Drug Treatment in the Community– A Case Study of System Integration Issues[1]

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WITH SLIGHTLY over 6.5 million Americans now under formal criminal justice control (in jail, prison or on probation or parole)—one-third to half of whom have substance abuse disorders—the demand for treatment far outweighs availability. In 1996, only 13 percent of state inmates were receiving treatment. More important, the type of treatment provided in justice settings is insufficient for chronic users. Nearly 70 percent of prisoners who receive treatment report attending only self-help groups or psycho-educational meetings, which are often inadequate for addressing the needs of persons with more severe substance-abuse disorders (Mumola, 1999; Belenko, 2002b). Similar needs-service mismatches are evident among offenders under probation supervision. Over 50 percent of the 4.5 million offenders under probation supervision have conditions of release that require substance abuse treatment; only 17 percent of these received drug treatment while on probation (Mumola, 1998; Bonczar, 1997).[2] Moreover, most of these services are inappropriate for the individuals' level of need, with many of the services being nonclinical (e.g., drug testing, drug education, self-help). And, nearly 40 percent of new prison intakes are due to technical violations from probation or parole supervision, largely due to substance abuse-related problems—a trend that exacerbates problems of prison crowding (Taxman, 2002; Bureau of Justice Statistics, 2000).

Addressing inadequacies in the offender treatment system will involve in part absorbing lessons learned from the extensive knowledge base on the general drug treatment delivery system developed over the past 30 years. NIDA-sponsored national studies such as the Drug Abuse Reporting Program (DARP), the Treatment Outcome Prospective Study (TOPS), and the Drug Abuse Treatment Outcome Studies (DATOS), and research programs funded by SAMSHA and CSAT such as PETS (Persistent Effects of Treatment Studies) have substantially increased our understanding of effective interventions and systems of services during this period. Policymakers, practitioners, and researchers have been able to turn their attention in recent years to encouraging wider acquisition of this knowledge and adoption of these evidence-based practices among general treatment practitioners (Backer, David, & Soucy, 1995; Chao, Sullivan, Harwood, Schildhaus, Zhand, & Imhof, 2000; Lamb, Greenlick, & McCarty, 1998; National Institute on Drug Abuse, 1999). Almost none of these efforts however, have focused specifically on the criminal justice field, including the thorny issues associated with the varying philosophies of a service-oriented treatment system and the justice system. Of the nearly 70 published articles from DATOS (Simpson, 2002), five were specific to the criminal justice offender (Farabee, Joshi, & Anglin, 2001; Farabee, Shen, Hser, Grella, & Anglin, 2001; Knight, Hiller, Broome, & Simpson, 2000; Hiller, Knight, Broome, & Simpson, 1998; Craddock, Rounds-Bryant, Flynn, & Hubbard, 1997). The picture painted by existing empirical data on the offender treatment systems is a captivating but incomplete collage that poses more questions than it answers.

With the majority of offenders participating in drug treatment outpatient programs in the community setting, a study of how these services are provided to the offender population is warranted. 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, and how the community treatment system provides services to drug court offenders. A study funded by he National Institute on Justice was intended to rigorously explore the organizational and structural issues regarding the use of treatment services and the subsequent impact of treatment delivery on client outcomes. In other words, how are drug treatment services provided within the framework of the drug court? What practices drive the drug court in recognition of the importance of treatment? This article will use the study findings to describe and discuss some of the issues surrounding drug treatment services provided to offenders in the community setting.

Drug Treatment in Drug Courts–The State of Knowledge

Recent studies of drug treatment courts have started to explore the issues about the provision

[1]This project is sponsored by The National Institute of Justice under Grant No. DC VX 0008. All opinions are those of the authors and do not reflect the opinion of the sponsoring agency. All questions should be directed to Faye S. Taxman at 301-403-4403 or at ftaxman@bgr.umd.edu. The authors would like to acknowledge that Dr. Don Anspach and Andrew Ferguson from the University of Southern Maine contributed to this project.

[2]Data pertaining to drug conditions and treatment for the probation population is readily available through the Bureau of Justice Statistics' Survey of Adults on Probation. No comparable national survey of the parole population is available.

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). In each of these studies, the percentage of drug court clients participating in treatment services varied considerably from 35 to 80 percent. The length of time in treatment 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 treatment. 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.

Two studies have examined the interaction between the justice and treatment agencies. Turner and her colleagues (2002) at RAND in a process study of 14 drug treatment courts confirm that drug court offenders have difficulties accessing treatment services in the community. In this study, the researchers found that the linkages between the drug treatment court and drug treatment system tend to be characterized by informality, where the court accesses available services but the drug treatment court and services are not well-integrated beyond these small-scale, often informal ties. Taxman and Bouffard (2002a), in their review of the data from a survey of 212 drug courts, 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, rather than the type or severity of their substance abusing behavior. Half of the drug courts reported that they have non-clinical staff screen clients for drug treatment court eligibility, and nearly 60 percent of the drug treatment courts excluded offenders from participation who were "not motivated for treatment." While drug courts are designed to integrate services across systems, the survey results found that few courts have developed such an approach. This raises many questions about the treatment services provided to offenders in the drug court setting and the impact of such services on outcomes.

Methodology

This study of drug treatment delivery in drug courts uses a combination of qualitative and quantitative methods to examine drug treatment and drug court operations in four relatively long-standing drug courts. Fieldwork was conducted from February 2001 to May 2002. On-site interviews were conducted with all dimensions of the drug court (e.g., judges, probation officers, defense attorneys, prosecutors, treatment administrators, and providers). Surveys were undertaken with 52 counseling staff employed by the treatment agencies and a total of 124 treatment sessions were also observed, using a structured tool designed to measure the nature and quantity of various clinical components of substance abuse treatment. A retrospective analysis of 2,357 drug court participants also was conducted to explore the impact of treatment participation on graduation rates and program rearrest and post-program rearrest. [3]

Sites

The sample of drug courts examined in this evaluation includes two located in relatively rural areas and two located in more urban settings. All four drug-court sites were chosen because their programs had been in operation long enough for their procedures to be institutionalized. In fact each of the courts was designated as a "Mentor Court" by the National Association of Drug Court Professionals. Site 1 is a small court operating in rural Louisiana, with a dedicated treatment provider that is part of the local county government. Site 2 is also a small, rural court operating in Oklahoma, which at the time of the evaluation was using two small private treatment providers within the community. Site 3 is a relatively large, long-running court in a medium-sized California city, which utilized existing drug treatment providers within the local community. Site 4 is a large court operating in a medium-sized Midwest city and used a dedicated public health treatment provider that was part of the court itself.

Retrospective Analysis of Drug Court Participants

The study included a retrospective analysis of 2,357 offenders enrolled in drug courts between January 1997 and December 2000. The sampling frame consists of all enrollees in drug courts, regardless of their level of participation, as long as they took part in a drug court for more than a day. Information about offender behavior and program participation was collected during their program participation (i.e., drug testing, treatment, sanctions, and graduation) and rearrest data was gathered for the 12-month post-program period. Rearrest data was gathered from the National Crime Information Center (NCIC) for all of the sites. For the most part, the most complete information was maintained by the treatment providers (as compared to the courts) and therefore the retrospective analysis tends to over-represent those drug court participants who actually attend their mandated drug treatment services.

Procedures for the Qualitative Components of the Study

As part of this study, the researchers examined the treatment components of the drug court program to learn more about the actual nature of services provided. Survey data as well as structured observations were the main techniques to gather information.

Observation of Treatment Services. Using weekly schedules provided by the treatment program administrators, the evaluation staff developed an observational schedule that maximized the number of meetings that could be observed during a four-day on-site visit. A total of 124 sessions were observed, which was approximately half of the scheduled sessions during the on-site visits. During each site visit, trained observers were assigned to unobtrusively observe treatment meetings at the various programs in the jurisdiction. Observers recorded the amounts of time (in minutes) spent on treatment topics and activities.

Counselor Surveys. Treatment program administrators also provided a list of staff who were directly involved in the delivery of services to drug court offenders. During the site visit, the researchers provided each of these counselors with a survey packet that was to be returned by mail. A total of 54 of the 92 counselors (58 percent) completed the survey. The items comprising these two questionnaires largely mirror those developed by Taxman, Simpson and Piquero (2002), including items representing conflict, labeling, social control, social learning, social dis-

[3] The methodology used the retrospective study to examine program compliance, completion, and recidivism for offenders participating in the drug court. A prospective study occurred with the treatment system to explore some of the issues related to the delivery of treatment system. Refer to Taxman, et al. for a discussion of the methodology (2002).

organization and other theories, including cognitive-behavioral (CBT) approaches.

Summary of Main Findings

Characteristics of the Drug Treatment Courts

The four drug courts included in this study adapted the general features of the drug court model to fit their particular needs. The courts for the most part were post-plea, except for site 4 (pre-plea). The courts used the existing judicial infrastructure to deliver services, holding status hearings weekly, except in site 2, where the hearings occurred twice a month. None of the four courts had a structured set of sanction protocols (i.e., graduated sanctions menus). Except for site 3, drug testing was administered by the treatment service agencies, with the treatment system sharing information on the testing results with court personnel. Drug testing tended to be more frequent in the early phases of the drug court program and was generally less intense as clients progressed in the program.

Treatment services were delivered either by an array of local providers (sites 2 and 3) or by a special treatment provider that had been contracted by the court (sites 1 and 4), as specified in Table 1. Both models of service acquisition included some access to residential drug treatment services if needed. Treatment services were offered during the full duration of the drug court period, ranging from 12 to 15 months, a treatment duration that is consistent with the recommendations of the National Association of Drug Court Professionals (1997). The drug treatment providers tend to be community-based organizations that are part of either the public health system or private agencies. Many offer a variety of services, including group counseling, relapse prevention (later phases), social and coping skills, and case management services. Support services are often offered through the local self-help community (AA, 12-step programs) in each jurisdiction. In one site the treatment providers have a formalized treatment curriculum to guide the treatment services. The use of a formalized curriculum has been suggested to be an important component of effective treatment services (Lamb, Greenlick & McCarty, 1998). None of the courts used a closed group format for treatment services (see Table 1).

Each court has a different process for determining who is eligible for participation in the drug court program. In two sites, the initial legal review of a case (of current offense and criminal history) is performed by prosecutors (sites 2 and 4), while probation performs this review in the other two sites (sites 1 and 3). None of the sites used a standard risk tool to guide the legal decision. The legal screening generally precedes the clinical screening/assessment; the decision-making process means that the severity of the substance abuse need is usually secondary to the participant's legal (offense and history) eligibility.

Characteristics of the Participants in Drug Treatment Courts

Table 2 presents the characteristics of the offenders participating in the four drug courts. Drug court participants tended to be male, with an average age range of 29 to 33 years old, and less than a third are employed at the time of placement in drug court. For the most part, offenders in these courts have had a significant criminal justice history, with over 59 percent having two or more prior arrests. Many of the offenders have also had arrests for personal and property offenses. The instant offense tends to be a drug crime, with a majority of the offenses being felonies. Prior substance abuse treatment experience varied by site, from 18 to 48 percent of participants.

Compliance with Drug Treatment Court Requirements

In the four drug courts under study, the typical offender participated in the following weekly activities during the initial stages of the drug court program, generally for the first two months: two drug tests, two or three treatment sessions (for 90 to 120 minutes each), and one status hearing (except at site 2, where the status hearing was bi-weekly). Some drug courts also required the offender to have contact with the case manager or supervision staff. While the logic behind the structured intervention is compatible with the goals of assisting the addict-offender to become committed to recovery and to be held accountable for his/her behavior, Table 3 illustrates the actual amount of participation in all phases of the program. (No information was available on status hearings in the case or automated files.)

Graduation Rates and Length of Time in Drug Court. The percentage of offenders successfully completing the drug court program ranges from 29 percent (site 4) to 47 percent (site 3). Most surprising is the actual length of time that the offenders participate in the drug court program. In each drug court, the expected duration of the program is 12 months. In this four-drug-court sample, it was common practice for both successful (average duration of 15 months) and unsuccessful graduates (average duration of 10 months) to participate in the program up to four times the expected program length (with a maximum duration of 44 months).

The four courts frequently allow offenders to extend their time in the drug court program; and, for those with more significant compliance problems, offenders can still be unsuccessfully terminated from the drug court program even though they have exhausted their time obligation in drug court. Across the four drug courts, slightly over 22 percent of the cases of unsuccessful graduates spent more than 12 months in drug court programming. Similarly, 53 percent of the successful graduates of these drug courts participated in the program well past the expected program length, suggesting that the 12-month time frame is generally too short to address the relapsing behavior and addictive nature of the addiction, or that the structured nature of the program is too demanding for many offenders to comply with all components. Alternatively, the components of the program are insufficient to address the recovery needs of the offender.

An analysis of the individual profiles of offenders finds significant differences between the types of offenders that are likely to successfully complete the drug court. In all sites except site 2, Caucasians are more likely to complete than African Americans or Hispanics—a common finding of other drug court programs. Graduates are also more likely to have higher educational backgrounds (high school diploma or above) than unsuccessfully terminated clients. Users of cocaine/crack, amphetamines, and opiates are also less likely to graduate than users of marijuana. In two sites (sites 2 and 3), it was found that participants with a history of prior substance abuse treatment are less likely to graduate than participants who are receiving treatment for the first time. At the two urban locations (sites 3 and 4), it was found that participants with more serious criminal histories are also less likely to succeed in drug court. This pattern suggests that some drug court programs have difficulty in dealing with participants presenting more severe drug using and criminal behaviors.

Drug Testing Compliance. On average, 64 percent of the successful graduates and 81 percent of the terminated offenders test positive at least once during their drug court program experience. Program compliance with drug testing requirements varies significantly but overall those that do not graduate tend to be less likely to meet the drug testing requirements.

Drug Treatment Compliance. Offenders that are unsuccessful graduates are more likely to miss treatment sessions. Overall, 62 percent of the graduates meet at least 75 percent of their treatment sessions, as compared to 21 percent of the offenders that were terminated from drug court. A review of the compliance with treatment

TABLE 1
Cross-Site Comparisons of Drug Court Structure, Operations and Phases

	Site 1	Site 2	Site 3	Site 4
Drug Court Structure	Post-plea, post adjudication	Post-plea, post adjudication	Post-plea, post adjudication	Pre-plea, pre-adjudication
Date of Inception	1997	1997	1993	1993
Program Length	15 months	3,6,9,12 months	12 months	12 months
Status Hearing				
Status Hearings	Weekly	Bi-Weekly	Weekly	Weekly
Drug Testing				
Random Testing	Yes	No	Yes	Yes
Tested By	Treatment	Treatment	External	Treatment
Amount by Phase	2x week, 2 months 2x week, 4 months 1x week, 3 months Monthly, 6 months	2x week, 3 months 1x week, 3 months 1x biweekly, 3 months Random, 3 months	2x week, 2 months 1x week, 4 months 1x week, 3 months	2x week, 2 months 1x week, 4 months 1x week, 4 months
Treatment				
No. of Providers	One Private	Two Private County Health	Multiple Contractors to County Health	County Health
Differentiated Tracks[3]	One	2 drug court tracks 4 treatment tracks	One	Six treatment tracks
Phase I	2 months	3 months	4 months	4 months
Phase II	4 months	3 months	4 months	4 months
Phase III	3 months	3 months	4 months	4 months
Phase IV	6 months	3 months	NA	NA
Closed Groups	No	No	No	No
Formalized Curriculum	No	Yes	Yes (some)	Yes
Indv Counseling in addition to Group	No	Yes	Yes	Yes

data illustrates that many offenders who successfully graduate are required to repeat various phases of the court program, with 30 percent of the graduates in treatment for 1.5 times the expected number of treatment sessions.

Rearrest Rates within Program. Of all of the participants, 14 percent of the completers and 42 percent of the terminated clients were arrested during program participation (including the extended time, beyond the 12 month that the offender remained in the program). Sixteen (16) percent of the arrestees were arrested more than once during the drug court program for new offenses. (Technical violations such as failure-to-appear were not considered in the new arrests.)

Rearrest Rates Post Program. As shown in Table 3, terminated clients are more likely to be rearrested for new offenses than are the program completers. Rearrest rates varied by site, but overall 9 percent of those successfully completing the program and 41 percent of those discharged were rearrested for a new offense within twelve months. Overall, those successfully completing the program took about 6.6 months till rearrest, whereas those terminated took an average of 4.5 months.

[3]Does not include participants placed in residential treatment.

Understanding the Dimensions of Drug Treatment Services

The second part of the study explored the nature of the drug treatment services delivered to drug court offenders to understand some of the results from the drug court participation. This section of the study involved the use of surveys and direct observations to quantify the services provided in order to understand the treatment program compliance and completion rates.

General Counselor Characteristics. Table 4 describes the basic information about the group of counselors working with these drug-involved

TABLE 2
Characteristics of Offenders Participating in Drug Courts by Site

	Site 1	Site 2	Site 3	Site 4	Total
Prior Criminal History					
Number of Prior Arrests					
None	10.9	34.9	8.6	22.1	17.9
One	23.2	20.8	14.7	28.5	23.1
Two or More	65.9	44.3	76.7	49.4	59
Mean Number of Prior Arrests	3.6	1.9	6.7	2.2	3.7
Types of Prior Arrests					
Personal	13.0	7.6	12.7	9.3	10.8
Property	29.5	19.2	23.1	27.1	25.5
Motor Vehicle/DWI	5.2	28.7	3.2	2.4	4.7
Drug	38.8	37.7	50.7	54.7	50.6
Other	13.6	6.8	10.3	6.5	8.5
Drug Court Arrest					
Personal	6.4	2.1	8.9	2.3	4.7
Property	22.3	7.3	9.3	9.7	10.6
Motor Vehicle	0.5	1.6	2.4	0.1	0.9
Drug	63.2	53.1	67.4	85.8	75.4
DUI/DWI	4.1	34.4	7.5	0.8	5.9
Other	3.6	1.6	4.7	1.2	2.5
Drug Court Arrest					
% Felony	65.2	63.5	-	96.8	59.7
Substance Abuse					
Ever Used (Lifetime)					
Alcohol	95.9	89.1	68.7	88.8	80.8
Marijuana	93.2	100	59.5	85.1	76.5
Crack/Cocaine	81.8	29.2	30.2	53.6	44.1
Amphetamines	5.0	58.9	67.5	19.7	43.7
Opiates	22.3	7.3	18.5	1.4	12.6
Other	38.2	24	10.4	14.1	16.9
Use Last 30 Days					
Alcohol	44.1	21.4	55.0	64.0	52.2
Marijuana	40.5	92.7	45.4	61.9	55.3
Crack/Cocaine	35.0	27.6	20.7	29.0	26.0

Amphetamines	0.0	13.5	51.3	6.2	26.4
Opiates	13.2	0.5	11.5	0.4	7.1
Other	6.4	6.8	9.0	2.7	6.5
% Prior Treatment Experience	48.2	27.1	17.8	37.5	28.2
Demographics					
% Male	80	79	46	72	65
% Caucasian	54	79	69	32	49
Mean Age	29	33	33	29	31
% High School Graduate/GED	37	63	25	52	40
% Employed at Admission	33	63	28	43	37

offenders. Counselors at these programs appear to have an average of four years of experience providing substance abuse treatment. The extent to which they had obtained advanced academic degrees varied by site, but it was generally low. Counselors generally work 30 to 40 hours per week, conducting between 3 and 6 group meetings (lasting from 6 to 8 hours total) per week. Overall, across all sites counselors reported that 41 percent of their time was spent in clinical tasks such as group or individual counseling with the remainder of their work time devoted to various administrative tasks (e.g., intakes, assessments, etc.). Group size was generally consistent across sites at about 10 to 13 clients per group, with caseloads ranging from 25 to nearly 77 offenders per counselor.

Counselors' Philosophies of Effective Treatment. Table 5 presents the important components of effective drug treatment as rated by the counselors working with drug court clients. Counselors rated their agreement with each of these statements using a five-point Likert scale ("1" = "strongly agreed with the statement," "5"= "strongly disagreed with the statement"). (Refer to Taxman, Simpson, and Piquero (2002) for a discussion about the instrument.) Overall, the findings show that counselors find most components to be relevant and agree that they need to part of a drug court program. This pattern of results suggests that the sample of drug court-involved counselors appear to rely upon a wide range of approaches to treatment, apparently being willing to apply almost any technique. It may also suggest that counselors do not generally have a strong affiliation or understanding of any particular approach to treatment, or that they do not implement a coherent treatment strategy in their programs.

Observation of Treatment Services. Table 6 presents information representing the proportion of all observed meetings in which any item from each category of treatment intervention occurred. For example, in site 1 (with five separate treatment programs observed) on average, only about 22 percent of the observed meetings contained any discussion of cognitive-behavioral components. Despite the vast literature demonstrating the effectiveness of cognitive-behavioral treatment components for dealing with substance abusers, no site had more than 22 percent of the observed meetings include these treatment components. Items in the education/aftercare category (mostly informational components, such as teaching clients the basic concepts and vocabulary associated with treatment or the impacts of various drug classes) were also relatively rarely employed in these programs. Similarly, items drawn from the Alcoholics Anonymous (i.e., Disease Model) and Therapeutic Community Models (e.g., confrontation, the reliance on peers as the agent of change) were also relatively rarely employed (in less than 20 percent of meetings).

Finally, treatment components aimed at creating a safe (physically and psychologically) environment for clients, as well as those fostering self-exploration, were somewhat more commonly employed, particularly in the programs operating in two sites where these items occurred in only about 25 percent of observed meetings. The observations revealed that the counselors in this sample of drug courts were employing a relatively wide range of treatment activities in group sessions. On the other hand, the cost of this diversity in treatment components appears to be that most topic areas are dealt with sparingly. Stated simply, treatment sessions tend to present a wide range of information in a largely superficial and brief manner.

Results presented in Table 7 are consistent with the survey findings that counselors use a variety of treatment components in a generally superficial approach to treatment. The counselors are dealing with a wide range of treatment issues in a "broad-based" manner, which is evident in the amount of time in a given meeting that is spent on any particular topic. For instance, in site 3, the average amount of meeting time spent on cognitive-behavioral components was 11 percent. Thus if the average group session was one and a half (1.5) hours, clients in these meetings would have spent approximately 10 minutes discussing cognitive-behavioral treatment components. Site 2 spent the most time addressing cognitive-behavioral components (26 percent of the meeting time in meetings where CBT occurred). The treatment topic area that received the most intense discussion (when it was presented) was the education/aftercare area.

Discussion and Implications of the Findings

This study was designed to examine how treatment services were provided to offenders who participated in a drug court in one of four settings. The retrospective analysis found that drug court program completion rates are low, ranging from 29 to 48 percent. This is on par with or slightly better than the typical outpatient drug treatment program, as determined by a nationwide study of outcomes from drug treatment programs (Simpson, et al., 1997), although drug court treatment services are provided for nearly four times the length of the traditional outpatient programming. It is apparent that program compliance varies considerably but few offenders are in total compliance. In each of these four drug courts, 53 percent of the graduates and 23 percent of the terminators were in drug court for more than the expected 12-month program—some for up to twice as long—presumably due to compliance problems. [The data available for this study only allow us to postulate this as a possible explanation.] The program failures are more likely to be

TABLE 3
Compliance with Drug Court Program Components and Time Spent in Drug Court by Graduation Status

	Site 1	Site 2	Site 3	Site 4	Site 5
% Graduate	31.8%	48.4%	36.2%	29.0%	33.1%
Expected Length	15 months	12 months	12 months	12 months	12 months
	G/T	G/T	G/T	G/T	G/T
Sample Size	70/150	93/99	262/461	354/878	779/1578
Program Length					
Maximum Months in Drug Court	42/44	33/36	33/42	45/43	45/44
Mean Months in Drug Court	20.9/9.8	12.6/8.8	14.6/8.1	16.4/11.0	15.7/9.9
% In Drug Court for More than 12 Months	65.7/14.7	50.5/22.2	51.7/15.2	54.0/28.6	53.8/23.1
Drug Testing					
% Positive	57.1/81.9	52.6/89.8	53.8/60.5	63.9/88.5	63.9/81.4
% Meet 75% of Required Tests	100/64.3	55.1/18.3	35.2/22.1	69.8/31.9	62.9/23.3
Drug Treatment					
% Meet 75% of Required Treatment Sessions	97.1/53.1	92.0/31.2	31.0/13.7	68.3/9.8	61.9/20.7
Rearrest Rates					
Within Program	9/15*	11/19*	21/73*	12/23*	14/42*
12 Months Post Drug Court	6/21*	11/39*	13/53*	7/38*	9/41*
Means Months to Rearrest	4.5/4.5	7.6/4.6	6.9/4.2	6.3/4.7	6.6/4.5

G=Successful Graduates; T=Unsuccessful
*P<.05

rearrested both within drug court program and post drug court program than program graduates.

A review of the qualitative data offers some insight into some of the program compliance, completion rates, and rearrest rates. The treatment providers for the drug court program, whether they are contractors or part of the public health system, and whether they operate both within the drug court setting or in their own clinics, appear to be providing treatment programming noted by the researchers in DATOS—a little bit of everything (Etheridge, et al., 1997; Simpson et al., 1997). The survey data reveal that treatment counselors do not have a philosophy of treatment and believe that a wide range of interventions is needed in treating the addict-offender population. Observations confirmed the survey data—counselors covered a wide range of material but spent little time and activities on skill development among the addict-offenders. The treatment services, although long in duration, did not have specific recovery goals. That is, the tendency is to use counselor-driven sessions that do not reflect a specific recovery philosophy, do not emphasize cognitive development, or do not focus on behavioral skill development. In essence, the practice does not appear to reinforce the Drug Court goals in that the treatment does not necessarily focus on the drug using habits of drug-involved offenders. In this manner, the drug treatment court programming—testing, treatment, sanctions, and status hearings—may not achieve one of the key goals of the drug court.

Given the qualitative data of observations and survey data of treatment counselors, it seems plausible that some of the compliance problems observed in the retrospective analysis may be due to the quality of services provided, the offender's perception that the services are not beneficial, or the offender's low level of satisfaction with the services provided.

TABLE 4
General Counselor Characteristics

	Site 1	Site 2	Site 3	Site 4	Total
Counselor Characteristic					
Respondents	3	3	21	8	38
(% Of solicited)	(50%)	(30%)	(65.6%)	(53.3%)	(54.4%)
% In Recovery	0	66.6%	38%	50%	40%
Modal Highest Degree Held	B.A.	Ph.D.	<H.S.	B.A.	<H.S.
(% w/modal degree)	(100%)	M.A., <H.S.	(48%)	(50%)	(40%)
Mean Years Providing Drug Treatment	4.0	2.5	4.7	6.1	4.8
Mean Age in Years	28.7	51.0	42.2	36.5	40.5
% White Counselors	33.3%	66.6%	19%	38%	28.6%
% African American Counselors	66.6%	33.3%	24%	25%	28.6%
Mean Hours Worked Week	40.0	27.2	40.3	30.0	36.8
Mean Number of Clients Assigned to Counselor	76.7	28.7	34.3	25.0	35.3
Mean Weekly Number of Groups (Hours/Week)	3.0	5.7	4.7	4.3	4.5
	(6.2 hours)	(8.0 hours)	(8.2 hours)	(6.8 hours)	(7.6 hours)

†- Data is from counselors who responded from all five of the programs examined at this site.
‡ - Data is from counselors who responded from both of the treatment programs at this site.

The observations and surveys confirm that there is a need for more attention to the nature of clinical services delivered to the offender population.

Conclusion and Steps for Integration

Failures on community supervision account for nearly 40 percent of the new intake to prison. Many of these failures are due to offenders not meeting the treatment conditions of release. This case study illustrated that supervision systems, and specialized programs like drug courts, need to attend to the issues of the treatment services offered to offenders participating in outpatient community-based programs. The findings from this study should persuade justice professionals to focus on the concept of integrated management of service delivery, not merely coordination. The importance of cognitive-behavioral services focused on skill development and recovery processes of offenders (Sherman, et al, 1997; Taxman, 1999). Yet, in these drug courts the treatment did not necessarily deliver the services.

The movement towards integration of services will require consideration of the following:

1. Justice and treatment teams should use quality assurance methods of treatment, testing, status hearings, sanctions and rewards to ensure that the supervision and treatment services are being delivered as planned. Quality assurance techniques should establish measurable standards for all components of the programming.
2. Treatment programming would benefit from a curriculum-driven clinical programming where there are measurable objectives. The curriculum provides a mechanism to ensure that counselors and clinical staff subscribe to a recovery process, and that the recovery process is being presented and developed in components that the offenders can comprehend.
3. Treatment programming may be focused on achieving clinical goals in each stage before proceeding to the next level.
4. Treatment programming may be assessed based on the severity of drug use and criminal behavior of drug court offenders. The programming may attend to substance abuse and criminal value systems to ensure offender long-term change.
5. Staff development of treatment and justice staff (e.g. judge, prosecutor, defender, supervision agent, etc.) may ensure that staff adopt a philosophy of recovery, a treatment curriculum, and directive skills that the addict-offender should develop during the drug court. Cross-training is critical to ensure that all treatment and justice programming reinforces the goals.
6. Treatment counselors and clinicians and the management of the program need to establish an operating philosophy that guides the care given to offenders.
7. Justice officials may compliment the treatment programming by using contingency management or graduated sanction/reward protocols. Research continues to find that structured, well-articulated behavioral expectations with set consequences are more likely to produce behavioral outcomes than responses that tend to be erratic.

TABLE 5
Mean Scores for Counselors' Philosophy of Effective Components
(1=Strongly Agree, 5=Strongly Disagree)

	Site 1	Site 2	Site 3	Site 4	Total
Effective Component Scales					
Conflict	1.4	1.8	1.8	2.2	1.9
Labeling	1.3	1.3	1.5	1.6	1.5
Social Control	1.0	1.6	1.6	1.4	1.5
Social Disorganization	1.8	1.8	1.9	1.9	1.9
Social Learning	1.8	1.7	1.5	1.3	1.5
Strain	1.6	1.5	1.5	1.2	1.4
Anti-social Values	1.8	1.8	1.6	1.4	1.6
Cognitive Skills Deficits	1.6	1.7	1.6	1.3	1.5
Disease Model	1.8	2.8	1.7	1.8	1.8
Psychopathic Character	1.8	2.8	1.9	2.3	2.1

†- Mean response for each scale is presented for responding counselors from all five of the programs at this site.
‡ - Mean response for each scale is presented for responding counselors from both treatment programs at this site.

TABLE 6
Observation of Treatment Meetings
(Percent of Meetings Observed Containing at Least One Item from the Category)

	Site 1	Site 2	Site 3	Site 4	Total
% Meetings					
Cognitive-Behavioral Items	19.5	16.8	22.4	15.3	18.5
Education and Aftercare Items	7.2	5.5	10.2	5.1	7.0
Safety and Self-Exploration Items	21.8	14.8	26.1	12.2	18.8
12-Steps (AA/NA) or Therapeutic Community (TC)	14.3	6.9	13.2	19.7	13.5

†- Data is presented from the average of five treatment programs at this site.
‡- Data is presented from the average of two treatment programs at this site.

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TABLE 7
Observation of Treatment Time
(Percent of Treatment Time Spent on Items in the Category[a]

	Site 1	Site 2	Site 3	Site 4	Total
% of Time					
Cognitive-Behavioral Items	8.2	26.5	11.1	16.6	15.6
Education and Aftercare Items	30.5	42.7	27.0	27.3	31.9
Safety and Self-Exploration Items	13.7	8.6	15.2	14.5	13.0
12-Steps (AA/NA) or Therapeutic Community (TC)	6.0	7.2	3.5	12.4	7.3

[a] – Time spent on topics rated as "other" is not included in this table, nor is time spent on breaks taken during the groups' scheduled meeting times.
†- Data is presented from the average of five treatment programs at this site.
‡- Data is presented from the average of two treatment programs at this site.

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