The National Drug Court Survey

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Introduction

Drug treatment courts are known as the most innovative means of integrating treatment into a criminal justice program for drug-involved offenders. With drug courts becoming increasingly popular over the past decade, federal efforts and site specific studies have been undertaken to gain a better grasp of their efficiency and effectiveness. However, no systematic survey has been conducted to provide an understanding of the structure of drug courts, the treatment services that they provide, and how these services are delivered to drug court participants. In an effort to improve knowledge of the national drug court landscape the Bureau of Justice Assistance, in collaboration with the National Institute on Drug Abuse, funded the National Drug Court Survey as a part of the Criminal Justice Drug Abuse Treatment Studies (CJ-DATS) research cooperative.

Methodology

The National Drug Court Survey sampling frame is comprised of drug court coordinators and the agencies that provide treatment services to participants in these courts. The drug court coordinators sample consists of courts within the 72 counties from the National Criminal Justice Treatment Practices Survey (NCJTP) (see Taxman, Young, Wiersema, Rhodes, & Mitchell (2007) for a complete discussion of NCJTP survey methodology), and adult drug treatment courts receiving implementation or enhancement grants from the Bureau of Justice Assistance since 2002. This resulted in an eligible sample of 208 adult drug courts. Drug court coordinators were asked to provide us with contact information for the treatment provider(s) used by their court. Forty-nine (49) (24 %) of the 208 courts did not provide information on treatment providers. We developed a list of the largest treatment providers in those communities using information from the Office of Applied Studies (SAMSHA). A response rate of 68% was achieved for the drug court coordinator sample, and we obtained matching treatment surveys for 75% of the responding courts.

	NCJTP Sample	BJA Sample	Total
# Surveyed Courts	**76**	**132**	**208**
% Responding Courts	72%	65%	68%
% with Responding Treatment Providers	76%	75%	75%
#Courts Indicating NO Treatment Providers	2	5	7

Characteristics of Adult Drug Courts

Drug courts have an average daily population (ADP) of 54 participants (DCPs),[1] with 32% having an ADP of less than 40, 41% having an ADP of 41-100, and 27% having over 100 DCPs. On average, courts graduate 38 participants each year, and discharge an average of 29 due to non-compliance.

Using sample weights based on the NCJTP survey, it is estimated that roughly 49,000 DCPs are in drug court programs on any given day.

Not all drug courts have a coordinator assigned specifically to administer the program, as 13% of courts use existing positions (i.e. judges or case managers) rather than creating specific positions

for drug court coordinators. The average coordinator has been in their position for slightly over 4 years, is female (65%), and falls between the ages of 36 to 55 (65%). The majority of coordinators have a Bachelors (32%) or Masters (44%) degree, most commonly in the fields of criminal justice (14%), counseling (14%), psychology 14%), or social work (12%).

Courts have an average of 12 full-time and/or part-time staff members. Of these employees, an average of 2.8 is classified as treatment counselors, and 1.2 is classified as treatment coordinators. Courts hired an average of 3.2 new employees in the past year.

Arrangements with Treatment Providers

Overall, most drug treatment courts (78%) have some form of formal or contractual agreement with treatment providers (roughly 23% do not have such an agreement).

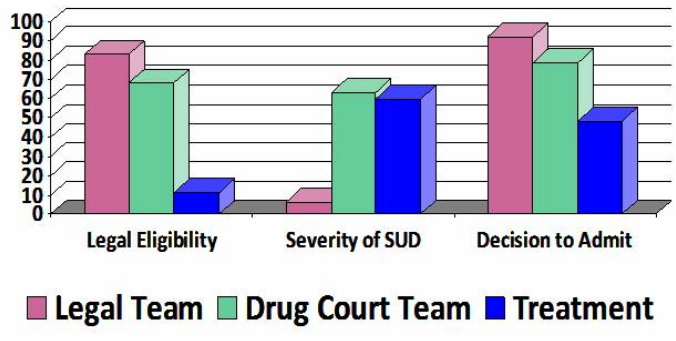
Thirty-three (33) percent of drug courts report having formal, written agreements with treatment providers. Agreements typically specify the types of services to be provided (62% of agreements contain this information), address confidentiality issues (53%), and/or require the treatment provider to attend case conferences (44%). Forty-six (46) percent of courts report having formal written agreements with one to three treatment providers, whereas 27% have an agreement with three or more providers.

Forty-three (43) percent of courts report having a contract for treatment services (through which financial arrangements are made to pay for services) in addition to their formal agreements. Roughly 13% of contracts require the drug court to pay service fees, while 20% require the DCP to cover all costs, and 68% have some combination of court and DCP payment.

Screening for Eligibility

Offender eligibility for drug court is most often determined by legal criteria, such as prior criminal history and current charges, while severity of an individual's substance use disorder is given less consideration. Members of the legal team (judges, defense attorneys, and prosecutors) also have more influence on the decision to admit. Whereas 92% of courts report the involvement of the legal team in reaching admission decisions, 79% of coordinators and case managers and only 48% of treatment providers are involved in this process.

Roughly two-thirds (68%) of drug courts use a standardized substance abuse screening tools, with the most commonly utilized being the Addiction Severity Index (ASI) (45% of courts use this tool), and the Substance Abuse Subtle Screening Inventory (SASSI) (23%). Twenty-one (21) percent of courts use a standardized risk assessment tool to measure an offender's likelihood to recidivate, with the most commonly used risk tools being the Level of Service Inventory-Revised (LSI-R) (18%) and the Wisconsin Risk/Needs (WRN) (4%). These tools are recognized as best practices in the correctional literature, as they help to ensure that offenders are selected for participation in programs based on their likelihood for present public safety challenges, with the goal being to assign offenders with higher risks of recidivism into more intensive programs (Taxman, 2006; Taxman, Cropsey, Young, and Wexler, 2007). Few (4%) courts use mental health screening tools. One-third (33%) of courts use a tool of



their own design, or one developed by a state agency.

Drug Court Programming

Fifty (50) percent of drug courts have four phases of programming, while 25% employ a three phase model. Roughly half of the courts are structured to begin with an orientation phase, and then move onto motivational enhancement, intensive treatment, and conclude with a relapse prevention phase, while the remaining half devises their own phase content. On average, programs last approximately one year.

Drug testing, self-help meetings, and group counseling are available across most phases. However, more intensive treatment services do not appear to be employed as frequently, especially as DCPs move along within the program. Clinical services (such as psychosocial education, family therapy sessions, individual counseling sessions, and motivational enhancement) are a part of phase one in 61% of drug courts. By phase three, slightly over half (54%) of courts continue to provide these services, and by phase four roughly one-third (36%) provide them.

Drug courts are known for their frequent status hearings with offenders to monitor progress, but attendance in status review hearings diminishes as DCPs move across phases. While 88% of drug courts require attendance in status review hearings every two weeks or more frequently in phase one, and 80% require this frequency of attendance in phase two, by phase three attendance is required in less than one-quarter (21%) of courts, and by phase four this falls to 15% (at which point 53% of courts have no set schedule for appearances at all).

Treatment Agencies and the Services they Provide

The treatment programs working with drug courts tend to have separate and/or different practices than the courts they work with. Less than half (42%) of courts report that the treatment provider typically reviews treatment plans developed by the court, while 38% report that this does not occur at all. Treatment agencies are not often part of the case planning process and, as outlined above, are usually outsiders in terms of determining program eligibility.

Slightly over half (56%) of treatment agencies use a standardized substance abuse assessment tool in their own program to assess substance use disorders. Agencies are just as likely to use state or agency developed tools (54%). Only half (52%) of the responding agencies reported use of a manualized protocol or curriculum. The most commonly utilized protocol is the MATRIX model (26%).

Services Delivery of Treatment Agencies	
Use a substance abuse screening tool	56%
Use a tool developed by the drug court or the state	54%
Specialized services for co-occurring disorders	31%
Specialized programs for adult offenders	42%
Provide CBT 2-3 times per week	59%

Less than two-thirds (59%) of treatment agencies provide Cognitive Behavioral Therapy (CBT) services 2-3 times per week or more. One-third (32%) of treatment agencies provide HIV/AIDS testing, 38% provide counseling for HIV/AIDS, 31% provide *specialized* services for co-occurring disorders, and 23% offer residential care for 28 days or less. Detoxification is provided in 19% of agencies, and medications such as Buprenorphine (provided in 17% of agencies), Antabuse (16%), Naltrexone (15%), and Methadone (12%) are rarely available.

Use of EBPs

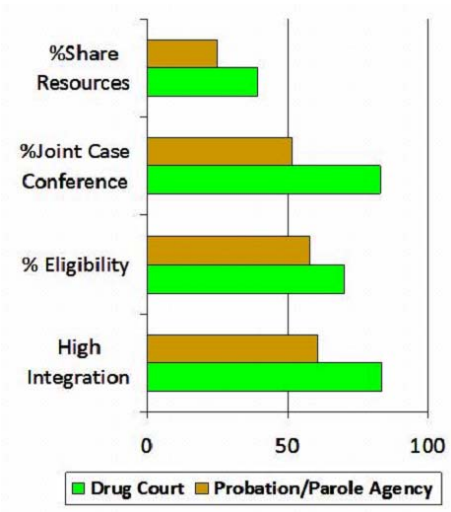
An average of 5.9 (of 11) evidence based treatment practices (EBPs) are implemented in drug courts. Drug courts are more likely to use EBPs than indicated in findings from the NCJTP survey on probation, parole, and other community correctional agencies (an average of 4.6).

Most common is addressing co-occurring disorders (96%), use of incentives (89%), a continuum of care (84%), drug testing as a part of phases (77%), systems integration (74%), and a planned duration of 90 days or more (72%). Risk tools (21%), the use of engagement techniques (38%), and involvement of family in treatment (41%) are the least frequently implemented EBPs. Drug courts with a written agreement and/or contract for treatment services are more likely to provide EBPs than courts without such agreements.

Use of Evidence-Based Practices- Percentage (N)	
Standardized Substance Abuse Assessment	68.1 (96)
Standardized Risk Assessment	20.6 (29)
Engagement Techniques	38.3 (54)
Address Co-occurring Disorders#	95.5 (190)
Family Involvement in Treatment	41.1 (58)
Planned Duration of 90 Days or More	72.3 (102)
Systems Integration	73.8 (104)
Continuum Care#	83.9 (167)
Drug Testing as a Part of Phases	77.3 (109)
Graduated Sanctions*	62.4 (88)
Incentives*	88.7 (125)
Qualified Staff*	53.2 (75)
Assessment of Outcomes*	69.5 (98)

*Percentage with scale score over 3 (1=Strongly Disagree – 5 Strongly Agree)
#Information comes from the National Survey of Drug Court Treatment Providers

Drug courts are structured to promote teamwork with each party involved in the program (judiciary, prosecutor, defender, treatment, community corrections, etc.). Joint activities such as developing joint policy and procedures manuals, joint staffings, cross-training of staff, and sharing DCPs needs for certain types of treatments are part of the process of effective operations; however, survey findings show that such practices are not maximally utilized.



Overall, drug court reported an average of 7.2 (of 12) integrated activities with treatment agencies, and an average of 4.7 integrated activities with prosecutorial agencies. Though integration with treatment agencies is higher than was found in the NCJTP survey of probation, parole and other community correctional agencies (an average of 5 integrated activities), these findings indicate that daily practices in drug treatment courts tend to resemble coordination efforts more than they embody truly integrative practices.

Implementation of the 10 Key Components of Drug Courts- Percentage (N)	
1) Drug courts integrate alcohol and other drug treatment services with justice system case processing*	99.3 (140)
2) Using a non-adversarial approach, prosecution and defense counsel promote public safety while protecting participants' due process rights*	59.6 (84)
3) Eligible participants are identified early and promptly placed in the drug court program	24.8 (35)
4) Drug courts provide access to a continuum of alcohol, drug, and other related treatment and rehabilitation services#	83.9 (167)
5) Abstinence is monitored by frequent alcohol and other drug testing	77.3 (109)
6) A coordinated strategy governs drug court responses to participants' compliance	22.0 (31)
7) Ongoing judicial interaction with each drug court participant is essential	7.8 (11)
8) Monitoring and evaluation measure the achievement of program goals and gauge effectiveness*	69.5 (98)
9) Continuing interdisciplinary education promotes effective drug court planning, implementation, and operations*	77.3 (109)
10) Forging partnerships among drug courts, public agencies, and community-based organizations generates local support and enhances drug court program effectiveness*	76.6 (108)

*Percentage with scale score over 3 (1=Strongly Disagree – 5 Strongly Agree)
#Information comes from the National Survey of Drug Court Treatment Providers

10 Key Components

Drug courts report implementing an average of 6.1 (of 10) key components. Nearly all courts (99%) report integrating alcohol and other drug treatment

services with case processing, while over three quarters (77%) establish partnerships between drug courts and other community agencies to garner local support and to enhance effectiveness, 77% promote continued education and training of staff, and 77% monitor abstinence via frequent drug testing. Sixty (60) percent of courts report using a non-adversarial legal approach. One-quarter (25%) of courts identify eligible participants early on in the criminal justice process, while 22% have a coordinated strategy for responding to compliance, and only 8% have ongoing judicial interaction.

Summary

The drug court model promotes integration, and compared to their community correctional counterparts, drug courts have been more successful in implementing evidence practices. Yet there is still room for growth. Drug courts can advance practices by considering the following:

- Implement standardized risk tools to identify moderate to high risk offenders: Over 68% of drug courts use standardized substance abuse screening tools, though only 21% use standardized risk assessment tools
- Further integrate treatment agencies into drug court operations: Treatment agencies are "part" of the drug court team, yet most courts do not require or do not include them in screening for eligibility, status review hearings, or work with other team members on treatment plans for offenders
- Move toward more standardized approaches to treatment: Only half (52%) of treatment agencies use a manualized treatment protocol, and staff training on these protocols is minimal (33% of agencies train staff on their protocol for up to two days, 23% of agencies train staff by having them watch other counselors, and 10% percent of agencies do not train staff at all)
- Implement proven, effective methods of care: NIDA has identified core principles of treatment including CBT, medications, and support systems (see *Principles of Drug Abuse Treatment for Criminal Justice Populations: A Research Based Guide* (NIDA, 2006), however, many drug courts and treatment agencies do not implement these practices
- Include more evidence based practices as a part of drug court programming: Though drug courts have done a better job of integrating EBPs than other criminal justice entities, the use of standardized risk tools, the employment of qualified staff, the involvement of family in treatment, and the use of engagement techniques are several areas where improvement is needed, and perhaps more importantly, realistic
- Work to broaden the scope of key practices: The 10 Key Components of drug courts should be modified to include more treatment services and evidence based practices
- Make *treatment* the focal point of drug treatment courts: Treatment services have yet to be the centerpiece of the drug court experience (the focus is on legal criteria, compliance, etc.), and until this becomes standard practice, drug courts will not be as effective as is possible, and their purpose only partially fulfilled

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[1] Three courts were excluded from this average due to their having an average daily population of over 1,000 DCPs.