Mee-Lee & Gastfriend, 2008) and had equivalent or worse outcomes than those receiving a higher level of care than what was indicated (Lovins et al., 2007; Lowenkamp & Latessa, 2005; Magura et al., 2003; Wexler et al., 2004). The negative impact of receiving an excessive level of care appears to be most pronounced for participants below the age of twenty-five (DeMatteo et al., 2006; Lowenkamp & Latessa, 2004; McCord, 2003; Petrosino et al., 2000; Szalavitz, 2010).

Substance use and dependence may begin during active military duty or after discharge. Between 2004 and 2006, 7.1 percent of U.S. veterans met the criteria for a substance use disorder (SAMHSA, 2014) with a quarter of 18- to 25-year-old veterans meeting criteria for a past-year

⁴ 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).

⁵ The *American Society of Addiction Medicine Patient Placement Criteria for the Treatment of Substance-Related Disorders* (ASAM-PPC) is the most commonly used placement criteria (Mee-Lee et al., 2001).

substance use disorder, which is more than double the rate of veterans aged 26–54 and five times the rate of veterans 55 or older. Of particular concern is the increase in dependence to opiates. Pain reliever prescriptions written by military physicians quadrupled between 2001 and 2009—to almost 3.8 million. Combat-related injuries and the strains from carrying heavy equipment during multiple deployments likely play a role in this trend. The 2010 report of the Army Suicide Prevention Task Force found that 29 percent of active duty Army suicides from fiscal year (FY) 2005 to FY 2009 involved alcohol or drug use; and in 2009, prescription drugs were involved in almost one third of the suicides (NIDA, 2013).

Behavioral health issues can be the result of military service as well. Military service members have a wide range of experiences during their period(s) of service. Those experiences alone or in combination with physical health issues and/or pre-existing criminogenic risk factors may result in behavioral health issues, including post-traumatic stress disorder (PTSD), depressive disorders, increased risk for suicide and co-occurring mental health and substance use disorders and others.

PTSD may also co-occur with substance abuse and anxiety disorders, further complicating treatment decisions (Friedman, 2014). The National Survey on Drug Use and Health found that “7.0 percent of veterans aged 18 or older experienced past year serious psychological distress (SPD), 7.1 percent met the criteria for a past year substance use disorder (SUD), and 1.5 percent had co-occurring SPD and SUD (based on combined 2004-2006 data, SAMHSA, 2007).” The more recent 2009 National Post-Deployment Adjustment Survey yielded a 20 percent PTSD occurrence and a 27 percent alcohol misuse occurrence for those veterans that had been deployed (Elbogen, Johnson, Newton, et al., 2012). The physical and psychological conditions veterans face as a result of their service may also relate or lead to secondary social issues. It should also be noted that these issues may co-occur. For example, homeless veterans are more likely to have chronic medical conditions and mental health needs than other homeless adults (O’Toole, Conde-Martel, Gibbon, Hanusa, & Fine, 2003).

Veterans are at an increased risk for suicide. Rates of death by suicide among veterans double that of the non-veteran population (Blodgett et al., 2013). While data collection relating to suicide deaths among veterans can be difficult to collect, additional studies document increase suicidal ideation and rates of suicides among veterans (Sundararaman, Panangala, & Lister, 2008). A 2005 National Violent Death Reporting System (NVDRS) report examining suicide rates among veterans identified that approximately 20 percent of all suicides in 16 states examined in a one-year period were committed by veterans (Karch et al 2005; Sundararman et al., 2008). Additionally veterans may have a higher exposure to risk factors for suicidal ideation including PTSD, TBI, depression, and exposure to combat (Tanelian and Jaycox, 2008).

Deployment is not the only source of challenges for veterans. Research suggests that, in addition to combat exposure, the effects of military training can make adjustment to civilian life difficult. Factors such as constant awareness of surroundings, always carrying a weapon, an unexpected need for fast driving, constant emotional control, and the need for strict discipline and obedience are essential for military training and deployment but can be problematic in a civilian setting (Clark, McGuire, & Blue-Howells, 2010).

Evidence suggests racial and ethnic minority participants may be more likely than non-minorities to receive a lower level of care than is warranted from their assessment results (Integrated Substance Abuse Programs, 2007; Janku & Yan, 2009).

B. In-Custody Treatment

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). Also, research shows that substance abuse treatment provided in jails

or prisons is not particularly effective (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 participants would complete outpatient treatment after their release from custody (Bahr et al., 2012; Martin et al., 1999; Wexler et al., 1999).

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). In a study of 69 drug court programs, recidivism was reduced as much as two fold in programs where 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. When drug courts are affiliated with large numbers of treatment providers outcomes were enhanced for programs in which the treatment providers communicate frequently with the court via e-mail or similar electronic means (Carey et al., 2012).

D. Treatment Dosage and Duration

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 participants 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, for drug courts treating those addicted to drugs and at high risk of recidivism or treatment failure, 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; but retain sufficient flexibility to accommodate individual differences in responses to treatment (Carey et al., 2012).

E. Treatment Modalities

Drug treatment can be provided in individual and group settings. Research shows that outcomes are significantly better in drug courts that require participants to attend individual sessions with a treatment provider or clinical case manager at least once per week during the first phase of the program (Carey et al., 2012; Rossman et al., 2011).

Group counseling can improve outcomes for drug court participants, but only under certain conditions. It is especially important that the groups apply evidence-based practices and that participants are screened for their suitability for group-based services (Andrews et al., 1990; Gendreau, 1996; Hollins, 1999; Lowenkamp et al., 2006). The size of the group also has implications for its effectiveness. 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).

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). 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). 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.

Drug courts must identify a range of complementary needs of its participants, refer them to indicated services, and ensure that the services are delivered in an effective sequence. This complex task must be informed by a professionally trained clinician or clinical case manager who can perform clinical and social service assessments, who understands how the services should be sequenced and matched to the participant, and can monitor and report on participant progress (Monchick et al., 2006; Rodriguez, 2011). Generally, clinical case managers are social workers, psychologists, or addiction counselors who have special training in identifying participant needs, referrals for indicated services, coordinating care between agencies, and reporting on participant progress in the program (Monchick et al., 2006; Rodriguez, 2011). Court case managers will generally administer a brief screening designed to identify participants who may require more substantial clinical assessments. Participants who score above a certain threshold on the screening instrument should be referred to a clinically-trained treatment professional for additional assessment.

F. Evidence-Based Treatments

A substantial body of research spanning several decades reveals that outcomes from correctional rehabilitation are significantly better when (1) individuals 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). Fidelity to the treatment model is maintained through continuous supervision of the treatment providers (Hollin, 1999; Landenberger & Lipsey, 2005; Lowenkamp et al., 2006; Lowenkamp et al., 2010; Lutze & VanWormer, 2007; Smith et al., 2009).

Examples of manualized CBT curricula that have been proven to reduce criminal recidivism among prisoners 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). The Matrix Model and RPT were developed for the treatment of addiction and MRT has been adapted successfully to treat drug-abusing prisoners (Bahr et al., 2012; Wanberg & Milkman, 2006) and drug court participants (Cheesman & Kunkel, 2012; Heck, 2008; Kirchner & Goodman, 2007).

G. Identify Services in Community to Target Participant Needs

In a study of 69 drug court programs, Carey et al. (2012) found that programs that offered ancillary services had better outcomes than those that did not. Programs that offered mental health treatment had 80% greater recidivism reduction, those that offered parent classes had a 65% greater recidivism reduction and those that offered family/domestic relations counseling had 65% greater recidivism reduction, compared to programs that did not offer these services. Programs offering parenting classes

reported 52% increase in cost savings and those offering anger management had 43% increase in cost savings compared to programs that did not offer these services.

Veterans may also face challenges with housing and maintaining employment. The U.S. Housing and Urban Development January 2013 national *single night* survey reported 57,849 homeless veterans (Henry, Cortes, & Morris, 2013). While this is a decrease from prior years, veteran homelessness is still a pressing issue as this number accounted for more than 12 percent of all homeless adults surveyed (Henry et al., 2013).

Employment statistics are also bleak: The youngest of veterans, aged 18 to 24, had a 30.4 percent jobless rate in October, way up from 18.4 percent a year earlier. Non-veterans of the same age improved, to 15.3 percent from 16.9 percent. For some groups, the numbers can look a good deal worse: for black veterans aged 18-24, the unemployment rate is a striking 48 percent (Beucke, 2011). Although unemployment numbers have steadied somewhat, high unemployment rates continue for young veterans. As of July 2013, post-9/11 veterans report higher unemployment rates than both non-veterans and veterans who served prior to 9/11 (Plumer, 2013).

I. Medications

Medically assisted treatment (MAT) can significantly improve outcomes for addicted persons (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). Positive outcomes have also been reported for antagonist medications, such as naltrexone, which are non-addictive and non-intoxicating. 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).

J. Provider Training and Credentials

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 participant outcomes if they are educated about the neuroscience of addiction (Steenbergh et al., 2012). Providers are better able to administer evidence-based practices when they receive three days of pre-implementation 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 populations in criminal justice settings and are accustomed to functioning in a criminal justice environment (Lutze & van Wormer, 2007).

K. 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). Individuals who are court mandated to attend self-help groups perform as well or better than non-mandated 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).

Successful outcomes are more likely if participants attend self-help groups and also engage in recovery-relevant activities like 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). Research has demonstrated that interventions can improve participant group engagement in self-help groups and recovery activities. Examples 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).

L. Trauma-Informed Services

Participants in drug court that exhibit trauma-related symptoms require specific, trauma-informed services beginning in the first phase of drug court and continuing, as necessary, throughout the participant's enrollment in the program. Individuals in the criminal justice system with PTSD are nearly one and half times more likely to reoffend than individuals without PTSD (Sadeh & McNiel, 2015). Additionally, participants with PTSD are at a much greater risk of being discharged prematurely or dropping out of substance abuse treatment than participants without PTSD (Mills et al., 2012; Read et al., 2004; Saladin et al., 2014). Even though all participants with trauma histories may not require formal PTSD treatment, each staff member, including court personnel and criminal justice professionals, should receive trauma-informed training (Bath, 2008).

M. Criminal Thinking Interventions

Drug court participants frequently exhibit criminal-thinking patterns that may lead to program failure and criminal recidivism (Gendreau et al., 1996; Helmond et al., 2015; Knight et al., 2006; Walters, 2003). Some drug court participants may hold counter-productive attitudes or values, have difficulty understanding their role in interpersonal conflict, as well as difficulty anticipating consequences before they act. These anti-social sentiments can cause participants to be viewed as suspicious or manipulative, and may lead to frequent conflict. There are several evidence based cognitive-behavioral interventions to address criminal-thinking patterns. Evidence based programs that demonstrate improved outcomes for participants include 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). Studies suggest that the most beneficial time to introduce these interventions is after participants are stabilized in treatment and are no longer experiencing acute symptoms of withdrawal (Milkman & Wanberg, 2007).

N. Overdose Prevention and Referral

Unintentional overdose deaths from illicit and prescribed opiates has tripled over the last fifteen years (Meyer et al., 2014), and individuals addicted to opiates are at a high-risk for overdose immediately following their release from jail or prison because their tolerance of opiates is reduced significantly during time in incarceration (Dolan et al., 2005; Strang, 2015; Strang et al., 2014). Drug courts should educate participants and their family members about simple overdose prevention and reversal strategies. Drug court personnel and other criminal justice professionals should be trained on the administration of overdose reversal medications such as naloxone, a non-addictive, non-intoxicating medication that poses a minimal risk of medical side-effects (Barton et al., 2002; Kim et al., 2009). Studies in Scotland and the United States have demonstrated that educating at-risk persons and their significant others about how to prevent or reverse an overdose significantly reduces overdose deaths (National Institute on Drug Abuse, 2014; Strang, 2015).

References:

- Andrews, D.A., & Bonta, J. (2010). *The psychology of criminal conduct* (5th ed.). Waltham, MA: Anderson Publishing.
- Andrews, D.A., Zinger, I., Hoge, R.D., Bonta, J., Gendreau, P., & Cullen, F.T. (1990). Does correctional treatment work? A clinically relevant and psychologically informed meta-analysis. *Criminology*, 28(3), 369–404.
- Arfken C., Agius E., Dickson M., Anderson H., & Hegedus A. (2005). Clinicians' beliefs and awareness of substance abuse treatments in research and non-research-affiliated programs. *Journal of Drug Issues*, 35(3), 547–558.
- Babor, T., & Del Boca, F. (Vol. Eds.) (2002). *Treatment matching in alcoholism*. In G. Edwards (Series Ed.), *International research monographs in the addictions*. Cambridge, UK: Cambridge University Press.
- Bahr, S.J., Masters, A.L., & Taylor, B.M. (2012). What works in substance abuse treatment programs for offenders? *The Prison Journal*, 92(2), 155–174.
- Banks, D., & Gottfredson, D.C. (2003). The effects of drug treatment and supervision on time to rearrest among drug treatment court participants. *Journal of Drug Issues*, 33(2), 385–412.
- Barton, E.D., Ramos, J., Colwell, C., Benson, J., Baily, J., & Dunn, W. (2002). Intranasal administration of naloxone by paramedics. *Prehospital Emergency Care*, 6(1), 54–58.
- Bath, H. (2008). The three pillars of trauma-informed care. *Reclaiming Children and Youth*, 17(3), 17–21.
- Beucke, D. (2011) Unemployment for young vets: 30%, and rising (2011). *Bloomberg Businessweek* Retrieved from http://www.businessweek.com/finance/occupy-wall-street/archives/2011/11/the_vets_job_crisis_is_worse_than_you_think.html
- Blodgett, J., Fuh, I., Maisel, N., & Midboe, A. (2013). A structured evidence review to identify treatment needs of justice-involved veterans and associated psychological interventions. Washington, DC: Department of Veterans Affairs. Available at: <http://csgjusticecenter.org/nrrc/publications/a-structured-evidence-review-to-identify-treatment-needs-of-justice-involved-veterans-and-associated-psychological-interventions/>
- Bourgon, G., & Armstrong, B. (2005). Transferring the principles of effective treatment into a “real world” prison setting. *Criminal Justice & Behavior*, 32(1), 3–25.
- Bourgon, G., Bonta, J., Ruge, T., Scott, T.L., & Yessine, A. (2010). The role of program design, implementation, and evaluation in evidence-based ‘real world’ community supervision. *Federal Probation*, 74(1), 2–15.
- Brabender, V. (2002). *Introduction to group therapy*. New York: John Wiley & Sons.
- Carey, S.M., Finigan, M.W., & Pukstas, K. (2008). *Exploring the key components of drug courts: A comparative study of 18 adult drug courts on practices, outcomes, and costs*. Portland, OR: NPC Research. Retrieved from <https://www.ncjrs.gov/pdffiles1/nij/grants/223853.pdf>
- Carey, S.M., Mackin, J.R., & Finigan, M.W. (2012). What works? The 10 key components of Drug Court: Research-based best practices. *Drug Court Review*, 8(1), 6–42.
- Chandler, R.K., Fletcher, B.W., & Volkow, N.D. (2009). Treating drug abuse and addiction in the criminal justice system: Improving public health and safety. *Journal of the American Medical Association*, 301(2), 183–190.
- Cheesman, F.L., & Kunkel, T.L. (2012). *Virginia adult drug treatment courts: Cost benefit analysis*. Williamsburg, VA: National Center for State Courts.
- Clark, S., McGuire, J., & Blue-Howells, J. (2010) Development of veterans treatment courts: Local and legislative initiatives. *Drug Court Review*, VII(I), 171-208. http://dn2vfhykblonm.cloudfront.net/sites/default/files/drug_court_review_vii.i_2010.pdf
- Cornish, J.W., Metzger, D., Woody, G.E., Wilson, D., McLellan, A.T., Vandergrift, B., & O'Brien, C.P. (1997). Naltrexone pharmacotherapy for opioid dependent federal probationers. *Journal of Substance Abuse Treatment*, 14(6), 529–534.

- Coviello, D.M., Cornish, J.W., Lynch, K.G., Boney, T.Y., Clark, C.A., Lee, J.D., O'Brien, C.P. (2012). A multisite pilot study of extended-release injectable naltrexone treatment for previously opioid-dependent parolees and probationers. *Substance Abuse*, 33(1), 48–59.
- Cullen, A.E., Clarke, A.Y., Kuipers, E., Hodgins, S., Dean, K., & Fahy, T. (2012). A multisite randomized trial of a cognitive skills program for male mentally disordered offenders: Violence and antisocial behavior outcomes. *Journal of Consulting & Clinical Psychology*, 80(6), 1114–1120.
- De Leon, G., Melnick, G., & Cleland, C.M. (2010). Matching to sufficient treatment: Some characteristics of undertreated (mismatched) clients. *Journal of Addictive Diseases*, 29(1), 59–67.
- DeMatteo, D. S., Marlowe, D. B., & Festinger, D. S. (2006). Secondary prevention services for clients who are low risk in drug court: A conceptual model. *Crime & Delinquency*, 52, 114-134.
- Dolan, K.A., Shearer, J., White, B., Zhou, J., Kaldor, J., & Wodak, A.D. (2005). Four-year follow-up of imprisoned male heroin users and methadone treatment: Mortality, reincarceration and hepatitis C infection. *Addiction*, 100(6), 820–828.
- Dowden, C., Antonowicz, D., & Andrews, D.A. (2003). The effectiveness of relapse prevention with offenders: A meta-analysis. *International Journal of Offender Therapy & Comparative Criminology*, 47(5), 516–528.
- Drake, R.E., O'Neal, E.L., & Wallach, M.A. (2008). A systematic review of psychosocial research on psychosocial interventions for people with co-occurring severe mental and substance use disorders. *Journal of Substance Abuse Treatment*, 34(1), 123–138.
- Edmunds, J.M., Beidas, R.S., & Kendall, P.C. (2013). Dissemination and implementation of evidence-based practices: Training and consultation as implementation strategies. *Clinical Psychology Science and Practice*, 20(2), 152–165.
- Elbogen, E., Johnson, S., Wagner, H., Newton, V., & Beckham, J. (2012) Financial well-being and post-deployment adjustment among Iraq and Afghanistan War veterans. Author Manuscript, *National Institute of Health*. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3390745/pdf/nihms378483.pdf>
- Ferguson, L.M., & Wormith, S. (2012). A meta-analysis of Moral Reconciliation Therapy. *International Journal of Offender Therapy & Comparative Criminology: OnLineFirst*. doi: 10.1177/0306624X12447771
- Finigan, M.W., Perkins, T., Zold-Kilbourn, P., Parks, J., & Stringer, M. (2011). Preliminary evaluation of extended-release naltrexone in Michigan and Missouri drug courts. *Journal of Substance Abuse Treatment*, 41(3), 288–293.
- Friedman, M.J. (March 2014). PTSD history and overview. Retrieved from <http://www.ptsd.va.gov/professional/PTSD-overview/ptsd-overview.asp>
- Gastfriend, D.R., Lu, S., & Sharon, E. (2000). Placement matching: Challenges and technical progress. *Substance Use & Misuse*, 35(12–14), 2191–2213.
- Gendreau, P. (1996). Offender rehabilitation: What we know and what needs to be done. *Criminal Justice & Behavior*, 23(1), 144–161.
- Gendreau, P., Little, T., & Goggin, C. (1996). A meta-analysis of the predictors of adult offender recidivism: What works! *Criminology*, 34(4), 575–608.
- Goldstein, N.E., Kemp, K.A., Leff, S.S., & Lochman, J.E. (2013). Guidelines for adapting manualized interventions for new target populations: A step-wise approach using anger management as a model. *Clinical Psychology: Science & Practice*, 19(4), 385–401.
- Gordon, M.S., Kinlock, T.W., Schwartz, R.P., & O'Grady, K.E. (2008). A randomized clinical trial of methadone maintenance for prisoners: Findings at 6 months post-release. *Addiction*, 103(8), 1333–1342.
- Gottfredson, D.C., Kearley, B.W., & Bushway, S.D. (2008). Substance use, drug treatment, and crime: An examination of intra- individual variation in a drug court population. *Journal of Drug Issues*, 38(2), 601–630.
- Gottfredson, D.C., Kearley, B.W., Najaka, S.S., & Rocha, C.M. (2007). How drug treatment courts work: An analysis of mediators. *Journal of Research on Crime & Delinquency*, 44(1), 3–35.

- Greenberg, G. A., Rosenheck, R. A., & Desai, R. A. (2007). Risk of incarceration among male veterans and nonveterans: Are veterans of the all-volunteer force at great risk? *Armed Forces & Society*, 33, 337–351.
- Gregoire, T.K. (2000). Factors associated with level of care assignments in substance abuse treatment. *Journal of Substance Abuse Treatment*, 18(3), 241–248.
- Grella, C. (2008). Gender-responsive drug treatment services for women: A summary of current research and recommendations for drug court programs. In C. Hardin & J.N. Kushner (Eds.), *Quality improvement for drug courts: Evidence-based practices* (Monograph Series No. 9; pp. 63–74). Alexandria, VA: National Drug Court Institute.
- Gutierrez, L., & Bourgon, G. (2012). Drug treatment courts: A quantitative review of study and treatment quality. *Justice Research & Policy*, 14(2), 47–77.
- Havnes, I., Bukten, A., Gossop, M., Waal, H., Stangeland, P., & Clausen, T. (2012). Reductions in convictions for violent crime during opioid maintenance treatment: A longitudinal national cohort study. *Drug and Alcohol Dependence*, 124(3), 307–310.
- Heck, C. (2008). MRT: Critical component of a local drug court program. *Cognitive Behavioral Treatment Review*, 17(1), 1–2.
- Helmond, P., Overbeek, G., Brugman, D., & Gibbs, J.C. (2015). A meta-analysis on cognitive distortions and externalizing problem behavior: Associations, moderators, and treatment effectiveness. *Criminal Justice and Behavior*, 42(3), 245–262.
- Henry, M., Cortes, A., & Morris, S. (2013). *The 2013 Annual Homeless Assessment Report (AHAR) to Congress*. Washington, DC: The US Department of Housing and Urban Development.
- Hollins, C.R. (1999). Treatment programs for offenders: Meta-analysis, “what works,” and beyond. *International Journal of Law & Psychiatry*, 22(3–4), 361–372.
- Howard, D.L. (2003). Culturally competent treatment of African American clients among a national sample of outpatient substance abuse treatment units. *Journal of Substance Abuse Treatment*, 24(2), 89–102.
- Huebner, B.M., & Cobbina, J. (2007). The effect of drug use, drug treatment participation, and treatment completion on probationer recidivism. *Journal of Drug Issues*, 37(3), 619–641.
- Humphreys, K., Kaskutas, L.A., & Weisner, C. (1998). The relationship of pretreatment Alcoholics Anonymous affiliation with problem severity, social resources, and treatment history. *Drug & Alcohol Dependence*, 49(2), 123–131.
- Integrated Substance Abuse Programs. (2007, April 13). *Evaluation of the Substance Abuse and Crime Prevention Act: Final report*. Los Angeles, CA: UCLA. Retrieved from <http://www.uclaisap.org/Prop36/documents/SACPAEvaluationReport.pdf>
- Janku, A.D., & Yan, J. (2009). Exploring patterns of court-ordered mental health services for juvenile offenders: Is there evidence of systematic bias? *Criminal Justice & Behavior*, 36(4), 402–419.
- Karch, D., Lubell, K., Friday, J., Patel, N., and Williams, D. (2005). Surveillance for Violent Deaths--- National Violent Death Reporting System, 16 States, 2005. Atlanta, GA: Center for Disease Control. Available at: <http://www.cdc.gov/mmwr/preview/mmwrhtml/ss5703a1.htm>
- Karno, M.P., & Longabaugh, R. (2007). Does matching matter? Examining matches and mismatches between patient attributes and therapy techniques in alcoholism treatment. *Addiction*, 102(4), 587–596.
- Kazantzis, N., Deane, F.P., & Ronan, K.R. (2000). Homework assignments in cognitive and behavioral therapy: A meta-analysis. *Clinical Psychology: Science & Practice*, 7(2), 189–202.
- Kelly, J.F., Magill, M., & Stout, R.L. (2009). How do people recover from alcohol dependence? A systematic review of the research on mechanisms of behavior change in Alcoholics Anonymous. *Addiction Research & Theory*, 17(3), 236–259.
- Kelly, J.F., Stout, R.L., Magill, M., & Tonigan, J.S. (2011a). The role of Alcoholics Anonymous in mobilizing adaptive social network changes: A prospective lagged meditational analysis. *Drug & Alcohol Dependence*, 114(2), 119–126.

- Kelly, J.F., Stout, R.L., Magill, M., Tonigan, J.S., & Pagano, M.E. (2011b). Spirituality in recovery: A lagged mediational analysis of Alcoholics Anonymous' principal theoretical mechanism of behavior change. *Alcoholism: Clinical & Experimental Research*, 35(3), 454–463.
- Kelly, J.F., Stout, R., Zywiak, W., & Schneider, R. (2006). A 3-year study of addiction mutual-help group participation following intensive outpatient treatment. *Alcoholism: Clinical & Experimental Research*, 30(8), 1381–1392.
- Kim, D., Irwin, K.S., & Khoshnood, K. (2009). Expanded access to naloxone: Options for critical response to the epidemic of opioid overdose mortality. *American Journal of Public Health*, 99(3), 402–407.
- Kinlock, T.W., Gordon, M.S., Schwartz, R.P., & O'Grady, K.E. (2008). A study of methadone maintenance for male prisoners: Three-month post-release outcomes. *Criminal Justice & Behavior*, 35(1), 34–47.
- Kirchner, R.A., & Goodman, E. (2007). Effectiveness and impact of the Thurston County, Washington Drug Court program. *Cognitive Behavioral Treatment Review*, 16(2), 1–4.
- Knight, K., Garner, B.R., Simpson, D.D., Morey, J.T., & Flynn, P.M. (2006). An assessment for criminal thinking. *Crime and Delinquency*, 52(1), 159–177.
- Koob, J., Brocato, J., & Kleinpeter, C. (2011). Enhancing residential treatment for drug court participants. *Journal of Offender Rehabilitation*, 50(5), 252–271.
- Krebs, C.P., Strom, K.J., Koetse, W.H., & Lattimore, P.K. (2009). The impact of residential and nonresidential drug treatment on recidivism among drug-involved probationers. *Crime & Delinquency*, 55(3), 442–471.
- Landenberger, N.A., & Lipsey, N.W. (2005). The positive effects of cognitive-behavioral program for offenders: A meta-analysis of factors associated with effective treatment. *Journal of Experimental Criminology*, 1(4), 451–476.
- Lapham, S.C., & McMillan, G.P. (2011). Open-label pilot study of extended-release naltrexone to reduce drinking and driving among repeat offenders. *Journal of Addiction Medicine*, 5(3), 163–169.
- Liang, B., & Long, M.A. (2013). Testing the gender effect in drug and alcohol treatment: Women's participation in Tulsa County drug and DUI programs. *Journal of Drug Issues*, 43(3), 270–288.
- Lipsey, M.W., Chapman, G.L., & Landenberger, N.A. (2001). Cognitive-behavioral programs for offenders. *Annals of the American Academy of Political & Social Science*, 578(1), 144–157.
- Lovins, L.B., Lowenkamp, C.T., Latessa, E.J., & Smith, P. (2007). Application of the risk principle to female offenders. *Journal of Contemporary Criminal Justice*, 23(4), 383–398.
- Lowenkamp, C.T., Flores, A.W., Holsinger, A.M., Makarios, M.D., & Latessa, E.J. (2010). Intensive supervision programs: Does program philosophy and the principles of effective intervention matter? *Journal of Criminal Justice*, 38(4), 368–375.
- Lowenkamp, C.T., Hubbard, D., Makarios, M., & Latessa, E. (2009). A quasi-experimental evaluation of Thinking for a Change: A real world application. *Criminal Justice & Behavior*, 36(2), 137–146.
- Lowenkamp, C.T., & Latessa, E.J. (2004). Understanding the risk principle: How and why correctional interventions can harm low-risk offenders. *Topics in Community Corrections: Assessment Issues for Managers*, pp. 3–8.
- Lowenkamp, C.T., & Latessa, E.J. (2005). Increasing the effectiveness of correctional programming through the risk principle: Identifying offenders for residential placement. *Criminology & Public Policy*, 4(2), 263–290.
- Lowenkamp, C.T., Latessa, E.J., & Smith, P. (2006). Does correctional program quality really matter? The impact of adhering to the principles of effective intervention. *Criminology & Public Policy*, 5(3), 575–594.
- Lutze, F.E., & van Wormer, J.G. (2007). The nexus between drug and alcohol treatment program integrity and drug court effectiveness: Policy recommendations for pursuing success. *Criminal Justice Policy Review*, 18(3), 226–245.
- Magura, S., Lee, J.D., Hershberger, J., Joseph, H., Marsch, L., Shropshire, C., & Rosenblum, A. (2009). Buprenorphine and methadone maintenance in jail and post-release: A randomized clinical trial. *Drug & Alcohol Dependence*, 99(1), 222–230.

- Magura, S., Staines, G., Kosanke, N., Rosenblum, A., Foote, J., DeLuca, A., & Bali, P. (2003). Predictive validity of the ASAM patient placement criteria for naturalistically matched vs. mismatched alcoholism patients. *American Journal on Addictions, 12*(5), 386–97.
- Marinelli-Casey, P., Gonzales, R., Hillhouse, M., Ang, A., Zweben, J., Cohen, J., Rawson, R.A. (2008). Drug court treatment for methamphetamine dependence: Treatment response and posttreatment outcomes. *Journal of Substance Abuse Treatment, 34*(2), 242–248.
- Martin, S.S., Butzin, C.A., Saum, C.A., & Inciardi, J.A. (1999). Three-year outcomes of therapeutic community treatment for drug-involved offenders in Delaware: From prison to work release to aftercare. *The Prison Journal, 79*(3), 294–320.
- McCord, J. (2003). Cures that harm: Unanticipated outcomes of crime prevention programs. *Annals of the American Academy of Political & Social Science, 587*(1), 16–30.
- McDonald, B. R., & Morgan, R. D. (2013). Enhancing homework compliance in correctional psychotherapy. *Criminal Justice & Behavior, 40*(7), 814–828.
- McKay, J.R. (2009a). Continuing care research: What we have learned and where we are going. *Journal of Substance Abuse Treatment, 36*(2), 131–145.
- McKee, M. (2010). *San Francisco drug court transitional housing program outcome study*. San Francisco: SF Collaborative Courts. Retrieved from <http://www.sfsuperiorcourt.org/sites/default/files/pdfs/2676%20Outcome%20on%20SF%20Drug%20Court%20Transitional%20Housing%20Program.pdf>
- Mee-Lee, D., & Gastfriend, D.R. (2008). Patient placement criteria. In M. Galanter & H.D. Kleber (Eds.), *Textbook of Substance Abuse Treatment* (4th ed., pp. 79–91). Arlington, VA: American Psychiatric Publishing.
- Mendoza, N.S., Trinidad, J.R., Nochajski, T.H., & Farrell, M.C. (2013). Symptoms of depression and successful drug court completion. *Community Mental Health Journal* (Online). doi: 10.1007/s10597-013-9595-5
- Messina, N., Calhoun, S., & Warda, U. (2012). Gender-responsive drug court treatment: A randomized controlled trial. *Criminal Justice & Behavior, 39*(12), 1539–1558.
- Meyer, R., Patel, A.M., Rattana, S.K., Quock, T.P., & Mody, S.H. (2014). Prescription opioid abuse: A literature review of the clinical and economic burden in the United States. *Population Health Management, 17*(6), 372–387.
- Milkman, H., & Wanberg, K. (2007). *Cognitive-behavioral treatment: A review and discussion for corrections professionals* (NIC No. 021657). Washington, DC: National Institute of Corrections, U.S. Dept. of Justice.
- Mills, K.L., Teesson, M., Back, S.E., Brady, K.T., Baker, A.L., Hopwood, S., Ewer, P.L. (2012). Integrated exposure-based therapy for co-occurring posttraumatic stress disorder and substance dependence: A randomized controlled trial. *Journal of the American Medical Association, 308*(7), 690–699.
- Mitchell, O., Wilson, D.B., & MacKenzie, D.L. (2007). Does incarceration-based drug treatment reduce recidivism? A meta-analytic synthesis of the research. *Journal of Experimental Criminology, 3*(4), 353–375.
- Monchick, R., Scheyett, A., & Pfeiffer, J. (2006). Drug court case management: Role, function, and utility (Monograph Series no. 7). Alexandria, VA: *National Drug Court Institute*.
- Moos, R.H., & Timko, C. (2008). Outcome research on 12-step and other self-help programs. In M. Galanter & H.D. Kleber (Eds.), *Textbook of Substance Abuse Treatment* (4th ed., pp. 511–521). Arlington, VA: American Psychiatric Publishing.
- National Association of Drug Court Professionals. (2013) *Adult drug court best practice standards* (Volume 1). Alexandria, VA: Author.
- National Center on Addiction and Substance Abuse. (2012). *Addiction medicine: Closing the gap between science and practice*. New York: Columbia University.
- National Institute on Drug Abuse. (2006). *Principles of drug abuse treatment for criminal justice populations: A research based guide* (NIH Publication No. 06-5316). Bethesda, MD: Author.

- National Institute on Drug Abuse (NIDA). (2013, March). DrugFacts: Substance Abuse in the Military. Retrieved from <http://www.drugabuse.gov/publications/drugfacts/substanceabuse-in-military>
- National Institute on Drug Abuse (2014). Nora's Blog: Naloxone—A potential lifesaver. Retrieved from <http://www.drugabuse.gov/about-nida/noras-blog/2014/02/naloxone-potential-lifesaver>.
- O'Brien, C.P., & Cornish, J.W. (2006). Naltrexone for probationers and parolees. *Journal of Substance Abuse Treatment, 31*(2), 107–111.
- O'Toole, T.P., Conde-Martel, A., Gibbon, J.L., Hanusa, B.H., & Fine, M.J. (2003). Health care of homeless veterans. *Journal of General Internal Medicine, 18*(11), 929–933. Retrieved from <http://www.ncbi.nlm.nih.gov/pmc/articles/PMC1494947/>
- Pearson, F.S., & Lipton, D.S. (1999). A meta-analytic review of the effectiveness of corrections-based treatments for drug abuse. *The Prison Journal, 79*(4), 384–410.
- Pearson, F.S., Lipton, D.S., Cleland, C.M., & Yee, D.S. (2002). The effects of behavioral/cognitive-behavioral programs on recidivism. *Crime & Delinquency, 48*(3), 476–496.
- Pelissier, B., Jones, N., & Cadigan, T. (2007). Drug treatment aftercare in the criminal justice system: A systematic review. *Journal of Substance Abuse Treatment, 32*(3), 311–320.
- Peters, R.H. (2008). Co-occurring disorders. In C. Hardin & J.N. Kushner (Eds.), *Quality improvement for drug courts: Evidence-based practices* (Monograph Series No. 9; pp. 51–61). Alexandria, VA: National Drug Court Institute.
- Peters, R.H., Haas, A.L., & Hunt, W.M. (2002). Treatment “dosage” effects in drug court programs. *Journal of Offender Rehabilitation, 33*(4), 63–72.
- Peters, R.H., Kremling, J., Bekman, N.M., & Caudy, M.S. (2012). Co-occurring disorders in treatment-based courts: Results of a national survey. *Behavioral Sciences & the Law, 30*(6), 800–820.
- Petrosino, A., Turpin-Petrosino, C., & Finckenauer, J.O. (2000). Well-meaning programs can have harmful effects! Lessons from experiments of programs such as Scared Straight. *Crime & Delinquency, 46*(3), 354–379.
- Plumer, B. (2013, November 11). The unemployment rate for recent veterans is incredibly high. *Washington Post*. Retrieved from <http://www.washingtonpost.com/blogs/wonkblog/wp/2013/11/11/recent-veterans-are-still-experiencing-double-digit-unemployment/>
- Prendergast, M.L., Pearson, F.S., Podus, D., Hamilton, Z.K., & Greenwell, L. (2013). The Andrews' principles of risk, needs, and responsivity as applied in drug treatment programs: Meta-analysis of crime and drug use outcomes. *Journal of Experimental Criminology: Online First*. doi: 10.1007/s11292-013-9178-z
- Read, J.P., Brown, P.J., & Kahler, C.W. (2004). Substance use and posttraumatic stress disorders: Symptom interplay and effects on outcome. *Addictive Behaviors, 29*(8), 1665–1672.
- Ries, R.K., Galanter, M., & Tonigan, J.S. (2008). Twelve-Step Facilitation: An adaptation for psychiatric practitioners and patients. In M. Galanter & H.D. Kleber (Eds.), *Textbook of Substance Abuse Treatment* (4th ed., pp. 373–386). Arlington, VA: American Psychiatric Publishing.
- Robinson, C.R., Lowenkamp, C.T., Holsinger, A.M., VanBenschoten, S., Alexander, M., & Oleson, J.C. (2012). A random study of Staff Training Aimed at Reducing Rearrest (STARR): Using core correctional practices in probation interactions. *Journal of Crime & Justice, 35*(2), 167–188.
- Robinson, E.A., Krentzman, A.R., Webb, J.R., & Bowler, K.J. (2011). Six-month changes in spirituality and religiousness in alcoholics predict drinking outcomes at nine months. *Journal of Studies on Alcohol & Drugs, 72*(4), 660–668.
- Rodriguez, P.F. (2011). Case management for substance abusing offenders. In C. Leukefeld, T.P. Gullotta & J. Gregrich (Eds.), *Handbook of evidence-based substance abuse treatment in criminal justice settings* (pp. 173–181). New York: Springer.
- Ross, S. (2008). The mentally ill substance abuser. In M. Galanter & H.D. Kleber (Eds.), *Textbook of Substance Abuse Treatment* (4th ed., pp. 537–554). Washington, DC: American Psychiatric Publishing.
- Rossman, S.B., Rempel, M., Roman, J.K., Zweig, J.M., Lindquist, C.H., Green, M., Farole, D.J. (2011). *The multisite adult drug court evaluation: The impact of drug courts* (Volume 4). Washington, DC:

- Urban Institute Justice Policy Center. Retrieved from <https://www.ncjrs.gov/pdffiles1/nij/grants/237112.pdf>
- Sadeh, N., & McNiel, D.E. (2015). Posttraumatic stress disorder increases risk of criminal recidivism among justice-involved persons with mental disorders. *Criminal Justice and Behavior*, 42(6), 573–586.
- Saladin, M.E., Back, S.E., Payne, R.A., Schumm, J., Goldsmith, R.J., & Chard, K.M. (2014). Posttraumatic stress disorder and substance use disorder comorbidity. In R.K. Ries, D.A. Fiellin, S.C. Miller & R. Saitz, *The ASAM principles of addiction medicine* (5th ed., pp. 1403–1417). Philadelphia: Wolters Kluwer.
- Sartor, C.E., McCutcheon, V.V., O’Leary, C.C., Van Buren, D.J., Allsworth, J.E., Jeffe, D.B., & Cottler, L.B. (2012). Lifetime trauma exposure and posttraumatic stress disorder in women sentenced to drug court. *Psychiatry Research*, 200(2–3), 602–608.
- Schoenwald, S. K., Mehta, T. G., Frazier, S. L., & Shernoff, E. S. (2013). Clinical supervision in effectiveness and implementation research. *Clinical Psychology: Science and Practice*, 20(1), 44–59.
- Shaffer, D.K. (2006). Reconsidering drug court effectiveness: A meta-analytic review (Doctoral dissertation, University of Cincinnati, 2006). *Dissertation Abstracts International*, 67, 09A (AAT No. 3231113).
- Shaffer, D.K. (2010). Looking inside the black box of drug courts: A meta-analytic review. *Justice Quarterly*, 28(3), 493–521.
- Smith, P., Gendreau, P., & Swartz, K. (2009). Validating the principles of effective intervention: A systematic review of the contributions of meta-analysis in the field of corrections. *Victims & Offenders*, 4(2), 148–169.
- Sobell, L.C., & Sobell, M.B. (2011). *Group therapy for substance use disorders: A motivational cognitive-behavioral approach*. New York: Guilford.
- Southam-Gerow, M. A., & McLeod, B. D. (2013). Advances in applying treatment integrity research for dissemination and implementation science: Introduction to special issue. *Clinical Psychology: Science & Practice*, 20(1), 113.
- Sperber, K.G., Latessa, E., & Makarios, M.D. (2013). Examining the interaction between level of risk and dosage of treatment. *Criminal Justice & Behavior*, 40(3), 338–348.
- Steenbergh, T.A., Runyan, J.D., Daugherty, D.A., & Winger, J.G. (2012). Neuroscience exposure and perceptions of client responsibility among addiction counselors. *Journal of Substance Abuse Treatment*, 42(4), 421–428.
- Strang, J., Bird, S.M., Dietze, P., Gerra, G., & McLellan, A.T. (2014). Take-home emergency naloxone to prevent deaths from heroin overdose. *British Medical Journal*, 349, g6580. doi:10.1136/bmj.g6580.
- Strang, J. (2015). Death matters: Understanding heroin/opiate overdose risk and testing potential to prevent deaths. *Addiction*, 110(S2), 27–35.
- Substance Abuse and Mental Health Services Administration (SAMHSA). (2014, September). *Veterans and military families*. Rockville, MD: Author. Retrieved from <http://www.samhsa.gov/veterans-military-families>
- Substance Abuse and Mental Health Services Administration, Office of Applied Studies. (2007, November 1). *The NSDUH report: Serious psychological distress and substance use disorder among veterans*. Rockville, MD: Author. Retrieved from <http://www.samhsa.gov/data/2k7/veteransDual/veteransDual.htm>
- Sundaraman, R., Panangala, S.V., & Lister, S. (2008). Suicide prevention among veterans. *Congressional Research Service*.
- Szalavitz, M. (2010, July 16). Does teen drug rehab cure addiction or create it? *Time Magazine: On-Line*. Retrieved from <http://time.com/time/printout/0,8816,2003160,00.html>
- Tanielian, T. & Jaycox, L.H. (Eds.). (2008). *Invisible Wounds of War: Psychological and Cognitive Injuries, Their Consequences, and Services to Assist Recovery* (MG-720-CCF, pp.492). Santa Monica, Calif.: *RAND Corporation*. Retrieved from <http://veterans.rand.org>

- Taxman, F.S., & Bouffard, J.A. (2005). Treatment as a part of drug court: The impact on graduation rates. *Journal of Offender Rehabilitation, 42*(1), 23–50.
- Timko, C., & DeBenedetti, A. (2007). A randomized controlled trial of intensive referral to 12-step self-help groups: One-year outcomes. *Drug & Alcohol Dependence, 90*(2), 270–279.
- Titus, J.C., Smith, D.C., Dennis, M.L., Ives, M., Twanow, L., & White, M.K. (2012). Impact of a training and certification program on the quality of interviewer-collected self-report assessment data. *Journal of Substance Abuse Treatment, 42*(2), 201–212.
- Tong, L.S.J., & Farrington, D.P. (2006). How effective is the “Reasoning and Rehabilitation” programme in reducing reoffending? A meta-analysis of evaluations in four countries. *Psychology, Crime & Law, 12*(1), 3–24.
- Tsai, J., Rosenheck, R., Kaspro, W., & McGuire, J. (2013). Risk of incarceration and other characteristics of Iraq and Afghanistan Era veterans in state and federal prisons. *Psychiatric Services 64*. doi: 10.1176/appi.ps.201200188. Retrieved from <http://ps.psychiatryonline.org/article.aspx?articleid=1487303>
- Tsai, J., Rosenheck, R.A., Kaspro, W. J., & McGuire, J. F. (2014). Homelessness in a national sample of incarcerated veterans in state and federal prisons. *Administration and Policy in Mental Health, 41* (3), 360–367.
- Velasquez, M.M., Maurer, G.G., Crouch, C., & DiClemente, C.C. (2001). *Group treatment for substance abuse: A stages-of- change therapy manual*. New York: Guilford.
- Vieira, T.A., Skilling, T.A., & Peterson-Badali, M. (2009). Matching court-ordered services with treatment needs: Predicting treatment success with young offenders. *Criminal Justice & Behavior, 36*(4), 385–401.
- Walters G.D. (2003). Predicting institutional adjustment and recidivism with the Psychopathy Checklist factor scores: A metaanalysis. *Law and Human Behavior, 27*(5), 541–558.
- Wanberg, K.W., & Milkman, H.B. (2006). *Criminal conduct & substance abuse treatment: Strategies for self-improvement and change* (2nd ed.). Thousand Oaks, CA: Sage.
- Weiss, R.D., Potter, J.S., & Iannucci, R.A. (2008). Inpatient treatment. In M. Galanter & H.D. Kleber (Eds.), *Textbook of Substance Abuse Treatment* (4th ed., pp. 445–458). Arlington, VA: American Psychiatric Publishing.
- Wexler, H.K., Melnick, G., & Cao, Y. (2004). Risk and prison substance abuse treatment outcomes: A replication and challenge. *The Prison Journal, 84*(1), 106–120.
- Wilson, D.B., Bouffard, L.A., & MacKenzie, D.L. (2005). A quantitative review of structured, group-oriented, cognitive- behavioral programs for offenders. *Criminal Justice & Behavior, 32*(2), 172–204.
- Wilson, J.A., & Davis, R.C. (2006). Good intentions meet hard realities: An evaluation of the Project Greenlight Reentry Program. *Criminology & Public Policy, 5*(2), 303–338.
- Withbrodt, J., Mertens, J., Kaskutas, L.A., Bond, J., Chi, F., & Weisner, C. (2012). Do 12-step meeting attendance trajectories over 9 years predict abstinence? *Journal of Substance Abuse Treatment, 43*(1), 30–43.
- Yalom, I.D. (2005). *The theory and practice of group psychotherapy* (5th ed.). New York: Basic Books.

V. Court Sessions/Judicial Monitoring/Status Hearings

A. PROFESSIONAL TRAINING**

Prior to assuming the role of Veterans Treatment Court Judge, or as soon thereafter as practical, the judge shall attend the judicial training program administered by the National Drug Court Institute. The judge shall attend training events at least every three years on topics such as legal and constitutional issues in veterans treatment courts, judicial ethics, evidence-based substance use and mental health treatment, behavior modification, and community supervision.

B. LENGTH OF TERM*

The judge or judges shall preside over the Veterans Treatment Court for no less than two consecutive years to maintain the continuity of the program and ensure knowledge of the Veterans Treatment Court policies and procedures.

C. CONSISTENT DOCKET*

Participants shall appear before the same judge or judges throughout their enrollment in Veterans Treatment Court. If more than one judge serves as a primary judge, the judges shall maintain consistency and accountability through frequent communication and status updates regarding participants.

D. FREQUENCY OF STATUS HEARINGS*

Participants shall appear before the judge(s) for status hearings no less frequently than every two weeks during the first phase of the program. The frequency of status hearings may be reduced gradually after participants demonstrate sustained adherence to program requirements such as abstinence from alcohol and illicit drugs, mental health maintenance and are regularly engaged in treatment. Status hearings shall be scheduled no less frequently than every four weeks until participants are in the last phase of the program.

E. LENGTH OF COURT INTERACTIONS*

The judge shall spend sufficient time during status hearings to review each participant's progress in the program.

F. JUDICIAL Demeanor*

The judge shall offer supportive comments to participants, stress the importance of their commitment to treatment and other program requirements, and express optimism about their abilities to improve their health and behavior. The judge shall not humiliate participants or subject them to foul or abusive language. The judge shall allow participants, at an appropriate time, the opportunity to explain their perspectives concerning factual controversies and the imposition of sanctions, incentives, and therapeutic adjustments.

G. JUDICIAL DECISION MAKING*

The judge shall be the ultimate arbiter of factual controversies and makes the final decision concerning the imposition of incentives or sanctions that affect a veteran's legal status or liberty. The judge shall make these decisions after taking into consideration the input of other Veterans Treatment Court team members and discuss the decision in court with the veteran or the veteran's legal representative. The judge shall consider the expert input of duly trained treatment professionals when imposing treatment-related conditions.

Supporting Evidence

The supporting evidence is based on the National Adult Drug Court Standards developed by the National Association of Drug Court Professionals, (2013), p.20 – 25; and (2015) p.38-50.

A. Professional Training

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). A national study of twenty-three adult drug courts found that programs 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 of drug courts in New York reported significantly better outcomes when judges were perceived by the participants as being open to learning about the disease of addiction (Farole & Cissner, 2007). Focusing on training in particular, research shows that outcomes are significantly better when drug court judges 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).

B. Length of Term

Evidence suggests many drug court judges are significantly less effective at reducing crime during their first year on the bench than during ensuing years (Finigan et al., 2007). A study of approximately seventy drug courts found nearly three times greater cost savings and significantly lower recidivism when judges presided over drug courts for at least two consecutive years (Carey et al., 2008, 2012). Significantly greater reductions in crime were also found when judges were assigned to drug courts on a voluntary basis and their term on the drug court bench was indefinite in duration (Carey et al., 2012).

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).

D. Frequency of Status Hearings

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 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 also 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).

E. 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).

F. Judicial Demeanor

Studies have consistently found that drug court participants perceived quality of 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 NIJ Multi-site Adult Drug Court Evaluation (MADCE) 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 side 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 side of controversies, and perceived the judge as being unbiased and benevolent in intent (Burke, 2010; Burke & Leben, 2007; Frazer, 2006; Lee, et al., 2013).

G. Judicial Decision Making

Research on the impact of a team approach to decision making is limited. In an evaluation of the Staten Island Treatment Court, respondents (judge, prosecutor, and defense attorney) cited the importance of strong relationships among the members of the drug court team in overcoming implementation challenges (O'keefe & Rempel, 2005). In focus groups, experienced treatment courts judges from California and New York reported that a "team approach" was a key ingredient to success (Farole, et al., 2005). A 2010 national survey of drug court professionals (judges, prosecutors, defense attorneys, drug court coordinators, treatment providers, probation officers, law enforcement officers and others) found agreement that the collaborative efforts of drug courts provided benefits to the justice, public health, and education systems. (VanWormer, 2010). In a study of nine drug courts in California, courts where more agency staff attended drug court meetings had more positive outcomes including fewer rearrests, court cases, jail days, and prison days (Carey et al., 2005).

References

Burke, K.S. (2010). Just what made drug courts successful? *New England Journal on Criminal & Civil Confinement*. 36(1), 39–58.

- Burke, K., & Leben, S. (2007). Procedural fairness: A key ingredient in public satisfaction [White paper]. *Court Review*, 44, 4–24.
- Carey, S.M., Crumpton, D., Finegan, M.W., & Waller, M. (2005). *California Drug Courts: A Methodology for Determining Costs and Benefits Phase II: Testing the Methodology*. Portland, OR: NPC Research. Retrieved from http://www.courts.ca.gov/documents/drug_court_phase_II.pdf
- Carey, S.M., Finigan, M.W., & Pukstas, K. (2008). *Exploring the key components of drug courts: A comparative study of 18 adult drug courts on practices, outcomes and costs*. Portland, OR: NPC Research. Retrieved from http://www.npcresearch.com/Files/NIJ_Cross-site_Final_Report_0308.pdf.
- Carey, S.M., Mackin, J.R., & Finigan, M.W. (2012). What works? The ten key components of drug court: Research-based best practices. *Drug Court Review*, 8(1), 6–42.
- Farole, D.J., Jr., Puffett, N., Rempel, M., & Byrne, F. (2005). Applying Problem-Solving Principles in Mainstream Courts: Lessons for State Courts. *Justice System Journal*, 26(1), 57–75.
- Farole, D.J., & Cissner, A.B. (2007). Seeing eye to eye: Participant and staff perspectives on drug courts. In G. Berman, M. Rempel & R.V. Wolf (Eds.), *Documenting Results: Research on Problem-Solving Justice* (pp. 51–73). New York: Center for Court Innovation.
- Festinger, D.S., Marlowe, D.B., Lee, P.A., Kirby, K.C., Bovasso, G., & McLellan, A.T. (2002). Status hearings in drug court: When more is less and less is more. *Drug & Alcohol Dependence*, 68(2), 151–157.
- Finigan, M., Carey, S.M., & Cox, A. (2007). *The impact of a mature drug court over 10 years of operation: Recidivism and costs*. Portland, OR: NPC Research. Retrieved from http://www.npcresearch.com/Files/10yr_STOP_Court_Analysis_Final_Report.pdf
- Frazer, M.S. (2006). *The impact of the community court model on defendant perceptions of fairness: A case study at the Red Hook Community Justice Center*. New York: Center for Court Innovation. Retrieved from http://www.courtinnovation.org/sites/default/files/Procedural_Fairness.pdf
- Goldkamp, J.S., White, M.D., & Robinson, J.B. (2002). An honest chance: Perspectives on drug courts. *Federal Sentencing Reporter*, 14(6), 369–372.
- Jones, C. G. (2013). Early-phase outcomes from a randomized trial of intensive judicial supervision in an Australian drug court. *Criminal Justice & Behavior*, 40, 453–468.
- Jones, C.G., & Kemp, R.I. (2013). The strength of the participant-judge relationship predicts better drug court outcomes. *Psychiatry, Psychology and Law* (Online). doi: 10.1080/13218719.2013.798392
- Marlowe, D.B. (2006). Judicial supervision of drug-abusing offenders. *Journal of Psychoactive Drugs*, 38(Suppl. 3), 323–331.
- Marlowe, D.B., Festinger, D.S., Arabia, P.L., Dugosh, K.L., Benasutti, K.M., & Croft, J.R. (2009). Adaptive interventions may optimize outcomes in drug courts: A pilot study. *Current Psychiatry Reports*, 11(5), 370–376.
- Marlowe, D.B., Festinger, D.S., Arabia, P.L., Dugosh, K.L., Benasutti, K.M., Croft, J.R., & McKay, J.R. (2008). Adaptive interventions in drug court: A pilot experiment. *Criminal Justice Review*, 33(3), 343–360.
- Marlowe, D.B., Festinger, D.S., Dugosh, K.L., Benasutti, K.M., Fox, G. & Croft, J.R. (2012). Adaptive programming improves outcomes in drug court: An experimental trial. *Criminal Justice & Behavior*, 39(4), 514–532.
- Marlowe, D.B., Festinger, D.S., Dugosh, K.L., Lee, P.A., & Benasutti, K.M. (2007). Adapting judicial supervision to the risk level of drug offenders: Discharge and six-month outcomes from a prospective matching study. *Drug & Alcohol Dependence*, 88(Suppl. 2), S4–S13.
- Marlowe, D.B., Festinger, D.S., & Lee, P.A. (2004a). The judge is a key component of drug court. *Drug Court Review*, 4(2), 1–34.
- Marlowe, D.B., Festinger, D.S., & Lee, P.A. (2004b). The role of judicial status hearings in drug court. In K. Knight & D. Farabee (Eds.), *Treating addicted offenders: A continuum of effective practices* (pp. 11-1–11-8). Kingston, NJ: Civic Research Institute.
- Marlowe, D.B. (2006). Judicial supervision of drug-abusing offenders. *Journal of Psychoactive Drugs*, 38(Suppl. 3), 323–331.

- Miethe, T.D., Lu, H., & Reese, E. (2000). Reintegrative shaming and recidivism risks in Drug Court: Explanations for some unexpected findings. *Crime & Delinquency*, 46(4), 522–541.
- Mitchell, O., Wilson, D.B., Eggers, A., & MacKenzie, D.L. (2012). Assessing the effectiveness of drug courts on recidivism: A meta-analytic review of traditional and nontraditional drug courts. *Journal of Criminal Justice*, 40(1), 60–71.
- National Association of Drug Court Professionals. (2013) *Adult drug court best practice standards* (Volume 1). Alexandria, VA: Author.
- National Institute of Justice. (2006, June). *Drug courts: The second decade* (Special report, NCJ 211081). Washington, DC: Office of Justice Programs, U.S. Dept. of Justice.
- O'Keefe, K.O., and Rempel, M. (2006). *The Staten Island Treatment Court evaluation: Planning, implementation, and impacts*. New York: Center for Court Innovation.
- Satel, S. (1998). Observational study of courtroom dynamics in selected drug courts. *National Drug Court Institute Review*, 1(1), 43–72.
- Saum, C.A., Scarpitti, F.R., Butzin, C.A., Perez, V.W., Jennings, D., & Gray, A.R. (2002). Drug court participants' satisfaction with treatment and the court experience. *Drug Court Review*, 4(1), 39–83.
- Senjo, S.R., & Leip, L.A. (2001). Testing and developing theory in drug court: A four-part logit model to predict program completion. *Criminal Justice Policy Review*, 12(1), 66–87.
- Shaffer, D.K. (2010). Looking inside the black box of drug courts: A meta-analytic review. *Justice Quarterly*, 28(3), 493–521.
- Turner, S., Greenwood, P., Fain, T., & Deschenes, E. (1999). Perceptions of drug court: How offenders view ease of program completion, strengths and weaknesses, and the impact on their lives. *National Drug Court Institute Review*, 2(1), 61–85.
- van Wormer, J. G. (2010). *Understanding Operational Dynamics of Drug Courts*. (Unpublished dissertation). Washington State University, Pullman, WA.
- Zweig, J.M., Lindquist, C., Downey, P.M., Roman, J., & Rossman, S.B. (2012). Drug court policies and practices: How program implementation affects offender substance use and criminal behavior outcomes. *Drug Court Review*, 8(1), 43–79.

VI. Drug and Alcohol Testing

A. POLICY AND PROCEDURES*

All programs shall have written drug and alcohol testing policies and procedures that address: chain of custody protocols (including direct observation of sample collection); protocols for determination of sample validity addressing dilution, tampering and adulteration; the process of contesting a sample; and measures to ensure that all testing is scientifically reliable and valid. Programs shall use scientifically valid and reliable testing procedures and establish a chain of custody for each specimen. If a participant denies substance use in response to a positive screening test, a portion of the same specimen shall be subjected to confirmatory analysis using an instrumented test, such as gas chromatography/mass spectrometry (GC/MS) or liquid chromatography/mass spectrometry (LC/MS). Programs shall have a policy that addresses training requirements for all staff administering drug and alcohol testing. Upon entering the veterans treatment court, participants shall receive a clear and comprehensive explanation of their rights and responsibilities related to drug and alcohol testing. This information shall be described in a participant contract or handbook and reviewed periodically with participants to ensure they remain cognizant of their obligations.

B. FREQUENCY OF TESTING*

Random drug and alcohol testing shall occur at least twice weekly. Testing may occur at any time, but shall also include during non-traditional work hours, in evenings, and on weekends and holidays. Participants shall be required to deliver a test specimen as soon as practicable after being notified that a test has been scheduled. Urine specimens shall be delivered no more than eight hours after being notified that a urine test has been scheduled. For tests with short detection windows, such as oral fluid tests, specimens shall be delivered no more than four hours after being notified that a test was scheduled.

C. RANDOM TESTING*

Drug and alcohol tests shall be administered randomly. Participants shall be required to submit samples within an appropriate time frame to detect drug and/or alcohol consumption.

D. SCOPE OF DRUGS TESTED*

Drug or alcohol testing shall not be limited to a single drug of choice but, instead, regularly include a panel of drugs in order to detect a broad array of known drugs of use in the local veterans treatment court population. Testing for the detection of alcohol consumption shall accompany all drug tests.

E. AVAILABILITY OF RESULTS*

Drug test results shall be available to the team and to the court within 48 hours of test administration.

F. LICIT ADDICTIVE OR INTOXICATING SUBSTANCES*

Consequences shall be imposed for the non-medical use of intoxicating or addictive substances, including but not limited to alcohol, cannabis (marijuana) and prescription medications, regardless of the licit or illicit status of the substance. The Veterans Treatment Court team shall consider expert medical input to determine whether a prescription for an addictive or intoxicating medication is medically indicated and whether non-addictive, non-intoxicating, and medically safe alternative treatments are available.

Supporting Evidence

The supporting evidence is based on the National Adult Drug Court Standards developed by the National Association of Drug Court Professionals, (2013), p.52-66; and (2015), p.26-37.

A. Policy and Procedures

Cary (2011) and McIntire and Lessenger (2007) describe techniques participants use to falsify samples including dilution, adulteration, substitution and tampering. Policies and procedures should focus on limiting opportunities to falsify samples (ASAM 2013, Cary 2011, Katz et al., 2007, Tsai et al, 1998). Chain of custody and reporting of results should also be focused on ensuring valid and reliable results (Meyer 2011). Drug and alcohol test results must be derived from scientifically valid and reliable methods in order to be admissible as evidence in legal proceedings (Meyer, 2011). Appellate courts have confirmed the scientific validity of several methods for analyzing urine, such as the enzyme multiple immunoassay technique (EMIT), gas chromatography/ mass spectrometry (GC/MS), liquid chromatography/mass spectrometry (LC/MS), as well as tests for sweat, oral fluid, and ankle-monitors (Meyer, 2011). Drug courts must follow customary chain-of-custody procedures for test specimens, including establishing a paper trail identifying each individual in custody of the testing specimen, and to have adequate labeling and security measures to maintain the integrity of the testing specimen. Drug court outcomes are significantly better when policies and procedures are clearly outlined in a participant handbook or manual (Carey et al., 2012). Criminal defendants were much more likely to react favorably to an adverse judgement if given advance notice regarding how the judgement would be made (Burke & Leben, 2007; Frazer, 2006; Tyler, 2007). Drug courts can improve participant's perceptions of fairness by detailing policies and procedures in a manual or handbook, and frequently reminding participants of testing procedures and participant requirements located in the contract or handbook.

B. Frequency of Testing

In a study of 69 drug courts Carey et al. (2012) found that programs that tested at least two times per week in phase one increased cost savings by 61% compared to programs that tested less frequently. Research has also shown the importance of testing on weekends and holidays because these are high risk times for drug and alcohol abuse (Kirby et al, 1995; Marlatt & Gordon, 1985). Drug courts that perform urine drug testing more frequently experience better outcomes in terms of higher graduation rates, lower drug use, and lower criminal recidivism amongst participants (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). Drug court participants consistently identified frequent drug and alcohol testing as being among the most influential factors for successful completion of the program (Gallagher et al., 2015; Goldkamp et al., 2002; Saum et al., 2002; Turner et al., 1999; Wolfer, 2006). For the first several months of the program, the most effective drug courts administer urine drug testing at least twice a week (Carey et al., 2008). A study of seventy drug courts demonstrated that programs that performed urine drug testing at least twice a week produced a 38% greater reduction in crime and were 61% more cost-effective than programs that performed urine drug testing less often (Carey et al., 2012). The metabolites of most drugs is detectable in urine for approximately two to four days, so testing less frequently could leave an unacceptable gap of time

where participants can abuse drugs and avoid detection, leading to poorer outcomes (Stitzer & Kellogg, 2008).

C. Random Testing

Research shows that drug testing is most effective when it is performed on a random basis (ASAM, 2013; ASAM, 2010; Auerbach, 2007; Carver, 2004; Cary, 2011; Harrell & Kleiman, 2002; McIntire et al., 2007). Auerbach (2007) and Cary (2011) suggest providing no more than 8 hour's notice that the test will be performed.

D. Scope of Drugs Tested

Research suggests that it is important to test for a broad array of drug types (Carey, 2011). Cary (2010) describes SPICE and K2, two synthetic cannabinoids that can be difficult to detect with standard drug testing. In a study including over 300 surveys and 25 interviews, Perrone et al. (2013) demonstrated that people switch from using marijuana to using synthetic cannabinoids to avoid detection during testing duration and switch back after the testing period.

E. Availability of Testing Results

In a study of 69 drug courts, Carey et al. (2012) found that programs in which drug test results were available in two days or less had 73% greater reduction in recidivism and 68% increase in cost savings, compared to programs that took longer to receive results.

F. Licit Addictive or Intoxicating Substances

Research has shown that the 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 court (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).

If addiction medications may be helpful, their use should be authorized only if a physician with training in addiction psychiatry or medicine carefully monitors the participant. There is a serious risk of morbidity, mortality, or illegal diversion of medications when general medical practitioners prescribe addiction medications to this population (Bazazi et al., 2011; Bohnert et al., 2011; Daniulaityte et al., 2012; Johanson et al., 2012).

References:

- Aharonovich, E., Liu, X., Samet, S., Nunes, E., Waxman, R., & Hasin, D. (2005). Post discharge cannabis use and its relationship to cocaine, alcohol, and heroin use: A prospective study. *American Journal of Psychiatry*, 162(8), 1507–1514.
- American Society of Addiction Medicine (2013). *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions* (Third Edition). Chevy Chase, MD: Author.
- American Society of Addiction Medicine (2010). *The ASAM Criteria: Treatment Criteria for Addictive, Substance-Related, and Co-Occurring Conditions*, (Second Edition). Chevy Chase, MD: Author.
- Auerbach, K. (2007) Drug testing methodologies. In J.E. Lessenger & G. F. Roper (Eds.), *Drug Court* (pp.215-233). New York: Springer-Verlag.
- Banks, D., & Gottfredson, D.C. (2003). The effects of drug treatment and supervision on time to rearrest among drug treatment court participants. *Journal of Drug Issues*, 33(2), 385–412.
- Bazazi, A.R., Yokell, M., Fu, J.J., Rich, J.S., & Zaller, N.D. (2011). Illicit use of buprenorphine/naloxone among injecting and non-injecting opioid users. *Journal of Addiction Medicine*, 5(3), 175–180.

- Bennett, T., Holloway, K., & Farrington, D. (2008). The statistical association between drug misuse and crime: A meta-analysis. *Aggression & Violent Behavior, 13*(2), 107–118.
- Boden, J.M., Fergusson, D.M., & Horwood, L.J. (2013). Alcohol misuse and criminal offending: Findings from a 30-year longitudinal study. *Drug & Alcohol Dependence, 128*(1–2), 30–36.
- Bohnert, A.S., Valenstein, M., Bair, M.J., Ganoczy, D., McCarthy, J.F., Ilgen, M.A., & Blow, F.C. (2011). Association between opioid prescribing patterns and opioid overdose-related deaths. *Journal of the American Medical Association, 305*(13), 1315–1321.
- Burke, K., & Leben, S. (2007). Procedural fairness: A key ingredient in public satisfaction. *Court Review, 44*(1-2), 4–25.
- Carey, S.M., Finigan, M.W., & Pukstas, K. (2008). Exploring the key components of drug courts: A comparative study of 18 adult drug courts on practices, outcomes and costs. Portland, OR: NPC Research. Available at http://www.npcresearch.com/Files/NIJ_Cross-site_Final_Report_0308.pdf
- Carey, S.M., Mackin, J.R., & Finigan, M.W. (2012). What works? The ten key components of drug court: Research-based best practices. *Drug Court Review, 7*(1), 6–42.
- Cary, P.C. (2010). Spice, K2 and the problem of synthetic cannabinoids. *Drug Court Practitioner Fact Sheet, VI* (1). National Drug Court Institute.
- Cary, P.C. (2011). The fundamentals of drug testing. In D.B. Marlow and W.G. Meyer (Eds.), *The Drug Court Judicial Benchbook* (pp.113-138). Alexandria, VA: National Drug Court Institute.
- Carver, J. (2004) Drug testing. A necessary prerequisite for treatment and crime control. In P.T. Bean & T. Nemitz (Eds.), *Drug Treatment: What Works*. London: Routledge.
- Daniulaityte, R., Falck, R., & Carlson, R.G. (2012). Illicit use of buprenorphine in a community sample of young adult non- medical users of pharmaceutical opioids. *Drug and Alcohol Dependence, 122*(3), 201–207.
- Frazer, M.S. (2006). The impact of the community court model on defendant perceptions of fairness. New York: Center for Court Innovation. Available at http://www.courtinnovation.org/sites/default/files/Procedural_Fairness.pdf
- Friedman, A.S., Glassman, K., & Terras, A. (2001). Violent behavior as related to use of marijuana and other drugs. *Journal of Addictive Diseases, 20*(1), 49–72.
- Gallagher, J.R., Nordberg, A., & Kennard, T. (2015). A qualitative study assessing the effectiveness of the key components of a Drug Court. *Alcoholism Treatment Quarterly, 33*(1), 64–81.
- Goldkamp, J.S., White, M.D., & Robinson, J.B. (2002). An honest chance: Perspectives on drug courts. *Federal Sentencing Reporter, 14*(6), 369–372.
- Gottfredson, D.C., Kearley, B.W., Najaka, S.S., & Rocha, C.M. (2007). How drug treatment courts work: An analysis of mediators. *Journal of Research on Crime & Delinquency, 44*(1), 3–35.
- Griffith, J.D., Rowan-Szal, G.A., Roark, R.R., & Simpson, D.D. (2000). Contingency management in outpatient methadone maintenance treatment: A meta-analysis. *Drug & Alcohol Dependence, 58*(1), 55–66.
- Harrell, A., Cavanagh, S., & Roman, J. (1998). Findings from the evaluation of the D.C. Superior Court Drug Intervention Program (Final report). Washington, DC: The Urban Institute.
- Harrell, A., & Kleiman, M. (2002) Drug testing in criminal justice settings. In C.G. Leukefeld, F. Tims, & D. Farabee (Eds.), *Treatment of drug offenders*. New York: Springer.
- Hawken, A., & Kleiman, M. (2009). Managing drug involved probationers with swift and certain sanctions: Evaluating Hawaii’s HOPE (NCJRS No. 229023). Washington, DC: National Institute of Justice. Available at <http://www.ncjrs.gov/pdffiles1/nij/grants/229023.pdf>
- Johanson, C., Arfken, C. L., di Menza, S., & Schuster, C. R. (2012). Diversion and abuse of buprenorphine: Findings from national surveys of treatment patients and physicians. *Drug and Alcohol Dependence, 120*(1), 190–195.
- Kinlock, T.M., Gordon, M.S., Schwartz, R.P., & O’Grady, K.E. (2013). Individual patient and program factors related to prison and community treatment completion in prison-initiated methadone maintenance treatment. *Journal of Offender Rehabilitation, 52*(8), 509–528.

- Kirby, K. C., Marlowe, D. B., Lamb, R. J., Husband, S. D., & Platt, J. J. (1995). Cognitive-Behavioral Cocaine Treatment With and Without Contingency Management. *NIDA Research Monograph, 153*, 346-346.
- Lane, S.D., Cherek, D.R., Pietras, C.J., & Tcheremissine, O.V. (2004). Acute marijuana effects on response-reinforcer relations under multiple variable-interval schedules. *Behavioural Pharmacology, 15*(4), 305–309.
- Marlatt, G.A., & Gordon, J.R. (Eds.). (1985). *Relapse prevention: Maintenance strategies in the treatment of addictive behaviors*. New York: Guilford Press.
- McIntire, R.L., Lessenger, J.E., & Roper, G.F. (2007). The drug and alcohol testing process. In J.E. Lessenger (Ed), *Drug Courts* (pp. 234-246). New York: Springer.
- Meyer, W.G., (2011). Constitutional and legal issues in drug court. In D.B. Marlowe & W.G. Meyer (Eds.), *The drug court judicial benchbook* (pp.139–157). Alexandria, VA: National Drug Court Institute. Retrieved from http://www.ndci.org/sites/default/files/nadcp/14146_NDCI_Benchbook_v6.pdf
- Perrone, D., Helgesen, R.D., & Fischer, R.G. (2013). United States drug prohibition and legal highs: How drug testing may lead cannabis users to spice. *Drugs: education, prevention, and policy, 20*(3): 216-224.
- Pedersen, W., & Skardhamar, T. (2010). Cannabis and crime: Findings from a longitudinal study. *Addiction, 105*(1), 109–118.
- Reynolds, M.D., Tarter, R.E., Kirisci, L., & Clark, D.B. (2011). Marijuana but not alcohol use during adolescence mediates the association between transmissible risk for substance use disorder and number of lifetime violent offenses. *Journal of Criminal Justice, 39*(3), 218-223.
- Saum, C.A., Scarpitti, F.R., Butzin, C.A., Perez, V.W., Jennings, D., & Gray, A.R. (2002). Drug court participants’ satisfaction with treatment and the court experience. *Drug Court Review, 4*(1), 39–81.
- Sechrest, D.K., & Shicor, D. (2001). Determinants of graduation from a day treatment drug court in California: A preliminary study. *Journal of Drug Issues, 31*, 129–147.
- Stitzer, M.L., & Kellogg, S. (2008). Large-scale dissemination efforts in drug abuse treatment clinics. In S.T. Higgins, K. Silverman, & S.H. Heil (Eds.), *Contingency management in substance abuse treatment* (pp. 241–260). New York: Guilford Press.
- Thompson, L.L., Claus, E.D., Mikulich-Gilbertson, S.K., Banich, M.T., Crowley, T., Krmpotich, T., Miller, D., & Tanabe, J. (2012). Negative reinforcement learning is affected in substance dependence. *Drug & Alcohol Dependence, 123*(1), 84–90.
- Tsai, S.-C.J., ElSohly, M.A., Dubrovsky, T., Twarowska, B., Towt, J., & Salamone, S.J. (1998). Determination of five abused drugs in nitrite-adulterated urine by immunoassays and gas chromatography-mass spectrometry. *Journal Analytical Toxicology, 22*(6), 474-480.
- Turner, S., Greenwood, P. Fain, T., & Deschenes, E. (1999). Perceptions of drug court: How offenders view ease of program completion, strengths and weaknesses, and the impact on their lives. *National Drug Court Institute Review, 2*(1), 61–85.
- Tyler, T.R. (2007). Procedural justice and the courts. *Court Review, 44*(1-2), 26.
- Wolfer, L. (2006). Graduates speak: A qualitative exploration of drug court graduates’ views of the strengths and weaknesses of the program. *Contemporary Drug Problems, 33*(2), 303–320.

VII. Incentives, Sanctions, and Therapeutic Adjustments

A. ADVANCE NOTICE**

Policies and procedures concerning the administration of incentives, sanctions, and therapeutic adjustments shall be specified in writing and communicated in advance to Veterans Treatment Court participants and team members. The policies and procedures shall 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. The Veterans Treatment Court team shall reserve a reasonable degree of discretion to modify a presumptive consequence in light of the circumstances presented in each case.

B. OPPORTUNITY TO RESPOND*

Participants shall be given an opportunity, at an appropriate time, to explain their perspective concerning factual controversies and the imposition of sanctions and therapeutic adjustments.

C. PROFESSIONAL DEMEANOR*

Interactions with participants from all service providers and team members shall always be professional in nature. Sanctions shall be delivered without expressing ridicule. Participants shall not be shamed or subjected to foul or abusive language.

D. PROGRESSIVE SANCTIONS**

The Veterans Treatment Court shall have a range of sanctions of varying magnitudes that may be administered in response to program infractions. For goals that are difficult for participants to accomplish (i.e. distal), such as abstaining from substance use or obtaining employment, the sanctions shall increase progressively in magnitude over successive infractions. For goals that are relatively easy for participants to accomplish (i.e. proximal), such as being truthful or attending counseling sessions, sanctions of a higher magnitude may be administered after only a few infractions.

E. THERAPEUTIC ADJUSTMENTS*

Participants shall not receive sanctions if they are otherwise compliant with their treatment and supervision requirements but are not responding to the treatment interventions. Under such circumstances, the appropriate course of action may be to reassess the individual and adjust the treatment plan accordingly. Adjustments to treatment plans shall be based on the recommendations of duly trained treatment professionals (e.g. participants are placed in the appropriate level of care).

F. INCENTIVIZING PROSOCIAL BEHAVIORS*/**

The Veterans Treatment Court shall place as much emphasis on incentivizing productive and prosocial behaviors as it does on reducing crime, substance use, and other infractions. 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.

G. JAIL SANCTIONS*

Jail sanctions shall be imposed judiciously and sparingly. Veterans treatment courts shall utilize a graduated sanction system unless a participant poses an immediate risk to themselves or public safety. Jail sanctions shall be definite in duration and typically last no more than three to five days.

Supporting Evidence

The supporting evidence is based on the National Adult Drug Court Standards developed by the National Association of Drug Court Professionals (2013) p.26 – 37; and (2015) p.59-74.

A. Advance Notice

A national study of twenty-three adult drug courts, called the NIJ-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. The most effective drug courts also described expectations for earning positive reinforcement and the manner in which rewards would be administered (Burdon et al., 2001; Stitzer, 2008).

Evidence from 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 when staff members in drug courts consistently reminded participants about their responsibilities in treatment and the consequences that would follow from graduation or termination (Young & Belenko, 2002).

Research shows that some flexibility improves outcomes, as well. Two of the above studies reported significantly better outcomes when the drug court team had some discretion to modify a presumptive consequence in light of the facts presented in each case (Carey et al., 2012; Zweig et al., 2012). 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).

B. Opportunity to Respond & C. Professional Demeanor

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).

D. Progressive Sanctions

In general, sanctions are less effective at low and high magnitudes than in the intermediate range (Marlowe & Kirby, 1999; Marlowe & Wong, 2008). The most effective drug courts develop a wide and creative range of intermediate-magnitude sanctions that can be increased or decreased in response to participants' behaviors (Marlowe, 2007).

Research suggests that different approaches should be taken for easier, as compared to more difficult to accomplish goals. For difficult goals, significantly better outcomes are achieved when the sanctions 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. For easier goals, on the other hand, applying higher-magnitude sanctions is more effective, as it prevents participants from getting accustomed to punishment and punishment becoming less effective (Marlowe, 2011).

E. Therapeutic Adjustments

It is important to differentiate between cases in which an individual is not engaging in treatment (non-compliance) and cases when an individual is not benefiting from the treatment that is being provided (non-responsiveness), because non-compliance and non-responsiveness suggest different responses (Marlowe, 2011). A series of studies have been conducted to assess an adaptive system used to help practitioners differentiate these cases and recommend enhanced supervision for non-compliance and enhanced clinical case management for non-responsiveness (Marlowe et al., 2008, 2009, 2012). Results show that that participants randomly assigned to the adaptive system were more than twice as likely to be drug abstinent in the first 18 weeks, than those who were not (Marlowe et al., 2012), though more recent research suggests that this approach is less effective at later stages of participation (Marlowe et al., 2013).

F. Incentivizing Productivity

Sanctions and positive reinforcement are most likely to be effective when administered in combination (DeFulio et al., 2013). 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, drug courts that offered higher and more consistent levels of praise and positive incentives from the judge

achieved significantly better outcomes (Zweig et al., 2012). Several other studies found that a 4:1 ratio⁶ of incentives to sanctions was associated with significantly better outcomes among drug users (Gendreau, 1996; Senjo & Leip, 2001; Woodahl et al., 2011).

Studies have revealed that drug courts achieved significantly greater reductions in recidivism and greater cost savings when they incentivized participants to participate in prosocial activities, like having a job, enrolling in school, or living in sober housing by requiring such participation as a condition of graduation from the program (Carey et al., 2012).

G. 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). 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. 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 (Carey et al., 2012).

References:

- Burdon, W.M., Roll, J.M., Prendergast, M.L., & Rawson, R.A. (2001). Drug courts and contingency management. *Journal of Drug Issues*, 31(1), 73–90.
- Burke, K., & Leben, S. (2007). Procedural fairness: A key ingredient in public satisfaction [White paper]. *Court Review*, 44(1–2), 4–25.
- Carey, S.M., Finigan, M.W., & Pukstas, K. (2008a). *Exploring the key components of drug courts: A comparative study of 18 adult drug courts on practices, outcomes and costs*. Portland, OR: NPC Research. Retrieved from http://www.npcresearch.com/Files/NIJ_Cross-site_Final_Report_0308.pdf
- Carey, S.M., Pukstas, K., Waller, M.S., Mackin, R.J., & Finigan, M.W. (2008b). *Drug courts and state mandated drug treatment programs: Outcomes, costs and consequences*. Portland, OR: NPC Research. Retrieved from http://www.npcresearch.com/Files/Prop36_Drug_Court_Executive_Summary_0308.pdf
- Carey, S.M., Mackin, J.R., & Finigan, M.W. (2012). What works? The ten key components of drug court: Research-based best practices. *Drug Court Review*, 8(1), 6–42.
- Cheesman, F.L., & Kunkel, T.L. (2012). *Virginia Adult Drug Treatment Courts: Cost benefit analysis*. Williamsburg, VA: National Center for State Courts.
- Cissner, A., Rempel, M., Franklin, A.W., Roman, J.K., Bieler, S., Cohen, R., & Cadoret, C.R. (2013, March). *A statewide evaluation of New York's adult drug courts: Testing which policies work best*. Paper presented at the New York Association of Drug Treatment Court Professionals Training. Retrieved from

⁶ 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.

<http://www.nyadtcp.org/userfiles/file/presentation/The%202012%20New%20York%20State%20Drug%20Court%20Evaluation.pdf>

- DeFulio, A., Stitzer, M., Roll, J., Petry, N., Nuzzo, P., Schwartz, R.P., & Stabile, P. (2013). Criminal justice referral and incentives in outpatient substance abuse treatment. *Journal of Substance Abuse Treatment, 45*(1), 70–75.
- Farole, D.J., & Cissner, A.B. (2007). Seeing eye to eye: Participant and staff perspectives on drug courts. In G. Berman, M. Rempel & R.V. Wolf (Eds.), *Documenting Results: Research on Problem-Solving Justice* (pp. 51–73). New York: Center for Court Innovation.
- Frazer, M.S. (2006). *The impact of the community court model on defendant perceptions of fairness: A case study at the Red Hook Community Justice Center*. New York: Center for Court Innovation. Retrieved from http://www.courtinnovation.org/sites/default/files/Procedural_Fairness.pdf
- Gallagher, J.R. (2013). African American participants' views on racial disparities in drug court outcomes. *Journal of Social Work Practice in the Addictions, 13*(2), 143–162.
- Gendreau, P. (1996). The principles of effective intervention with offenders. In A. Harland (Ed.), *Choosing correctional options that work* (pp. 117–130). Thousand Oaks, CA: Sage.
- Harrell, A., Cavanagh, S., & Roman, J. (1999). *Findings from the evaluation of the D.C. Superior Court Drug Intervention Program: Final report*. Washington, DC: The Urban Institute.
- Harrell, A., & Roman, J. (2001). Reducing drug use and crime among offenders: The impact of graduated sanctions. *Journal of Drug Issues, 31*(1), 207–231.
- Hawken, A., & Kleiman, M. (2009). *Managing drug involved probationers with swift and certain sanctions: Evaluating Hawaii's HOPE* (NCJRS No. 229023). Washington, DC: National Institute of Justice. Retrieved from <http://www.ncjrs.gov/pdffiles1/nij/grants/229023.pdf>
- Hepburn, J.R., & Harvey, A.N. (2007). The effect of the threat of legal sanction on program retention and completion: Is that why they stay in drug court? *Crime & Delinquency, 53*(2), 255–280.
- Kilmer, B., Nicosia, N., Heaton, P., & Midgette, G. (2012). Efficacy of frequent monitoring with swift, certain, and modest sanctions for violations: Insights from South Dakota's 24/7 Sobriety Project. *American Journal of Public Health, 103*(1), e37–e43.
- Marlowe, D.B. (2007). Strategies for administering rewards and sanctions. In J.E. Lessenger & G.F. Roper (Eds.), *Drug courts: A new approach to treatment and rehabilitation* (pp. 317–336). New York: Springer.
- Marlowe, D.B. (2011). Applying incentives and sanctions. In D.B. Marlowe & W.G. Meyer (Eds.), *The drug court judicial benchbook* (pp.139–157). Alexandria, VA: National Drug Court Institute. Retrieved from http://www.ndci.org/sites/default/files/nadcp/14146_NDCI_Benchbook_v6.pdf
- Marlowe, D.B., Festinger, D.S., Foltz, C., Lee, P.A., & Patapis, N.S. (2005). Perceived deterrence and outcomes in drug court. *Behavioral Sciences & the Law, 23*(2), 183–198.
- Marlowe, D.B., Festinger, D.S., Arabia, P.L., Dugosh, K.L., Benasutti, K.M., Croft, J.R., & McKay, J.R. (2008). Adaptive interventions in drug court: A pilot experiment. *Criminal Justice Review, 33*(3), 343–360.
- Marlow, D.B., Arabia, P.L., Benasutti, K.M., and Croft, J.R. (2009). Adaptive interventions may optimize outcomes in drug courts: A pilot study. *Current Psychiatry Reports, 11*, 370-376.
- Marlow, D.B., Festinger, D.S., Dugosh, K.L., Benasutti, K.M., Fox, G., & Croft, J.R. (2012). Adaptive programming improves outcomes in drug court: An experimental trial. *Criminal Justice and Behavior, 39*(4), 514–532.
- Marlowe, D.B., & Kirby, K.C. (1999). Effective use of sanctions in drug courts: Lessons from behavioral research. *National Drug Court Institute Review, 2*(1), 1–31.
- Marlowe, D.B., & Wong, C.J. (2008). Contingency management in adult criminal drug courts. In S.T. Higgins, K. Silverman, & S.H. Heil (Eds.), *Contingency Management in Substance Abuse Treatment* (pp.334–350). New York: Guilford Press.
- Miethe, T.D., Lu, H., & Reese, E. (2000). Reintegrative shaming and recidivism risks in Drug Court: Explanations for some unexpected findings. *Crime & Delinquency, 46*(4), 522–541.
- Nagin, D.S., & Pogarsky, G. (2001). Integrating celerity, impulsivity, and extralegal sanction threats into a general deterrence: Theory and evidence. *Criminology, 39*(4), 865–892.

- National Association of Drug Court Professionals. (2013) *Adult drug court best practice standards* (Volume 1). Alexandria, VA: Author.
- National Institute on Drug Abuse. (2006). *Principles of drug abuse treatment for criminal justice populations* (NIH Pub. No. 06-5316). Bethesda, MD: Author.
- Rossman, S.B., Rempel, M., Roman, J.K., Zweig, J.M., Lindquist, C.H., Green, M., . . . Farole, D.J. (2011). *The multisite adult drug court evaluation: The impact of drug courts* (Volume 4). Washington, DC: Urban Institute Justice Policy Center. Retrieved from <https://www.ncjrs.gov/pdffiles1/nij/grants/237112.pdf>
- Senjo, S.R., & Leip, L.A. (2001). Testing and developing theory in Drug Court: A four-part logit model to predict program completion. *Criminal Justice Policy Review*, 12(1), 66–87.
- Stitzer, M.L. (2008). Motivational incentives in drug courts. In C. Hardin & J.N. Kushner (Eds.), *Quality improvement for drug courts: Evidence-based practices* (pp. 97–105). Alexandria, VA: National Drug Court Institute.
- Tyler, T.R. (2007). Procedural justice and the courts. *Court Review*, 44(1–2), 26–31.
- Wodahl, E.J., Garland, B., Culhane, S.E., & McCarty, W.P. (2011). Utilizing behavioral interventions to improve supervision outcomes in community-based corrections. *Criminal Justice & Behavior*, 38(4), 386–405.
- Young, D., & Belenko, S. (2002). Program retention and perceived coercion in three models of mandatory drug treatment. *Journal of Drug Issues*, 22(1), 297–328.
- Zweig, J.M., Lindquist, C., Downey, P.M., Roman, J., & Rossman, S.B. (2012). Drug court policies and practices: How program implementation affects offender substance use and criminal behavior outcomes. *Drug Court Review*, 8(1), 43–79.

VIII. Cultural Competence

A. EQUIVALENT ACCESS*

Eligibility criteria for the veterans treatment courts are non-discriminatory in intent and impact. If an eligibility requirement has the unintended effect of differentially restricting access for members of a historically disadvantaged group⁷, the requirement shall be adjusted to increase the representation of such persons unless doing so would jeopardize public safety or the effectiveness of the veterans treatment court. The assessment tools that are used to determine veterans' eligibility for the veterans treatment court shall be validated for use with members of historically disadvantaged groups represented in the respective arrestee population.

B. EQUIVALENT RETENTION**

The Veterans Treatment Court shall regularly monitor whether members of historically disadvantaged groups complete the program at rates equivalent to other participants. If completion rates are significantly lower for members of a historically disadvantaged group, the Veterans Treatment Court team shall investigate the reasons for the disparity, develop a remedial action plan, if warranted, and evaluate the success of the remedial actions.

C. EQUIVALENT TREATMENT*

Reasonable efforts shall be made to provide members of historically disadvantaged groups the same levels of care and quality of treatment as other participants with comparable clinical needs. The Veterans Treatment Court shall administer evidence-based treatments that are effective for use with members of historically disadvantaged groups represented in the Veterans Treatment Court population.

D. EQUIVALENT INCENTIVES AND SANCTIONS*

Members of historically disadvantaged groups shall receive the same incentives and sanctions as other participants for comparable achievements or infractions. The Veterans Treatment Court shall regularly monitor the delivery of incentives and sanctions to ensure they are administered equivalently to all participants.

E. EQUIVALENT DISPOSITIONS*

Members of historically disadvantaged groups shall not receive a disparate legal disposition or sentence for completing or failing to complete the Veterans Treatment Court program based on being a member of a historically disadvantaged group.

⁷ Members of historically disadvantaged groups are defined as, "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 (The National Adult Drug Court Standards, Vol. 1)."

Supporting Evidence

The supporting evidence is based on the National Adult Drug Court Standards developed by the National Association of Drug Court Professionals (2013) p.11-19; and (2015) p.59-66.

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 researchers 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).

Assessment tools used to determine candidates’ eligibility for drug and DUI courts are often validated on samples of predominantly Caucasian males and may not be 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).

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).

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).

C. Equivalent Treatment

Racial and ethnic minorities often receive lesser quality treatment than non-minorities 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 defendants. 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.

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 under-represented in clinical trials of addiction treatments, the treatments are frequently less beneficial for these individuals (Burlew et al., 2011; Calsyn et al., 2009).

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.

Substantial evidence shows that women, particularly those with histories of trauma, perform significantly better in gender-specific substance abuse treatment groups (Dannerbeck et al., 2002; Grella, 2008; Liang & Long, 2013; Powell et al., 2012). This gender-specific approach has been demonstrated to improve outcomes for female drug court participants in at least one randomized controlled trial (Messina et al., 2012). Similarly, a study of approximately seventy drug courts found that programs offering gender-specific services reduced criminal recidivism significantly more than those that did not (Carey et al., 2012). 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).

Special sensitivity is needed with female vets, many of whom may have been exposed to Military sexual trauma. Mixed male/female groups should be approached cautiously. The Department of Defense estimates there are about 19,000 sexual assaults in the military per year but according to the latest Pentagon statistics (2013), only 1,108 troops filed for an investigation during the most recent yearly reporting period and during that period only 575 cases were processed. No outside audit has been conducted of the military's numbers. Of the cases processed, only 96 went to court-martial. Another investigation found that only one in five females and one in 15 males in the United States Air Force would report having been sexually assaulted by service members. The Service Women's Network (SWAN) (2012)⁶ reports the following consequences of military rape, sexual assault and sexual harassment: While rape, sexual assault, and sexual harassment are strongly associated with a wide range of mental health conditions for both men and women veterans, Military Sexual Trauma (MST) is the leading cause of post-traumatic stress disorder (PTSD) among women veterans, while combat trauma is the leading cause of PTSD among men. The Veterans Health Administration (VHA) found that 22 percent of all female VHA users screened positive for MST in 2010. Stress, depression, and other mental health issues associated with surviving rape, sexual assault, and sexual harassment make it more likely that survivors will experience high rates of substance abuse and will have difficulty finding work after discharge from the military.

D. Equivalent Incentives and Sanctions

Some commentators have questioned whether racial or ethnic minority participants are sanctioned more severely than non-minorities 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; Guastafarro & 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.

E. Equivalent Dispositions

Concerns have similarly been expressed that racial or ethnic minority participants might be sentenced more harshly than non-minorities 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 non-minorities 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 non-minorities to be sentenced to prison (Jeffries & Bond, 2012).

References:

- Arabia, P.L., Fox, G., Caughie, J., Marlowe, D.B., & Festinger, D.S. (2008). Sanctioning practices in an adult felony drug court. *Drug Court Review*, 6(1), 1–31.
- Belenko, S. (2001). *Research on drug courts: A critical review: 2001 update*. New York: National Center on Addiction and Substance Abuse at Columbia University.
- Bowers, J. (2008). Contraindicated drug courts. *UCLA Law Review*, 55(4), 783–833.
- Brocato, J. (2013). The impact of acculturation, motivation, and the therapeutic alliance on treatment retention and outcomes for Hispanic drug-involved probationers. *Journal of Ethnicity in Criminal Justice*, 11, 150-180.
- Bureau of Justice Assistance. (2012). *Program performance report: Enhancement grantees of the Adult Drug Court Discretionary Grant Program*. Washington, DC: Author. Retrieved from https://www.bja.gov/Publications/DrugCt_Enhancement_PPR_06-12.pdf
- Burlew, A.K., Weekes, J.C., Montgomery, L., Feaster, D.J., Robbins, M.S. Rosa, C.L., Wu, L. (2011). Conducting research with racial/ethnic minorities: Methodological lessons from the NIDA Clinical Trials Network. *American Journal of Drug & Alcohol Abuse*, 37(5), 324–332.
- Callahan, L., Steadman, H.J., Tillman, S., & Vesselinov, R. (2013). A multisite study of the use of sanctions and incentives in mental health courts. *Law & Human Behavior*, 37(1), 1–9.
- Calsyn, D.A., Hatch-Maillette, M., Tross, S., Doyle, S.R., Crits-Christoph, P., Song, Y.S., Harrer, J.M., Berns, S.B. (2009). Motivational and skills training HIV/STI sexual risk reduction groups for men. *Journal of Substance Abuse Treatment*, 37(1), 138–150.
- Carey, S.M., Mackin, J.R., & Finigan, M.W. (2012). What works? The ten key components of Drug Court: Research-based best practices. *Drug Court Review*, 8(1), 6–42.
- Carle, A.C. (2009, February). Assessing the adequacy of self-reported alcohol abuse measurement across time and ethnicity: Cross-cultural equivalence across Hispanics and Caucasians in 1992, nonequivalence in 2001–2002. *BioMed Central Public Health*, 9, 60. Retrieved from <http://www.biomedcentral.com/1471-2458/9/60>.

- Castro, F.G., Barrera, M., & Steiker, L.K.H. (2010). Issues and challenges in the design of culturally adapted evidence-based interventions. *Annual Review of Clinical Psychology*, 6, 213–239.
- Cresswell, L.S., & Deschenes, E.P. (2001). Minority and nonminority perceptions of drug court program severity and effectiveness. *Journal of Drug Issues*, 31(1), 259–291.
- Dannerbeck, A., Harris, G., Sundet, P., & Lloyd, K. (2006). Understanding and responding to racial differences in drug court outcomes. *Journal of Ethnicity in Substance Abuse*, 5(2), 1–22.
- Dannerbeck, A., Sundet, P., & Lloyd, K. (2002). Drug courts: Gender differences and their implications for treatment strategies. *Corrections Compendium*, 27(12), 1–26.
- DeVall, K.E., & Lanier, C.L. (2012). Successful completion: An examination of factors influencing drug court completion for white and nonwhite male participants. *Substance Use & Misuse*, 47(10), 1106–1116.
- Drug Policy Alliance. (2011). *Drug courts are not the answer: Toward a health-centered approach to drug use*. Los Angeles: Author.
- Finigan, M.W. (2009). Understanding racial disparities in drug courts. *Drug Court Review*, 7(2), 135–142.
- Fosados, R., Evans, E., & Hser, Y. (2007). Ethnic differences in utilization of drug treatment services and outcomes among Proposition 36 offenders in California. *Journal of Substance Abuse Treatment*, 33(4), 391–399.
- Frazer, M.S. (2006). *The Impact of the community court model on defendant perceptions of fairness*. New York: Center for Court Innovation.
- Gallagher, J.R. (2013). African American participants' views on racial disparities in drug court outcomes. *Journal of Social Work Practice in the Addictions*, 13(2), 143–162.
- Grella, C. (2008). Gender-responsive drug treatment services for women: A summary of current research and recommendations for drug court programs. In C. Hardin & J.N. Kushner (Eds.), *Quality improvement for drug courts: Evidence-based practices* (Monograph Series No. 9; pp. 63–74). Alexandria, VA: National Drug Court Institute.
- Guastafarro, W.P., & Daigle, L.E. (2012). Linking noncompliant behaviors and programmatic responses: The use of graduated sanctions in a felony-level drug court. *Journal of Drug Issues*, 42(4), 396–419.
- Guerrero, E.G., Marsh, J.C., Duan, L., Oh, C., Perron, B., & Lee, B. (2013). Disparities in completion of substance abuse treatment between and within racial and ethnic groups. *Health Services Research* (Online). doi: 10.1111/1475-6773.12031
- Hartley, R.E., & Phillips, R.C. (2001). Who graduates from drug courts? Correlates of client success. *American Journal of Criminal Justice*, 26(1), 107–119.
- Huddleston, W., & Marlowe, D.B. (2011). *Painting the current picture: A national report on drug courts and other problem solving court programs in the United States*. Alexandria, VA: National Drug Court Institute.
- Huey, S.J., & Polo, A.J. (2008). Evidence-based psychosocial treatments for ethnic minority youth. *Journal of Clinical Child & Adolescent Psychology*, 37(1), 262–301.
- Hwang, W. (2006). The psychotherapy adaptation and modification framework: Application to Asian Americans. *American Psychologist*, 61(7), 702–715.
- Integrated Substance Abuse Programs. (2007, April 13). *Evaluation of the Substance Abuse and Crime Prevention Act: Final report*. Los Angeles, CA: UCLA. Retrieved from <http://www.uclaisap.org/Prop36/documents/SACPAEvaluationReport.pdf>
- Janku, A.D., & Yan, J. (2009). Exploring patterns of court-ordered mental health services for juvenile offenders: Is there evidence of systematic bias? *Criminal Justice & Behavior*, 36(4), 402–419.
- Jeffries, S., & Bond, C.E.W. (2012). Does a therapeutic court context matter? The likelihood of imprisonment for indigenous and nonindigenous offenders sentenced in problem-solving courts. *International Journal of Law, Crime & Justice*, 41(1), 100–114. Retrieved from <http://dx.doi.org/10.1016/j.ijlcrj.2012.11.006>
- Lawson, W.B., & Lawson, A. (2013). Disparities in mental health diagnosis and treatment among African Americans: Implications for the correctional systems. In B. Sanders, Y. Thomas, & B.

- Deeds (Eds.), *Crime, HIV and health: Intersections of criminal justice and public health concerns*. New York: Springer.
- Leukefeld, C., Webster, J.M., Staton-Tindall, M., & Duvall, J. (2007). Employment and work among drug court clients: 12-month outcomes. *Substance Use & Misuse*, 42(7), 1109–1126.
- Liang, B., & Long, M.A. (2013). Testing the gender effect in drug and alcohol treatment: Women’s participation in Tulsa County drug and DUI programs. *Journal of Drug Issues*, 43(3), 270-288.
- Marlowe, D.B. (2013). Achieving racial and ethnic fairness in drug courts. *Court Review*, 49(1), 40–47.
- Marsh, S. (2009). The lens of implicit bias. *Juvenile & Family Justice Today*, 18, 16–19.
- Marsh, J.C., Cao, D., Guerrero, E., & Shin, H.C. (2009). Need-service matching in substance abuse treatment: Racial/ethnic differences. *Evaluation & Program Planning*, 32(1), 43–51.
- Messina, N., Calhoun, S., & Warda, U. (2012). Gender-responsive drug court treatment: A randomized controlled trial. *Criminal Justice & Behavior*, 39(12), 1539–1558.
- Miller, J.M., & Shutt, J.E. (2001). Considering the need for empirically grounded drug court screening mechanisms. *Journal of Drug Issues*, 31(1), 91–106.
- National Association of Criminal Defense Lawyers. (2009). *America’s problem-solving courts: The criminal costs of treatment and the case for reform*. Washington, DC: Author.
- National Association of Drug Court Professionals. (2013) *Adult drug court best practice standards* (Volume 1). Alexandria, VA: Author.
- Nicosia, N., MacDonald, J.M., & Pacula, R.L. (2012). *Does mandatory diversion to drug treatment eliminate racial disparities in the incarceration of drug offenders? An examination of California’s Proposition 36*. Cambridge, MA: National Bureau of Economic Research. Retrieved from <http://www.nber.org/papers/w18518>
- O’Hear, M.M. (2009). Rethinking drug courts: Restorative justice as a response to racial injustice. *Stanford Law & Policy Review*, 20(2), 101–137.
- Perez, D.M., & Wish, E.D. (2011). Gender differences in the validity of the Substance Abuse Subtle Screening Inventory–3 (SASSI-3) with a criminal justice population. *International Journal of Offender Therapy & Comparative Criminology*, 55(3), 476–491.
- Powell, C., Stevens, S., Dolce, B.L., Sinclair, K.O., & Swenson-Smith, C. (2012). Outcomes of a trauma-informed Arizona family drug court. *Journal of Social Work Practice in the Addictions*, 12(3), 219–241.
- Schmidt, L., Greenfield, T., & Mulia, N. (2006). *Unequal treatment: Racial and ethnic disparities in alcoholism treatment services*. Bethesda, MD: National Institute on Alcohol Abuse and Alcoholism. Retrieved from <http://pubs.niaaa.nih.gov/publications/arh291/49-54.htm>
- Service Women’s Action Network (SWAN). (2012, July). Rape, sexual assault and sexual harassment in the military. *Quick Facts*. Author. Retrieved from <http://servicewomen.org/wp-content/uploads/2012/10/Final-RSASH-10.8.2012.pdf>
- Vito, G., & Tewksbury, R. (1998). The impact of treatment: The Jefferson County (Kentucky) Drug Court program. *Federal Probation*, 62(2), 46–51.
- Wu, L.T., Pan, J.J., Blazer, D.G., Tai, B., Stitzer, M.L., & Woody, G.E. (2010). Using a latent variable approach to inform gender and racial/ethnic differences in cocaine dependence: A National Drug Abuse Treatment Clinical Trials Network Study. *Journal of Substance Abuse Treatment*, 38(Suppl. 1), S70–S79.

IX. Data and Evaluation

A. ELECTRONIC CASE MANAGEMENT**

Programs shall regularly enter data into the Problem-Solving Court Management Information System (PSCMIS) for use in case and program management. Programs shall review statistics relevant to program performance and implement policy adjustments and training when necessary. To ensure that the data is accurate, the program shall identify a Veterans Treatment Court team member who is responsible for data quality assurance.

B. TIMELY AND RELIABLE DATA ENTRY*

Staff members shall record information concerning the provision of services and in-program outcomes within forty-eight hours of the respective events. Timely and reliable data entry shall be required of each staff member.

C. INDEPENDENT EVALUATION*/**

Programs should undergo a process evaluation and an outcome evaluation every three years. Where such information is available, new arrests, new convictions, and new incarcerations shall be monitored for at least three years following each participant's entry into the veterans treatment court. Offenses shall be categorized according to the level (felony, misdemeanor, or summary offense) and nature (e.g., person, property, drug, or traffic offense) of the crime involved. Outcomes shall be examined for all eligible participants who entered the veterans treatment court regardless of whether they graduated, withdrew, or were terminated from the program. Outcome evaluations shall be conducted by an independent evaluator. Programs shall work closely with the evaluator to ensure that the evaluation results can be utilized to: examine program effectiveness and cost-efficiency, make improvements to program practices, and inform data collection processes in preparation for future evaluations.

D. COMPARISON GROUPS*

Outcomes for Veterans Treatment Court participants shall be compared to those of an unbiased and equivalent comparison group. Individuals in the comparison group should meet legal and clinical eligibility criteria for participation in the Veterans Treatment Court, but not enter the program for reasons having no relationship to their outcomes. Comparison groups shall not include individuals who refused to enter the Veterans Treatment Court, withdrew or were terminated from the program, or were denied entry to the program because of their legal charges, criminal history, or clinical assessment results. Participants in the Veterans Treatment Court and comparison groups shall have an equivalent opportunity to engage in conduct of interest to the evaluation, such as substance use and criminal recidivism. Outcomes for both groups shall be examined over an equivalent time period beginning from a comparable start date. If participants in either group were incarcerated or detained in a residential facility for a significantly longer period of time than participants in the other group, the length of time participants were detained or incarcerated is accounted for statistically in outcome comparisons. Outcomes shall be examined for all eligible participants who entered the

Veterans Treatment Court regardless of whether they graduated, withdrew, or were terminated from the program.

E. USING DATA AND EVALUATION RESULTS TO PROGRAM MANAGE*

Programs shall use the results of independent program evaluations results and regular reviews of programmatic data and performance measure reports as the basis for program change. As policy changes are made, data and performance measure reports and evaluation shall be used to examine effectiveness of the policy change and make further adjustments when necessary.

Supporting Evidence

The supporting evidence is based on the National Adult Drug Court Standards developed by the National Association of Drug Court Professionals, (2013), p.34-40; and (2015), p.66-74.

A. Electronic Case Management

Accurate record keeping is critical to data and evaluation. A study including 18 drug courts found that programs that used paper files to keep records necessary to perform evaluations had higher investment costs, lower graduation rates, and less improvement in outcome costs than programs that used electronic records for these purposes (Carey et al., 2008). In a study of 69 drug courts, keeping electronic records, as opposed to paper case files, was a critical step to allowing programs to track their own statistics and to participate in evaluations conducted by independent evaluators (Carey et al., 2012).

B. Timely and Reliable Data Entry

Poor data entry by staff is a substantial threat to a valid program evaluation. The optimum time to record information about services and events is when they occur, otherwise known as real-time recording. Real-time recording prevents lapses in memory from causing gaps in recorded information, and with such a wide variety of services and events in need of recording, it is the most reliable method. True real-time recording is challenging to accomplish but in all circumstances, data should be recorded within forty-eight hours of events. After forty-eight hours, errors in data recording have been shown to increase significantly, and after one week, the data is likely to be inaccurate, so much so that it would be more prudent to leave the data as missing rather than try to fill in the gaps from faulty memory (Marlowe, 2010). Failure to record service, performance, and event information in a reliable and timely manner jeopardizes the effectiveness of the program and the quality of participant care.

C. Independent Evaluation

In addition to keeping accurate records, engaging with independent researchers to conduct evaluations of drug court programs has been shown to be valuable. Carey et al. (2008) found that programs that participated in more than one evaluation conducted by an independent evaluator had improved outcome costs compared to those that did not (Carey et al., 2008). While drug courts should be continually monitoring program performance internally according to best practices, they can benefit greatly by inviting an independent evaluator to examine their program and make recommendations for improvement. Drug courts that involved an independent evaluator and implemented at least some of their recommendations were twice as cost-effective and twice as effective at reducing crime as drug courts that did not involve an independent evaluator (Carey et al., 2008, 2012). Participant perceptions of the program are often highly predictive of outcomes, particularly perceptions of the manner in which incentives and sanctions are delivered (Goldkamp et al., 2002; Harrell & Roman, 2001; Marlowe et al., 2005), the quality of treatment services provided (Turner et al., 1999), and the procedural fairness of

the program (Burke, 2010; McIvor, 2009). Participants are much more likely to be forthright with an independent evaluator about their perceptions than with program staff, who control their fate in the criminal justice system. Insights from independent evaluators could provide valuable remedies for program deficiencies that can lead to improved participant perceptions and outcomes.

D. Comparison Groups

In order to measure the effectiveness of drug court programs, it is important to address the question of whether the drug court program is responsible for the favorable outcomes of some participants, or if those participants would have had equal success outside the program. The performance of drug court participants must be compared to an unbiased and equivalent comparison group. Comparing the performance of the drug court to what most likely would have happened if the drug court did not exist is referred to as testing the counterfactual hypothesis, and it helps determine whether the drug court was effective (Popper 1956). There are acceptable and unacceptable methods of forming comparison groups, and the validity of the results will vary depending on how the comparison group was formulated. The strongest inference of causality is reached with the random assignment method. Eligible participants are randomly assigned to either the drug court program or to a comparison group. Random assignment provides the greatest likelihood that the groups started out with an equal chance of success, and is the best indicator of program effectiveness (Campbell & Stanley, 1963; Farrington, 2003; Farrington & Welsh, 2005; National Research Council, 2001; Telep et al., 2015). Some drug courts are reluctant to use the random assignment method as it denies potentially effective services to eligible participants. This makes random assignment a strong choice for programs with insufficient capacity, and a number of courts with insufficient capacity have successfully used random assignment to form comparison groups (e.g., Gottfredson et al., 2003; Jones, 2011; Turner et al., 1999). A second acceptable method to form comparison groups is the quasi-experimental comparison group. This group is formulated from individuals who were eligible for the drug court program, but chose not to enter for reasons unlikely to be related to their outcomes. A third is the matched comparison group, where staff construct a comparison group from a large and heterogeneous pool, such as a statewide probation database. There are also unacceptable methods to forming a comparison group. Comparison groups should not be formulated from individuals who refused to enter the drug court, were denied access to the drug court because of criminal or clinical histories, individuals who dropped out of drug court, or individuals who were terminated prematurely from the drug court program. It is likely these individuals were disadvantaged from the outset, and their inclusion in comparison groups will bias the results of any comparison (Campbell & Stanley, 1963).

E. Using Data and Evaluation Results to Program Manage

The final step in the evaluation process is using results from data analysis and evaluation to adjust program practices. Carey et al. (2008) found that programs that reported program statistics and used evaluation data to modify court operations had higher graduation rates (60% vs. 39%) and better results in terms of outcome costs (34% vs. 13%) compared to programs that did not. In their 2012 study, Carey et al. found that programs benefited substantially from using both their own program statistics to modify court operations and from using the results of independent evaluations to modify court operations. Programs that made modifications based on regular reporting of program statistics experienced 105% reduction in recidivism and 131% increase in cost savings, while those that use results of independent evaluations showed an 85% reduction in recidivism and 100% increase in cost savings. (Carey et al., 2012).

References:

- Burke, K.S. (2010). Just what made drug courts successful? *New England Journal on Criminal & Civil Confinement*, 36(1), 39–58.
- Campbell, D.T., & Stanley, J.C. (1963). *Experimental and quasi-experimental designs for research*. Chicago: Rand McNally College Publishing Company.
- Carey, S.M., Finigan, M.W., & Pukstas, K. (2008). Exploring the key components of drug courts: A comparative study of 18 adult drug courts on practices, outcomes and costs. Portland, OR: NPC Research.
- Carey, S.M., & Perkins, T. (2008). *Methamphetamine users in Missouri Drug Courts: Program elements associated with success* (Final report). Submitted to the Missouri Office of the State Court Administrator.
- Carey, S.M., Mackin, J.R., & Finigan, M.W. (2012). What works? The ten key components of drug court: Research-based best practices. *Drug Court Review*, 7(1), 6–42.
- Farrington, D.P. (2003). A short history of randomized experiments in criminology: A meagre feast. *Evaluation Review*, 27(3), 218–227.
- Farrington, D.P., & Welsh, B.C. (2005). Randomized experiments in criminology: What have we learned in the last two decades? *Journal of Experimental Criminology*, 1(1), 9–38.
- Goldkamp, J.S., White, M.D., & Robinson, J.B. (2002). An honest chance: Perspectives on drug courts. *Federal Sentencing Reporter*, 14(6), 369–372.
- Gottfredson, D.C., Najaka, S.S., & Kearley, B. (2003). Effectiveness of Drug Treatment Courts: Evidence from a randomized trial. *Criminology & Public Policy*, 2(2), 171–196.
- Hallfors D. & Godette D. (2002) Will the 'principles of effectiveness' improve prevention practice? Early findings from a diffusion study. *Health Education Research*, 17(4), 461-70.
- Harrell, A., & Roman, J. (2001). Reducing drug use and crime among offenders: The impact of graduated sanctions. *Journal of Drug Issues*, 31(1), 207–232.
- Jones, C. (2011, November). Intensive judicial supervision and drug court outcomes: Interim findings from a randomized controlled trial. *Crime & Justice Bulletin*, 152, 1–16. Available at <http://www.bocsar.nsw.gov.au/Documents/cjb152.pdf>
- Marlowe, D.B. (2010). Introductory handbook for DWI court program evaluations. Alexandria, VA: National Center for DWI Courts. Available at <http://www.dwicourts.org/sites/default/files/nadcp/DWI%20Ct%20Eval%20Manual%20REVISED-8-10.pdf>
- Marlowe, D.B., Festinger, D.S., Foltz, C., Lee, P.A., & Patapis, N.S. (2005). Perceived deterrence and outcomes in drug court. *Behavioral Sciences & the Law*, 23(2), 183–198.
- McIvor, G. (2009). Therapeutic jurisprudence and procedural justice in Scottish drug courts. *Criminology & Criminal Justice*, 9(1) 29–49.
- National Research Council. (2001). Informing America’s policy on illegal drugs: What we don’t know keeps hurting us. Washington, DC: National Academy Press.
- Popper, K. (1959). *The logic of scientific discovery*. New York: Harper & Row.
- Telep, C.W., Garner, J.H., & Visser, C.A. (2015, July 3). The production of criminological experiments revisited: The nature and extent of federal support for experimental designs, 2001–2013. *Journal of Experimental Criminology: Online*. doi:10.1007/s11292-015-9239-6
- Turner, S., Greenwood, P., Fain, T., & Deschenes, E. (1999). Perceptions of drug court: How offenders view ease of program completion, strengths and weaknesses, and the impact on their lives. *National Drug Court Institute Review*, 2(1), 61–85.

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Appendix A

Nebraska Veterans Treatment Court Progression Plan

The goal of Veterans Treatment Court is to assist veterans and their families in addressing behavioral health issues that are contributing to a cycle of addiction and/or criminal activity, and provide an opportunity to reestablish law abiding, productive lives within the community. The average length of participation in Veterans Treatment Court is 18-24 months. This Progression Plan follows the Nebraska Supreme Court's Veterans Treatment Court Best Practice Standards [NSC VTC Best Practice Standards](#), and was designed to provide objective, measurable, and consistent progression through any Nebraska Veterans Treatment Court program.

All Veterans Treatment Courts shall ensure each veteran adheres to the core requirements of the progression plan. Specific details including, but not limited to, program structure, delivery of services, and programming details shall be determined by each individual treatment court. Veterans Treatment Court shall ensure the core requirements of the progression plan are completed in compliance with the Nebraska Treatment Court Standards. Any individual plan may be modified based on the circumstances of the individual's progress through the program.

Eligible veterans must complete the Screening Process before a decision is made on program entry, as follows:

1. Screening Stage/Process

Goal: To ensure the admission of high-risk and high-need veterans through objective eligibility and exclusion criteria and validated eligibility assessments.

Purpose: To complete evidence-based screenings and assessments to determine eligibility and suitability for veteran candidates.

- Obtain DD Form 214 or other proof of service
- Behavioral Health Consultation and Diagnostic Evaluation as required
- Evaluation(s) completed following the Standardized Model of Substance Abuse Services [NSC Standardized Model for Delivery of Substance Abuse Services](#). Validated Screens and Assessment(s) completed (LS/CMI, GAIN-SS, RANT, SSI, SRARF, Mental Health Screening Form III, and Financial Eligibility Screen)
- Baseline drug test

Note: Collateral information obtained during the Screening Stage shall be used to determine eligibility for voucher access and utilized to determine if there is a need for additional assessment(s). Information obtained during this process can be utilized to access adult mental health services.

2. Early Recovery

Goal: To establish a foundation of support through treatment, initial stabilization and ancillary services.

Purpose: To support the veteran through the utilization of an individualized program plan, treatment, and ancillary services.

- Approve Residence
- Drug Testing ⁸
- Evaluate medical needs (medical, dental, vision, and auditory)
- Begin or Continue Treatment⁹
- Volunteer Veteran Mentor
- Peer Support Groups ¹⁰
- Develop VA linkages to utilize ancillary services ¹¹
- Educate and inform on community based ancillary services
- Status hearings ¹²
- Individualized Program Plan
 - Target criminogenic needs and responsivity factors¹³
 - Short and long-term goals
 - Ongoing assessment
 - Critical Path Map

Veterans shall complete objectives, display program compliance, demonstrate meaningful progress with the veteran’s individual treatment plan and the veteran’s individual supervision

⁸ Nebraska Veterans Treatment Court Best Practice Standards p. 42

⁹ Nebraska Veterans Treatment Court Best Practice Standards p. 22 (D and E)

¹⁰ Nebraska Veterans Treatment Court Best Practice Standards p. 24 (K)

¹¹ Nebraska Veterans Treatment Court Best Practice Standards p. 23 (G)

¹² Nebraska Veterans Treatment Court Best Practice Standards p. 37 (D)

¹³ Nebraska Veterans Treatment Court Best Practice Standards p. 23 (G)

plan, for a minimum of 14 days, and attend a minimum of 4 weeks of status hearings to be eligible for advancement.

3. Decision-Making

Goal: Reduce criminogenic risk/needs, strengthen recovery and behavior health through the application of learned skills and behavior modification.

Purpose: Strengthen recovery and behavioral health by providing veterans with the tools needed to create opportunities for behavior change. Veterans should be able to demonstrate an understanding and commitment to recovery and behavior change.

Continued expectations from Early Recovery

Approved Residence
Drug Testing
Continuum of care
Volunteer Veteran Mentor
Peer Support Groups
Develop and utilize ancillary services
Status hearings
Individualized Program Plan

Additional expectations for the veteran

- Psycho-educational classes, as needed
- Completion of or engaged in primary treatment services
- Life Skills (hygiene, budgeting, vocational rehab.)¹⁴
- Healthy lifestyles (dental/medical, nutrition, exercise)¹⁵
- Obtain employment and/or further education
- Establish program fee schedule
- Obtain valid driver's license or begin process of obtaining a valid driver's license

¹⁴ Nebraska Veterans Treatment Court Best Practice Standards p. 23 (G)

¹⁵ Nebraska Veterans Treatment Court Best Practice Standards p. 23 (G)

Veterans shall complete objectives, display program compliance, demonstrate meaningful progress with the veteran's individual treatment plan and the veteran's individual supervision plan, and have 90 days sustained sobriety to be eligible for advancement.

4. Community Transition

Goal: To establish sustainable mechanisms for healthy and pro-social community involvement.

Purpose: Practicing coping skills to avoid relapse, sustain recovery, and improve behavioral health; building healthy pro-social relationships and other support system; and, becoming economically self-sufficient.

Continued expectations from Early Recovery

Approved Residence

Drug Testing

Continuum of care

Volunteer Veteran Mentor

Peer Support Groups

Develop and utilize ancillary services

Status hearings

Individualized Program Plan

Continued expectations from Decision Making

Psycho-educational classes, as needed

Continuum of care

Life Skills (hygiene, budgeting, vocational rehab.)

Healthy lifestyles (dental/medical, nutrition, exercise)

Program fee schedule

Obtain valid driver's license or begin process of obtaining a valid driver's license

Additional expectations for the veteran

- Completing outpatient and/or demonstrating progress toward treatment goals
- Addressing financial obligations
- Gainful employment and/or education
- Cognitive Programming

- Positive community involvement

Veterans shall complete objectives, display program compliance, demonstrate meaningful progress with the veteran's individual treatment plan and the veteran's individual supervision plan, and have 120 days sustained sobriety to be eligible for advancement.

5. Sustained Recovery/Maintenance

Goal: A lifelong commitment to recovery from substance use, mental health management, and leading a pro-social life.

Purpose: Demonstrating independence for a continued sober, healthy, and crime-free lifestyle.

Continued expectations from Early Recovery

Approved Residence

Drug Testing

Continuum of care

Volunteer Veteran Mentor

Peer Support Groups

Utilize ancillary services

Status hearings

Individualized Program Plan

Continued expectations from Decision Making

Psycho-educational classes as needed

Continuum of care

Life Skills (hygiene, budgeting, vocational rehab.)

Healthy lifestyles (dental/medical, nutrition, exercise)

Program fee schedule

Obtain valid driver's license or continue process of obtaining a valid driver's license

Continued expectations from Community Transition

Completing outpatient and/or demonstrating progress toward treatment goals

Addressing financial obligations

Gainful employment and/or education

Cognitive Programming

Positive community engagement

Veterans shall complete objectives, display program compliance, demonstrate meaningful progress with the veteran's individual treatment plan and the veteran's individual supervision plan, and have 120 days sustained sobriety to be eligible for advancement.

6. Graduation Requirements

- 180 days sustained sobriety
- 180 days continuous employment
- Long term recovery plan and mental health maintenance plan
- Fees paid in full
- Positive community engagement
- Completion of all Veterans Treatment Court programming requirements