

AN EVALUATION OF TREATMENT IN THE MAINE ADULT DRUG COURTS

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EXECUTIVE SUMMARY: TREATMENT AS PART OF DRUG COURTS IN MAINE

Drug courts are a critical component of the treatment system for offenders in Maine. Treatment is provided by local community providers and funded by the Office of Substance Abuse (OSA) while the drug court is run by the courts with cooperation from probation and pretrial services. Maine undertook the treatment component in the drug courts through the design and implementation of a treatment process that has: 1) screening for substance abuse; 2) engaging the offender in multi-phase treatment programs that begins with motivation enhancements and ends with maintenance; and 3) ensuring quality by providing staff with training in the use of the treatment protocol and then monitoring through quality control mechanisms. The manualized DSAT curriculum provides the treatment staff with a tool that guides the offender through the recovery process. The questions raised are whether the DSAT curriculum advances the recovery of offenders and the ways in which the drug court affects outcomes from treatment. This study examined these issues.

DSAT Curriculum: A Good Investment

As part of a broader study, the researchers contracted with two experts in the field to review the degree to which the DSAT curriculum could be considered evidenced-based practice. One of the experts was an academician and the other was a practitioner that is highly recognized in the field. Both reviewers observed that the treatment is well-designed relying on cognitive behavioral tenets to assist the offenders with the recovery process. The treatment consists of three main phases: motivational enhancement, intensive skill-based cognitive behavioral sections devoted to stabilizing the offender and identifying factors that affect use, and maintenance to reinforce the skills learned during the intensive phases. The treatment is manualized with a specific curriculum for each session along with corresponding goals and objectives and exercises for each session. Additionally, specialized sessions are devoted to female and male offenders.

Reviewers of the DSAT curriculum as well as the current researchers also observed that while the curriculum was sound, the practice of integrating the treatment within the drug court programming needed several modifications to comply with components of evidence-based practice. The three areas that were noted are: 1) no standardized method was available to make eligibility based on the offender's risk level, instead the tendency was for each drug court to have their own process to determine risk level and most often than not risk was defined by legal charge and the prosecutor's office; 2) the drug courts did not have defined set of graduated sanctions and incentives to address the behavior of offenders; and 3) the curriculum does not deal with the ancillary services that offenders often need in terms of criminal value systems, housing, transportation, and so on.

To determine the quality of the services delivered to offenders, the researchers also observed the tapes from the quality assurance component of the treatment sessions. (OSA hired a consultant to review the tapes on a regular basis to give the treatment providers feedback on the quality of the sessions delivered to clients. The purpose of these tapes is to give the counselors appropriate feedback on the delivery to build their processing skills.) The researchers reviewed the tapes on four dimensions: 1) adherence to the treatment session; 2) usage of appropriate cognitive behavioral techniques; 3) usage of appropriate processing techniques; and 4) achievement of session goals and objectives. The researchers reviewed 10 tapes and found that the counselors overall adhered to the curriculum and used cognitive techniques. Counselors needed more practice in terms of processing information provided by the offenders, an advanced clinical skill. Overall, most of the session goals were met.

Treatment: Offenders Progress except when Control Sanctions are Used

To measure the impact of the DSAT treatment, the researchers recruited 99 subjects in nine months to participate in a study of the drug court. The 99 subjects from each of six drug courts agreed to participate in a baseline and follow-up interviews. The interviews included the following assessments to measure: 1) legal pressure, 2) severity of addiction behavior, 3) psycho-social measures of adjustment and recovery, and 4) rapport with counselors. Additionally the study reviewed the offender's performance in the drug court. The data was used to identify factors that predict positive outcomes which can be used to advance the drug court and treatment programming. Using administrative data, the researchers were able to determine that the subjects recruited for this study are similar to offenders participating in the drug court.

The study was designed as a process study to examine the offenders as they progress through the drug court. In the study, 34 (34%) were in the motivation phase, 39 (39%) in the intensive phase, 18 (18.2%) in maintenance phase, and 8 in the post-DSAT phase at intake. The average length of time in each phase was 87 days for motivation, 130 days for intensive, and 128 days for maintenance phase. At the end of the data collection period, 31 offenders (36.5%) graduated, 38 (44.7%) were active, and 16 (18.8%) were expelled. During the course of the drug court program, 58 percent had some type of negative behavior that resulted in a sanction by the court (a part of the drug court). In response to this negative behavior, the tendency of the court was to use control oriented sanctions (65%) or mixed (a combination of treatment and control) sanctions (18%). The most frequent sanctions were incarceration, increased reporting, and termination from the program. Very few sanctions relied on treatment option such as intensifying the treatment services, using self-help groups, community service, or written assignments. Offenders given control sanctions were more likely to be expelled in the drug court than offenders given treatment-oriented sanctions.

Involvement in the DSAT programming appears to have a number of benefits for the participants. Using the CEST (Client Evaluation Self Test), we compared the results for clients that had both a baseline and follow-up interview. The results indicate that participation in the DSAT curriculum experienced a reduction in depression, hostility, and risk-taking behaviors, and an increase in social conformity, and therapeutic involvement. Equally important is that clients have the ability to identify personal progress, have a good attitudes towards program staff, develop a good rapport with counselors, and recognize the competence of counselors; such offenders are more likely to make positive changes.

Multivariate models of predicting successful completion of the drug court program found that certain offender characteristics (have a partner and last grade completed) are important to outcomes as well as therapeutic engagement and social conformity. A limitation of these models is the sample size and a small percentage of offenders that were expelled in this sample.

Lessons Learned from this Study

Delivering treatment to substance abusing offenders is a difficult enterprise. Drug courts have the greatest potential to improve treatment outcomes for offenders if they offer good quality treatment services, retain offenders in treatment for over 90 days, and address compliance behaviors. This study has shown that a strategic approach towards drug treatment offered in a drug court setting have many positive outcomes. The underlying issue is that DSAT is a thorough and strategic approach in that it is built on a solid curriculum with a focus on addressing different aspects of recovery and assisting the offender in achieving skills to address recovery issues. As shown in this evaluation, DSAT can be effectively delivered through the mechanisms that were employed by OSA to include training the

counselors, using quality assurance mechanisms, and working with the drug courts on the programming issues to support treatment engagement.

The DSAT curriculum appears to engage many of the offenders in the treatment process. The results from the CEST instrument illustrate that the treatment program had a number of positive benefits on offenders including more social conformity and less risk taking behavior. And, many of the offenders had a good rapport with the counselors which is an important predictor of engaging offenders in treatment programming. Another attribute of the DSAT process is that relationship between the offender and counselors was positive.

Study findings revealed that the courts had a tendency to use control-oriented sanctions, and bivariate results suggest that these are not likely to improve drug court outcomes. The use of control sanctions appears to undermine the drug treatment programming. More offenders who receive control sanctions are more likely to be expelled from the program. Treatment based sanctions may reinforce the treatment progress that offenders are making in the DSAT treatment program, and may help retain the offender in the drug court program. For the Maine Drug Courts, program retention is an issue, and it appears that actions by the court may be useful in improving program retention. The sanctions used were rather flat and were not progressive, indicating that the sanction practice tends not to meet the criteria of evidence-based sanctions or reinforcers.

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The most profound example of an innovation in the substance abuse service delivery systems for offenders is the drug treatment court developed in 1989 in Miami, Florida. The court was viewed as the vehicle to bring the conflicting models of punishment and rehabilitation into a setting where the two philosophies could be integrated, instead of relying upon disparate programmatic components of treatment, drug testing, supervision/oversight, and compliance management (Taxman and Bouffard, 2002b; Goldkamp, White & Robinson, 2001; Anspach and Ferguson, 2002). The drug court model has as its rationale the reduction of drug use and related criminal behavior through the primary interventions of treatment and the judicial oversight (Belenko, 1999; 2001; Taxman & Bouffard, 2002b; Cooper, 2001; Goldkamp, White, & Robinson, 2001).

The drug court concept, as implemented in a variety of settings, provides the opportunity to explore how treatment is integrated into the drug court setting. Few drug court studies have examined the use of treatment services and the clinical progress that can occur as a result of the provision of drug treatment, as well as the impact of the drug court processes (e.g. status hearings and sanctions) on program outcomes (e.g. graduation, arrests, etc.). In other words, how are drug treatment services provided within the framework of the drug court? Do offenders make progress towards prosocial skills during the provision of treatment services? The available literature on drug treatment courts does not address these questions. Nor does it demonstrate how the drug treatment court can reinforce the goal of providing drug treatment: *to reduce the recidivism of drug involved offenders by changing their drug using habits.*

Drug Treatment Courts: The State of Knowledge

In the last decade drug court programs have thrived and grew to a nationwide phenomenon with over 1200 courts (Huddleston, Freeman-Wilson, & Boone, 2004), yet studies of drug courts have not occurred at the same pace. Most scholars admit that the quality of the studies, and the limited number of studies on drug treatment courts, undermines the confidence that can be given to the generally accepted positive findings about the drug treatment court. As observed by Goldkamp, White & Robinson (2001):

“The findings appear to show a dramatic and consistent drug court crime reduction effect, with drug court graduates generally showing substantially lower rearrest rates...from entry than nongraduates. As popular as these kinds of analyses may be among advocates seeking to declare the efficacy of drug courts, they are biased in the direction of showing positive results, and as such, are highly misleading. Basically, the much-heralded findings show that the successes succeed and the failures fail (2001:32).

Recent studies of drug treatment courts have started to explore the issues of the provision of treatment services. Several major studies have been conducted that employ sound research methods to explore the efficacy of drug courts, and to measure the services delivered to offenders (Harrell, Cavanaugh & Roman, 1998; Goldkamp, et al., 2001; Peters & Murrin, 1998; Gottfredson, Najaka, & Kearley, 2002; Anspach & Ferguson, 2002). In each study, the percentage of drug court clients actually participating in treatment services per se varied considerably from 35 to 80 percent. And, the actual length of time spent in treatment (as opposed to the intended length of stay, which is generally 12 or more months) for clients in these programs also varied from under 30 days to over two years. The general finding appears to be that the longer the period of time in treatment, the greater the likelihood that the offender will graduate from drug court. And, more importantly, participation in drug treatment services, not necessarily just the drug court, reduces the likelihood of rearrest. Banks and Gottfredson (2003) found that 40 percent of the drug court offenders that participated in treatment were rearrested within a two-year window as compared to slightly over 80 percent of the drug treatment court offenders

that did not participate in treatment¹. Goldkamp, White and Robinson (2001) found that the more treatment sessions participated in, or the greater the percentage of time in treatment during the drug court program, the greater the reduction in rearrests. The same is true for the four-site study conducted by Anspach and Ferguson (2002) that found treatment participation is a critical variable affecting the graduation rates from these drug courts.

Taxman and Bouffard (2002a), in their secondary review of the data from a survey of 212 drug courts conducted by the Center for Substance Abuse Treatment (CSAT), assess the disjuncture between the delivery of treatment services and drug court operations. In key areas, the drug court respondents highlighted the lack of policy and procedures that support the drug court's mission of providing treatment services for offenders. For example, drug courts tended to target eligibility for drug court based on the offense and criminal history, with less apparent focus on the type or severity of their substance abusing behavior. Nearly half (49%) of the drug courts reported that eligibility screening is conducted by non-clinical staff (e.g., probation officers). While this is appropriate in terms of screening for legal criteria, these staff may not have sufficient training and experience to conduct appropriate clinical assessment, which often follows legal screening of cases. Again, legal eligibility is generally based on legal considerations not substance abuse dependency. In relation to the clinical assessment phases, nearly 60 percent of the drug treatment courts reported that they excluded offenders from participation who were "not motivated for treatment", yet one of the strengths of the drug court model is its ability to use the criminal justice system to leverage offenders into treatment who may not otherwise be motivated to tackle their drug use and its associated other problems. Half of the drug courts reported not having any formal (e.g., written) clinical placement criteria to determine what type of treatment services the offender should receive.

¹ Offenders can enter drug treatment court and be expected to participate in treatment but either due to the inavailability of treatment or the offender's failure to comply with treatment, the offender does not participate in drug treatment.

While these varied policies and procedures may be effective at ensuring individualized assessment and placement, the potential exists that they may also indicate areas in which additional policy and practical coordination between treatment and court systems is needed to streamline and solidify the processing of cases so that various responsibilities are not overlooked by one agency or another. As an additional example of a service area where improved coordination of activities may be merited, this CSAT report revealed that when case management services were provided, these services were infrequently provided by the drug treatment court itself (24% reported that the drug court coordinator provided such services), instead of being delegated to the treatment provider (26%) or a probation official outside the court (24%). According to these survey results, many of the courts also have more than one agency conducting drug tests (e.g., treatment providers, probation, etc.) and often the results were not shared. While drug courts are designed to integrate services across systems, these findings suggest that there are still several areas that may benefit from improvements in terms of coordination and communication between the court and treatment systems.

To date, research on the “black box” of drug courts’ actual intervention components is limited, particularly regarding the utilization of drug treatment services provided within the context of drug courts. The findings from the few well-designed studies on drug courts (Gottfredson, Najaka, & Keareley, 2002; Goldkamp, White, & Robinson, 2001) confirm that there is variation in the delivery of key functional components of drug courts—treatment, testing, and sanctions. One of the more informative studies of the delivery and effectiveness of treatment within the drug court was conducted by Gottfredson and her colleagues (2002). In particular, this study found that those who received drug court services, but no substance abuse treatment, did no better in terms of post-program recidivism than did those who were not in the drug court at all. As such, while the court and other criminal justice system components are essential in making sure that individuals go to treatment, the “active ingredient” (borrowing from a medical analogy) appears to be the participation in appropriate substance abuse treatment, as those who received testing and supervision alone showed no improvements in recidivism,

despite the suggestion of critics such as Kleiman (2001) that treatment was not necessary. Indeed the combination of these systems is likely what makes the model effective, however that is not to say that effective persuasion (the court processes) would be all that effective if the treatment that is received is not of good quality (any more than quality treatment can be effective if people do not participate in it, as has been the problem prior to the development of the drug court model). Having at least the suggestion emerging in the literature that treatment is a central effective component of the drug court model, the following study explores some of the issues related to the delivery of drug treatment within a drug court setting and then presents several fundamental issues for drug courts to consider in terms of the more thorough integration of these various services within the drug court program.

Drug Treatment Courts in Maine

The state of Maine has been an avid user of the drug treatment court concept. The state administers a variety of drug courts, but the subject of this study are the six adult drug treatment courts. The funding for the drug treatment and case managers in the drug treatment courts are provided by the Office of Substance Abuse Services (OSA). The courts provide the funding for the judiciary and the status hearings. Drug courts have had a premier position in the state for the last five years, and the OSA has funded process evaluations of the different adult and juvenile drug courts consistently. Dr. Donald Anspach and Mr. Andrew Ferguson from the University of Southern Maine have served as the evaluators and have worked with the drug treatment courts during their developmental and implementation time period (see <http://www.maine.gov/dhhs/bds/osa/cj/adtc.htm> for copy of the most recent study findings.)

Recognizing the importance of the treatment provided in the drug courts, the Office of Substance Abuse Services developed a thorough manualized treatment curriculum for the drug courts, and for all offender populations. OSA contracted with a firm that develops treatment programs and curriculums to create the Differential Substance Abuse Treatment (DSAT) curriculum and processes—this is a comprehensive system that integrates all of the components of an evidence-based practice in treatment

services to offenders. The DSAT treatment process has four stages: 1) orientation and motivation enhancement (MET) (open ended for 4 to 10 weeks). In this first phase the focus is on treatment readiness to improve retention. The number of sessions in the MET phase that a client is required to attend varies by the needs of the client and is determined after a comprehensive clinical assessment. From here, the clients enter either the Pre-treatment group phase (to continue to develop treatment receptivity and basic treatment skills) or directly enter the next phase; 2) cognitive and behavioral skill development (intensive services) for 10 to 15 weeks. The curriculum includes sessions on: Education, Decisional Balance, Looking at Addiction, Personal Goal Setting, Risk Strategies, Coping by Thinking, Interpersonal Problem Solving, Support, Assertiveness Skills, Relapse Prevention, Leisure Skills, Job Skills, Communication/Social Skills, Coping with Emotions, and Relapse Prevention; 3) skill modeling and maintenance for 12 to 24 weeks. In addition, the offender in the drug court program can participate in individual sessions and aftercare that includes other community related services such as mental health, service, housing, and so on. The DSAT treatment curriculums are well-developed treatment programs with each section having specific goals and objectives for each session, curriculum, skill development and practice exercises, and assessment of the skills gained. The program includes several treatment phases and types of meetings. The groups are to be run in closed session (all offenders enter at the same time) to ensure that there is a cohesive group therapy session built on trust and achievement of core skills among the offenders. Some of the sessions are designed for different gender and cultural issues with services to address the multiple needs of the offender community in treatment. Dr. Anspach commissioned two external reviewers of the curriculum with both confirming that the manuals were well developed and integrated core concepts of cognitive behavioral therapy for offenders.

Most importantly, OSA invested in on-going skill enhancement of the counselors that encourages counselors to learn the curriculums, advance in the application of the curriculum, and receive feedback on the development of their own clinical skills. All of this contributes to the certification process for counselors. That is, the DSAT process includes a component of quality control

to ensure that the counselors are familiar with the curriculum and display expertise in the cognitive behavioral therapy methodology. While infrequently recognized as a core component of the DSAT program, this process provides a methodology to ensure that the therapy provided to the offenders is at the highest quality available. And, it develops the skill sets of the counselor community in Maine. Videotape of group therapy sessions occur on a frequent basis, and then provide an avenue for the counselor to be rated on their skill sets. This process will allow the counselors to advance their skills in core areas that need attention.

The DSAT process also includes the use of screening, assessment, and treatment placement criteria to determine whether an offender will benefit from the DSAT community based treatment model. The screening is an invalidated tool that merely identifies a potential substance abuse problem. The Addiction Severity Index (ASI) is used in conjunction with a modified American Society of Addictive Medicine (ASAM) as criteria for treatment placement. However, the drug court process itself uses legal charge first to determine eligibility for involvement in the drug court. The substance abuse assessment becomes secondary, which is common for many drug court systems (see Anspach and Ferguson, 2002 for a discussion of this point).

Drug Treatment: Can Offenders Progress?

OSA requested that Dr. Anspach conduct a special evaluation of the DSAT drug treatment curriculum as part of the evaluation of the drug treatment courts. Dr. Anspach entered into a subcontract with Dr. Faye S. Taxman (then with the University of Maryland) to conduct this study. The purpose of this substudy was to examine whether offenders made any clinical progress in drug treatment during their participation in drug court, and the impact of the drug court processes on offender outcomes. The study was focused on the drug treatment per se, and not the drug court processes.

The study involved two components: 1) a review of a subset of clinical video tapes of DSAT; and 2) a review of the progress of 99 offenders that volunteered to be interviewed periodically during the study period (around 15 months).

A. DSAT TAPE REVIEW

A sample of video taped treatment sessions were taken from an community DSAT agency in Maine. (In practice, OSA has all agencies receive feedback on their sessions either through videotape or direct observations. In this study, we only used a sample of the tapes.) Three different counselors were asked to video tape their treatment sessions with their group of clientele. Although approximately 25 tapes were recorded, resource constraints limited the number of tapes that could be observed to ten. These ten were randomly selected to be observed and coded using the observational tool. The tapes that were selected varied in their treatment phase, specific session content and counselor. Each tape is approximately two hours in duration. Table 1 presents information related to the ten observed tapes, including the treatment phase for each session, the stated purpose of each session (from program manuals), and the observers who were trained in the observational skills. (See Bouffard and Taxman for a description of the methodology.)

Table 1. Session Phase and Description

Tape	Phase/Session Label	Program Description*	Observers' Descriptions
1	<i>MET 3:</i> Drugs on Trial	Motivation Building	Motivation; pros and cons of substance use
2	<i>Intensive 6:</i> Coping by Thinking	Thinking influencing emotions and behavior; productive and destructive thinking	Linking thoughts and actions; understanding cognitive processes or feelings; creating new ways of thinking
3	<i>Intensive 15:</i> Relapse Prevention	Relapse Prevention	Relapse prevention
4	<i>MET:</i> Drugs on trial	Motivation Building	Motivation; pros and cons of substance use
5	<i>Intensive 6:</i> Coping by thinking	Thinking influencing emotions and behavior; productive and destructive thinking	Coping by thinking, destructive & constructive thoughts; rethinking patterns
6	<i>Intensive 3:</i> Looking at Addiction	Why and how people become addicted	Understanding addiction; desired and undesired consequences of drugs/alcohol
7	<i>Intensive 9:</i> Assertiveness	Ability to act assertive in high risk situations	Assertiveness
8	<i>Intensive 13:</i> Communication/ Social Skills	How to communicate better with people	Communication and social skills
9	<i>Intensive 14:</i> Coping with Emotions	How to cope with emotional challenges (anger)	Emotional management, identifying and coping with emotions
10	<i>Intensive 15:</i> Relapse Prevention	Relapse prevention	Relapse/trigger prevention

* Hubbard, D.J. (2002)

Procedures and Materials

This section describes the data collection methods and observational tool used to assess the therapeutic integrity of this program. In general, the current version of the observational tool measures the amount of time spent on various treatment topics and activities by having trained observers record, in five-minute increments, the amount of time dedicated to these various treatment items, as they observe these activities. Items on the observational tool generally represent treatment components representing the cognitive-behavioral perspective, 12-steps/ Alcoholics Anonymous approaches, therapeutic community concepts, educational topics (e.g. parenting skills, anger management), and community management items (e.g., introducing new clients, check-ins), among others (see Table 2).

After observing a given meeting, the researchers also complete summary ratings which describe the treatment meeting more generally, for instance in terms of the level of involvement of the clients and the primary format used in the meeting (e.g., staff lecture, group discussion).

Observers were instructed to record only the primary treatment activity and format taking place at any given time. In other words, if the treatment clients were observed discussing their current emotional processes regarding their family members, the observers coded that as a discussion of “current emotional processes” rather than as a discussion of “family issues”, since the primary purpose of the treatment activity was to uncover the emotional processes, not to deal with lingering family issues. While this means that observer’s ratings were precise and avoided potentially confounding overlap of observed items, it also means that they lack some degree of completeness, as only the primary topic being reviewed was coded.

Table 2. Description of Observational Categories

Observational Category	Description and “Sample Items”
Treatment Group Management	Rule setting, announcements; “Check-In”, “Introduce new clients”, “Room Set-up”
Cognitive-Behavioral Treatment	Examine and develop new cognitive, emotional, and social skills; “Existing Cognitive Processes”, “Trigger Analysis”, “Relapse Prevention”
12 Steps/ TC	Alcoholics Anonymous traditions, therapeutic community components; “Moral Inventory”, “Reliance on a Higher Power”, “Confrontation by Peers”
Safety/ Self-Exploration	Issues related to a safe group environment, exploration of past issues; “Psychological Safety”, “Past Family Experiences”
Education/ Aftercare	Delivery of educational or after care planning services; “Vocational Education”, “Parenting Skills”, “After Care Treatment Planning”

This observational tool has proven useful in more fully documenting the specific content of substance abuse treatment services offered to participants in both jail-based drug treatment and in adult drug court treatment services. As previously discussed, the main point of emphasis here is on reliability and validity of the observational tool devised to measure the amount of time spent on various treatment topics and activities. Three observers were trained in the use of the observational tool. Definitions of

each item of the tool were reviewed and discussed at length. In order to determine inter-rater reliability, each observer separately watched each of the ten tapes and recorded their own observations resulting in three observations for each tape.

Validity of the tool will be discussed in terms of the comparison of these observed classifications with the stated approach used in the programs, though discrepancy between classifications based on the observations and the stated therapeutic approach of the program might also suggest that the program is not delivered with therapeutic integrity.

Results

Each of the tables in this section presents the range of time (in minutes) that each item was observed, across the three observers of each taped treatment session. For example, if Observer 1 rated 12 minutes of Staff-lead Discussion, Observer 2 rated 10 minutes and Observer 3 rated 13 minutes, the range (longest and shortest total time would be 10-13 minutes), while the difference in the amount of time rated for this item would be 3 minutes. Thus in interpreting the reliability of this observational process the smaller the value of the range, the more reliably the observers were able to rate or agree on the total amount that item was observed during each session. In addition, the average range is then calculated for each item (horizontally in the tables; as the mean range for that item in all 10 taped sessions, 0's included) and for each taped meeting (vertically in the tables; as the mean range for all items within each meeting, 0's included).

Treatment Format and Miscellaneous Treatment Tools. This section explores the type of treatment format most commonly used within each observational session and the type of tool, if any, used within the session (See Table 3). Most of the discrepancy between the observers' ratings was in the item representing a Staff-lead discussion format. Most of this inconsistency occurred as a result of difficulties differentiating between what constituted 'staff-lead discussion' and other treatment formats such as 'client-lead discussions' or 'writing exercises'. These conflicting observations are mainly due in part to the way that some of common treatment tools were employed in the program and a lack of

precision in the definition of the “Staff-lead discussion” item. For example, if a counselor leading the group asked the clients to work on a group exercise (developing a written list of possible responses to a hypothetical scenario), there may be discrepancy in whether the observers recorded this as ‘staff-lead discussion’ or ‘writing exercises’. In this example, due to the fact that the staff was still essentially leading the discussion, one observer might code this format as Staff-lead discussion while another might focus on the fact that the clients were taking time to write an exercise thus coding the actions differently.

Table 3. Treatment Format and Miscellaneous Treatment Tools

		Number of Sessions Observed										
		1	2	3	4	5	6	7	8	9	10	<i>Mean</i>
Treatment Format	Staff Presentation	0	0	0-8 (8)	0	0-6 (6)	0	0	0	0	0	1.4
	Staff Lead Discussion	66- 85 (19)	113 - 124 (11)	84- 115 (31)	36- 62 (26)	79- 112 (33)	79- 89 (10)	58- 79 (21)	54- 78 (24)	90- 100 (10)	30- 45 (15)	2.0
	Client Presentation	0	0	0- 16 (16)	0	0	0	0	0	0	0	1.6
	Client Lead Discussion	0	0- 17 (17)	0	0	0	0	0- 22 (22)	0	0	0- 15 (15)	5.4
	Open Discussion	0- 10 (10)	0	5-5 (0)	18- 18 (0)	0	0	0	0-8 (8)	0	0	1.8
Miscellaneous Treatment Tools	Counselor Shares Personal Information	0	0	0	0	0-4 (4)	0-1 (1)	0	0	0-1 (1)	0	0.6
	Writing Exercises	0-3 (3)	0- 25 (25)	0-7 (7)	0	0	0	0- 14 (14)	0	5-9 (4)	0	5.3
	Other Homework	0-3 (3)	0-4 (4)	0	0	0	0- 12 (12)	0	0-7 (7)	0	0-8 (8)	3.4
	Video Tapes/ Movies	0	0	0	0	0	0	0	0	0	0	0
	Ceremonies	0	0	0	0	0	0	0	0	0	0	0
	Role Plays	0- 11 (11)	0	0	0	0	0	0	20- 30 (10)	12- 20 (8)	10- 17 (7)	0
<i>Mean</i>		4.18	5.18	5.64	2.36	3.91	2.09	6.09	4.27	2.0	3.45	

Relapse Prevention and Cognitive-Behavioral Treatment. This section (see Table 4) examines the level of agreement in ratings among the three observers in relation to relapse prevention and cognitive-behavioral treatment (CBT) items. In general, there was relatively good agreement among the observers within this set of items, with most items showing no more than an average of five minutes discrepancy per meeting. In addition, all three raters agreed on 7 of 17 items that no amount of that item occurred in the taped meetings. On the other hand, some meetings were particularly more difficult to consistently code (taped meeting number 3 for instance). However, most of this discrepancy appears to have occurred due to difficulties in distinguishing between two aspects of relapse prevention (i.e., RP planning and trigger analysis). Thus, most of the source of disagreement within this meeting, seems to center on the inability to consistently decide whether what was being observed was best categorized as an attempt to increase clients' awareness of the triggers of their relapse or as an attempt to plan how to respond to those triggers. In essence the observers agreed on the general nature of the intervention at hand, but not on the specific focus of the relapse prevention activity.

Table 4. Relapse Prevention and Cognitive-Behavioral Treatment

		Number of Sessions Observed										
		1	2	3	4	5	6	7	8	9	10	<i>Average</i>
Relapse Prevention	Trigger Analysis/ Awareness	0	0-3 (3)	0- 40 (40)	0	0	18- 25 (7)	0	0	0	0	5.0
	Relapse Prevention Planning	0	0	69- 123 (54)	0-3 (3)	0	0	0	0	0	38 45 (7)	6.4
	Aftercare Treatment Planning	0	0	0	0	0	0	0	0	0	0	0
	Aftercare Social Service Planning	0	0	0	0	0	0	0	0	0	0	0
	Aftercare Support Planning	0	0	0	0-1 (1)	0	0	0	0	0	0	0
Cognitive- Behavioral Treatment	Link Feelings/ Thoughts Behaviors	0	35- 50 (15)	0	0	16- 48 (32)	0	0	0	0-5 (5)	0	5.2
	Existing Attitudes/ Values	0	0	0	0- 20 (20)	0	0-5 (5)	0	0	0-1 (1)	0	2.6
	New Attitudes/ Values	0	0	0	0	0	0	0	0	0	0	0
	Existing Cognitive Processes	0	39- 39 (0)	0	0	22- 55 (33)	0	0	0	3-5 (2)	0	3.5
	New Cognitive Skills	0	27- 55 (28)	0	0	35- 49 (14)	0	0	0	0	0	4.2
	Existing Emotional Processes	0	0- 13 (13)	0	0	0- 16 (16)	0-2 (2)	0	0	60-69 (9)	0	4.0
	New Emotional Skills	0	0	0	0	0	0	0	0	12-22 (10)	0	1.0
	Self Efficacy (self-esteem)	0	0	0	0	0	0	0	0	0	0	0
	Structured Social Skills	0	0	0	0	0	0	0	0	0	0	0
	Problem Solving/ Coping Skills	0	0	0	0	0	0	0	0	0-6 (6)	0	0.6
Daily Living Skills	0	0	0	0	0	0	0	0	0	0	0	
Anger Management	0	0	0	0	0	0	0	0	0	0	0	
<i>Mean</i>	0	3.47	5.53	1.41	5.59	0.82	0	0	1.94	0.4	1	

Treatment Readiness and Contingencies. The following table examines the treatment readiness and contingencies used in the sessions observed. Each of the sessions are two hours in duration, so any item that has less than five minutes per item or meeting different is considered to be in agreement with the raters. For the most part the treatment providers used good skills to address treatment readiness issues and to do contingencies.

Table 5. Treatment Readiness and Contingencies

		Number of Sessions Observed										
		1	2	3	4	5	6	7	8	9	10	<i>Average</i>
Treatment Readiness	Clinical Education	0-8 (8)	0-3 (3)	3-7 (4)	0	0-3 (3)	15- 25 (10)	0-3 (3)	0-1 (1)	0-9 (9)	0	4.1
	Motivation Building	65- 81 (16)	0	0-1 (1)	42- 60 (18)	0	0-3 (3)	0	0	0	0-3 (3)	4.1
	Alternative Goals	0	0	0	0	0	0	0	0	0	0	0
Contingencies	Formal Sanctions	0	0	0	0	0	0	0	0	0	0	0
	Rewards/ Positive Recognition	0	0	0	0	0	0	0	0	0	0	0
	Confrontation by Counselor	0	0	0	0	0	0	0-1 (1)	0-1 (1)	0	0	0.2
	Confrontation by Peers	0	0	0	0	0	0	0	0-1 (1)	0	0	0.1
<i>Average</i>		3.4	0.4	0.7	2.6	0.4	1.9	0.6	0.4	1.3	0.4	

12-Steps Programming, Education and Community Management. None of the observers noted any of 12-steps programming or education items (see Table 6) as occurring in this sample of meetings. The only variation in the community management category was a small range of observed amount of time spent on rules, housekeeping, and/or announcements. In general then there was relatively consistent agreement among these observers that these types of treatment items were not occurring in the sample of meetings.

Table 6. 12-Steps Programming, Education, and Community Management

		Number of Sessions Observed										
		1	2	3	4	5	6	7	8	9	10	<i>Average</i>
12-Steps Programming	Acceptance of Powerlessness	0	0	0	0	0	0	0	0	0	0	0
	Spirituality/ Higher Power	0	0	0	0	0	0	0	0	0	0	0
	Moral Inventory	0	0	0	0	0	0	0	0	0	0	0
	Making Amends	0	0	0	0	0	0	0	0	0	0	0
	Other 12-steps Traditions	0	0	0	0	0	0	0	0	0	0	0
Education	Parenting Skills	0	0	0	0	0	0	0	0	0	0	0
	Academic Education	0	0	0	0	0	0	0	0	0	0	0
	Vocational Education	0	0	0	0	0	0	0	0	0	0	0
	Job Skills Training	0	0	0	0	0	0	0	0	0	0	0
Community Management	Introduce New Clients	0	0	0	0	0	0	0	0	0	0	0
	Check-In	0	0	0	0	0	0	0	0	0	0	0
	Rules/ Housekeeping/ Announcements	2-5 (3)	4-7 (3)	5-7 (2)	0	0-2 (2)	0-3 (3)	0	0-3 (3)	0-5 (5)	0	2.1
	Community Building Activity	0	0	0	0	0	0	0	0	0	0	0
	Physical Exercise/ Warm Up	0	0	0	0	0	0	0	0	0	0	0
	Relaxation/ Visualization	0	0	0	0	0	0	0	0	0	0	0
	Physical Safety in Group	0	0	0	0	0	0	0	0	0	0	0
	Psychological Safety in Group	0	0	0	0	0	0	0	0	0	0	0

Summary of Observations. Table 7 presents the average disagreement among the 3 observers, across all item types by meeting. In general then, the observers were on average no more than 3 minutes apart from one another in their ratings of these several dozen treatment content/format items in this sample of ten videotaped meetings. Across all meetings and all items types these three observers were

able to produce ratings of the amount of time spent on various topics that were only slightly more than 90 seconds different from one another.

Table 7. Overall Average Range

	Number of Sessions Observed										<i>Overall Total Average</i>
	1	2	3	4	5	6	7	8	9	10	
<i>Total Average</i>	1.28	2.14	2.86	1.49	2.60	0.93	1.25	0.93	1.42	0.84	1.57

Table 8 presents results for the reliability of the observational tool, aggregated across item category. In general, the lowest level of reliability seems to have occurred among the Treatment Format items. This finding is likely due to the difficulties encountered in precisely capturing the nature of several specific treatment activities commonly used in this sample of meetings. In essence the difficulty centered on how to categorize in-class writing assignments and other forms of in-class, small group work that did not accurately fit the definition of “staff-lead discussion”. The next largest indicator of disagreement appears to have occurred within the Relapse Prevention and Cognitive-behavioral item category. As noted above, this disagreement generally occurred as a result of difficulties in consistently classifying relapse prevention activities as either initial “trigger analysis” or subsequent planning to prevent relapse based on the knowledge of these triggers. For the most part, however the disagreement occurred over which component of relapse prevention to code the activity as. In this case, then the disagreement is not between competing item types, but rather between which component of the overall activity type labeled “relapse prevention” to code. While examining the average range of observed time including zero’s in the calculation of the mean serves to reduce the appearance of any discrepancy in the observers’ ratings, information presented in Table 3 regarding the average discrepancy (among only those meetings/items where there was a discrepancy, meaning without zeros in the calculation) still shows relatively good levels of agreement across observers. Generally, these average differences among observers reveal less than 15 minutes of disagreement, again primarily in terms of treatment format

items and relapse prevention items, both of which have been described above. Finally, as one additional way to assess the level of agreement among the three observers by item category, the third column in Table 8 includes the proportion of all items at all meetings in which all three observers rated the item as a zero. Across item categories, all three observers rated from 66% to 88% of the items as not occurring at all.

Table 8. Overall Reliability of Item Categories

Category Items	Mean	Mean without 0's	Number of 0's
Treatment Format and Miscellaneous Treatment Tools	3.92	11.65	73/110 (66.36%)
Relapse Prevention and Cognitive-Behavioral Treatment	1.92	14.17	147/170 (86.47%)
Treatment Readiness and Contingencies	1.21	5.31	54/70 (77.14%)
12-Steps, Education and Community Management	0.12	3.00	159/180 (88.33%)
Summary	1.57	8.53	433/530 (81.7%)

B. DSAT STUDY OF 99 OFFENDERS

The following presents the results of an evaluation of the Maine Drug Court program with a special examination of the treatment offered in the drug court program. The evaluation strategy was designed to monitor the progress of drug court offenders as they progress through the various treatment stages included in the DSAT model of treatment used by the drug courts in Maine. The study team had hoped to obtain a comparison group of similar offenders that were placed on probation during the same period of time but the University of Southern Maine (USM) and the Maine Department of Corrections could not reach agreement during the two years of this study regarding access to this comparison group.

Data collection for the study took place from mid-July 2003 through November 2004. The research strategy involved collecting information on drug court offenders from administrative and case management records as well as through a series of personal interviews with drug court offenders.

Interviews were conducted at a baseline period (entrance into the study) and then again at three and six

month follow-up periods after the baseline interview. Of particular interest in the study was whether offenders made any clinical progress during the period of time that the offender was involved in DSAT and the impact of drug court processes (e.g. treatment, drug testing, sanctions and status hearings) on offender outcomes.

Data Sources

Several data sources were merged together to conduct this study. A unique research identifier was developed to allow for the linkage of data sources.

Administrative Data. The data were collected for all drug court offenders as part of a routine admissions process into the drug court program. Basic demographic information was gathered on the offenders' education, employment, family and living situation including drug use, treatment history, and criminal history.

Case Management Data. The final status at the end of the study period and documentation of DSAT stage progression were also included. The data also included rewards and sanctions imposed on drug court offenders during involvement in the drug court.

Study Instrumentation/Personal Interviews. Personal surveys were conducted with those offenders that agreed to participate in the study (see below for a discussion of this). The surveys administered included a criminal justice supervision survey, a legal pressure survey, and addiction severity index (ASI), and outpatient treatment surveys. These surveys belong to a battery of well-established and validated instruments that are used to capture key dimensions of the offender's progress in the drug treatment program (and other correctional interventions). They were selected for this evaluation because of their capacity to measure offender progress in treatment during the different stages considering some of the psycho-social status of the offender such as the readiness to change, social supports, self-efficacy, hostility, conformity, therapeutic engagement, personal progress, counselor rapport, and so on. (Refer to Appendix C for a copy of the instruments). The surveys were completed by the offenders and took about an hour to complete.

Sample

Each offender had to volunteer to participate in this study. Volunteers were solicited across the six county courts in the Maine drug court program during the recruitment period of July 2003 through May of 2004. Offenders were given the opportunity to participate through in-person requests made by independent researchers. Gift certificates to local grocery stores were offered as an incentive to participate.

During this recruitment period, offenders had a choice as to whether to participate in the study. A total of 99 offenders (34% of the 290 active clients) agreed to participate in the study. The primary reason that offenders indicated that they were not interested in participating in the study was that the offender had a busy schedule that did not allow them to easily juggle transportation, jobs, childcare and other responsibilities. As an alternative approach to recruitment, researchers approached offenders on treatment check-in day with case managers. On treatment check-in days, offenders are often required to spend considerable time meeting with or waiting for case managers. This approach proved to be a more effective venue for recruiting offenders to participate in the study. Grocery store gift certificates were again offered as an incentive. Researchers continued to recruit offenders for the study regardless of their phase in the program from July of 2003 until May 2004.

Of the 99 offenders that agreed to participate in the study and completed a baseline survey, 58 completed the three-month follow-up and 21 also completed the 6-month follow-up. Additional efforts to gather follow-up surveys from offenders that had been incarcerated included letters sent to the facility requesting continued participation in the study and several interviews occurred in prison.

Table 9 includes a breakdown of the sample by drug court of assignment. Most of the offenders are from Cumberland (26%) followed by Washington (23%), Penobscot (20%) Androscoggin (15%), York (11%) and Oxford (4%).

Table 9: Distribution of the Sample in the Study Across Drug Court

County	Percent (%)
York	11
Cumberland	26
Androscoggin	15
Oxford	4
Penobscot	20
Washington	23
<i>Total</i>	99

Characteristics of Study Population

The offenders in the drug courts in Maine tend to be those with prior history of involvement in the treatment and the criminal justice system. More than three-quarters (78%) reported prior substance abuse treatment. The majority (49%) reported opiates as the substance of choice, followed by alcohol (27%), marijuana (11%), cocaine (10%) and other drugs (4%). Many of the offenders reported (74%) use of more than one substance (see Appendix A).

Offenders also started using substances at relatively young ages which according to the research literature increases their odds of having further problems with alcohol and drugs during their lives. The average age of first use was about 13. Those in the sample were also likely to report prior involvement with the criminal justice system. The average number of prior arrests was 7, which indicates that this population was also heavily involved in the criminal justice system. About 90% of the sample reported prior drug arrests. Approximately one-third of the sample (31%) has co-occurring disorders with a diagnosis of mental illness along with substance abuse.

Although a large number of the offenders reported having children (65%), there did not appear to be other personal characteristics which are consistent with stability. The majority did not have a partner at time of drug court admission (64%) and 44% were unemployed. Forty-seven percent (47%) had less

than a 12th grade education. The overwhelming majority of offenders in the sample were male (67%) and white (93%).

As shown in Table 10, 45% of the offenders who participated were still active in the drug court. Thirty-seven (37) percent had graduated and 19% had been expelled. The most common reason for expulsion was for positive drug tests (9 of the 16 offenders). New criminal behavior was reported for 2 of the expelled offenders and 2 were expelled for failure to report to the drug court. No reason was reported for expulsion for four offenders

Table 10: Status at the Completion of the DSAT Study

Status	N	Percentage (%)
Active	38	44.7
Expelled	16	18.8
Graduated	31	36.5
Total	85	100.0

Generalizability of the DSAT Study Participants

Since this study sample was voluntary, there was some concern about the generalizability of the results to the population of drug court offenders. Using the demographic data from the administrative dataset for all offenders admitted to the drug court from January 2002 until May of 2004, we were able to determine the extent to which this sample was representative of the larger drug court population. The administrative variables examined included: the offenders court, employment at admission, gender, race, education, family status, prior drug treatment, prior arrests and convictions and status at the end of the study period (see appendix B tables 1-10).

Using a chi-square measure of association or means test, the study subjects were found to be similar to the general population of drug court participants. That is the study subjects matched the drug court participants that did not volunteer for this study based on age, prior arrests, prior drug treatment, court, employment, race, education, and family status. Gender appears to be the one differentiating feature with more female volunteering to be in this study than present in the general drug court

population; those participating in the study were less likely to have a partner at admission. These results support the generalizability of our findings to the Maine drug court population.

Offender Progress through the Maine Drug Court

Offenders admitted into the drug court are expected to move through the various treatment components based on the DSAT treatment model. The advantage of the DSAT treatment model is that it is a comprehensive treatment model that includes different levels of care based on the psychosocial functioning of the offender in the treatment process. Prior work on the DSAT model (see prior work that reviewed the DSAT model) found that the treatment curriculums were comprehensive and integrated state-of-the-art knowledge about cognitive behavioral strategies that present the offender with the skills to manage their addiction. The phases of the DSAT model are: motivational, intensive, and maintenance; most of the treatment time is spent in intensive sessions. The model allows offenders to move up and down in the treatment process according to their progress. One drawback is that many of the sites use closed sessions where offenders might have to wait before they can enter the program. According to Table 10, about 34% of the sample was recruited in the study during the motivational phase of treatment when they took the survey, 39% were in the intensive phase and 18% were in the maintenance phase. Several offenders remained in the drug court program after the maintenance phase as they waited to graduate from the drug court.

Table 11A: Treatment Phase at the Time of Entrance into the Study.

Phase	N	Percentage (%)
Motivational	34	34.3
Intensive	39	39.4
Maintenance	18	18.2
Post DSAT	8	8.1
<i>Total</i>	99	100.0

Table 11B: Length of Time in Each Phase of the DSAT Treatment Model

Length and Phase	N	Minimum Number of Days	Maximum Number of Days	Mean	Std. Deviation
Motivational	68	10.00	399.00	87.76	59.29
Intensive	43	70.00	329.00	129.81	58.87
Maintenance	28	53.00	488.00	128.46	85.89

Table 11B presents the length of time spent in each phase during the study period for all offenders in the study. Sixty-eight offenders entered phase 1. The average number of days spent in phase 1 was approximately 87. Of the 68 offenders, 43 entered phase 2 with an average stay of 129 days. Phase 1 and 2 had a similar standard deviation of about 58 days or approximately two months. For phase three, the average stay was similar to phase 2, about 128 days but the standard deviation was much larger at 85 days or almost three months.

To examine if those who successfully completed the program differed from those who did not in terms of length of stay in each phase, we conducted an analysis of variance to test for significant differences. Table 12 indicates that there are no significant differences in length of stay by status (active, graduated and expelled) at the end of the study.

Table 12: Length of Stay in Each Phase by Status at End of Study

Phase	Group	Sum of Squares	df	Mean Square	F	Sig.
Motivational	Between	1444.351	2	722.18	.201	.819
	Within	234045.9	65	3600.71		
	Total	235490.2	67			
Intensive	Between	3379.378	2	1689.69	.475	.625
	Within	142199.1	40	3554.98		
	Total	145578.5	42			
Maintenance	Between	2746.668	1	2746.67	.364	.552
	Within	196460.3	26	7556.17		
	Total	199207.0	27			

Sanctions are used by the drug court program to address noncompliant behavior. Table 12 is a list of violations documented by case manager for the offenders in the study. Of the 99 offenders in the

study, only 58 (58%) received any sanctions for negative behavior. The negative behavior was generally for positive drug testing (32%). At least one offender had up to six violations for this issue. Program violations and missed calls were also issues for which offenders were sanctioned with about 14% of the population committing at least one of these behaviors. Nine percent were sanctioned for admitted drug use. It does not appear that sanctions are used when offenders do not obtain employment.

Table 13: Types of Violations

	N	Number of Behaviors		% > 1
		Minimum	Maximum	
Positive Drug Tests	99	0	6	32
Admit Drug Use	99	0	3	9
Dishonest Behavior	99	0	1	5
Missed NA or AA meetings	99	0	2	4
Missed PO or CM meeting	99	0	3	6
Missed treatment sessions	99	0	2	4
Remain unemployed	99	0	5	0
Failure to provide urine sample	99	0	0	7
Curfew Violation	99	0	1	4
Absconder	99	0	1	2
Program Violations	99	0	2	14
Missed phone calls	99	0	3	14
New criminal behavior	99	0	1	6

Drug courts used a number of sanctions to address behavior of the drug court offenders. The nature of the sanctions range from treatment oriented sanctions to more control oriented sanctions. Table 13 includes the sanctions used for negative behaviors in this study group. The most common form of sanction was incarceration with 40% of the offenders receiving that sanction, followed by increased reporting (18%) and termination from drug court (14%). Some of the available control oriented sanctions were not used at all including level demotion and house arrest. The treatment oriented sanctions used included community service with 13% of the offenders receiving this sanction at least once.

Table 14: Type of Sanctions By Specific Categories

	N	Number of Behaviors		% > 1
		Minimum	Maximum	
<u>Control Oriented Sanctions</u>				
Incarceration sanctions	99	0	4	40
Increased reporting	99	0	3	18
Curfew restrictions	99	0	1	2
Termination	99	0	1	14
Level demotion	99	0	0	0
Sat in docket	99	0	0	0
House arrest	99	0	0	0
Verbal warning	99	0	1	1
<u>Treatment Oriented Sanctions</u>				
Community service	99	0	5	13
Increased NA and AA meetings	99	0	3	8
Written assignments	99	0	2	11

From the sanctions options, we constructed a variable to capture the sanction orientation on a continuum ranging from treatment to control oriented for each of the offenders. The number of control sanctions was divided by the total sanctions and a four category continuum was created that ranged from no sanctions, treatment sanctions, mixed and control. Table 15 includes a frequency of this variable.

Table 15: Type of Sanctions Given

Type of Sanctions	N	Percentage (%)
No Sanctions	45	45.5
Treatment	8	8.1
Mixed	9	9.1
Control	37	37.4
Total	99	100.0

More than half of the sample experienced some form of sanctions which is expected in a drug court setting. Thirty seven (37%) percent of the sample experienced control oriented sanctions followed by mixed (9%) and treatment (8%). Table 16 shows that expelled offenders were more likely to experience control-oriented sanctions than the graduated or active groups. The types of violations by status group were investigated to determine if expelled offenders were more likely to engage in serious violations. In table 17, an analysis of variance is presented that compares the number of violations for

particular behaviors across the active, graduated and expelled groups. The only significant differences in the number of violations among the three groups was for the number of positive drug tests and violations for new criminal activity. To determine which groups differ, an examination of the means of these violations across groups in Table 17 shows that expelled offenders were more likely to have violations for positive drug tests and new criminal activity.

Table 16: Sanction Orientation by Status in the Drug Court Program

Orientation	Status (N [%])			Total
	Active	Expelled	Graduated	
No Sanctions	18 (47.4%)	4 (25.0%)	15 (48.4%)	37 (43.5%)
Treatment	3 (7.9%)	--	5 (16.1%)	8 (9.4%)
Mixed	5 (13.2%)	--	4 (12.9%)	9 (10.6%)
Control	12 (31.6%)	12 (75.0%)	7 (22.6%)	31 (36.5%)
Total	38 (100.0%)	16 (100.0%)	31 (100.0%)	85 (100.0%)

Table 17: Analysis of Variance Violations by Status

Violation	Group	Sum Of Squares	df	Mean Square	F	Sig.
Positive Drug Test	Between	20.689	2	10.345	12.479	.000
	Within	40.619	49	.829		
	Total	61.308	51			
Admit Drug Use	Between	.457	2	.229	1.020	.368
	Within	10.985	49	.224		
	Total	11.442	51			
Dishonesty	Between	.262	2	.131	1.506	.232
	Within	4.258	49	.087		
	Total	4.519	51			
Missed NA/AA Meeting	Between	.185	2	.092	.822	.446
	Within	5.508	49	.249		
	Total	5.692	51			
Missed PO/CM Meeting	Between	.567	2	.284	1.139	.329
	Within	12.202	49	.249		
	Total	12.769	51			
Missed Treatment Sessions	Between	.302	2	.151	1.190	.313
	Within	6.217	49	.127		
	Total	6.519	51			
No Drug Sample	Between	.000	2	.000		
	Within	.000	49	.000		
	Total	.000	51			
No Employment	Between	.764	2	.382	.614	.545
	Within	30.467	49	.622		
	Total	31.231	51			
Past Curfew	Between	.185	2	.092	1.290	.284
	Within	3.508	49	.072		
	Total	3.692	51			
Left without Advise	Between	.064	2	.032	1.713	.191
	Within	.917	49	.019		
	Total	.981	51			
Technical Violation	Between	20212	2	1.106	2.730	.075
	Within	19.846	49	.405		
	Total	22.058	51			
Violations for Missed Call	Between	.022	2	.011	.023	.977
	Within	24.035	49	.491		
	Total	24.058	51			
New Criminal Behavior	Between	.498	2	.249	3.818	.029
	Within	3.194	49	.065		
	Total	3.692	51			

Table 18: Mean Number of Violations by Status

Status		New Criminal Behavior	Positive Drug Test
Active	Mean	.000	.8636
	N	22	22
	Std. Deviation	.000	.99021
Expelled	Mean	.250	1.9167
	N	12	12
	Std. Deviation	.45227	1.16450
Graduated	Mean	.0556	.2222
	N	18	15
	Std. Deviation	.23570	.54832
Total	Mean	.0769	.8846
	N	52	52
	Std. Deviation	.26907	1.09641

Impact of Drug Court on Psychosocial Functioning of the Offender

From the instruments that were used in the study, several scales were created to reflect psychological and social functioning of the offenders, treatment experiences and criminal justice system experiences. These scales and their descriptive statistics are listed in Appendix C. The survey items used to construct the addiction severity index were not used to construct this index (The ASI was not used in these models because offenders preferred not to answer the ASI questions as part of the follow-up surveys.)

Measuring Progress in Treatment. To identify indicators of progress over time in the psychological, social, treatment, and legal scales, we conducted several T-tests (see Table 19). First we compared scale measures for offenders who were in the drug court for less than 3 months to those that were in the drug court for more than 3 months regardless of treatment phase. These results are presented in the first three columns. They show that those who had been in the drug court program more than 3 months had significantly lower anxiety and hostility measures as well as less risk taking behavior than at baseline. They also scored significantly higher scores on social conformity scale and therapeutic engagement. They had made more personal progress, felt more positive about program staff and scored higher on counselor rapport.

Although these findings offer important insight about the characteristics that differentiate those who progress longer in the drug court, it is equally important to explore whether or not individuals in the program experience change on any of these scales as a result of program involvement. To examine this possibility, we conducted a paired-samples t-test comparing offender scores at the baseline survey with their scores at the 3 month follow-up (see last column table 18). Those factors that changed over the course of the program are depression where the score was significantly lower at the 3 month follow-up. There was also a decrease in hostility and risk-taking behavior. There was more social conformity and higher therapeutic involvement. All of these are indicators of progress in treatment, particularly as lower hostility scores indicate that the offender is becoming more receptive to change and addressing issues in their behaviors. Increased therapeutic involvement also indicates that the offender is becoming vested in the treatment process.

What these findings suggest is that there are some static factors that are related to an offender's progress through the drug court program. These factors include the offender's ability to identify personal progress and their attitudes toward the program staff, counselor rapport and counselor competence. Additionally, there are other factors that are not only related to progress, but also show *change* in the expected direction while in the program.

Table 19. T-Test Comparisons of Drug Court Progress

	Independent samples T-test (baseline only comparison)			Paired-Samples T-Test (baseline – 3 mon)	
	mean < = 3months (n=32)	mean >3 months (n=53)	diff.	diff. (n=56)	
Self Esteem scale	49	52	3.7	3	
Depression Psych scale	30	30	0.5	-3 *	
Anxiety self-scale	39	32	-7.3 *	-4	
Self-Efficacy	51	53	2.5	-5 *	
Hostility-social function scale	33	26	-7.6 **	-3 *	
Risk Taking-social function	44	35	-8.1 **	-3 *	
Social Conformity	48	52	4.4 *	3 *	
Treatment Readiness	57	57	0	0	
External Pressures	48	46	-1.37	-2	
Therapeutic Engagement	51	56	5.3 *	3 *	
Personal Progress	56	62	6.4 **	1	
Trust Group	50	53	2.8	1	
Program Staff	51	58	6.9 *	2	
Peer support	49	52	2.9	2	
Social Support	52	56	4.2	2	
Treatment Services	42	45	3.5	1	
Counselor rapport	53	59	6.1 *	2	
Counselor Competence	53	59	6 *	3	
Perception of Legal Pressure	77	75	-2.5	0.5	

* p < 05

** p < .01

Bivariate Predictors of Drug Court Outcomes. The next issue is to determine which of the administrative, psychological, social, and treatment factors distinguish among those in the active, graduated, and expelled outcomes. We conducted a multinomial logistic regression to compare effects for a dependent variable with three outcomes (graduated, active, and expelled). First we examine the offenders circumstances upon entering the program and for analytic purposes we refer to these as the administrative or background variables such as whether or not the offender was employed upon entering the program, if they had a partner at the time of admission, if they were dual diagnosed, drug of choice (alcohol vs. narcotics), if they were a polyuser, drug use frequency, gender, race, age at first criminal

activity, age at first drug use, age at admission, number of prior arrests, number of prior drug arrests, number of prior convictions, last grade completed and if they were on probation.

In Table 19 the results of multinomial logistic regression are presented. Each variable was entered separately into the model and the bivariate coefficients for each variable are shown. Highlighted in bold are the variables that show significance for at least one comparison group. No factors were significant for all three comparisons. According to Table 19, there are some significant factors that distinguish the graduated from the active group. Those in the active group had more drug arrests, prior arrests and convictions than those in the graduated group. Those in the active group were also more likely than those in the graduated group to have had a partner at the time of admission.

Several factors also distinguished the graduated from the expelled groups. Those in the graduated group were more likely than those in the expelled group to have had a partner at the beginning of the program. Offenders that graduated were also more likely than those who were expelled to have been employed at admission. Finally, offenders that graduated were less likely to have experienced control-oriented sanctions. Offenders that graduated were more likely than active offenders to have completed more years of education. The only factor that distinguished the expelled from the active group was the use of control-oriented sanctions. Expelled offenders were more likely than active and graduated offenders to have experienced control oriented sanctions.

Table 20. Bivariate Multinomial Logistic Regression Results Predicting Status at End of Study - Administrative Variables

Poly Drug User (polyuser)	-0.018	0.973	0.978	0.253	0.996	0.24
Drug Use Frequency	-0.254	0.575	0.043	0.92	0.297	0.511
Non white	-0.944	0.251	-1.455	0.251	-0.511	0.597
Gender	-0.059	0.907	0.869	0.242	0.927	0.2
Age at First Use	-0.132	0.28	-0.18	0.244	-0.048	0.745
Prior Convictions	0.176	0.039	0.136	0.193	-0.04	0.673
Number of Prior Arrests	0.173	0.022	0.085	0.365	-0.088	0.323
Drug Arrests	0.169	0.029	0.077	0.422	-0.092	0.311
On Probation At Admission	0.004	0.994	0.573	0.447	0.568	0.438
Last Year Education	-0.463	0.017	-0.297	0.19	0.166	0.422
Drug Choice	-0.561	0.33	0.643	0.316	1.204	0.066
Control Oriented Sanctions	-0.459	0.407	2.331	0.001	1.872	0.006

**Table 21. Bivariate Multinomial Logistic Regression Results
Predicting Status at End of Study**

	Model 1 active (1) -grad (0)		Model 2 expelled (1) -grad(0)		Model 3 expelled (1) -active (0)	
	B	sig.	B	Sig	B	sig.
External Pressures	0.013	0.626	0.028	0.41	0.015	0.644
Depression	0.03	0.143	0.054	0.038	0.024	0.322
Self Efficacy	-0.038	0.115	-0.052	0.096	-0.014	0.644
Hostility	0.028	0.148	0.053	0.031	0.024	0.273
Risk Taking	0.027	0.193	0.063	0.02	0.036	0.151
Treatment Readiness	-0.015	0.563	-0.063	0.043	-0.048	0.099
Self Esteem	-0.041	0.051	-0.078	0.006	-0.036	0.161
Anxiety	0.053	0.008	0.048	0.049	-0.005	0.837
Social Conformity	-0.096	0.01	-0.14	0.003	-0.043	0.262
Social Support	-0.068	0.03	-0.096	0.008	-0.028	0.327
Peer Support	-0.055	0.029	-0.056	0.073	-0.001	0.969
Therapeutic Engagement	-0.08	0.003	0.102	-0.002	-0.022	0.4
Personal Progress	-0.077	0.01	-0.094	0.007	-0.017	0.538
Trust Group	-0.046	0.04	-0.061	0.02	-0.016	0.473
Program Staff	-0.057	0.01	-0.073	0.004	-0.016	0.411
Counselor Rapport	-0.094	0.002	-0.116	0.001	-0.022	0.371
Counselor Competence	-0.086	0.002	-0.108	0.001	-0.022	0.328
Treatment Services	-0.065	0.042	-0.052	0.19	0.014	0.718
Perception of Legal Pressure	0.026	0.44	-0.006	0.947	-0.032	0.412

Table 20 includes the bivariate results predicting group membership from the psychological and social function scales, program attitude scales and the perception of legal pressure. Many of these scales distinguished the graduated from expelled group. Offenders who were expelled reported higher levels of negative functioning including higher levels of hostility, risk taking and anxiety. They also reported lower levels of treatment readiness, self-esteem, social conformity, social support, personal progress and therapeutic engagement. Offenders who were expelled also had lower scale values for program related measures including negative attitudes toward program staff, counselor competence, counselor rapport and group trust.

Some of these same factors also distinguished the active vs. graduated group membership. Active offenders reported higher levels of anxiety, less social conformity, social support and personal progress than those that graduated. Like the expelled group, they also reported lower scale

values for program measures including therapeutic engagement, program staff, counselor rapport and competence and group trust than the graduated group. Active offenders additionally reported significantly lower levels of peer support and treatment services than the graduated group. None of the measures distinguished the active from the expelled group.

Attitudes toward the drug court program clearly distinguish the graduated group from both the expelled and active groups. Those that graduated viewed program components much more favorably than expelled and active groups. Psychological and social function scales also significantly distinguish the graduated from the expelled groups, and offer some distinction between the graduated and active groups. None of the scales differentiated the expelled from the active groups which further bolsters the importance that it is the use of sanctions that separates the expelled from the active group.

Multivariate Predictors of Status Outcome. From the bivariate results, the factors that significantly distinguished the graduated, active and expelled groups were considered for the multivariate model. Since there was little evidence of a distinction between the expelled and active group based on factors, we combined the active and expelled groups together. The outcome measure for this analysis was coded 1 if the offender graduated and 0 if they were expelled or active. Thus our outcome measure is based on a measure of success rather than failure in completing the drug court program.

Using the factors demonstrating significance in the bivariate analysis as independent variables (see Tables 21), we conducted a multivariate logistic regression analysis to determine the unique influence of each on whether or not an offender graduated. We began with a consideration of the background information on each offender. We included as independent variables whether or not the offender had a partner at the time of drug court admission, if he or she was employed at the time of admission and the last year of education completed. The variables measuring prior arrests, drug arrests and convictions were highly correlated so each was entered separately (drug arrests is included in the table). The results are reported in the Model 1 columns of Table 21. The results show that having a

partner and education were significant predictors of success in the drug court program. Employment was not a significant predictor and the use of control-oriented sanctions did not predict successful drug court completion. Prior drug arrests were also not a significant predictor of successful completion. To preserve the degrees of freedom, employment, drug arrests and control oriented sanctions were excluded from further analysis.

We then considered the variables measuring attitudes toward the program. A test for multi-collinearity revealed that many of the program indicators were highly correlated with each other. Of these indicators, therapeutic engagement was highly correlated (.6 or above) with all of the other relevant program indicators with the exception of treatment services (See Appendix D). Thus, therapeutic engagement was chosen to represent the offender's attitudes toward the program and treatment readiness.

In Model 2 of Table 22, attitudes toward treatment services were entered first into the model predicting drug court outcome. The results indicate that those who have positive attitudes toward treatment services were more likely to graduate and this effect was significant after controlling for education and having a partner. In Model 3, therapeutic engagement was entered into the model along with treatment services, having a partner and education. The results indicated that those who score higher on the therapeutic engagement scale are more likely to graduate and this effect is significant when controlling for the other factors. Therapeutic engagement also appears to mediate the effect of treatment service on the likelihood of graduating since treatment effects are no longer significant.

A test for multi-collinearity among the psychological and social function scales revealed that many of the scales were highly correlated with each other (see Appendix D). Since the strength and direction of the correlations varied, we entered each into the model separately while controlling for having a partner, education and treatment services. Given that these variables were also highly correlated with therapeutic engagement, we excluded therapeutic engagement from Model 4. We entered scores for anxiety, hostility, self-esteem, risk-taking and social conformity separately. Only

social conformity demonstrated significance (see Model 4). Those scoring higher on the social conformity scale were significantly more likely to graduate when controlling for treatment services, education and having a partner. Social conformity also mediated the impact of treatment services to the point of insignificance.

Table 22. Logistic Regression Results Predicting Successful Completion of Drug Court Program

Variable	<u>Model 1</u>		<u>Model 2</u>		<u>Model 3</u>		<u>Model 4</u>	
	B	Exp(B)	B	Exp(B)	B	Exp(B)	B	Exp(B)
Have Partner	1.126 *	3.084	1.47 **	4.2	1.37 *	3.9	1.45 **	4.2
Last Grade Completed	0.489 *	1.63	0.44 *	1.55	0.414 *	1.5	0.373 *	1.4
Employment at Admission	0.329	1.39						
Control Oriented								
Sanctions	-1.089	0.337						
Prior Drug Arrests	-1.01	0.904						
Treatment Services			0.07 *	1.068	0.046	1.04	0.049	1.05
Therapeutic Engagement					0.066 *	1.07		
Social Conformity							0.081 *	1.09
<i>Model Chi-square</i>	16.9**		19.95**		23.3**		21.6**	

p< .05* , p<.01**

Discussion

This study was designed to examine the issues related to drug treatment within adult drug courts in Maine. A process and outcome studies of the Adult Drug Courts were the responsibility of Dr. Don Anspach of the University of Southern Maine. His team has been conducting these studies for the last several years to assist the drug courts in implementation issues and to assist the drug courts in learning about outcomes. The studies have generally found that the drug courts in Maine target populations with prior drug treatment experience and those that have not been successful in community supervision in the past—a population that tends to be more difficult. The process evaluations have found that the drug courts deal with a slightly smaller target population than desired in some courts, and that for the most part the drug court process is followed. Outcomes are similar to national outcomes for drug treatment

courts where 56 percent successfully complete the program within an average of 414 day window (see Anspach and Ferguson, 2005). Recidivism rates are 23 percent after one year of termination from the drug treatment court which is low given the characteristics of the target population for these drug treatment courts.

Drug treatment within the drug court program is a critical component of the intervention. Unlike other jurisdictions, Maine has developed and implemented a comprehensive drug treatment program for drug court participants. DSAT meets the established standards of NADCP for a 12 month treatment intervention that is comprehensive. DSAT was designed to consist of three critical phases of the treatment process: 1) motivation; 2) intensive skill building and cognition building; and 3) stabilization. More importantly the DSAT process incorporates a number of components to move offenders along the continuum of care based on their own progress instead of an arbitrary timeline. The study of drug treatment within the drug court was designed to determine whether the investment in quality drug treatment services has served to advance the outcomes from the drug treatment court in Maine. While it would have been preferable to conduct an experimental design to address this question, the funding and study time period did not allow for this to occur. Instead a quasi-experimental design using pre-post measures was implemented to determine whether the offenders in the drug treatment court made any clinical progress towards recovery. And, to what degree did drug court actions (e.g. supervision, drug testing, sanctions, etc.) impact the ultimate outcomes from the drug treatment courts. The answers to these questions provide an important starting point for considering how best to provide drug treatment to drug offenders in a drug court finding, an important question that few address (see Anspach and Ferguson, 2002; Taxman and Bouffard, 2002; Taxman and Bouffard, 2005).

Overall the findings from this study of DSAT has served the state of Maine well. The design of the curriculum and the training of the counselors (with period quality reviews) have resulted in the treatment programming being well implemented. A review of nearly half of the available quality review tapes found that for the most part the counselors implemented the cognitive skills in the reviewed

sessions. The skills for the most part were advancing, and that the counselors improved over time (for those that had multiple tests). The tapes revealed that there was a need for more emphasis on treatment format, time management, and using tools in the treatment sessions. That is the counselors have the techniques and understand the core components of the DSAT manualized treatment component, more emphasis however is needed in applying them in sessions and using the appropriate group management skills. It is apparent that the process to implement DSAT was thoughtful and focused on developing the skill sets of the counselors in these drug treatment courts—OSA had a separate contract with a treatment organizational to train the counselors in various sessions and to work on acquiring these tapes. All of these revealed an approach that appears to contribute to the quality of treatment sessions. This is an area that many states are struggling.

Another part of the study examined the treatment process and outcomes for 99 offenders that were drug treatment court participants during the period of time that we were conducting this study. These 99 offenders are similar to the census of 236 offenders that were in drug treatment court at the time of the study except that more female offenders agreed to participate in the study. Similar to the work by Anspach and Ferguson, the offenders that tended to be terminated early from the drug treatment court were those that were dual-diagnosis. The study sample included 44 percent that were active during the whole study period, 18 percent that were expelled, and 36 percent that graduated successfully. We were able to measure progress in treatment for the offenders, some for only 3 months and others for six months (depending on the length in treatment). Overall we found that offenders tended to improve clinically during their involvement in treatment, although as expected those that were expelled did not improve as much as the other offenders. We also found that offenders that reported a rapport with the counselors (were engaged in the therapy process) did well as well as those offenders that recognized the need to conform socially. These are both significant variables that can improve outcomes for offenders. High continuous scores on hostility and risk taking behaviors are good predictors of failure in drug treatment courts, and these tend to be offenders that make less clinical progress.

The research also found that the type of sanctions used in the drug court program may impact the outcomes from the program. Expelled offenders tended to have almost all control-oriented sanctions, even for program technical violations. Treatment oriented violations—more self help groups, changes of phase in treatment, individual counseling, etc.—were not used for the expelled offenders while they were used for those in the active and/or graduated category. The small sample sizes do not allow us to conclude that control oriented sanctions contributed to negative outcomes, the bivariate relationships and significance level lead us to believe that the nature of the drug treatment court services may affect the ultimate outcomes. That is, for the offenders that are less likely to be engaged in the treatment sanctions and/or those that engage in high risk or are hostile, treatment-oriented sanctions may provide a remedy to facilitate the offender's commitment to the goals of the drug court program. But, the control sanctions do not seem to further the engagement to the goals of the drug treatment court. A need exists to further explore these issues to determine how best to use the drug court program for these higher risk offenders that are more likely to fail.

Conclusion

Quality drug treatment services has been raised as a national issue regarding the need to ensure that the tax dollars are well spent and achieve the greatest outcomes. Many states have struggled with the concerns that drug treatment services overall may not achieve the desired outcomes, and that much of the issues have to do with the quality of services provided and the qualifications of treatment staff (Lamb, Greenlick, McCarty, 1998). The state of Maine in their drug treatment courts has taken a strategy that is considered desirable but few achieve—to develop a curriculum that is based upon sound principles of therapy, to train and advance the skills of the counselors that deliver the services, to evaluate the implementation and provide periodic feedback to improve outcomes, to include researchers in the team to provide objective feedback to the team regarding progress and components that should improve outcomes, and to address issues such as retention and screening tools as they occur. This evaluation study has shown that such a strategy can advance the delivery of treatment services.

The challenges before the state of Maine are the integration of treatment within the drug court setting. While the graduation rate overall is respectable (56 percent per Anspach and Ferguson, 2005), great strides need to be devoted to the 44 percent that do not graduate. The results from this study would suggest that the non-graduates are more likely to be the more difficult offenders with multiple needs (e.g., dual diagnosis, employment issues, hostile, higher levels of risk-taking behavior, etc.). And, the actions of the drug treatment court may need to be more attuned to the factors that can engage these offenders in a therapeutic process. The drug treatment court, as part of an overall strategy for advancing drug treatment and court practices, may desire to consider some of the following:

- Educate the judiciary on engagement and cognitive behavioral strategies for offenders that tend to be high risk and hostile, and those that appear to be less engaged in the treatment process;
- Educate the judiciary on the use of treatment oriented sanctions to shape offender behavior as part of the natural continuum of responses to negative offender behavior and advance the use of treatment related rewards to reinforce positive behaviors
- Advance the use of the judiciary (as is the case in a few drug courts that we observed) to have informal sessions with offenders to discuss treatment and the value of the treatment processes as well as the drug treatment court; and,
- Use different assessment tools to determine offenders that are less engaged in treatment, less committed to conformity, more high risk takers, and more likely to be hostile.

A few minor adjustments should assist with further integrating the drug treatment services into the fabric of the drug court. Maine has an excellent start with the DSAT curriculum, and these additional components may serve to continue the progress.

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Appendix A
Frequency Tables

Table 1

PARTYN Have partner

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00 No	52	52.5	61.2	61.2
	1.00 Yes	33	33.3	38.8	100.0
	Total	85	85.9	100.0	
Missing	System	14	14.1		
Total		99	100.0		

Table 2

EMPYN employed at admission

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00 No	37	37.4	43.5	43.5
	1.00 Yes	48	48.5	56.5	100.0
	Total	85	85.9	100.0	
Missing	System	14	14.1		
Total		99	100.0		

Table 3

GENDER gender

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00 Female	28	28.3	32.9	32.9
	1.00 Male	57	57.6	67.1	100.0
	Total	85	85.9	100.0	
Missing	System	14	14.1		
Total		99	100.0		

Table 4**NONWHITE race (recode)**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00 Non-white	6	6.1	7.1	7.1
	1.00 White	79	79.8	92.9	100.0
	Total	85	85.9	100.0	
Missing	System	14	14.1		
Total		99	100.0		

Table 5**PRIORTX prior substance abuse treatment**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00 No	19	19.2	22.4	22.4
	1.00 Yes	66	66.7	77.6	100.0
	Total	85	85.9	100.0	
Missing	System	14	14.1		
Total		99	100.0		

Table 6**DRUG1 Drug of choice**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	1.00 Alcohol	23	23.2	27.4	27.4
	2.00 Mariguana	9	9.1	10.7	38.1
	3.00 Cocaine	8	8.1	9.5	47.6
	4.00 Opiates	41	41.4	48.8	96.4
	6.00 Other	3	3.0	3.6	100.0
	Total	84	84.8	100.0	
Missing	99.00	1	1.0		
	System	14	14.1		
	Total	15	15.2		
Total		99	100.0		

Table 7

POLYUSER poly drug user

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00 No	21	21.2	26.3	26.3
	1.00 Yes	59	59.6	73.8	100.0
	Total	80	80.8	100.0	
Missing	99.00	5	5.1		
	System	14	14.1		
	Total	19	19.2		
Total		99	100.0		

Table 8

LASTGRAD last grad completed

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	8.00	4	4.0	5.1	5.1
	9.00	7	7.1	9.0	14.1
	10.00	9	9.1	11.5	25.6
	11.00	17	17.2	21.8	47.4
	12.00	32	32.3	41.0	88.5
	13.00	3	3.0	3.8	92.3
	14.00	5	5.1	6.4	98.7
	16.00	1	1.0	1.3	100.0
	Total	78	78.8	100.0	
Missing	99.00	7	7.1		
	System	14	14.1		
	Total	21	21.2		
Total		99	100.0		

Table 9

KIDSYN Have children

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00 No	17	17.2	35.4	35.4
	1.00 Yes	31	31.3	64.6	100.0
	Total	48	48.5	100.0	
Missing	99.00	37	37.4		
	System	14	14.1		
	Total	51	51.5		
Total		99	100.0		

Table 10

PRIORARR # prior arrests

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	4	4.0	4.7	4.7
	1.00	9	9.1	10.6	15.3
	2.00	6	6.1	7.1	22.4
	3.00	12	12.1	14.1	36.5
	4.00	11	11.1	12.9	49.4
	5.00	3	3.0	3.5	52.9
	6.00	1	1.0	1.2	54.1
	7.00	12	12.1	14.1	68.2
	8.00	5	5.1	5.9	74.1
	10+	22	22.2	25.9	100.0
	Total	85	85.9	100.0	
Missing	System	14	14.1		
Total		99	100.0		

Table 11**PRIORCON # prior convictions**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	6	6.1	7.1	7.1
	1.00	14	14.1	16.5	23.5
	2.00	12	12.1	14.1	37.6
	3.00	11	11.1	12.9	50.6
	4.00	6	6.1	7.1	57.6
	5.00	16	16.2	18.8	76.5
	7.00	2	2.0	2.4	78.8
	8.00	5	5.1	5.9	84.7
	9.00	3	3.0	3.5	88.2
	10+	10	10.1	11.8	100.0
	Total	85	85.9	100.0	
Missing	System	14	14.1		
Total		99	100.0		

Table 12**DRUGARR #prior drug arrests**

		Frequency	Percent	Valid Percent	Cumulative Percent
Valid	.00	8	8.1	9.4	9.4
	1.00	6	6.1	7.1	16.5
	2.00	10	10.1	11.8	28.2
	3.00	16	16.2	18.8	47.1
	4.00	4	4.0	4.7	51.8
	5.00	4	4.0	4.7	56.5
	6.00	13	13.1	15.3	71.8
	7.00	2	2.0	2.4	74.1
	8.00	4	4.0	4.7	78.8
	9.00	1	1.0	1.2	80.0
	10+	17	17.2	20.0	100.0
Total	85	85.9	100.0		
Missing	System	14	14.1		
Total		99	100.0		

Appendix B.

Table 1. Gender by Participation

Crosstab

		INSTUDY			
		no	yes	Total	
GENDER	Female	Count	45	28	73
		% within INSTUDY	22.0%	32.9%	25.2%
	Male	Count	160	57	217
		% within INSTUDY	78.0%	67.1%	74.8%
Total		Count	205	85	290
		% within INSTUDY	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	3.853 ^b	1	.050		
Continuity Correction ^a	3.291	1	.070		
Likelihood Ratio	3.730	1	.053		
Fisher's Exact Test				.055	.036
Linear-by-Linear Association	3.840	1	.050		
N of Valid Cases	290				

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 21.40.

Table 2. Race by Participation

Crosstab

			INSTUDY		Total
			no	yes	
NONWHITE	Non-white	Count	16	6	22
		% within INSTUDY	7.8%	7.1%	7.6%
	White	Count	188	79	267
		% within INSTUDY	92.2%	92.9%	92.4%
Total		Count	204	85	289
		% within INSTUDY	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.052 ^b	1	.819		
Continuity Correction ^a	.000	1	1.000		
Likelihood Ratio	.053	1	.818		
Fisher's Exact Test				1.000	.517
Linear-by-Linear Association	.052	1	.819		
N of Valid Cases	289				

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 6.47.

Table 3. Have partner by Participation

Crosstab

			INSTUDY		Total
			no	yes	
PARTYN	No	Count	87	52	139
		% within INSTUDY	44.4%	61.2%	49.5%
	Yes	Count	109	33	142
		% within INSTUDY	55.6%	38.8%	50.5%
Total		Count	196	85	281
		% within INSTUDY	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	6.685 ^b	1	.010		
Continuity Correction ^a	6.030	1	.014		
Likelihood Ratio	6.726	1	.010		
Fisher's Exact Test				.013	.007
Linear-by-Linear Association	6.661	1	.010		
N of Valid Cases	281				

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 42.05.

Table 4. Have Children by Participation

Crosstab

		INSTUDY			
		no	yes	Total	
KIDSYN	No	Count	54	17	71
		% within INSTUDY	39.7%	35.4%	38.6%
	Yes	Count	82	31	113
		% within INSTUDY	60.3%	64.6%	61.4%
Total		Count	136	48	184
		% within INSTUDY	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.275 ^b	1	.600		
Continuity Correction ^a	.124	1	.725		
Likelihood Ratio	.277	1	.598		
Fisher's Exact Test				.730	.365
Linear-by-Linear Association	.274	1	.601		
N of Valid Cases	184				

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 18.52.

Table 5. Poly Drug User by Participation

Crosstab

		INSTUDY			
		no	yes	Total	
POLYUSER	No	Count	49	21	70
		% within INSTUDY	25.9%	26.3%	26.0%
	Yes	Count	140	59	199
		% within INSTUDY	74.1%	73.8%	74.0%
Total		Count	189	80	269
		% within INSTUDY	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.003 ^b	1	.956		
Continuity Correction ^a	.000	1	1.000		
Likelihood Ratio	.003	1	.956		
Fisher's Exact Test				1.000	.535
Linear-by-Linear Association	.003	1	.956		
N of Valid Cases	269				

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 20.82.

Table 6. Prior Substance Abuse Treatment by Participation

Crosstab

		INSTUDY			
		no	yes	Total	
PRIORTX	No	Count	52	19	71
		% within INSTUDY	27.2%	22.4%	25.7%
	Yes	Count	139	66	205
		% within INSTUDY	72.8%	77.6%	74.3%
Total		Count	191	85	276
		% within INSTUDY	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.731 ^b	1	.393		
Continuity Correction ^a	.498	1	.480		
Likelihood Ratio	.744	1	.388		
Fisher's Exact Test				.457	.242
Linear-by-Linear Association	.728	1	.393		
N of Valid Cases	276				

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 21.87.

Table 7. Status at End of Study by Participation

Crosstab

		INSTUDY			
			no	yes	Total
STATUS	Active	Count	86	38	124
		% within INSTUDY	42.0%	44.7%	42.8%
	Expelled	Count	60	16	76
		% within INSTUDY	29.3%	18.8%	26.2%
	Graduated	Count	59	31	90
		% within INSTUDY	28.8%	36.5%	31.0%
Total		Count	205	85	290
		% within INSTUDY	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	3.753 ^a	2	.153
Likelihood Ratio	3.884	2	.143
Linear-by-Linear Association	.201	1	.654
N of Valid Cases	290		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 22.28.

Table 8. Court by Participation

Crosstab

		INSTUDY			
		no	yes	Total	
COURT	York	Count	41	8	49
		% within INSTUDY	20.0%	9.4%	16.9%
	Portland	Count	32	22	54
		% within INSTUDY	15.6%	25.9%	18.6%
	Lewiston	Count	44	15	59
		% within INSTUDY	21.5%	17.6%	20.3%
	Rumford	Count	15	4	19
		% within INSTUDY	7.3%	4.7%	6.6%
	Bangor	Count	37	16	53
		% within INSTUDY	18.0%	18.8%	18.3%
	Washington	Count	36	20	56
		% within INSTUDY	17.6%	23.5%	19.3%
Total		Count	205	85	290
		% within INSTUDY	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)
Pearson Chi-Square	9.576 ^a	5	.088
Likelihood Ratio	9.861	5	.079
Linear-by-Linear Association	1.459	1	.227
N of Valid Cases	290		

a. 0 cells (.0%) have expected count less than 5. The minimum expected count is 5.57.

Table 9. Employment by Participation

EMPYN * INSTUDY Crosstabulation

		INSTUDY			
		no	yes	Total	
EMPYN	No	Count	78	37	115
		% within INSTUDY	39.6%	43.5%	40.8%
	Yes	Count	119	48	167
		% within INSTUDY	60.4%	56.5%	59.2%
Total		Count	197	85	282
		% within INSTUDY	100.0%	100.0%	100.0%

Chi-Square Tests

	Value	df	Asymp. Sig. (2-sided)	Exact Sig. (2-sided)	Exact Sig. (1-sided)
Pearson Chi-Square	.381 ^b	1	.537		
Continuity Correction ^a	.235	1	.628		
Likelihood Ratio	.379	1	.538		
Fisher's Exact Test				.598	.313
Linear-by-Linear Association	.379	1	.538		
N of Valid Cases	282				

a. Computed only for a 2x2 table

b. 0 cells (.0%) have expected count less than 5. The minimum expected count is 34.66.

Table 10. T-Test for Prior arrests, convictions, grade completed by participation

Independent Samples Test

		Levene's Test for Equality of Variances		t-test for Equality of Means					95% Confidence Interval of the Difference	
		F	Sig.	t	df	Sig. (2-tailed)	Mean Difference	Std. Error Difference	Lower	Upper
Prior Arrests	Equal variance assumed	3.500	.062	1.179	268	.239	1.7709	1.50200	-1.18636	4.72809
	Equal variance not assumed			1.465	261.717	.144	1.7709	1.20873	-.60920	4.15094
Prior Convictions	Equal variance assumed	1.690	.195	.700	268	.484	.5833	.83273	-1.05620	2.22286
	Equal variance not assumed			.801	223.682	.424	.5833	.72847	-.85221	2.01887
Drug Arrests	Equal variance assumed	2.251	.135	.675	269	.500	.9283	1.37472	-1.77826	3.63488
	Equal variance not assumed			.859	267.495	.391	.9283	1.08054	-1.19912	3.05575
Last Grade Completed	Equal variance assumed	.398	.529	-.690	253	.491	-.1593	.23069	-.61360	.29504
	Equal variance not assumed			-.730	168.531	.466	-.1593	.21822	-.59008	.27152

Appendix C: Instrumentation

Appendix C

	N	Minimum	Maximum	Mean	Std. Deviation
ASELFEX A - self esteem-psych self scale	99	20.00	70.00	51.2343	12.31925
BDEPRX B-depression-psych self scale	99	10.00	61.67	30.0941	12.25960
CANXIETY anxiety-psych self scale	99	10.00	65.71	35.0649	14.00821
DSELFEX self efficacy-pysh self scale	99	32.86	70.00	52.7900	10.20120
EHOSTILE hostility -social function scale	99	10.00	60.00	28.8561	13.07839
FRISKTAK Risk Taking from social function scale	99	11.43	70.00	38.3883	12.65717
GSOCFORM SC social conformity	99	30.00	70.00	51.4083	7.95631
HTREATRD TR - treatment readiness	99	32.50	70.00	57.5029	9.95409
EPEXRESS EP-external pressures	99	23.33	68.33	47.7081	9.11203
TETHEEN TE theraputic engagement	99	23.33	70.00	55.5463	11.34926
PPERSPG PP personal progress	99	32.50	70.00	60.2551	10.14870
TGTRUST TG-trust group	99	10.00	70.00	52.4641	13.13188
PSFSTAFF program staff	99	10.00	70.00	55.6987	14.15809
CRCOUNS CR-counselor rapport	99	22.50	70.00	57.5789	11.44211
SSUPPT CC counselor competence	99	10.00	70.00	57.3058	12.68296
TSTREAT TS - treatment services	99	22.31	62.31	44.5751	8.63130
SUPPEER SUP-Peer support	99	22.50	70.00	51.2063	10.60615
SSUPPORT SS-Social Support	99	25.00	69.17	55.1816	9.41848
PLPSCORE Perception of legal pressure score baseline	99	39.00	94.00	75.6869	8.06940
Valid N (listwise)	99				

Perception of Legal Pressure Scale Scoring Notes

The PLP instrument is a work in progress that remains under development. The current version includes 35 items. Item scores are summated to yield an overall score with higher scores indicating greater perceived legal pressure. At present, all items in the instrument are utilized for scoring except for questions 6 through 9. The tool is structurally divided into 3 subsections. The first 5 items provide information about the criminal justice and treatment actors that referred and are monitoring the respondent, and the nature of promises made by the respondent regarding the treatment mandate. The second section consists of Likert-scaled items about different aspects of coerced treatment. The last section addresses specific expectations and perceptions about consequences for failing to carry out the treatment mandate.

Questions 1 thru 5 are scored as counts of the actors identified by the respondent. To make this scoring comparable with the rest of the items and to reduce skewed scores, each of these is truncated at 3 (i.e., 3 or more on an item is scored as '3'). Scores can thus range from 0 to 3.

The Likert-type items in questions 10-31 are scored as 0-3. Responses on the form are recorded as 1-4, so 1 must be subtracted from the entered values, leaving values ranging from 0-3. The following items must be **reverse coded** so higher scores reflect greater perceived coercion: 11, 13, 14, 15, 16, 19, 20, 22, 23, 26, 27, 28, 30.

The final 4 items, questions 32-35, utilize a severity scale that ranges in value from 1 to 7. Scores associated with responses A-J (each of which specify a legal or treatment consequence) are shown below. For these items to be standardized, each scored value is divided by 2.33. Each of the items can thus range from 0-3.

Severity Scale

2 years in prison (F)	7
1 year in prison (B)	6
1 year in jail (H)	6
6 months in jail (C)	5
sent to long-term TX (A)	4
few days in jail (E)	3
warning & more drug tests/court (D)	2
returned to more intense outpatient (I)	1
more time in TX (J)	1
warning & essay (G)	0

The 31 scored items are summed and then rounded to the nearest integer (to eliminate decimals from items 32-35) to create the total PLP score. The hypothesized subscale dimensions of the PLP, including knowledge, monitoring, enforcement, and severity, are shown on the next page.

Hypothesized PLC Dimensions/Subscales

Information or Knowledge (8)

1. Number of sources referring
3. Number of promises made to legal agents comply with mandate
4. Number of legal agents explaining consequences of dropout
10. The legal agent made sure I clearly understood what would happen if I failed to complete this tx program.
12. The staff of this tx program have a good understanding of my legal situation and what would happen if I failed.
14. If I fail the program, what I hear from other participants is different from what the legal agent tells me.
21. The agent has been very consistent in explaining what would happen if I don't complete the tx program.
24. What I hear from the tx staff about what will happen if I fail is very consistent with what the agent tells me.

Monitoring (7)

2. Number of legal agents keeping track of treatment progress
5. Number of legal agents who find out if failed in treatment
13. If I quit going to the treatment program, it would take a week or more before the drug court found out.
19. If I used drugs occasionally, the drug court would probably not find out.
25. Every few weeks, someone on the treatment staff talks or writes the legal agent about how I'm doing.
29. Other participants tell me that the judge and other people in the court stay involved and closely monitor tx.
31. If I start missing meetings and doing poorly in the treatment program the agent will hear about it right away.

Enforcement (10)

15. If I miss a lot of days in the treatment program or if I use drugs, the judge will send me to jail for just a few days.
16. As long as I don't split, the drug court will give me several chances before sending me to prison.
17. Going after and catching people who drop out from the drug court and split is a high priority.
18. Other participants think the judge will follow through and send them to prison if they keep messing up in tx.
20. I hear from other participants that the judge does not use jail to punish unless you break a lot of rules.
22. If I don't like this tx program, I can just talk to the agent and they will send me to another program.
23. Drug court judges threaten a lot, but they don't usually send people to jail for breaking rules.
26. I don't think the judge would really sentence me to prison if I fail in drug court.
28. I have heard that you can have several dirty drug tests in drug court before they will punish you.
29. If I split the tx program and get caught, I would probably get a warning and at least one more chance in tx.

Severity (6)

11. If it turns out I really don't like this tx program, I would probably just leave and deal with the consequences.
27. Having to do time in jail or prison would not be all that hard for me right now.
32. What do you think would happen in the drug court if you missed some meetings or had 1 or 2 dirty drug tests?
33. What do you think would happen if you split the program and then turned yourself in a month later?
34. What do you think would happen if you split the program and got rearrested for felony drug possession?
35. Which of these is closest to the minimum sentence you plad to when you opted into the drug court?

ITEM-SCORING GUIDE FOR EVALUATION OF SELF AND TREATMENT

(TCU CORRECTIONAL OUTPATIENT FORMS)

SECTION A. RATINGS OF SELF PSYCHOLOGICAL FUNCTIONING SCALES

A. Self Esteem (SE)

- 8. You have much to be proud of.
- 9. In general, you are satisfied with yourself.
- 23. You feel like a failure. ®
- 33. You feel you are basically no good. ®
- 51. You wish you had more respect for yourself. ®
- 60. You feel you are unimportant to others. ®

B. Depression (DP)

- 3. You feel sad or depressed.
- 14. You have thoughts of committing suicide.
- 20. You feel lonely.
- 28. You feel interested in life. ®
- 42. You feel extra tired or run down.
- 52. You worry or brood a lot.

C. Anxiety (AX)

- 15. You have trouble sitting still for long.
- 24. You have trouble sleeping.
- 39. You feel anxious or nervous.
- 41. You have trouble concentrating or remembering things.
- 46. You feel afraid of certain things, like elevators, crowds, or going out alone.
- 56. You feel tense or keyed-up.
- 62. You feel tightness or tension in your muscles.

D. Self Efficacy (PM)

“Pearlin Mastery Scale,” taken from Pearlin, L., & Schooler, C. (1978).

[The structure of coping. *Journal of Health and Social Behavior*, 19, 2-21.]

- 6. You have little control over the things that happen to you. ®
- 11. There is really no way you can solve some of the problems you have. ®
- 17. There is little you can do to change many of the important things in your life. ®
- 25. You often feel helpless in dealing with the problems of life. ®
- 32. Sometimes you feel that you are being pushed around in life. ®
- 45. What happens to you in the future mostly depends on you.
- 53. You can do just about anything you really set your mind to do.

Note. Numbers for each item indicate its location, and response categories are 1=Strongly Disagree to 7=Strongly Agree. Each scale is scored by averaging responses to items and multiplying by 10 (scores therefore range from 10 to 70); ® designates items with reflected scoring.

SOCIAL FUNCTIONING SCALES

E. Hostility (HS)

- 13. You feel mistreated by other people.
- 16. You like others to feel afraid of you.
- 30. You have urges to fight or hurt others.
- 35. You have a hot temper.
- 40. Your temper gets you into fights or other trouble.
- 49. You get mad at other people easily.
- 55. You have carried weapons, like knives or guns.
- 61. You feel a lot of anger inside you.

F. Risk Taking (RT)

- 1. You like to take chances.
- 10. You like the "fast" life.
- 21. You like friends who are wild.
- 22. You like to do things that are strange or exciting.
- 31. You avoid anything dangerous. ®
- 48. You only do things that feel safe. ®
- 57. You are very careful and cautious. ®

G. Social Conformity (SC)

- 2. You feel people are important to you.
- 4. You feel honesty is required in every situation.
- 18. You have trouble following rules and laws. ®
- 27. You depend on "things" more than "people". ®
- 36. You keep the same friends for a long time.
- 43. You work hard to keep a job.
- 50. Your religious beliefs are very important in your life.
- 59. Taking care of your family is very important.

TREATMENT MOTIVATION SCALES

H. Treatment Readiness (TR)

- 7. You have too many outside responsibilities now to be in this treatment program. ®
- 19. This treatment program seems too demanding for you. ®
- 29. This treatment may be your last chance to solve your drug problems.
- 34. This kind of treatment program will not be very helpful to you. ®
- 38. You plan to stay in this treatment program for awhile.
- 44. You are in this treatment program because someone else made you come. ®
- 54. This treatment program can really help you.
- 58. You want to be in a drug treatment program.

I. External Pressures (EP – not scored as scale)

- 5. You have serious drug related health problems.
- 12. You could be sent to jail or prison if you are not in treatment.
- 26. You feel a lot of pressure to be in treatment.
- 37. You have legal problems that require you to be in treatment.
- 47. You are concerned about legal problems.
- 63. You have family members who want you to be in treatment.

SECTION B. RATINGS OF TREATMENT PROCESS

PARTICIPATION IN TREATMENT

“TC Offender Progress Scales” adapted from De Leon, G. (1997).

[Offender Self-Rated Progress Checklist. New York: Center for Therapeutic Community Research.]

For application and measurement properties, see Hiller, M. L. (1996).

[Correlates of recidivism and relapse for parolees who received in-prison substance abuse treatment in Texas. Fort Worth: Texas Christian University.] and Melnick, G., De Leon, G., Thomas, G., Kressel, D., & Wexler, H. K. (1999). [Inmate motivation and participation in prison treatment programs (Manuscript submitted for publication).]

J. Therapeutic Engagement (TE)

1. You feel and show concern for others during group counseling.
18. You accept being confronted by others during group counseling.
20. You confront others about their real feelings during group counseling.
22. You are willing to talk about your feelings during group counseling.
24. You say things to give support and understanding to others during group counseling.
26. You give honest feedback to others during group counseling.

K. Personal Progress (PP)

8. You have made progress with your drug/alcohol problems.
11. You have made progress with your emotional or psychological issues.
14. You have made progress toward your treatment program goals.
28. You have made progress in understanding your feelings and how they can influence behavior.

L. Trust Group (TG)

3. You trust the treatment staff.
5. You have developed positive trusting friendships while at this program.
30. You trust other offenders in this program.
34. You trust the security staff.

M. Program Staff (PSF)

7. The treatment staff cares about you and your problems.
10. The treatment staff is helpful to you.
13. The security staff cares about you and your problems.
16. The security staff is helpful to you.

COUNSELOR ATTITUDE AND BEHAVIOR

N. Counselor Rapport (CR)

2. Your counselors are easy to talk to.
19. Your counselors speak in a way that you understand.
21. Your counselors respect you and your opinions.
23. Your counselors understand your situation and problems.
25. You trust your counselors.
27. Your counselors help you view problems/situations realistically.
29. Your counselors focus your thinking and planning.
31. Your counselors make you feel foolish or ashamed. ®

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O. Counselor Competence (CC)

4. Your counselors help you develop confidence in yourself.
6. Your counselors are well organized and prepared for each counseling session.
9. Your counselors develop treatment plans with reasonable objectives for you.
12. Your counselors keep you focused on solving specific problems.
15. Your counselors remember important details from your earlier sessions.
17. Your counselors help you make changes in your life.

32. Your counselors teach you useful ways to solve your problems.
33. You are motivated and encouraged by your counselors.

SECTION C. RATINGS OF PROGRAM ATTRIBUTES

P. Treatment Services (TS)

1. This program location is convenient for you.
2. You need more educational or vocational training services.
4. Program staff here are efficient at doing their jobs.
6. Time schedules for counseling sessions at this program are convenient for you.
9. You get too much personal counseling at this program. ®
11. You need more individual counseling sessions.
13. You need more group counseling sessions.
16. This program is organized and run well.
18. You need more lecture classes.
20. You are satisfied with this program.
22. You need more medical care and services.
24. You need more help with your emotional troubles.
28. This program is requiring you to learn responsibility and self-discipline.

Q. Peer Support (SUP)

3. Other offenders at this program care about you and your problems.
8. Other offenders at this program are helpful to you.
15. You are similar to (or like) other offenders of this program.
26. There is a sense of family (or community) in this program.

R. Social Support (SS)

5. Several people close to you have serious drug problems. ®
7. You have people close to you who respect you and your efforts in this program.
10. You have people close to you who understand your situation and problems.
12. You have people close to you who can always be trusted.
14. You have people close to you who motivate and encourage your recovery.
17. You have people close to you who expect you to make positive changes in your life.
19. You have improved your relations with other people because of this treatment.
21. Other offenders in this program are helpful in your recovery.
23. You have people close to you who help you develop confidence in yourself.
25. You have close family members who help you stay away from drugs.
27. You work in situations where drug use is common. ®
29. You have good friends who do not use drugs.

Appendix D.

Table 1. Pearson Correlations

		Correlations					
		EHOSTILE hostility -social function scale	FRISKTAK Risk Taking from social function scale	ASELFEX A - self esteem-psych self scale	TSTREAT - treatment services	TSGSOCFORM SC social conformity	CANXIETY anxiety-psych self scale
EHOSTILE hostility -social function scale	Pearson Correlatic	1	.562**	-.519**	.020	-.457**	.657**
	Sig. (2-tailed)	.	.000	.000	.848	.000	.000
	N	99	99	99	99	99	99
FRISKTAK Risk Taking from social function scale	Pearson Correlatic	.562**	1	-.234*	-.250*	-.472**	.338**
	Sig. (2-tailed)	.000	.	.020	.013	.000	.001
	N	99	99	99	99	99	99
ASELFEX A - self esteem-psych self scale	Pearson Correlatic	-.519**	-.234*	1	-.040	.405**	-.640**
	Sig. (2-tailed)	.000	.020	.	.693	.000	.000
	N	99	99	99	99	99	99
TSTREAT TS - treatm services	Pearson Correlatic	.020	-.250*	-.040	1	.262**	.175
	Sig. (2-tailed)	.848	.013	.693	.	.009	.082
	N	99	99	99	99	99	99
GSOCFORM SC soci conformity	Pearson Correlatic	-.457**	-.472**	.405**	.262**	1	-.364**
	Sig. (2-tailed)	.000	.000	.000	.009	.	.000
	N	99	99	99	99	99	99
CANXIETY anxiety-ps self scale	Pearson Correlatic	.657**	.338**	-.640**	.175	-.364**	1
	Sig. (2-tailed)	.000	.001	.000	.082	.000	.
	N	99	99	99	99	99	99

** - Correlation is significant at the 0.01 level (2-tailed).

* - Correlation is significant at the 0.05 level (2-tailed).

Table 1. Cont.

Correlations

		CC counselor competence	SUP-Pee r support	SS-Social Support	PP personal progress	TG-trust group	TE theraputic engagement	program staff	CR-course lor rapport
CC counselor competence	Pearson Correlation	1	.503**	.744**	.770**	.703**	.744**	.814**	.887**
	Sig. (2-tailed)	.	.000	.000	.000	.000	.000	.000	.000
	N	99	99	99	99	99	99	99	99
SUP-Peer support	Pearson Correlation	.503**	1	.566**	.512**	.614**	.562**	.472**	.512**
	Sig. (2-tailed)	.000	.	.000	.000	.000	.000	.000	.000
	N	99	99	99	99	99	99	99	99
SS-Social Support	Pearson Correlation	.744**	.566**	1	.758**	.551**	.613**	.592**	.745**
	Sig. (2-tailed)	.000	.000	.	.000	.000	.000	.000	.000
	N	99	99	99	99	99	99	99	99
PP persona progress	Pearson Correlation	.770**	.512**	.758**	1	.499**	.659**	.628**	.747**
	Sig. (2-tailed)	.000	.000	.000	.	.000	.000	.000	.000
	N	99	99	99	99	99	99	99	99
TG-trust group	Pearson Correlation	.703**	.614**	.551**	.499**	1	.660**	.762**	.691**
	Sig. (2-tailed)	.000	.000	.000	.000	.	.000	.000	.000
	N	99	99	99	99	99	99	99	99
TE theraputic engagemen	Pearson Correlation	.744**	.562**	.613**	.659**	.660**	1	.637**	.778**
	Sig. (2-tailed)	.000	.000	.000	.000	.000	.	.000	.000
	N	99	99	99	99	99	99	99	99
program staff	Pearson Correlation	.814**	.472**	.592**	.628**	.762**	.637**	1	.770**
	Sig. (2-tailed)	.000	.000	.000	.000	.000	.000	.	.000
	N	99	99	99	99	99	99	99	99
CR-course or rapport	Pearson Correlation	.887**	.512**	.745**	.747**	.691**	.778**	.770**	1
	Sig. (2-tailed)	.000	.000	.000	.000	.000	.000	.000	.
	N	99	99	99	99	99	99	99	99

**Correlation is significant at the 0.01 level (2-tailed).