CEU MATRIX
THE INSTITUTE FOR ADDICTION & CRIMINAL JUSTICE STUDIES

DRUG TREATMENT COURTS: AN INTEGRATED APPROACH

3 Continuing Education Credits

Asynchronous Distance Learning Course

Content Level: Beginning

Course Author: Diane Sherman, Ph.D.

Last Updated: 2026

Approved by such credentialing bodies as:

- **National Association of Alcoholism and Drug Abuse Counselors (NAADAC) #94564**
- **National Board of Certified Counselors (NBCC) #6310**

All approval bodies are listed at ceumatrix.com/accreditations

For questions or to request accessibility accommodations please email us at: support@ceumatrix.com

Welcome to CEU Matrix. We have been committed to supporting the continuing education of behavioral health professionals since 2007. Please reach out with any questions, ideas, or feedback.

Do the best you can until you know better.
Then when you know better, do better.

— Maya Angelou

COPYRIGHT

ABOUT THE INSTRUCTOR

Diane Sherman, Ph.D., NCACII is an organizational consultant and national trainer. She has worked in the substance abuse profession since 1975. In her consulting services, she has three specific areas of focus: coaching, consultation and continuing education. Dr. Sherman provides Executive Coaching for those persons seeking to maximize their leadership potential. She is a CARF surveyor and consultant for agencies seeking or maintaining national accreditation. Presently, she is responsible for monitoring substance abuse services for the Georgia Department of Juvenile Justice. Dr. Sherman also conducts continuing education opportunities with Brown University through the Northeast Addiction Transfer and Technology Center. Over her professional tenure, Diane has trained nationally for NAADAC, National Association of Drug Court Professionals, CARF, Southeast School of Addiction Studies, South Carolina Behavioral Health Services Association, Tennessee Advanced School on Addiction, and locally for Georgia Department of Human Resources, Georgia Council on Substance Abuse, and Georgia Addiction Counselors Association.

Current Outcomes: What the Research Shows

Since the first drug treatment court opened in Miami-Dade County in 1989, the model has expanded significantly. The question is no longer whether drug courts work, but how well and for whom.

A 2024 study published in BMC Psychiatry examined treatment-based diversion as an alternative to imprisonment using nationwide registry data from 11,893 participants. The results were concrete: substance misuse decreased by 7 percentage points, adverse mental health events dropped by 5 percentage points, and adverse somatic health events fell by 9 percentage points. Participants also accumulated 3 fewer criminal charges compared to standard incarceration or probation periods. The researchers concluded that treatment-based court intervention represents "a superior alternative to incarceration in its target group" from both public health and criminal justice perspectives (Virtanen et al., 2024).

These findings align with what drug court practitioners have observed for decades, but they carry added weight because of the study's scale and its use of within-individual comparisons — meaning each participant served as their own control, comparing outcomes during court-mandated treatment against their own outcomes during probation or parole.

Recovery is not a single event. It is a trajectory. A 2024 longitudinal study tracked recovery capital — the internal and external resources that support sustained recovery — among 165 drug treatment court clients over one year across five data collection points. Researchers found significant individual variability in recovery capital trajectories, with educational attainment emerging as a strong predictor of gains. Participants in opioid intervention courts entered with lower baseline recovery capital than those in traditional drug courts, suggesting these individuals may require more intensive support from the outset. The study also documented a strengthening negative relationship between active drug use and recovery capital over time, particularly among opioid court participants (Knapp et al., 2024).

What does this mean for practitioners? The data supports what clinical experience suggests: early identification of participants with lower recovery capital — those with less education, fewer social supports, and more severe substance use histories — can inform more targeted treatment planning within the drug court framework.

The Opioid Crisis and Drug Court Evolution

The opioid crisis has reshaped drug courts in fundamental ways. Traditional drug court models were designed primarily around cocaine, marijuana, and alcohol use. Opioid use disorder presents different clinical realities: higher overdose risk, stronger physiological dependence, and the critical role of pharmacological intervention in treatment.

In response, a new model has emerged: the opioid intervention court. A 2024 study in the Journal of Addiction Medicine compared outcomes between an innovative opioid intervention court and traditional drug courts across two New York State counties, analyzing records for 618 participants. The opioid court model achieved an 81.2% rate of medication for opioid use disorder initiation, compared to 45.9% in traditional drug courts. Participants in the opioid court also connected to treatment faster (Elkington et

al., 2024).

However, the opioid court model did not outperform traditional drug courts on every measure. Traditional drug court participants demonstrated higher retention rates, which the researchers attributed to the opioid court's non-punitive approach versus the traditional model's use of immediate sanctions for noncompliance. This finding highlights a tension at the center of drug court practice: the balance between therapeutic engagement and structured accountability.

Medication-Assisted Treatment in Drug Courts

The integration of medications for opioid use disorder into drug court programming represents one of the most significant shifts in the field since the Ten Key Components were published in 1997. Historically, many drug courts prohibited or discouraged participants from using medications such as methadone, buprenorphine, or naltrexone — viewing pharmacological treatment as inconsistent with an abstinence-based recovery model.

That position has shifted substantially. A 2022 national survey of 169 drug courts in U.S. counties with high opioid mortality found that 73% of programs now report providing access to all FDA-approved medications for opioid use disorder. Over 90% offer agonist medications specifically (Marlowe et al., 2022).

The gap between policy and practice remains significant. The same survey found that only 25% to 50% of eligible participants actually receive medications in most programs. Twenty-four percent of surveyed programs reported that court staff still override physician medication decisions. And 36% of jails in these jurisdictions do not provide agonist medications during custodial sanctions — meaning a participant stabilized on buprenorphine who receives a short jail sanction may be forced into abrupt medication discontinuation (Marlowe et al., 2022).

These barriers are not trivial. Abrupt discontinuation of opioid agonist medications increases overdose risk upon release. For drug court practitioners, understanding the clinical rationale for medication-assisted treatment — and the risks of interrupting it — is essential for participant safety.

A separate qualitative study identified additional structural barriers to medication access in drug courts and police diversion programs across three states. Researchers found that limited treatment facility availability, stigmatizing attitudes toward medications among justice system professionals, and insufficient dedicated resources all impede effective treatment linkage (Dickson-Gomez et al., 2022).

Communication and Team Dynamics

The Ten Key Components emphasize interdisciplinary collaboration, but they describe it in structural terms — who sits at the table, how often the team meets. Less attention has been given to how individual team members actually communicate day to day, and how those behaviors affect outcomes.

A 2023 study published in Psychological Services examined communication and collaboration practices within a single drug court team in a Midwestern urban setting, using surveys, process

evaluation data, and qualitative interviews with 19 team members. The researchers found that individual-level communication behaviors — how team members share information, raise concerns, and negotiate disagreements — play a meaningful role in overall program effectiveness. The study underscored the need to move beyond structural descriptions of teamwork and toward operationalized, measurable indicators of communication quality (Farringer & Manchak, 2023).

For drug court practitioners, the implication is practical: effective collaboration is not guaranteed by assembling the right people. It requires deliberate attention to how those people interact — including how treatment providers communicate clinical progress to judges, how prosecutors and defense counsel navigate the non-adversarial framework, and how disagreements about participant compliance are resolved.

Factors That Predict Drug Court Graduation

Not all drug court participants complete the program. Understanding which factors predict graduation — and which predict termination — allows programs to allocate resources more effectively and intervene earlier for at-risk participants.

A 2022 study analyzed 247 felony-level drug court participants (113 graduates, 134 terminated) from a southeastern metropolitan jurisdiction. In multivariate analysis, the strongest individual predictor of graduation was lower emotional and personal risk needs at intake. On the programmatic side, three factors emerged: individual counseling sessions positively predicted graduation, while jail sanctions and monetary fines negatively predicted completion (Randall-Kosich et al., 2022).

The finding about sanctions deserves particular attention. Drug courts rely on graduated sanctions as a core component. The research does not suggest eliminating sanctions — but it does suggest that jail-based sanctions and financial penalties may be counterproductive for some participants. Programs may benefit from examining whether their sanction structures align with participants' clinical needs and recovery trajectories, rather than applying a uniform response to noncompliance.

Trauma and Co-Occurring Mental Health Disorders

Drug court participants carry significant trauma histories. The relationship between substance use, criminal behavior, and trauma exposure is well documented, but the question for drug court practitioners is whether participation in the program itself affects mental health outcomes — and for whom.

A 2023 longitudinal study tracked 983 drug court participants enrolled between 2009 and 2017, measuring PTSD symptoms and broader mental health at baseline, 6 months, and 12 months. Participants showed significant improvements in both PTSD symptoms and overall mental health over the course of drug court participation (Zielinski et al., 2023).

However, the study identified an important moderating effect: participants who entered with clinical-level PTSD experienced less improvement in broader mental health over time compared to those with lower baseline trauma. In other words, while drug court helps, severe trauma at entry may limit the extent of mental health gains without integrated, trauma-specific intervention.

This finding reinforces the importance of thorough trauma screening during the initial assessment process discussed earlier in this course. The nine screening domains established by CSAT address a broad range of concerns, but clinicians should pay particular attention to trauma history — not as a checkbox, but as a factor that may shape the participant's entire treatment trajectory. Programs that incorporate evidence-based trauma interventions alongside standard substance abuse treatment may see stronger outcomes for this subpopulation.

The clinical implications extend to assessment instrument selection and interpretation. Standard screening tools like the CAGE, MAST, and DAST — all discussed earlier in this course — measure substance use severity but do not capture trauma exposure or PTSD symptomatology. Drug court assessment protocols that include a validated trauma screener, such as the PTSD Checklist used in the Zielinski study, provide clinicians with a more complete picture of participant needs. This additional data point can inform treatment matching, identify participants who may need co-occurring disorder services from the outset, and help the drug court team anticipate which participants may require modified expectations around early program compliance.

The broader point is that drug court participants are not a homogeneous population. They arrive with varying combinations of substance use severity, criminal history, mental health conditions, trauma exposure, educational attainment, and social support. Effective screening and assessment — the foundation of Key Component #3 — must account for this complexity rather than applying a one-size-fits-all approach.

Bridging the Gap: Collaboration Between Drug Courts and Treatment Providers

The shift toward medication-assisted treatment in drug courts has created a new operational challenge: how drug court teams and community-based treatment providers work together. The traditional drug court model assumed that the treatment provider was a member of the court team, attending staffings and providing regular updates to the judge. Medication-assisted treatment introduces external prescribers — physicians, nurse practitioners, opioid treatment programs — who may not be integrated into the drug court's collaborative framework.

A 2023 study in the Journal of Substance Use and Addiction Treatment examined this dynamic through interviews with 21 drug court staff across seven courts. The researchers identified specific facilitators of successful collaboration: agencies that offered medication alongside comprehensive services (rather than medication alone), jails that provided in-house medication with community referrals at release, and established provider relationships built on responsive communication. Barriers included limited clinic hours, restricted methadone availability, inadequate communication between court staff and prescribers, and skepticism among some court staff regarding prescribing practices (Pivovarova et al., 2023).

For practitioners, these findings point to a concrete action item: drug court teams that invest in building relationships with medication providers — attending joint meetings, establishing shared communication protocols, and educating team members on the clinical rationale for medication — report fewer barriers to participant access. The collaboration does not happen by default. It requires the same deliberate planning that the Ten Key Components prescribe for other aspects of drug court

operations.

Program Quality and Individual Needs: Both Matter

The question of what drives drug court success — program design or participant characteristics — has practical implications for how courts allocate resources and structure interventions. A 2023 study of 848 participants across nine drug courts tested whether program-level factors, individual-level factors, or a combination best predicted two key outcomes: graduation and arrest avoidance during participation (Breno et al., 2023).

The results were clear: both matter, and neither alone tells the full story. Client education level and substance use patterns predicted graduation, but so did program-level factors including staffing levels and adherence to clinical standards. For arrest avoidance during participation, criminal history and substance use patterns mattered on the individual side, while total program hours offered, staffing ratios, and how consistently rewards and sanctions were implemented mattered on the program side.

The combined model — accounting for both individual and programmatic factors simultaneously — outperformed either single-factor model. The researchers concluded that drug courts should invest in enhancing program quality and maintaining adequate staffing alongside individualized treatment planning. One without the other leaves outcomes on the table.

For drug court practitioners, the takeaway is actionable: a well-designed program can partially compensate for higher-risk participants, and attentive individualized treatment can improve outcomes even in programs with structural limitations. The Ten Key Components provide the framework, but staffing, clinical standards, and consistency of implementation determine whether that framework translates into results.

Adapting to New Realities: Virtual Drug Court Services

The COVID-19 pandemic forced drug courts to adopt virtual service delivery rapidly and without precedent. While the emergency has passed, the experience raised lasting questions about how technology can — and should — be integrated into drug court operations.

A 2022 study surveyed 1,356 drug court clients across 121 courts about their experiences with virtual services. The findings revealed a nuanced picture: clients reported greater comfort in virtual court sessions compared to appearing in person before a judge. However, they also reported that judges seemed less familiar with their individual cases in remote settings — a concern directly relevant to Key Component #7, which emphasizes ongoing judicial interaction as essential to participant success (Ray et al., 2022).

Treatment services showed a similar split. In-person group therapy sessions strengthened connections between group members and between clients and staff. Virtual group sessions, by contrast, reduced client anxiety about participation — potentially lowering a barrier for individuals who find group settings intimidating or triggering.

The practical implication is that drug courts should not view virtual and in-person services as interchangeable. Each modality has distinct strengths. Courts that maintain hybrid service models may serve their participants best by using in-person sessions for relationship-building activities — team staffings, judicial reviews, group therapy — while offering virtual options for individual check-ins, case management contacts, and participants with transportation or childcare barriers. The research suggests that the question is not whether to use technology, but how to use it without sacrificing the interpersonal connections that make drug courts effective.

The Scope of Drug Courts Today

The drug court model has grown substantially since the first program opened in Miami-Dade County in 1989. Drug courts and problem-solving courts now operate in every U.S. state and territory. The model has expanded beyond adult criminal courts to include juvenile drug courts, family dependency treatment courts, veterans treatment courts, tribal healing to wellness courts, and the newer opioid intervention courts described earlier in this section.

This expansion reflects a broader recognition within the criminal justice system that substance use disorders require clinical intervention, not solely punitive responses. The evidence base supporting this position has grown considerably. Multiple systematic reviews and large-scale evaluations have consistently demonstrated that drug court participants show lower recidivism rates, reduced substance use, and improved employment and health outcomes compared to similar offenders processed through traditional court systems.

However, drug courts are not a uniform intervention. Program design, local resources, judicial leadership, team composition, and the availability of evidence-based treatment all vary significantly across jurisdictions. The Ten Key Components provide a foundational framework, but how those components are implemented determines outcomes.

Rural jurisdictions face particular challenges. Limited access to treatment providers, fewer medication prescribers, longer travel distances for participants, and smaller budgets for staffing and services all constrain program design. Urban programs contend with different pressures: higher caseloads, greater substance diversity among participants, more complex co-occurring disorders, and the logistical challenges of coordinating across larger court systems and multiple treatment agencies.

Despite these variations, the research reviewed throughout this course points to consistent principles. Drug courts work best when they integrate treatment with judicial oversight, maintain adequate staffing, apply sanctions and incentives consistently, screen comprehensively for co-occurring conditions including trauma, provide access to medication-assisted treatment when clinically indicated, and invest deliberately in team communication and collaboration. These are not aspirational goals. They are evidence-based practices supported by peer-reviewed research conducted within drug court settings over the past several years.

As the field continues to evolve — incorporating medication-assisted treatment, trauma-informed approaches, virtual service delivery, and more sophisticated screening and assessment practices — drug court practitioners must remain current with the research literature and willing to adapt their practices accordingly. The original vision of the drug court model remains sound: accountability combined with

treatment produces better outcomes than incarceration alone. The research now tells us much more about how to execute that vision effectively.

Drug Treatment Courts: An Integrated Approach

Introduction

In the late 1980's drug courts were implemented as a response to provide an intervention for non-violent substance abusing offenders. Notably, the Miami/Dade County Drug Court was the first court implemented. It has been operational since 1989 when the Honorable Judge Herbert M. Klien continued to experience repeated and detrimental effects of drug offenses within his circuit. He "became determined to solve the problem of larger numbers of people on drugs." (Miami's Drug Court: A Different Approach, 1993) This drug court has become a model program for the Nation (National Criminal Justice Reference Service, n.d.).

Trends reveal substance-abusing offenders, who were also returning to the legal system repeatedly, have heavily affected the criminal justice system. Many offenders were committing non-violent crimes related to alcohol or other drug charges. The traditional adversarial system of justice was ineffective at addressing substance abuse issues. At the same time, treatment and continued support for substance abusers, has diminished greatly, in both the private and public system. The innovation of drug court treatment combined with legal case processing increases the participant's accountability while providing long-term treatment to assist in behavioral change through sustained program support. Potential outcomes of supportive court monitoring combined with treatment suggest the offender will experience a change in behavior and decrease recidivism (National Association of Drug Court Professionals, 2000; Senjo & Leip, 2001)

Drug treatment courts ensure the full involvement of the key stakeholders. The primary stakeholders include a presiding judge and sometimes an alternate judge, designated to oversee all proceedings of the drug court process, prosecution, defense counsel, law enforcement, police / sheriff department, probation, correctional staff, community partners, and substance abuse treatment representatives. Combined, the drug court team directs a mandated process of accountability and treatment of the drug court participant in an effort to accomplish three outcomes: (1) reduce recidivism, (2) provide treatment, and (3) accountability of the offender. In exchange for involved participation in drug treatment court, the offender may be offered a variety of outcomes depending upon the individual program (U.S. Department of Justice, Drug Courts Program Office, 1997).

Welcome

Welcome to this course on Drug Treatment Courts. This is an introductory course, designed to provide information for the new or relatively inexperienced drug court practitioner.

I am Diane Sherman. I am an independent organizational consultant specializing in substance abuse services. I graduated from Columbus State University, Georgia, in 1988 with a Masters of Science degree in Health Services Administration. I have my doctorate degree in Industrial/ Organizational Psychology. I am also a National Certified Addiction Counselor-II and a Certified Employee Assistance Professional. My professional career spans over 25 years.

In the past 10 years, I have been fortunate to provide consulting and facilitation services for drug treatment and behavioral health agencies. I have consulted with drug treatment courts in Georgia. I have completed a statewide program evaluation for superior court drug court programs. I am also a program surveyor for CARF, an international accrediting agency. In 2001, I contributed to the development and implementation of their current drug treatment courts national accreditation standards. I have conducted training events and presented workshops at local, regional, and national conferences drug court treatment and topics relevant to addiction professionals.

I hope you will enjoy this course as review Drug Treatment Courts. This broad overview covers four topics identified in the course objectives. With certainty, my background as a consultant and an addiction professional will influence this course. Though many of you will come to this course from a variety of backgrounds, we all will have a lot to share with, and to learn from, one another.

Section 1:
Drug treatment courts: An Integrated Approach

OVERVIEW

In the late 1980's, drug courts were implemented as a response to provide an intervention for non-violent substance abusing offenders. Notably, the Miami/Dade County Drug Court was the first court implemented. It has been operational since 1989 when the Honorable Judge Herbert M. Klein continued to experience repeated and detrimental effects of drug offenses within his circuit. He “became determined to solve the problem of larger numbers of people on drugs." (Miami's Drug Court: A Different Approach, 1993 as cited in National Criminal Justice Reference Service, n.d.). This drug court has become a model program for the Nation.

The following link provides a brief glimpse and useful information about drug courts provided on the website for the National Association for Drug Court Professionals.

- Facts on Drug Courts located at: http://www.nadcp.org/whatis/facts.html

Trends reveal substance-abusing offenders, who were also returning to the legal system repeatedly, have heavily affected the criminal justice system. Many offenders were committing non-violent crimes related to alcohol or other drug charges. The traditional adversarial system of justice was ineffective at addressing substance abuse issues. At the same time, treatment and continued support for substance abusers, has diminished greatly, in both the private and public system. The innovation of drug court treatment combined with legal case processing increases the participant's accountability while providing long-term treatment to assist in behavioral change through sustained program support. Potential outcomes of supportive court monitoring combined with treatment suggest the offender will experience a change in behavior and decrease recidivism (National Association of Drug Court Professionals, 2000; Senjo & Leip, 2001).

Please take time to connect to the following link:

- Drug war facts: Drug courts and treatment as an alternative to incarceration, located at http://www.drugwarfacts.org/drugcour.htm

The authors of the website offer a variety of perspectives related to drug courts and treatment as an alternative to traditional drug treatment. While this reading may be viewed as non-traditional to some, critical thinking and examining issues from various perspectives is crucial for any student. Also, remember that when surfing the Internet for facts or other information, it is important to know where the original research or source of information is cited. This website offers both perspective and source.

Drug Court Team

Drug treatment courts ensure the full involvement of the important stakeholders. The primary stakeholders, also known as the drug court team, include a presiding judge and sometimes an alternate judge, designated to oversee all proceedings of the drug court process, in addition to prosecution, defense counsel, law enforcement, police / sheriff department, probation, correctional staff, community partners, and substance abuse treatment representatives. Combined, the drug court team directs a mandated process of accountability and treatment of the drug court participant in an effort to accomplish three outcomes: (1) reduce recidivism, (2) provide treatment, and (3) accountability of the offender. In exchange for involved participation in drug treatment court, the offender may be offered a variety of outcomes depending upon the individual program (U.S. Department of Justice, Drug Courts Program Office, 1997).

We will take an in-depth look at the defining components later in the course. You will find a link to the PDF file for the document at http://www.ncjrs.gov/pdffiles1/bja/205621.pdf

Integrating substance abuse treatment with legal case processing

Our profession of substance abuse treatment has always held a tenant of treating the whole family, not just the identified patient. The same principle, a holistic approach, is true for drug treatment courts. An integrated system which includes collaboration of the judge, legal case processing and substance abuse treatment representatives, can go far beyond adjudication and incarceration as a sole consequence of substance abusing offenders. Thus, the defendant's case is diverted from the usual court proceedings while participating in substance abuse

treatment. The potential benefits of an integrated system which combines accountability with treatment has benefits which potentially include:

- recovery from addictive behavior;
- improved physical and mental health;
- opportunities for employment and education;
- enhanced social functioning and community involvement
- increased public safety;
- family reunification; and,
- favorable disposition from the court.

There is no single model for drug courts. The type of the program and court processing will heavily depend on preliminary discussions of the team. It may be strongly influenced by the prosecution or district attorney who is communicating with the presiding judge during preliminary preparations. Initial start-up funding or other contributing funds from local or state sources may also influence the type of program. Across the Nation, a wide range of models include:

- Pre-plea - diversion to treatment in which the defendant is released from pretrial custody under conditions that include participation in a substance abuse treatment program to include regular or random urine screening.
- Pre-adjudication - in which the defendant renders a plea but is not adjudicated, with specific stipulations that (2) further prosecution will be held in abeyance; (b) if the defendant successfully completes the program, the charges will be dismissed; and (c) if the defendant does not complete the program, prosecution will proceed on the original charge.
- Post-adjudication - in which the defendant pleads guilty and is sentenced to the substance abuse program, with the understanding that (a) sentence will be deferred; (b) if the defendant successfully completes the program the guilty plea will be vacated and charges dropped; and (c) if the defendant fails to complete the program the sentence for the original charge will be imposed.
- Sentenced with probation revocation - in which a defendant on probation has violated some condition of the probation, and is mandated to a substance abuse treatment program.

Participants who appear eligible for drug court may not be automatically referred to it. Eligibility of participants will depend on the drug court model, prescribed eligibility standards and target population. For example, some courts will only accept first time offenders or some only juvenile offenders. Sometimes eligibility may be limited to citizens of a specified geographic region, i.e., only county residents. The bottom line is the drug treatment court should define the parameters that identify who are eligible and acceptable for participating in the drug court.

UNDERSTANDING THE BASICS

Judicial System

The judicial system is based on law, state and local procedures and the culture of the local jurisdiction. The court is the hub of adjudication; the approach is commonly adversarial. Criminal conduct is the primary focus of the defendant's behavior; substance abuse is usually secondary.

Traditional Court versus Drug Court Characteristics	
Traditional	**Drug Court**
Court team of judge, prosecution, defense counsel	Drug court team created to achieve goals of accountability, monitoring and supportive treatment intervention
Adversarial	Non-adversarial
Goal = process case and apply the law	Goal = restore defendant as a productive non-criminal member of society
Judge exercises limited role in defendant's supervision	Judge plays central role in monitoring and supervision of defendant while in treatment
Interventions for substance abuse at discretion or order of the judge	Formalized, structured treatment
Relapse may lead to violation, increased sentence or return to custody	Graduated sanctions used to respond to relapse

(Sherin & Maloney, 1996)

Key persons involved in the court system include the judge, prosecution, law enforcement and defense counsel. The prosecution brings forth charges against the defendant on the basis of law, and evidence provided by law enforcement or the police. Defense counsel or the public defender represents the defendant. The judge presides over the court proceedings. The judge advises or assures the defendant is aware of:

- his or her rights;
- conditions of pretrial release;
- conducts hearings and trial to determine guilt or innocence;
- sentences the defendant who has pleaded guilty or is found guilty.

Further, there are some broad goals or values of the court which influence court proceedings. These include due process, protection of individual rights, the right to a quick hearing or expeditious resolution of the case, and an appropriate disposition (Sherin & Maloney, 1996).

With the inception of drug courts, and the favorable involvement of the key persons involved, there appears to be consensus that incarceration is best used for those offenders who are a greater threat to society. Incarcerating substance abusing offenders for drug use or possession, who are not afforded treatment, is an ineffective intervention that is unlikely to change criminal behavior associated with drug seeking or use of substances (Sherin & Maloney, 1996).

Substance abuse treatment systems

The primary purpose of treatment is to provide an intervention with the purpose of reducing or ending the client's behavior or patterns abuse of substances. These are complex patterns and issues unique to the substance abuser. They are influenced by a variety of experiences to include cultural, social, family, biological, and physical.

Another tenant of substance abuse treatment is the continuum of severity. Generally speaking, substance use and abuse gets worse over time. If left uninterrupted, it is fatal, complicated by physical deterioration or health problems.

Models of interventions differ. Some support the disease concept or medical model of addiction. Others support a harm reduction model, often advocated by public health professionals designed to prevent increased impact of addiction. Still others support a social use or controlled use concept in which the provider supports the client's lowered frequency of substance use.

Continued use of substances within a court-mandated process such as drug court is unacceptable. However, relapse is common feature of addiction. Granted, some see relapse, or returning to the use of substances, as a step in the recovery process. It is not uncommon for substance abusers to relapse once or several times before fully embracing recovery. Some see it as breaking the law. The bottom line is the drug court team must have a collaborative and unified approach in deciding how to respond to the offender's relapse. The finesse of the team will come with team building, understanding and respecting each other's position and basic principles of their specialization, and having a unified response to individual offenders.

Finally, the greatest difference between drug court treatment and traditional treatment is that of accountability and sustained support. Many treatment providers do not engage measures of accountability, such as urine drug screens. Also, the availability of treatment has diminished over the years as funding or insurance has decreased. Often indigent clients have nowhere to turn except to a public health system that is over-burdened and under-supported.

Research reveals that substance-abusing offenders who engage in long term treatment and continual support are more likely to experience reduced criminal activity and substance abuse (Sherin & Maloney, 1996). One national study conducted by the National Institute on Justice reviewed a sample of 17000 graduates. Participants (one year post graduation) experienced 16.4 percent recidivism rate, charged with a felony (Huddleston, Freeman-Wilson, & Boone, 2004). In addition, drug court cases are processed quicker, with immediate enrollment into treatment, thus expediting the calendar of pending court cases. Certainly, these limited examples demonstrate that drug court is more cost effective than traditional case processing, enforcement and incarceration. Additional cost benefits include reduced costs on the criminal justice system for incarceration or costs to victims. Increased retention in drug court treatment is another benefit of this model, with retention rates reported between 67 and 71 percent (American University as cited in Huddleston, Freeman-Wilson, & Boone, 2004).

Additional drug court benefits and cost savings, with more valuable information about drug and other problem solving courts is located in the document “Painting the Current Picture: A National Report Card on Drug Courts and Other Problem Solving Court Programs in the United States.” (Huddleston, Freeman-Wilson, & Boone, 2004).

Collaborative leadership

Collaboration among all persons involved in the planning and drug treatment court process is critical for overall program success of integrating substance abuse treatment with legal case processing. In this context, it is critical to emphasize collaborative.

THINK now - there are various professionals at the table; each with different training; and each who have probably come to the table with different academic training and a different perspective on substance abusing offenders. While the judge and prosecutor have traditionally lead the way in establishing drug courts, they have been supported by various professionals within the legal and criminal justice systems, treatment agency, community, and the community. Team building and collaborative leadership has been a critical factor in enhancing the drug court team and in the overall success of the drug court treatment program.

Finally, there is the issue of shared common goals, albeit, among a team of professionals with a range of values, perspectives and priorities. Only when the team can concur on the goals of the drug court can the vision be articulated to policy makers, legislators, partners, and the community. Five goals of collaboration include:

- reduced criminal behavior
- better use of jail space
- improved delivery of drug treatment services
- effective health prevention and disease management
- improved productivity through employment and lesser dependence on the public system.

Section 2:
Defining Drug Courts: The Key Components

We have taken an in-depth look at an integrated approach to drug treatment courts in the last section. We will continue to examine this integrated approach, by reviewing nationally accepted standards and benchmarks. First, let us look at the planning process - the pre-drug court process.

DRUG COURT PROGRAM PLANNING

Drug courts are ideally implemented using a coordinated, systematic approach. Thorough and deliberate planning, structured around an identified timeframe, is required to facilitate the most successful intervention and program outcome. Planning begins with the judge identifying the need and appropriate application of a drug court process within his or her jurisdiction, and identifying essential team members.

The drug court team and initial planning group are important members for proper planning. The judge, court administrator, clerk, prosecutor, defense (public defender or defense representative from the local bar association) treatment provider, and law enforcement representative may be included in the initial planning team (Sherin & Mahoney, 1996). Additional team members may include representatives from probation, jail, pre-trial services, community-based agencies, or case managers, included at the invitation of the judge. Team members should have an understanding of the multiple needs of the population to be served and are sensitive to economic, class, gender, racial, ethnic, and cultural differences (U.S. Department of Health and Human Services, 1997; U.S. Department of Justice, 1997).

Detailed planning must be accomplished. It addresses a wide variety of issues, to include target population and related needs, participant eligibility, a defined drug court model, supportive services, type of treatment intervention and treatment providers, formal written policies and procedures, information management, and program and outcome evaluation (U.S. Department of Justice, 1997).

The timeframe for the initial pre-drug court planning process may be flexible, but should allow enough time to consider various challenges to the desired drug court process. Sometimes the initial planning process involves visiting other drug courts to observe the uniqueness of the daily drug court process. As the planning

process continues, and challenges arise, the drug court team can collectively address these issues, while experiencing team building, growth, and expansion. Upon discovery, mechanisms can be installed to address shortfalls or oversights from the planning process (U.S. Department of Justice, 1997).

There must be a dedicated commitment from each team member and the member's respective agency to the planning process. Scheduled meetings and task accomplishments are necessary to address specific issues or responses (Sherin & Mahoney, 1996). The planning process works to accomplish specific tasks such as the description of the substance abuse problem in the judicial circuit or jurisdiction and goals of the drug court program (Sherin & Mahoney, 1996). Additional tasks include identification of the target population, treatment, and case management providers and funding resources. The team works to define participant eligibility criteria, written operational procedures, resources, identify an information management system and determine the program evaluation goals and objectives prior to the first participant being enrolled in the drug court (U.S. Department of Justice, 1997).

The judge may request each team member to sign a written contract or Memorandum of Agreement. It is the key document that describes a transition from a planning commitment to confirmed program design and long-term involvement, offering full participation of their respective agency. This document can describe the member's role and responsibility, can reflect intent, interest and support of the drug court process, and may be signed by each team member (Sherin & Mahoney, 1996).

Generally, treatment based drug courts offer a creative opportunity to design a system where partners and supportive agencies join to achieve a solution. The drug court team must identify goals, objectives, and community need. Resources - expertise, manpower, services, information management, materials, physical plant, and funding - must be identified, and community partnerships must be nurtured.

Community partnering can include education by the drug court team members to address differing values or beliefs about substance abusing offenders and public safety. Community education and outreach gives program officials an opportunity to cultivate a public presence and enhance community support.

Partners to the drug court may be asked to sign an Interagency Agreement. This written agreement guides each individual's or agency's contribution to the entire

scope of the drug treatment court. Elements of an interagency agreement may include:

- identified point of contact or agency representative
- description of the services
- description of information that will be shared among the partner agencies and drug court team
- agency's role and responsibility to the drug court
- identification of wrap-around services provided for drug court participants
- description of consequences for non-compliance with the identified service
- description of method of communication or documents needed for notification of progress, compliance/non-compliance, and reports.
- guarantee that data sharing methods will comply with state and federal confidentiality regulations
- commitment to program evaluation conducted operating independently of all participating drug court agencies

TREATMENT-BASED DRUG COURTS: COMMON CHARACTERISTICS

The following represents a list of common characteristics of drug treatment courts. They should be addressed during the planning process in preparation for program implementation. In combination with the 10 Key Components, describing how these characteristics or action items will be implemented will assist the planning team via thorough planning efforts. These common characteristics include:

- Case disposition is non-adversarial
- Treatment based court is developed by a team of key stakeholders
- Representatives of substance abuse and mental health treatment, public and/or private, participate as full partners to the planning process
- Substance abuse treatment is comprehensive, established on a continuum of care, and serves the needs of the participant

- Treatment providers are licensed by state regulatory authority, and treatment staff are licensed practitioners or certified addiction counselors
- Comprehensive treatment planning will be accomplished by licensed or certified practitioners who will also advise the court on the participant's progress in treatment
- The court recognizes substance abuse a chronic, relapsing disorder, and provides a structured and coordinated response to relapse episodes
- Drug testing is used to monitor accountability
- The court imposes certain sanctions in response to the participant's non-compliance
- Treatment is a therapeutic intervention using evidence based treatment services effective for substance abusing offenders. Treatment is not used for punitive or restrictive purposes.
- Final authority regarding continuance in the program, sanctions, incentives, or termination from the program rests with the court following consultation among the team and with the treatment provider and/or case manager
- Successful program completion may result in dismissal of charges or other mitigation of sanctions
- program evaluation will examine issues critical to each participating justice or health system (U.S. Department of Health and Human Services, 1997).

THE TEN KEY COMPONENTS

Defining Drug Courts: The Key Components was published in 1997 (U.S. Department of Justice, 1997). It is an outcome of a collaborative effort between the National Association of Drug Court Professionals and drug court practitioners, supported by a grant awarded to the Drug Court Program Office, Office of Justice Programs, U.S. Department of Justice. The document is organized around ten "key components" which describe the primary categories and benchmarks necessary for drug treatment courts.

- You can find the PDF document at the following link: http://www.ncjrs.gov/pdffiles1/bja/205621.pdf

Also take time to review the following publication: Painting the Current Picture: A National Report Card on Drug Courts and Other Problem Solving Court Programs in the United States (Huddleston, Freeman-Wilson, & Boone, 2004). It is the latest report on drug courts and it is located online at the website of the National Drug Court Institute. This document gives valuable and current information about the state of affairs of drug courts on the national scene, providing input and research from various sources.

- The link is*:* http://www.ndci.org/publications/paintingcurrentpicture.pdf

The Ten Key Components provides a firm foundation for defining drug courts (Huddleston, Freeman-Wilson, & Boone, 2004). Upon closer program review, an overwhelming majority of drug treatment or other problem solving courts have been developed and implemented based upon these ten components.

In the event you are not able to open The Ten Key Components document, we will proceed with a detailed look at the components and defining benchmarks. Whether you are new to drug courts, or experienced, these publications are critical for continual program self-evaluation and program enhancements.

Key Component #1 - Drug courts integrate alcohol and other drug treatment services with justice system case processing. The mission of drug court is to stop substance-abusing behavior associated with criminal activity. Through a coordinated effort and an integrated approach, drug courts promote recovery through accountability. The drug court team works together with a common goal of helping citizens referred to drug court to change behavior and lives. Continuous communication among the team about the participant's treatment progress is critical. Drug court treatment is usually viewed as a continuum of care, and generally divided into phases. Treatment may consist of various interventions.

Key Component #2 - Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights. To facilitate the participant's treatment, the prosecutor and defense must shed their traditional adversarial courtroom approach and work together as a team. The prosecutor's responsibility is to ensure public safety by ensuring the defendant is eligible and complies with all program requirements. The defense's responsibility is to protect the rights of the defendant while encouraging full participation in the program. The focus of the team is to promote recovery and enhance law-abiding behavior

Key Component #3 - Eligible participants are identified early and promptly placed in the drug court program. Eligibility is defined by written criteria. There is a critical timeframe immediately after arrest to identify, screen and determine those eligible for drug court. Eligible participants are promptly advised of drug court as an option to case processing, as well as the program requirements. "Time is of the essence"; in other words the critical window described as "immediately following arrest" lends itself to the opportunity for early intervention and referral into treatment. Trained professionals screen defendants based upon legal and substance abuse history, and suitability for treatment.

Key Component #4 - Drug courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services. In a drug court model, the treatment experience begins with initial appearance before the drug court judge and continues through treatment completion. Drug court consists of a variety of strategies supportive of a comprehensive therapeutic experience. Beyond the counseling intervention, each participant should be assured of referral and access to additional identified needs provided by wrap-around resources. These services may include a referral for co-occurring mental illness, medical concerns, communicable disease, educational or employment resources, and resources to address childhood trauma or domestic violence. Certainly, this is not exhaustive. When identified by the treatment professional, additional services can be included into treatment planning. Funding for treatment services must be assured and dedicated to the drug court. Treatment must have quality controls and adhere to federal confidentiality laws, or other local or state statutes.

Key Component #5 - Abstinence is monitored by frequent alcohol and other drug testing. Frequent alcohol and other drug (AOD) testing is a critical component of the drug court. Written AOD testing procedures are based on prescribed guidelines. Testing is administered at scheduled or random intervals. Testing intervals generally change as the participant progresses through defined treatment phase requirements. The drug court team is immediately notified of positive or fraudulent tests and enlists a coordinated strategy in response to non-compliance issues.

Key Component #6 - A coordinated strategy governs drug court responses to participants' compliance. A foundational principle of AOD treatment is that addiction is chronic, manifested in relapse behavior, and can be fatal. However, responding appropriately to a relapse can aid in the participant's recovery by learning about the circumstances that influenced the relapse. Generally, the participant's progress is measured by compliance with treatment and court requirements. Participants are given

incentives and sanctions for compliance or non-compliance. A coordinated strategy can provide a concrete plan for the participant and all team members. Responses for compliance or non-compliance may vary in intensity. Written responses to compliance that emphasizes consistency and predictability should be given to all drug court participants at the time of orientation.

Key Component #7 - Ongoing judicial interaction with each drug court participant is essential. The judge is an active leader and participant on the drug court team. The judge maintains an interactive and supervisory relationship with the team and participants. Drug court judges often move beyond their traditional role in the judicial system, supporting and encouraging appropriate behavior by the participant or discouraging and penalizing inappropriate behavior. Status hearings are used to monitor participant progress and compliance.

Key Component #8 - Monitoring and evaluation measure the achievement of program goals and gauge effectiveness. Monitoring and evaluation are fundamental to an effective drug court system. Long-term and short-term program goals and objectives should be measurable, achievable and described in behavioral terms. Clearly defined goals shape the management information, outcomes and program evaluation systems of the drug court. Data formatted into reports are useful the drug court team, policy makers and funding sources. Periodic program reports provide needed day-to-day information for the drug court team in order to make improvements in drug court operations and support program effectiveness indicators. Information management systems must adhere to written guidelines in order to protect against unauthorized access of confidential data.

Key Component #9 - Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations. All drug court team members should be involved in team building and interdisciplinary education. Attendance at training and education events by all members of the drug court team is essential. Interdisciplinary education exposes criminal justice and judicial professionals to treatment concerns, and vice versa. Treatment curriculum is developed describing the drug court programs goals, expectations, policies and procedures, and includes additional topics such as nature of AOD abuse, addiction, relapse prevention strategies, sanctions and incentives, drug testing policy and practices, cultural competence, co-occurring conditions, federal and state confidentiality laws , and other statutory requirements.

Key Component #10 - Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court program effectiveness. The drug court can take advantage of increased opportunities through developing and sustaining sound community partnerships. The drug court is pivotal in fostering a

partnership and commitment to shared responsibility and participation of program partners. This may include, but not be limited to, community support from law enforcement agencies, community support groups, social service or health agencies, the faith community, treatment and rehabilitation providers. An organized steering committee aids in the acquisition and distribution of resources.

Section 3:

Screening and assessment for substance abuse among adult offenders in the criminal justice system

From an experiential perspective, let me say that this module is generic, yet blends screening and assessment with data collection related to criminal history. However, as practitioners, as many of us are, you will appreciate that screening and assessment is a dynamic process, one that blends many methods of data collection with personal interaction in order to arrive at the most appropriate recommendation. It is difficult to capture all possible options within the scope of this module. You will just have to hone your skill and have good clinical supervision in order to make continuous improvement on your own clinical evaluation practices. With that editorial said, let's proceed.

All drug court participants should be involved in a screening and assessment process. This will enable decisions to be made in tandem. First, the drug court coordinator can determine if the participant is eligible and appropriate for the drug court. Second, the treatment provider can make the most appropriate treatment recommendation for the individual. Let us start with definitions.

Definitions

Screening: gathering and sorting of pertinent information to determine if a participant has a substance abuse problem, is eligible for drug court and if so, whether a clinical assessment is appropriate (Inciardi, 1994).

Assessment: collection of detailed information concerning an individual's alcohol and other drug use/abuse, history, patterns, and related areas of concern (Inciardi, 1994).

Clinical evaluation: is a systematic approach to screening and assessment used to guide the evaluator to a conclusion and recommendation (Inciardi, 1994).

Clinical Screening

For clarity, there are two types of screening performed in drug courts – legal and clinical. Prior to considering screening process, legal eligibility criteria should be pre-determined during the planning stages. Legal eligibility should be written, should include exclusionary criteria, and included in an operations or policy manual. In this section, we will be focusing on clinical screening.

You will remember from last section that screening and assessment is incorporated into Key Component 3 of the Ten Key Components (U.S. Department of Justice, Drug Courts Program Office, January 1997). Screening is accomplished by either the drug court coordinator or the treatment provider, depending on the staffing structure and resources.

My experiences have observed the *legal screening* is accomplished by the prosecutor, law enforcement, or a designated representative. Again, drawing this back to Section 2, you will remember the prosecutor and defense counsel have specific responsibilities in determining if a potential participant is (1) screened and (2) eligible, based on legal history and current charges, and is fully advised of the parameters of drug court. Refer to Key Component #2 (U.S. Department of Justice, Drug Courts Program Office, January 1997).

Clinical screening, rather than legal, will be the focus of this discussion. Clinical screening is the process by which preliminary data is gathered and prioritized to determine the most appropriate course of action, given the individual's needs, characteristics and resources (U.S. Department of Health and Human Services, 2002). The primary purpose of screening is to examine preliminary data that could support a treatment intervention and level of care recommendations. It is used to determine the most immediate disposition for the potential participant. Screening is conducted at the earliest point possible in legal case processing. Ultimately, the screening process helps the screener to determine which potential participant is a substance abusing offender, *and* potentially eligible for the drug court program.

Screening, from a contrasting perspective, is used to determine those who *would not* meet basic eligibility criteria for the drug court treatment program – or those legal exclusionary criteria noted on page 21. In some cases, and depending on the requirement imposed by the funding, federal eligibility requirements must be upheld. Individuals with a history of violence, felonies, drug dealing, manufacturing or distribution, and crimes committed while in possession of a weapon are some of the exclusionary criteria of many drug court treatment programs receiving federal funding. Further individuals with needs exceeding the scope of treatment services may be excluded from the drug court treatment program, solely due to limited resources. This may include individuals with concurrent concerns such as developmental disability, chronic mental illness, or psychiatric problems.

Clinical Screening Domains

There are nine domains established by the Center for Substance Abuse Treatment (CSAT) which contribute to the screening process. They can be found in the publication Addiction Counseling Competencies: The Knowledge, Skills and Attitudes of Professional Practice (U.S. Department of Health and Human

Services, 2002). This publication was prepared under a cooperative agreement between the Addiction Technology Transfer Center and CSAT of the Substance Abuse and Mental Health Services Administration (SAMHSA). The nine domains follow, in summary:

- Establish rapport.
- Gather data systematically using screening instruments that are sensitive to the needs or characteristics of the client.
- Screen for toxicity, intoxication, and withdrawal symptoms; for co-occurring disorders; conduct risk assessment.
- Identify the impact of substance use on the client's life and current circumstances.
- Determine readiness for treatment.
- Review treatment options appropriate for client's needs.
- Apply accepted criteria for diagnosis of substance use disorders in making a treatment recommendation.
- Construct an initial action plan based on client's needs, preferences, and resources.
- Based on initial plan, implement steps to initiate referral and ensure client's follow-up.

In addition to the above, the drug court program screening consists of determining the presence of several concerns, and thus, screen for appropriateness of enrollment into drug court. These concerns include:

- The presence of an alcohol or other drug use problem;
- Past treatment history;
- The relationship of substance use to the current charge;
- Individuals with a history of violent offenses, or severe, persistent, or chronic mental health or psychiatric problems;
- Individuals with developmental disabilities;
- Individuals who would not otherwise be eligible to release to treatment as an alternative to legal case processing (Inciardi, 1994).

The above information is relevant for adults and adolescents. Juvenile or youth drug court screening instruments may also address:

- Current offense
- Prior juvenile detention / training school admissions
- Disciplinary incidents in juvenile detention
- Use of isolation / seclusion management
- Prior probation or parole violations.

Clinical Assessment

The clinical assessment is different from clinical screening. It is an ongoing process of gathering information that is to make the most appropriate treatment recommendation for the drug court participant. Assessment results will assist the drug court clinician in recommending the treatment level of care, dose, intensity, and frequency.

The assessment process is a dynamic one. It identifies client's strengths, limitations, and readiness for change. The assessment process is also one in which the clinician collaborates with the client and others to gather and interpret information necessary for treatment planning and determining client progress (U.S. Department of Health and Human Services, 2002).

The clinical assessment process may take between one to three sessions to complete. Completion of the assessment will depend on the drug courts requirements for assessment practices, verification of collateral data, and report writing. In most cases, the assessment includes a personal interview with the participant, an alcohol or other drug screen, and completion of paperwork. Often, as documented in an operations manual, there is a specified timeframe for the completion of the assessment process, to include for report writing. Assessment purpose and goals include:

- To determine the extent and severity of an alcohol or other drug abuse problem;
- To determine the client's readiness for treatment;
- To identify co-occurring mental health or physical problems;
- To determine if the client is an appropriate candidate for the level of care provided by the drug treatment court;

- To evaluate the resources accessible to the participant to facilitate a positive intervention – i.e., family support, social or community support, educational and vocational status;
- To engage the client in the preliminary treatment process (Inciardi, 1994).

Clinical Assessment Domains

Similar to the earlier discussion on screening, CSAT has established four domains that contribute to the assessment process. They, too, can be found in the publication Addiction Counseling Competencies: The Knowledge, Skills and Attitudes of Professional Practice (U.S. Department of Health and Human Services, 2002). These domains, in summary, include:

- Selection and use of a comprehensive assessment process.
- Analysis and interpretation of data to determine treatment recommendations.
- Documenting assessment findings and treatment recommendations.
- The addiction professional is involved in appropriate supervision and consultation.

Screening and Assessment: Knowledge, Skills, Attitudes and Ethical Considerations

First, before we actually get to instruments, we will cover some general and ethical concerns of screening, assessment and the use of such instruments. The professional clinician's success in implementing ethical screening and assessment practices depends on one’s ability to develop competency based knowledge and skills (U.S. Department of Health and Human Services, 2002). Each professional practice, screening and assessment, has an established set of knowledge, skills and attitudes.

Professionals must have *knowledge* of the test, instrument or questionnaire. One must understand the application of the instrument to include the purpose, demographics, validity, reliability, and limitations. Testing instruments must used for the population for which the instrument was constructed and normed. Professionals must know how to gather information as recommended by the test

developer, and how to interpret the results. Professionals must know how age, developmental level, culture, and gender affect interpersonal communication, data collection, and patterns of substance use. Finally, professionals must know how to apply standards of confidentiality (Cohen & Swerdlik, 2002).

Screening and assessment practices also require *skill* and proficiency in the administration and scoring of the instrument. Information gathering, interpretation, and report writing is another skill. The professional must have the skill in screening for physical, mental health, or other concerns related to substance use.

Attitudes include having an appreciation for the value of the information gathering process, and the significance of the impact of the test results as communicated in the report. In addition, the professional must have a respect for the limits of the screening or assessment instruments, and one's ability to interpret results. This will include proper selection of an instrument for the drug courts target population.

Ethical concerns are crucial for the clinical practice and service delivery. The clinician's awareness of problems related to screening and assessment is critical (Stevens & Smith, 2001). It has often been said that there is no problem with the instrument, only the test administrator. Clinicians must be aware of personal bias about substance abuse clients. A belief that the substance-abusing offender is irresponsible, untrustworthy, or untreatable, and this may influence the clinician's ability to ethically conduct screening and assessment.

The process of evaluating a client is not an exact science. There is no single instrument that will determine with absolute certainty that the client has a problem with use, abuse, or addiction, or is predisposed to successfully engaging in the treatment intervention. Lack of specific standards that define use or abuse may complicate matters for a clinician, and thus lead to shortcuts based on stereotypes or presumptions about the client. The purpose of the instrument will be defeated, despite psychometric soundness, if the assessor does not practice ethical management of testing practices (Cohen & Swerdlik, 2002).

Using a standard screening and assessment instrument will be essential for the assessor to enhance diagnostic impressions and treatment recommendations, and minimize individual biases or attitudes (Stevens & Smith, 2001). However, the recommendation is the result of the ***entire*** evaluation process including the clinical interview, test results, collateral data, clinical impressions, and diagnostic criteria. Said another way, an assessment instrument should not be the sole determinant of diagnostic impressions and treatment recommendations (Cohen & Swerdlik, 2002).

Screening and Assessment Instruments

The CAGE Questionnaire

The National Institute on Alcohol Abuse and Alcoholism (2003) provides some very useful information about The CAGE Questionnaire. (You will find the website link in the reference section.) The CAGE is questionnaire that is "friendly" for the user and can be used with a non-confrontational approach to determine the presence of substance abuse or related concerns. Most addiction and drug court professionals are familiar with this questionnaire. It consists of four questions that can screen for alcohol use. With minor modifications of substituting the word "drugging" for "drinking", the CAGE can also be used to screen for drug use. The four questions are:

- Have you ever felt the need to **C**ut down on your drinking / drugging?
- Do you feel **A**nnoyed by people complaining about your drinking / drugging?
- Do you ever feel **G**uilty about your drinking / drugging?
- Do you ever drink an **E**ye-opener in the morning to relieve the shakes?

or

- Do you ever use drugs first thing in the morning to take the **E**dge off?

or

- Do you ever use drugs to change the **E**ffects of another drug you have taken?

Research reveals that a "yes" answer to two of the above four CAGE questions will correctly identify 75 percent of alcoholics/addicts who respond, and accurately eliminate 96 percent of non-alcoholics/addicts (Inciardi, 1994).

There is a CAGE for Youth and Adolescents (Stevens & Smith, 2001). The questions follow:

- Have you ever used before or during school?
- Have you ever missed school (or been truant) because of use or just to use?
- Have you ever lied in order to use?

- Have you ever avoided nonusers?
- About how often do you get intoxicated?
- About how often do you use more than one drug when you get intoxicated?

The Michigan Alcoholism Screening Test (MAST)

The MAST is probably the most researched self-administered instrument used for assessing alcohol use or abuse (Stevens & Smith, 2001). It is a 25-item questionnaire useful with male and female, as well as adult and adolescent populations. When originally designed, it was validated on alcoholics seeking treatment. Realistically it can be used with all populations. Research reveals it correctly identifies alcohol use or abuse in up to 95 percent of alcoholics.

The Short Michigan Alcoholism Screening Test (SMAST)

The SMAST is a 13 item questionnaire that can be administered in writing or verbally. The 13 questions are taken from the 25 questions of the MAST. Again, it is useful with male and female, adult and adolescent populations (Stevens & Smith, 2001).

The Drug Abuse Screening Test (DAST)

Another self report instrument is the DAST, a 20-item questionnaire designed to identify characteristics associated with drug use, excluding alcohol. You may correctly conclude from the name that it is derived from the MAST, and contains similar language (Stevens & Smith, 2001). In clinical trials scoring results differentiated among alcohol, drug and polysubstance abuse groups. You will find a rich amount of information located on the Internet at http://eib.emcdda.eu.int/index.cfm?fuseaction=public.Content&nNodeID=3637&sLanguageISO=EN. On this site, there is also a PFD and HTML file of the DAST that you can download without scoring interpretation information. However, it does not give you the scoring information.

The Substance Abuse Subtle Screening Inventory (SASSI)

The SASSI is a personal favorite of mine. It is simple, and easy to score and interpret. The training for the SASSI is widely accessible. It is also an instrument that was normed using a criminal justice population – so it is very relevant for drug court participants. The SASSI is used for both male and female clients, adults and adolescents, and the test administrator has separate test and scoring materials for each population – adult or adolescent. The company has recently

announced the newest version – the Spanish SASSI. You will find information about the SASSI on the company website located at http://www.sassi.com/sassi/index.shtml.

The Addiction Severity Index (ASI) &

The Addiction Severity Index -Adolescent (ASI-A)

The ASI collects a wide range of information related to addiction and addictive behaviors. This instrument is originally designed for adults, and more recently for adolescents. The strength of the ASI is collection of data across seven domains – medical, employment, substance use, alcohol use, drug use, family relationships, psychiatric. Administration and scoring will be enhanced with training and stringent practices to maintain one's competence.

The ASI is commonly used, especially since it is mandated by many state substance abuse regulatory authorities. My experience is there are limitations with this instrument. I would recommend you closely review the adolescent version for appropriateness for your population As a trainer of the ASI, and a clinician, there are probably better instruments to use which are designed for youth. In addition, this instrument was not normed on a criminal justice population. The questions in the substance abuse domain ask the client about use of substances over the past 30 days and lifetime. If someone has been in a closed setting, or incarcerated, the information may not give as accurate a picture. Finally, severity and composite scoring can be very subjective without close supervision and continuous use to remain familiar with scoring standards.

Readiness for Change

Readiness for change has to do with the participant's perception of the need for treatment. It includes one's willingness to engage in treatment, insight into one's charges associated with substance abuse or criminal behavior, and the willingness to change. It also includes one's ability to examine what previous attempts have been made, and how successful those attempts were. Readiness

for change does not measure high for mandated clients. Motivation for treatment is often seen as a better choice over incarceration. Sometimes when a potential drug court participant is fully informed of all requirements of the drug court, he or she may choose incarceration instead. However, many mandated clients may neither want treatment nor like it.

Clients, even resistant ones, are more likely to engage in treatment when several things happen: (1) early intervention; (2) respectful and professional interaction with the assessor; (3) the participants understands what treatment is about, what options are available, the process of treatment, and the full benefits.

Professional Qualifications

Any individual properly trained can accomplish the screening process. Ethical codes of conduct and professional, ethical standards usually reflect principles of test-user qualifications, qualifying professionals by training, education, and experience (Cohen & Swerdlik, 2002). With instruments mentioned in this session, training workshops are plentiful to learn the details of the test application, administration, scoring, and use of the instrument.

Special Issues in Assessment

Professionals working in this drug court system which integrates legal case processing with substance abuse treatment must be aware of the range of issues related to participants (Inciardi, 1994). These issues include gender, race, ethnicity, spirituality, affiliation with organized religion, communication style, literacy, sexual orientation, economic, or other related socio-cultural issues. The presence of special issues should always be considered in making an appropriate placement for treatment.

Linkages and coordination

Coordination between the judicial system and treatment will facilitate a more effective outcome for drug court partners and participants (Inciardi, 1994). The intent of screening and clinical assessment recommendation is to facilitate treatment and care management services (a.k.a. “case management”). Coordination between the judicial system and treatment can include common goals and objectives of the drug court and the treatment program, described in measurable, achievable terms, and within a specified timeframe. Sharing of services information about special needs should be agreed upon, and maintained

consistent with federal laws and regulations, and state statutes pertaining to confidentiality. When coordination between the partners and the team is maintained, the most appropriate interventions can be implemented. Also, shared decision making through a drug court team approach can be supported and reinforced. Encouragement of the team approach to screening, assessment and treatment or legal interventions, will strengthen the drug court team and support appropriate management of each participant's case (Inciardi, 1994).

ADOLESCENT INSTRUMENTS RESOURCES

The following is a list of addition instruments specific to adolescent populations. Where possible, links are listed for websites with more information. This listing does not represent an endorsement of any, but only an informational resource list for your use.

Anger Questionnaire (AQ)	Assess aggression / anger management issues
Behavioral Emotional Rating Scales (BERS)	http://www.nasponline.org/publications/cq287Test.html
Behavior Assessment Skills for Children-2	http://www.agsnet.com/Group.asp?nGroupInfoID=a3800
Diagnostic Intervention Schedule for Children (DISC)	http://www.fasttrackproject.org/techrept/c/cdc/
Child and Adolescent Functional Assessment Scale (CAFAS)	To assess role performance, thinking, behavior to ward self and others, mood and substance abuse
Juvenile Substance Abuse Profile	http://www.riskandneeds.com/rna_JSAP.htm
Massachusetts Youth Screening Instrument (MAYSI-2) and the Brief Symptom Inventory	http://www.ilppp.virginia.edu/Juvenile_Forensic_Fact_Sheets/ScreenInst.html
Massachusetts Youth Screening Instrument (MAYSI-2)	http://www.maysiware.com/MAYSI2.htm
Screening and Assessing Adolescents for Substance Use Disorders (TIP 31), instrument summaries	http://ncadi.samhsa.gov/govpubs/bkd306/31k.aspx?
Personal Experience Inventory (PEI)	http://pubs.niaaa.nih.gov/publications/Assesing%20Alcohol/InstrumentPDFs/48_PEI.pdf http://eib.emcdda.europa.eu/index.cfm?fuseaction=public.Content&nNodeID=4370&sLanguageISO=EN

Problem Oriented Screening Inventory for Teenagers (POSIT)	http://eib.emcdda.europa.eu/index.cfm?fuseaction=public.Content&nNodeID=4439&sLanguageISO=EN
Youth at Risk for Mental Illness and Suicide: Screening Instruments and Assessment in SBHCs	http://www.nasbhc.org/TAT/Youth_at_risk_for_MH.htm

Juvenile drug courts may also conduct two additional types of assessments – risk and needs. A risk assessment will determine the need for pre-trial detention or the likelihood for institutional custody. Positive screening may reveal exclusionary criteria for potential juvenile participants. One specific instrument is the Youth Level of Services, an instrument that measures the likelihood of recidivism. Another is the Youth Assessment Screening Instrument which is a criminal behavior / delinquency risk tool.

OTHER MATERIALS RESOURCES

Look around the SAMHSA website at (http://www.samhsa.gov/index.aspx). In fact, I suggest you contact CSAT and order a complete set of each Treatment Improvement Protocol (TIP) and Technical Assistance Publication (TAP) series. They are free and there for the asking. The website for the National Clearinghouse for Alcohol and Drug Information is http://store.health.org/catalog/SC_Itemlist.aspx.

Here is the link for Screening and Assessing Adolescents for Substance Use Disorders, TIP 31, http://ncadi.samhsa.gov/govpubs/bkd306/31k.aspx?

Here is the link for the TIP series
http://www.treatment.org/Externals/tips.html

Here is the link for the TAP series
http://www.treatment.org/Taps/index.html

I would suggest you order Screening and Assessment for Alcohol and Other Drug Abuse among Adults in the Criminal Justice System, TIP Series 7 from SAMHSA which has the instruments above in the appendix.

In addition, here is a direct link to the appendix for the instruments http://www.health.org/govpubs/bkd138/7k.aspx.

Here is a link for Simple Screening Instruments for Outreach for Alcohol and Other Drug Abuse and Infectious Diseases, Treatment Improvement Protocol (TIP) Series 11
http://ncadi.samhsa.gov/govpubs/bkd138/7k.aspx?

Screening and assessing adolescents for substance use disorders
http://www.guideline.gov/summary/summary.aspx?ss=15&doc_id=1816&nbr=1042

Section 4:
Legal and ethical issues for drug court professionals

Introduction

The issues covered in this section - ethical principles, protection of data, confidentiality, dual relationships, and competence - represent some of the more common reasons for ethical complaints. To further complication the matter, these areas rapidly evolve in terms of how the courts view them in malpractice situations, licensing boards interpret of rules, and state statutes. While it is important to understand Federal Confidentiality laws, I urge you to investigate your State statutes and professional (state and/or national) licensing or credentialing board about these issues related to substance abuse and mental health services. If a helping professional ever encounters difficulties that could potentially turn into an ethical dilemma or violation, those state and/or national licensing or credentialing agencies or boards are ones which define the standards and consequences to which the professional is held accountable

Ethical Principles and Code of Conduct

It is necessary to have an ethical code in order to protect the interest of the participant (Bissell & Royce, 1994; Koocher & Keith-Spiegel, 1998). The participant should be the central focus of the delivered services, whether in clinical practice or another specialization. An ethics code establishes minimum standards of practice and it can be a resource for professionals. Well constructed, a code of ethics can be a source of confidence for the client and the professional (Bissell & Royce, 1994).

Helping professionals must take every reasonable step to assure and respect the privacy of clients, while the relationship is current and after it has concluded. This includes:

- preserving confidentiality of all participant contact
- maintaining, storing and exchanging records and other information directly or indirectly relevant to the client which preserves privacy both during and post-treatment
- understanding the nature and limitations of confidentiality, privacy of data, and informed consent understanding and interpreting Federal, State and other statutes

- understanding the ethical and legal qualifications of confidentiality practices - when information must be disclosed, or is permitted to be disclosed, and when and to whom it is to be disclosed (Steinman, Richardson, & McEnroe, 1998).

Ethical conduct helps the participant establish trust in the professional and clinical relationship. An ethics code provides guidelines for the professional's behavior and conduct, and guidelines for decision making to resolve ethical dilemmas. Generally, there are some consistent principles which clinicians subscribe to - do no harm, autonomy, helping others, fair and just actions, faithfulness, dignity, treatment of others, pursuit of excellence and accountability (Koocher & Keith-Spiegel, 1998).

A code of ethics or conduct, however, does not make professionals conduct themselves consistent with these principles. Nor does an ethics code make professionals resolve dilemmas ethically. It is the professional's responsibility to implement sound decision making skills for resolving situations when they arise and to avoid dilemmas or violations (Koocher & Keith-Spiegel, 1998).

Professional and Ethical Responsibilities

Drug court practitioners, and specifically addiction counselors, have an obligation to adhere to accepted ethical and behavioral standards of conduct. This includes professional development (U.S. Department of Health and Human Services, 2002a). Addiction counselors must adhere to an established code of ethics that defines professional conduct. Knowledge base includes various issues. It is imperative to for the addiction counselor to understand Federal, State, agency and professional ethics codes. The addiction professional should know about and be able to articulate client rights and responsibilities, professional scope of practice, and mandatory reporting practices. Last, the addiction counselor must know about ethical violations, the consequences of violating an ethics code, and the avenue for addressing alleged ethical violations (U.S. Department of Health and Human Services, 2002a).

Data / Information Protection

Many professionals confuse confidentiality, consent, privilege, and data privacy. In most cases, it is in the honesty with which you tell your participants what they can expect from you, and the degree to which you safeguard privacy and confidentiality, that helps separate you in your role as a professional. Duty-to-warn situations, stemming from the famous Tarasoff decisions, are especially challenging cases in point of confidentiality decision making. Individual states vary in how each one responds to duty to warn.

The premise of protecting information as confidential centers around the fact that a person seeking treatment services will be more likely to admit themselves when their identify and information is protected. Theoretically, substance abusers are more likely to enroll into treatment when there is an assurance that information about their drug use will not be readily available to the public (Tauber, Weinstein & Taube, 1999). Further, the protection of confidential information is pivotal to enhancing the trusting relationship between a participant and the clinician (Koocher & Keith-Spiegel, 1998).

There are several sources of ethical codes of professional conduct. Multiple layers of ethical codes and standards to which the professional must adhere may exist may include licensing board, state regulatory laws, and Federal laws. First, confidentiality is defined and protected under Federal regulations (Department of Health and Human Services, 2002). Like Federal confidentiality laws, one's professional ethical duties prohibit disclosure of information. A clinician licensed by the State licensing or regulatory board is obligated to protect private and confidential information obtained in the course of delivering professional services. Specific ethical standards pertaining to protection of confidentiality of clients are contained in the state licensing board's professional code of conduct, as well as professional membership associations, such as the American Psychology Association. In addition, state licensing laws and regulatory rules that may govern licensed professionals may include an ethical code of professional conduct.

You must make sure you completely understand the Federal and state laws, regulations, and professional ethical standards to which you are held accountable. While there may be a consensus about this topical information, States may vary on details particularly pertaining to local statutes and laws governing helping professionals. In addition, State laws may change, being influenced from year to year, either by malpractice litigation or legislative influence.

State laws

State confidentiality laws are individually determined by various professional or legislative influences within that state. These laws may be more restrictive than the Federal confidentiality laws, but they may not override the Federal regulations. In other words, the Federal regulations are stricter than the State law, State law must yield. Even where State law conflicts with Federal laws, there is often some way to find compliance with the Federal law through exceptions. In most circumstances, a drug treatment court can comply with State law by following the Federal guidelines (Tauber, Weinstein & Taube, 1999).

Federal regulations

Federal drug and alcohol regulations set forth statutory mandates which define the scope, purpose and application of the privacy of person's identity and records. The confidentiality law restricts the disclosure and use of information about persons involved in or seeking substance abuse treatment services. Title 42, part 2 of the Code of Federal Regulations (CFR) was implemented in 1975 by the Department of Health, Education and Welfare, and updated in 1987 by the successor of HEW, the Department of Health and Human Services. In this session the term "confidentiality law" refers to Title 42, Part 2, CFR U.S. (Department of Health and Human Services, 2002; Inciardi, 1994).

The Federal confidentiality law applies primarily to programs which have received federal funding or federal assistance. Indirectly, this applies to programs which receive some form of federal assistance, such as tax-exempt status, or state or local government funding which is in whole or in part augmented by federal dollars. Services are described as any program which specializes, in part or on whole, in providing treatment regardless of the modality, counseling, to include assessment, diagnosis, and referral services for persons with alcohol or other drug problems. The type of services provided is not limited by the label of the service, or the service delivery modality. The mere fact that someone has inquired about services, though not admitted or enrolled in treatment, is protected under Federal, and most State, confidentiality laws.

Confidentiality and drug court professionals

There are some general stipulations concerning legal and ethical matters and drug court practitioners. Drug court professionals are expected to comply with State and Federal confidentiality laws. They should take time to understand both the impact of such laws on their programs, and the impact on drug court operations. Many conflicts related to data protection and individual privacy can be resolved through use of consent forms

Protection of a drug court participant, and his or her information, is protected under Federal laws. This applies to the identity, diagnosis, prognosis, or treatment of any participant in the substance abuse treatment program. However, this does not apply to discussion about a particular participant as long as the identity, name, or other identifying information is not revealed (Tauber, Weinstein & Taube, 1999).

Re-disclosure of information already disclosed is also protected under Federal confidentiality laws. Thus, if a participant "Bob" authorizes by written consent for the probation officer to disclose information to the drug court practitioner, the practitioner cannot re-disclose the information without first obtaining "Bob's" written consent.

Information disclosure or re-disclosure within a program

Information about a participant, the participant's progress, diagnosis, prognosis or other information may be disclosed within a program or to any entity having direct administrative control over that program. This would include anyone on the drug court team, but would not include treatment programs outside the primary treatment provider, any partners or any agencies that have a collaborative relationship with the drug court unless an Interagency Memorandum of Understanding is signed.

Multiple treatment providers may work in collaboration with the drug courts, especially when the offer different levels of care. For example, “ABC Recovery” may offer outpatient services, which “XYZ Residential” may provide residential treatment. Both agencies work in partnership with the drug court, but do not have direct administrative control over the drug court. To properly disclose information with a multiple program system, the drug court coordinator should maintain a written Interagency Memorandum of Agreement.

Exceptions to Federal Confidentiality Regulations

Exceptions to the strict confidentiality laws permit disclosure of patient identifying information in some cases:

1. when the participant has permitted disclosure per written consent which properly identifies specific information
2. internal drug court program communications
3. reporting non-patient identifying information
4. crimes on drug court program premises or against program personnel
5. medical emergencies
6. mandated reports of child abuse or neglect
7. research
8. drug court program audits or evaluations
9. court orders
10. qualified service organization agreement

Qualified Service Organization Agreement

When multiple treatment agencies collaborate with the drug court, it is recommended the drug court design a qualified service agreement to ensure the protection of a participant's confidential information (U.S. Department of Health and Human Services, 2002b). A qualified service organization is an external professional or an agency that provides services to the drug court that the drug court does not provide. The professional or agency external to the drug court treatment provider must be able to communicate without restrictions with the drug court. A qualified service organization is one that enters into an agreement with the drug court and acknowledges that it is bound by Federal and State confidentiality laws, and agrees to not re-disclose information without proper consent. Once a qualified service agreement is signed, unrestricted communication can occur between the drug court and the provider, but only to the extent of services provided by the agency as defined on the agreement. Typically, this agreement extends only between the drug court and the external provider, and not between providers. Thus, the qualified service agreement permits communication without the drug court practitioner having to secure a written consent to disclose information each time he or she needs to interact with the external provider.

Complying with Communicable Disease Reporting Requirements

All States require health care professionals to report cases of communicable disease to the local public health authority (U.S. Department of Health and Human Services, 2002b). These reporting requirements assist the state authority in tracking, monitoring, and treating anyone with a communicable disease, and other persons involved with the identified client.

While these mandated reporting requirements may appear in conflict with Federal confidentiality laws, exceptions to the regulations may be implemented to permit programs to comply, and assist participants in access to testing and treatment. First, the most appropriate and best way for drug court programs to comply is secure informed consent to both mandated and follow-up services at the time of enrollment, and with informed consent practices. Second, a drug court program may be able to comply with mandated reporting by making an anonymous report. Patient identifying information may be given to the public health authority as long the drug court does not disclose that participant is in treatment or receiving treatment services. Common sense says this would be difficult since "Mr. smith calling from the ABC County drug treatment court"

immediately identifies the program as a treatment service delivery system. Therefore, a third way to comply with mandated reporting is via a qualified service organization agreement since the public health authority provides services external to the drug court that the drug court does not provide within the treatment setting.

Drug court practitioners must be informed about all mandated reporting requirements in order to comply with State statutes while protecting patient identifying information. The best way to understand such requirements is to visit the particular public health authority. Use the visit to learn the particulars of what information is mandated, and what information is voluntary to disclose. You must also know and understand the circumstances to be reported as well as the reporting protocol.

Dual relationships

Maintaining a clearly defined role and professional boundary with drug court participants is expected by most professional ethics standards and code of conduct (American Psychological Association, 2004; Koocher & Keith-Spiegel, 1998). Clearly stated, blended boundaries places the relationship between the drug court practitioner and the participant at risk (Pope, 1991 as cited in Koocher & Keith-Spiegel, 1998). The American Psychological Association (APA) (2004) ethical standards defines a multiple relationship as one in which the clinician attains different roles with the same person (the drug court participant), or with another who is closely associated with that the participant, or makes promises to engage in a relationship in the future with either the participant or one closely associated or related to the participant. The APA (2004) issues a directive to the clinician to refrain from engaging in multiple relationships that could reasonably be expected to cause harm, impair the judgment of the professional, or create the potential or risk or exploitation.

Role conflicts can also cause ethical difficulties for the drug court practitioner. A number of issues can arise out of the practitioner's efforts to address one's personal emotional needs, further clouding the therapeutic relationship with the participant. Relationship dependencies, recovery, emotional/dependency needs may affect the practitioner’s judgment, and thus the clinical relationship. Sometimes things that occur on a daily basis may negatively affect the practitioner. For example, running into a participant at the grocery store or at a 12-step meeting can create a stressful reaction. Yet, these circumstances may be unavoidable in small geographic or rural settings. The key is to maintain the original professional relationship during these circumstances, acknowledge the participant's presence, and continue with one's daily business. It is advisable for

the practitioner to discuss such possibilities with the participant at the outset of treatment so he or she will understand how the drug court practitioner will respond. This should be considered to alleviate the participant's potential public discomfort, to maintain confidentiality, and to minimize misrepresentation of the practitioner's (Koocher & Keith-Spiegel, 1998).

Psychological Testing and Ethics

Drug court practitioners who are test administrators have an ethical obligation to ensure an understanding of test instrument reliability, validity, and the appropriate application of a testing instrument when conduction assessments (American Psychological Association, 2004). Test reliability refers to the repeatability of test results, revealing a consistent outcome over time, in different situations. Reliability also ensures the proper use of the test instrument (Koocher & Keith-Spiegel, 1998; Cohen & Swerdlik, 2002). Tests that demonstrate high test-retest reliability are said to be stable. These tests reveal the same results on a consistent basis regardless of extraneous factors and are absent of test taking enhancements, such as extra studying or tutoring in-between tests. Tests that are unreliable are useless since there can be no determination if the results are yielded from the instrument or from the skill being measured.

Test validity refers to the test measuring what it is intended to measure. A test is valid for a particular purpose and its recommended application (Koocher & Keith-Spiegel, 1998; Cohen & Swerdlik, 2002). For example, a test that is designed to measure criminal thought measures criminal thought. Valid tests are also reliable tests.

Computer assisted psychological assessments.

Computer assisted psychological assessments (CAPA) is something of the present, rather than the future. CAPA means the drug court practitioner is assisted by the computer in test administration, interpretation, and report writing. The use of CAPA has both advantages and disadvantages. It is presumed that using CAPA permits a more effective counseling outcome. In addition, the use of CAPA decreased time between test administration, scoring and interpretation, elimination of scoring errors, reduced test bias, and accommodations for special needs of test takers. The practitioner can dedicate greater time on interpersonal skills, tasks, and cognitive therapies, while the a participant is involved in instructional services using a computer. However, the benefits of CAPA need to be evaluated against the potential limitations of technology such as rapport and observation of behavior. Other disadvantages include the expense of equipment,

training to use technology hardware and software, difficulty with observing test taker's non-verbal cues, the lack of options to skip ahead, test taker feeling intimidated, and the security of test data, scores and interpretive comments (Cohen & Swerdlik, 2002).

Drug court practitioners need to maintain practices to avoid ethical dilemmas of test administration. Practitioners need to remember that testing reveals the findings of the data, and nothing more. Practitioners should be able to explain the limitations of the test results and their professional opinion. If the test findings are incongruent, then the practitioner has an obligation to include remarks in the discussion section of the report. In addition, drug court practitioners need to be aware of test development standards and for whom the test was used to understand if the test represents a good choice for the purpose intended. For example, the last week we discussed the Addiction Severity Index (ASI) which is a test instrument commonly used for assessing substance use. However, the ASI was not normed using a criminal justice population. Therefore, if a drug court practitioner is using the ASI, the results may be skewed in substance abuse assessments of offenders. Ethically it is better not to use a test instrument rather than trying to fit the client into use of the instrument for which it was not designed.

Clinical Practice versus Forensics

There are specific differences between forensic and clinical treatment roles. The primary difference is methodology, the intent of the service, and to whom the service is owed. Increasingly, psychologists, addiction counselors, and other mental health practitioners are asked to testify on behalf of their client. In this capacity, you can testify on information relative to the history of the client as provided by the self-report, the client's response to treatment, prognosis, mood, affect, behavior, and other statement made by the client while in treatment. You remain in the role of the treating clinician and serve as a 'fact witness", offering your observations and clinical impressions of the client, without offering opinions about any legal questions. The responsibility of clinical practitioner is to his or her client. That being said, clinicians must also know the legal system, as well as its process and procedures. Clinicians are not lawyers and should be careful not to overstep their boundaries, being careful not to put themselves at risk (Koocher & Keith-Spiegel, 1998). The best advise here is leave the legal work to the lawyer.

Forensic professionals or evaluators are those professionals who are retained by an attorney or appointed by a court to investigate a specific situation. Forensic psychologists are required to maintain objectivity in their work, their report and their testimony, rather than act as an advocate are clinical practitioners. Forensic professionals are ultimately responsible to the court and not to the client or the attorney who retains them (Koocher & Keith-Spiegel, 1998).

Ethically, it is necessary to avoid dual roles and minimize any conflict of interest as a drug court practitioner. This means it is crucial for a drug court practitioner to understand the differences in role, responsibility, and interaction of a clinician compared to a forensics expert. A practitioner who has provided clinical services cannot ethically provide forensic evaluation or services of a client. In contrast, a forensic evaluator cannot provide clinical services to the subject of the investigation (Koocher & Keith-Spiegel, 1998).

There are two core differences between forensics and clinical practitioners. They are methodology, and the nature of the service and to whom it is owed. Clinical practitioners provide clinical interventions to assist clients with resolving interpersonal, clinical, and other concerns. The methodology is usually the self-report of the client that services as the primary data for treatment. The forensic practitioner differs because of his or her use of multiple sources for information. These may include psychological testing, interviews extensive with various sources, collateral interviews, review of police, medical, employment or other public records, and the review of legal materials or depositions, or other investigative reports. In a phrase, the forensic professional trusts no single source, but looks for a theme across sources. The responsibility of the forensic professional is to the court (Koocher & Keith-Spiegel, 1998).

Competence and Credentials

Credentials exist as a tangible indicator of accomplishment of minimum standards, and as a means to determine competence within the specialization. There are several major issues in ethical standards concerning professional competence.

1. Helping professionals have an ethical responsibility to continuously improve their knowledge, skills, and abilities within their own specialization

2. Helping professionals must work within their specialization, commonly defined by education, training, and experience, and not claim either directly or indirectly to have credentials, expertise or training they do not actually have.

3. While one must strive to work within ethical standards, ethical codes or principles often require helping professionals insist others who work in their field are equally qualified and credentialed (Steinman, Richardson, & McEnroe, 1998).

Generally, there are three levels of credentialing which distinguish competency among helping professionals (Koocher & Keith-Spiegel, 1998). Primary credential includes formal academic training, direct supervision, and direct observation of the professional's behavior during formal training. Secondary credential includes professional licensing and certification processes. Tertiary simply states a person holds both primary and secondary credentials. Attainment and sustained credentials establishes a professional's competence; however, the primary credential is the only one researched to have predictive validity for competence.

Closing

I want to personally say thank–you for sharing in this opportunity.

It is my hope that you have been able to gain something from this experience which will better assist you in understanding and implementing drug court practices and making program improvements to your program and services.

I have certainly been impressed with this integrated approach to helping the substance abusing offender through a drug court treatment model. Many other traditional options – out-patient and in-patient treatment programs, community mental health services – are slowly dying on the budgetary and legislative vine. The offender population is often one who needs supportive assistance of a public program. After all, if s/he did not, then they would go off to a private program and not be as visible within the criminal justice system. The drug treatment court model is an effective system and alternative sentencing option to traditional substance abuse treatment which provides accountability and supportive treatment to the substance abusing client who is linked within the criminal justice system.

It is critical for the drug court professional to have a good educational foundation, training experience, and supervised work experiences to aid in the success of the model. At the same time I urge you to continue to hone your skills and continue to grow by attending cross-disciplinary training in your area. Competence in professional development means that you continue to expand your knowledge and skills in working with substance abusing offenders. Your knowledge about working with the population, from a legal and clinical approach, will be invaluable in the delivery of your services, in your professional demeanor, and hopefully, the outcomes of your program.

Finally, I urge you to continue to do your work with excellence. You now have new knowledge and information to put into practice, and I hope you will use it in a way that will positively impact the life of others, as well as to make improvements or enhancements to your program. Keep a firm ethical footing. Continue to get supervision. Deliver respectful services to your participants. Maintain healthy professional boundaries. And above all else, provide valuable aid and assistance to your clients.

REFERENCES

American Psychological Association. (2004). Ethical principles of psychologists and code of conduct. Retrieved November 27, 2004 from http://www.apa.org/ethics/code2002.html

Bissell, L. & Royce, J.E. (1994). Ethics for addiction professionals (2nd Ed.). Center City, MN: Hazleden

Breno, A., Ramezani, N., Guastaferro, W., Cummings, A., Murphy, A., & Taxman, F. S. (2023). What matters more in explaining drug court graduation and rearrest: Program features, individual characteristics, or some combination. International Journal of Offender Therapy and Comparative Criminology, 67(12), 1211-1229. https://doi.org/10.1177/0306624X221086558

Cohen, R.J. & Swerdlik, M.E. (2002). Psychological testing and assessment: An introduction to tests and measurement. (5th Ed.). Boston, MA: McGraw Hill Companies, Inc. Common Sense for Drug Policy (2004). Drug War Facts. Retrieved September 29, 2004 from http://www.drugwarfacts.org/drugcour.htm Dorf, Michael C. (2001). Drug treatment courts and other problem-solving institutions: An idea whose time is coming. Retrieved September 29, 2004 from http://writ.corporate.findlaw.com/dorf/20011224.html

Dickson-Gomez, J., Spector, A., Krechel, S., Li, J., Montaque, H. D. G., Ohlrich, J., Galletly, C., & Weeks, M. (2022). Barriers to drug treatment in police diversion programs and drug courts: A qualitative analysis. American Journal of Orthopsychiatry, 92(6), 692-701. https://doi.org/10.1037/ort0000643

Elkington, K. S., Ryan, M. E., Basaraba, C., Dambreville, R., Alschuler, D., Wall, M. M., Garcia, A., Christofferson, M., Andrews, H. F., & Nunes, E. V. (2024). Examining the impact of the innovative opioid court model on treatment access and court outcomes for court participants. Journal of Addiction Medicine, 18(6), 635-642. https://doi.org/10.1097/ADM.0000000000001330

Farringer, A. J., & Manchak, S. M. (2023). Communication and collaboration in a drug court team. Psychological Services, 20(4), 929-940. https://doi.org/10.1037/ser0000735

Huddleston, C.W., Freeman-Wilson, K., & Boone, D.L. (2004). Painting the current picture: A national report card on drug courts and other problem solving court programs in the United States. Alexandria, VA: National Drug Court Institute

Inciardi, J.A. (1994). Screening and assessment for alcohol and other drug abuse among adults in the criminal justice system. Treatment improvement protocol (TIP) series, #7. DHHS Publication No. (SMA) 94-2076. Rockville, MD: U.S. Department of Health and Human Services

Knapp, K. S., Kulak, J. A., Homish, D. L., Granfield, R., Homish, G. G., & Kahn, L. S. (2024). Longitudinal trajectories in recovery capital and associations with substance use among adult drug treatment court clients. Drug and Alcohol Dependence, 260, 111343. https://doi.org/10.1016/j.drugalcdep.2024.111343

Koocher, G.P. & Keith-Spiegel, P. (1998). Ethics in psychology, Professional standards and cases. New York: Oxford University Press. National Association of Drug Court Professionals (2000). Facts on drug courts. Retrieved September 7, 2006 from http://www.nadcp.org/whatis/ National Association of Drug Court Professionals. (2000). Retrieved September 7, 2006 from http://www.nadcp.org/ National Criminal Justice Reference Center (n.d.). Retrieved September 29, 2004 from http://www.ncjrs.gov/. National Institute on Alcohol Abuse and Alcoholism. (2003). CAGE Questionnaire. Retrieved November 8, 2004 from http://www.niaaa.nih.gov/publications/cage.htm

Marlowe, D. B., Theiss, D. S., Ostlie, E. M., & Carnevale, J. (2022). Drug court utilization of medications for

opioid use disorder in high opioid mortality communities. Journal of Substance Abuse Treatment, 141, 108850. https://doi.org/10.1016/j.jsat.2022.108850

Pivovarova, E., Taxman, F. S., Boland, A. K., Smelson, D. A., Lemon, S. C., & Friedmann, P. D. (2023). Facilitators and barriers to collaboration between drug courts and community-based medication for opioid use disorder providers. Journal of Substance Use and Addiction Treatment, 147, 208950. https://doi.org/10.1016/j.josat.2022.208950

Randall-Kosich, O., Whitaker, D. J., Guastaferro, W. P., & Rivers, D. (2022). Predicting drug court graduation: Examining the role of individual and programmatic characteristics. Journal of Substance Abuse Treatment, 135, 108654. https://doi.org/10.1016/j.jsat.2021.108654

Ray, B., Kunkel, T., Bryant, K., Hedden, B., Andraka-Christou, B., O'Neil, M., & Huynh, P. (2022). Client attitudes toward virtual treatment court. Journal of Substance Abuse Treatment, 140, 108833. https://doi.org/10.1016/j.jsat.2022.108833

Senjo, S. & Leip, L.A. (2001). Testing therapeutic jurisprudence theory: An empirical assessment of the drug court process. Western Criminology Review, 3(1). [Online]. Retrieved September 29, 2004 from http://wcr.sonoma.edu/v3n1/senjo.html Drug Treatment Courts: An Integrated Approach

Sherin, K.M. & Mahoney, B. (1996). Treatment drug courts: Integrating substance abuse with legal case processing. Rockville, MD: U.S. Department of Health and Human Services

Steinman, S.O., Richardson, N.F., & McEnroe, T. (1998). The ethical decision making manual for helping professionals. Pacific Grove, CA: Brooks/Cole Publishing Company

Stevens, P., & Smith. R.L. (2001). Substance abuse counseling: Theory and practice (2nd Ed.). Upper Saddle River, NJ: Prentice-Hall, Inc

Tauber, J., Weinstein, S.P., & Taube, D. (1999). Federal confidentiality laws and how they affect drug court practitioners. Alexandria, VA: National Drug Court Institute. U.S. Department of Health and Human Services (1997). Substance abuse treatment planning guide and checklist for treatment-based drug courts (DHHS publication number SMA 97-3136). . Rockville, MD. U.S. Department of Health and Human Services. (2002). Addiction counseling competencies: The knowledge, skills, and attitudes of professional practice. Technical assistance publication (TAP) series, #21. DHHS Publication No. (SMA) 02-3750. Rockville, MD: U.S. Department of Health and Human Services. U.S. Department of Health and Human Services. (2002a). Addiction counseling competencies. The knowledge, skills, and attitudes of professional practice. Technical assistance publication (TAP) series, #21. DHHS Publication No. (SMA) 02-3750. Rockville, MD: U.S. Department of Health and Human Services. U.S. Department of Health and Human Services. (2002b). Confidentiality of patient records for alcohol and other drug treatment. Technical assistance publication (TAP) series, #13. Rockville, MD: U.S. Department of Health and Human Services. Retrieved September 7, 2006 from http://www.treatment.org/Taps/TAP13/TAP13TOC.HTML U.S. Department of Justice, Drug Courts Program Office. (January 1997). Defining Drug Courts: The Key Components. Retrieved September 29, 2004 from http://www.ncjrs.gov/pdffiles1/bja/205621.pdf

Virtanen, S., Aaltonen, M., Latvala, A., Forsman, M., Lichtenstein, P., & Chang, Z. (2024). Effectiveness of substance use disorder treatment as an alternative to imprisonment. BMC Psychiatry, 24(1), 260. https://doi.org/10.1186/s12888-024-05734-y

Zielinski, M. J., Roberts, L. T., Han, X., & Martel, I. D. (2023). A longitudinal analysis of PTSD and other mental

health symptoms among people sentenced to drug treatment court. Psychological Trauma: Theory, Research, Practice, and Policy, 15(6), 1022-1026. https://doi.org/10.1037/tra0001125

Answer the following questions by selecting the most appropriate response.

1. There is a single model of drug courts which is comprised of a team which is strongly influenced by the judge.

    a. True
    b. False

2. Which of the following is not a drug court mode?

    a. Pre-adjudication
    b. Post-adjudication
    c. Sentence diversion
    d. Pre-plea

3. Defendants who appear eligible for drug court treatment may NOT be automatically referred to the program.

    a. True
    b. False

4. Of the following characteristics of a drug court, which one is NOT relevant to drug court compared to a traditional court setting?

    a. Formal treatment
    b. Goal is to process case and apply the law
    c. Judge has a central role in monitoring defendant
    d. Use of graduated sanctions

5. Drug court cases are process quicker than on a traditional calendar and can provide a cost efficient approach to legal case processing.

    a. True
    b. False

6. One benefit of a drug treatment court model is reported increased retention rates estimated at:

    a. 47 – 51.
    b. 71 – 82.
    c. 67 – 71.
    d. 37 – 41.

7. Of the four goals of collaboration, which of the following is NOT included?

    a. Reduced criminal behavior and better use of jail space
    b. Unlimited delivery of treatment services
    c. Improved productivity through employment
    d. Effective health prevention

8. In the drug court planning implementation process, which of the following is NOT a task of the team?

    a. Description of substance abuse problem in the state
    b. Defined drug court model
    c. Eligibility criteria of target population
    d. Resources for treatment

9. A written drug court Interagency Agreement is suggested to be signed by the partners of the drug treatment court to serve as a guide and define the contributions of each partner to the drug treatment court.

    a. True
    b. False

10. Elements of an Interagency Agreement should include the following EXCEPT:

    a. methods for sharing confidential information.
    b. partner agency's role and responsibilities.
    c. goals, objectives and community need.
    d. treatment and wrap-around services for participants.

11. To facilitate a participant's treatment, the prosecution and defense counsel must maintain their traditional courtroom approach.

    a. True
    b. False

12. Since drug court treatment is based on an integrated approach combining treatment with legal case processing, the approach to case disposition remains adversarial as in a traditional court.

    a. True
    b. False

13. Status hearing are used to _____ participant progress and compliance.

    a. admonish
    b. sanction
    c. monitor
    d. manage

14. The drug court team is responsible for establishing and forging community relationship, to include aiding in the acquisition and distribution of resources.

    a. True
    b. False

15. For drug courts, there are two types of screening:

    a. legal and forensic.
    b. legal and clinical.
    c. individual and clinical.
    d. legal and confidential.

16. Potential drug court participants could be deemed ineligible for participation in drug court, for past offenses including:

    a. dealing drugs.
    b. history of violent criminal behavior.
    c. crimes committed while in possession of a weapon.
    d. All of the above are correct responses

17. Individuals with needs beyond the scope of the treatment court may be excluded from participation based solely on limited resources.

    a. True
    b. False

18. Screening for drug court is generally conducted by:

    a. a trained clinical professional.
    b. the judge.
    c. prosecution or defense.
    d. Either a or c are correct responses

19. The four domains relevant to clinical assessment include the following EXCEPT:

    a. a comprehensive process and documentation of findings.
    b. determining readiness of treatment and designing an initial treatment plan.
    c. interpretation of data and analysis of findings.
    d. addiction professionals in supervision.

20. Federal confidentiality regulations are established in 1975 by:

    a. Title 2, part 42, Code of Federal Regulations.
    b. Title 42, part 2, Code of Federal Regulations.
    c. Title 42, part 2, Code of Federal Requirement.
    d. Title 2, part 42, Code of Confidential Regulations.

21. Discussion of a participant's confidential information is not protected since the participant is a defendant in a drug court treatment program as an alternative to traditional sentencing.

    a. True
    b. False

22. The fact that a participant was screened and deemed not eligible for drug treatment court services is protected under the scope of confidential and protected information even though the participant did not engage in services.

    a. True
    b. False

23. Exceptions to federal confidentiality include all of the following EXCEPT:

    a. qualified service agreement.
    b. internal drug court communications.
    c. written permission from the participant.
    d. medical appointments.

24. A drug court professional may be in compliance with mandated reporting of sexually transmitted or communicable disease by reporting the participant's results via an anonymous call, or by reporting the participant while not identifying the participant is in alcohol or other drug treatment.

    a. True
    b. False

25. Since the treatment provider sees the participant regularly in treatment, it makes sense for the provider to be the participant's sponsor at 12-step meeting outside the agency.

    a. True
    b. False