NATIONAL DRUG COURT INSTITUTE

REVIEW

Volume III, Issue 2
Winter 2001

NATIONAL DRUG COURT INSTITUTE
ALEXANDRIA, VIRGINIA

NATIONAL DRUG COURT INSTITUTE REVIEW

Volume III, Issue 2
Winter 2001

NATIONAL DRUG COURT INSTITUTE
ALEXANDRIA, VIRGINIA

NATIONAL DRUG COURT INSTITUTE REVIEW

Volume III, Issue 2
Winter 2001

NATIONAL DRUG COURT INSTITUTE

Judge Karen Freeman-Wilson, Executive Director
C. West Huddleston, III, Director
4900 Seminary Road, Suite 320
Alexandria, Virginia 22311
Tel. (703) 575-9400
Fax. (703) 575-9402
www.ndci.org

NDCI is supported by the Office of National Drug Control Policy, Executive Office of the President and the Drug Courts Program Office, Office of Justice Programs, U.S. Department of Justice.

This document was prepared under Cooperative Agreement Number 1999-DC-VX-K001 from the Drug Courts Program Office, Office of Justice Programs, U.S. Department of Justice. Points of view or opinions in this document are those of the authors and do not necessarily represent the official position of the U.S. Department of Justice.

Drug courts perform their duties without manifestation, by word or conduct, of bias or prejudice, including, but not limited to, bias or prejudice based upon race, gender, national origin, disability, age, sexual orientation, language or socioeconomic status.

INTRODUCTION

The Editorial Board is pleased to present the second issue of volume three of the *National Drug Court Institute Review* (Volume III, 2). Volume III takes a look at three important areas to the drug court field: the question of community reintegration and drug courts' involvement therein, change-focused drug courts and the application of the strengths-based approach, and integrating evidence-based substance abuse treatment into juvenile drug courts. Each of these areas represents a component of the future of the drug court movement, and each component has a role to play in furthering the institutionalization of drug courts throughout the United States.

These issues, and the information we are able to uncover about them, are important to the continued development and evolution of the drug court model.

In this issue:

- Carol Fisler, Greg Berman, and Aubrey Fox present an edited transcript of a focus group that discussed community reintegration and drug courts. This discussion raised a number of questions, including "What responsibilities do drug courts have to participants after they leave the court?" "What role should drug courts play in the process of reintegration into the community?" "When should the job of drug court end?" Out of this discussion the authors found a tentative consensus: while drug courts should be cautious about expanding their requirements for participants, drug courts should be creative in employing their symbolic authority to ease the transition of program graduates back into community life.
- Michael D. Clark, MSW, CSW, focuses on improving the effectiveness of the therapeutic approach in leading

to positive behavior change with drug court participants. Mr. Clark reviews important research taken from therapy outcome studies and identifies and discusses the four factors found in common with most effective treatment models. Mr. Clark then relates the four common factors to working with drug court participants.

- Jeff Randall, Ph.D., Colleen Halliday-Boykins, Ph.D., Phillippe B. Cunningham, Ph.D., and Scott W. Henggeler, Ph.D., discuss the importance of integrating evidence-based substance abuse treatments into juvenile drug courts. The authors present multisystemic therapy (MST) as an example of an evidence-based model that has achieved early success in this area. MST is also discussed in relationship to NIDA's Thirteen Principles of effective treatment, and specifically how MST meets those principles.

- Finally, this issue of the *NDCIR* concludes with a "Research Update" on three recent drug court research evaluations, compiled by authors of those evaluations themselves.

THE NATIONAL DRUG COURT INSTITUTE REVIEW

Published semi-annually, the *NDCIR*'s goal is to keep the drug court practitioner abreast of important new developments in the drug court field. Drug courts demand a great deal of time and energy of the practitioner. There is little opportunity to read lengthy evaluations or keep up with important research in the field. Yet, our ability to marshal scientific and research information and "argue the facts" can be critical to a program's success and ultimate survival.

The *NDCIR* builds a bridge between law, science and clinical communities, providing a common tool to all. A headnote and subject indexing system allows access to evaluation outcomes, scientific analysis and research on drug court related areas. Scientific jargon and legalese are interpreted for the practitioner into a common language.

Although the *NDCIR*'s emphasis is on scholarship and scientific research, it also provides commentary from experts in the drug court and related fields on important issues to drug court practitioners.

THE NATIONAL DRUG COURT INSTITUTE

The National Drug Court Institute Review is a project of the National Drug Court Institute. NDCI was established under the auspices of the National Association of Drug Court Professionals and with the support of the Office of National Drug Control Policy, Executive Office of the President and the Drug Courts Program Office, Office of Justice Programs, U.S. Department of Justice.

The National Drug Court Institute's mission is to promote education, research and scholarship to the drug court field and other court-based intervention programs.

Historically, education and training in the drug court field have only been available at regional workshops and the annual national conference; analysis and scholarship were largely limited to anecdotes and personal accounts.

That situation has changed. Evaluations exist on dozens of drug court programs. Scholars and researchers have begun to apply the rigors of scientific review and analysis to the drug court model. The level of experience and expertise necessary to support an institute now exist.

Since its creation in December 1997, NDCI has launched a comprehensive practitioner training series for judges, prosecutors, public defenders, court coordinators, treatment providers, and community supervision officers; developed a research division responsible for developing a scientific research agenda and publication dissemination strategy for the field, as well as developing a series of evaluation workshops; and published a monograph series on relevant issues to drug court institutionalization and expansion.

ACKNOWLEDGEMENTS

I wish to thank all those who have contributed to this issue of the *National Drug Court Institute Review*. To the Office of National Drug Control Policy, Executive Office of the President, and the Drug Courts Program Office, Office of Justice Programs, U.S. Department of Justice, for the leadership, support, and collaboration that those agencies have offered to the National Drug Court Institute; and to Carol Fisler, Greg Berman, Aubrey Fox, Michael D. Clark, Dr. Jeff Randall, Dr. Colleen Halliday-Boykins, Dr. Phillippe B. Cunningham, Dr. Scott W. Henggeler, Monica M. Turley, Ashley Hollweg, Dr. Robert B. Hampson, Dr. Donald F. Anspach, and Andrew S. Feguson for their contributions as authors.

Judge Karen Freeman-Wilson (Ret.)
Executive Director
National Drug Court Institute

CONTENTS

EDITED TRANSCRIPT: RISKS AND REWARDS: DRUG COURTS AND COMMUNITY REINTEGRATION

By Carol Fisler, Greg Berman, and Aubrey Fox

The next chapter of participants' lives: the return to independent community living after graduation from drug court is a question with which drug courts increasingly are being confronted. After all, the ultimate test for drug courts is not whether their clients graduate, but whether they are able to live drug-free and become law-abiding members of society. This raises some difficult questions for drug courts. What responsibilities do drug courts have to participants after they leave the court? Is it possible to ease their reintegration into the community? What tools and resources would be most helpful to drug court graduates in managing the transition? What role should drug courts play in the process? If drug courts are to take on this challenge, do they need to change the way they are structured? And what are the boundaries? When should the job of a drug court end? These questions and many other related issues are addressed in this edited transcript of a focus group session that took place in November 2000.

Carol Fisler is the Director of the Brooklyn Mental Health Court, a project of the Center for Court Innovation. The Center for Court Innovation is a public-private partnership that works to promote new thinking about how courts can solve difficult problems such as addiction, delinquency, child neglect, and domestic violence. Greg Berman and Aubrey Fox are, respectively, Acting Director and Associate Director of Special Projects at the Center. The introduction to this essay was co-written by Greg Berman and Aubrey Fox; the transcript was edited by Carol Fisler.

ARTICLE SUMMARIES

IMPORTANCE OF REINTEGRATION

[1] Drug court graduates, while no longer under the supervision of the court, must continue in their recovery.

WHAT IS REINTEGRATION?

[2] The process of reintegrating a drug court graduate is multi-faceted, involving the individual, their family, the court, and the community.

THE COURT'S ROLE

[3] A drug court's involvement must be balanced with participants' needs and community expectations, while being ever mindful of the limitations on the court.

THE COURT'S AUTHORITY

[4] Within their own specific jurisdictional limits, drug courts must balance participation with program resources when mandating reintegration.

COURTS AND COMMUNITIES

[5] Drug courts cannot and should not attempt to alter the community; they may provide leadership and guidance in identifying and acquiring resources.

RISKS INVOLVED

[6] The degree to which a drug court and its judge should take a leadership role in connecting court and community should be limited, due to possible community resistance and the drug court's limited resources.

JUDICIAL ETHICS

[7] Disagreements exist over a drug court judge's relationship with the participant and his or her partnering with the community.

COURTS AND TREATMENT

[8] The drug court needs to hold treatment providers accountable.

INTRODUCTION

In little more than a decade, drug courts have become a standard feature of the judicial landscape in this country. Every state has at least one, and some, such as New York and California, have dozens. The rapid proliferation of drug courts has been driven by research that suggests that drug courts have succeeded in reducing drug use, improving recidivism rates**,** and generating significant cost savings. In the process, the judges and lawyers who have spearheaded the drug court movement have encouraged courts to change the way they do business, adopting a problem-solving approach to cases fueled by addiction and building unprecedented partnerships with government and non-profit treatment providers. These are not insignificant accomplishments, to be sure.

These achievements do not mean that the drug court story is finished, however. What remains for drug courts is to determine how to make a difference in the next chapter of participants' lives: the return to independent community living after graduation from drug court. After all, the ultimate test for drug courts is not whether their clients graduate, but whether they are able to live drug-free and become law-abiding members of society.

The obstacles to accomplishing this goal are substantial. Drug court graduates often leave treatment without jobs, without education, and without prospects. At the same time, many must find housing, avoid old habits and acquaintances, and mend broken connections with loved ones. They need, in short, to build new lives for themselves.

This raises some difficult questions for drug courts. What responsibilities do drug courts have to participants after they leave the court? Is it possible to ease their reintegration into the community? What tools and resources would be

most helpful to drug court graduates in managing the transition? What role should drug courts play in the process? If drug courts are to take on this challenge, do they need to change the way they are structured? And what are the boundaries? When should the job of a drug court end?

To explore these and other questions related to community reintegration, the U.S. Department of Justice's Drug Courts Program Office, in collaboration with the Center for Court Innovation, convened a small group of drug court judges, treatment providers, policymakers, and academics for a day-long roundtable. The conversation, which was held in Washington, DC, in November 2000, was a wide-ranging one. Along the way, participants discussed the key elements of reintegration, the relationship between courts and communities, the limits of a court's coercive authority, and the ethical and legal challenges posed by reintegration.

Needless to say, these are topics that do not lend themselves to silver bullets or simple answers. Consensus was hard to reach. The participants did, however, share a general enthusiasm for involving drug courts in the reintegration process. "I think the community wants courts to be in the business of reintegration," said Judge John Schwartz of Rochester, NY. Participants pointed to a range of services that, based on experience, they had identified as particularly helpful to graduates, including employment, education, health, and housing.

The enthusiasm for drug courts taking on reintegration was, however, severely tested when several participants broached the idea of adding new requirements for drug court graduation or lengthening the period of court supervision. The most heated exchanges of the day were devoted to the use of coercion to facilitate reintegration. "Do you put someone in jail because he doesn't get a GED? Do you require him to get a good job? … Where do you draw the

line?" asked Valerie Raine, the former coordinator of the Brooklyn Treatment Court. "Parole and probation periods expire," remarked John Marr, the director of Choices Group, Inc., a treatment program based in Nevada. "We can't say, 'Oh, I'm sorry. Because you have a disease that you're going to deal with for the rest of your life, the court is going to continue to hold you for the rest of your life.'"

These concerns led many participants to nominate another role for drug courts in reintegration – relying on their symbolic authority to "provide leadership," "marshal resources," and "generate support" for program graduates. Drug courts could "use their leadership to empower external agencies to do a better job," said Foster Cook, associate professor and director of substance abuse programs at the University of Alabama at Birmingham. "That includes identifying programs, bringing resources into the court, and strengthening the resources that are available when people go out." Several participants asserted that drug courts could improve the accountability and effectiveness of treatment providers, requiring them to do better discharge planning and employment training as a standard component of drug treatment. According to Elizabeth Peyton, a consultant specializing in strategies for integrating substance abuse and criminal justice services, "Judges have had to be very demanding in terms of what they expect treatment providers to do."

Not all participants were as eager to encourage drug courts to play a more active leadership role. Several pointed out that drug courts are designed to hear cases, not engage in community organizing. Participants also cautioned against "romanticizing what courts can do." As Queens County, NY, Supreme Court Judge Leslie Leach said, "I think the task of trying to create better neighborhoods is too great for drug courts to take on."

Nevertheless, after a day's worth of discussion, a tentative consensus emerged: that while drug courts should be cautious about expanding their requirements, they should be creative in employing their symbolic authority to ease the transition of program graduates back into community life. "I think drug courts will sound and feel different as we move forward," asserted Delaware Superior Court Judge Richard Gebelein. "The questions that the judge asks are going to be different. We won't just be asking the defendant: 'How many clean urines have you had?' … We'll be asking: 'Where are you in getting some community help? Are you involved with any kind of organizations? What have you done to implement your discharge plan? Have you made the contacts the plan calls for? Do you have your sponsor?' And we'll be expecting the treatment providers to show what they are doing to help implement the discharge plan."

What follows is an edited transcript of the conversation, which took place over the course of a day in Washington, DC, in November 2000.

PARTICIPANTS

Ed Brekke
Administrator, Los Angeles Superior Court

Hon. Sharon Chatman
Judge, Santa Clara Superior Court, California

Foster Cook
Associate Professor and Director of the Substance Abuse Programs, Department of Psychiatry, University of Alabama at Birmingham

John Feinblatt (moderator)
Director, Center for Court Innovation

Hon. Richard Gebelein
Associate Judge, Superior Court of Delaware

Robert Tuttle
Associate Professor of Law, George Washington University Law School

Marsha Weissman
Executive Director, Center for Community Alternatives, New York City and Syracuse, New York

Ann Wilson
Alcohol and Drug Abuse Coordinator, Division of Juvenile and Adult Court Programs, Missouri

Robin Wright
Senior Deputy Administrator, First Judicial Court, Pensacola, Florida

WHY REINTEGRATION?

[1] Feinblatt: Let's start with a threshold question. Why is reintegration important?

Peyton: Drug courts want people to graduate when they complete their time in a program or produce enough clean urines. Unfortunately, some graduates aren't doing very well when they get back into the community. Graduating people from drug court isn't enough; we have to look at their ability to sustain long-term change after they graduate.

Weissman: Frankly, there's a lot of unevenness in how treatment programs deal with reentry or reintegration issues. Many treatment programs define substance abuse very narrowly; they have a hard time dealing with addiction in the context of someone's life, which can include problems with anger management, self esteem, domestic violence or a host of other issues. All too often, treatment providers don't take up these life issues. Then people get out of residential treatment and it's a shock. They need to learn to negotiate the worlds they are returning to. I think drug courts need to

play a part in this, but in figuring out the role of the drug court, we have to look to research about what works and doesn't work and how long recovery takes.

Judge Chatman: Participants in drug courts want us to be involved in reintegration. In talking to the participants as we develop exit plans, they tell us that they want to know how to survive out there. Those of us who have worked in drug courts know that some individuals, as they near graduation, do something to fail because they want to stay under the umbrella of care and nurturing that we provide for them. Judges can set requirements for participants, beyond just staying clean and sober, that will assist them with those first steps toward reintegration.

Marr: We're wrestling with the concepts that addiction is a disease and that recovery is a lifelong process, which means that substance abusers might stay in treatment forever. So we have to balance the need for drug court participants to maintain some level of involvement in treatment for the rest of their lives against the limitations on how long the court can hold them. We have determinate sentencing. We have legal processes. Parole and probation periods expire. We can't say, "Oh, I'm sorry. Because you have a disease that you're going to deal with for the rest of your life, the court is going to continue to hold you for the rest of your life."

KEY ELEMENTS OF REINTEGRATION

[2] Feinblatt: What's involved in reintegrating a drug court participant into the community? What are the elements?

Judge Schwartz: The answer to that question should start with a definition of some of the basic requirements to graduate from drug court. In our program we require a GED. We also require that graduates have a job. We've learned that a lot of participants don't know how to fill out a job

application or what clothes to wear at an interview. You can get them off drugs, but if they can't get a job they're going to go right back on drugs.

Brekke: Part of the reintegration process is making referrals to social services, medical services, and housing. We turn participants over to other resources, like alumni groups, Alcoholics Anonymous, Narcotics Anonymous, and faith groups. You need to find the resources that you have in your community and integrate them into your drug court program.

Shapiro: Families are a critical part of the process of reintegration, but their role is complex. For many people, families are part of the reason they use drugs. But guess what? Families are also the reason that people stay in treatment and are able to keep on a path to recovery. So reintegration has to involve long-term strategies to include families. Families can become a natural source of coercion to replace the authority of the court. Reintegration has to include teaching families how to help their loved ones stay in treatment, stay employed, get up for work, do all of those life skill kinds of things.

Kimbrough-Melton: That's a really important point. A lot of times when we think about reintegration we're talking about connecting people to services, which is something that obviously we need to do. If they don't have a GED, if they don't have employment, we need to connect them to those services. But what people need goes a lot further than services. We really need to help them rebuild connections with other people. We need to think about who it is that's going to help them sustain their recovery once they get back out into the community. Is it going to be the family? Is it going to be their neighbors? Is it going to be their faith community? If we just focus on services, we're not going far enough.

Huddleston: I'm interested in Carol Shapiro's comment that we need to transfer coercion from the court to another natural source in order to keep people in recovery. I think the challenge of reintegration is to help people develop internal motivation. We can't be continually turning over the power of coercion to this person and that person. The addict has to own part of this himself.

Holland: I've been hearing people talking about reintegration or going back into the community, but the reality is the majority of drug courts are using outpatient treatment. People are in the community while they're in treatment. So they're involved in changing relationships with their support networks throughout their involvement in drug court, which makes this question a little bit more confusing for me. Maybe the question needs to be how we can change the way that drug courts and treatment providers involve families and communities during the treatment process rather than after.

Wright: Reintegration has different meanings in different courts and with different populations. For offenders with heavy terms of probation, we can mandate court-ordered aftercare and require that they get jobs and maintain those jobs for several years. But for a pretrial diversion population, once they are done with drug court, we really have no jurisdiction over them. When you look at reintegration in the family court context, it's even more complex because there reintegration means reunification with children, and we want to insure the safety of that family. Finally, with the juvenile drug court we have to look at developing social peers, getting them reconnected in schools, and giving their families support. So I think it's very hard to develop a generic definition of reintegration and guidelines that apply to all the various courts and populations.

Cook: What we've been describing, and what I think applies in all types of courts, is an extension of the continuum of care to include supportive networks and connections within the community to benefit the offender after graduation.

Sviridoff: We've also been talking about expanding the continuum of care to deal with reintegration issues before graduation. There's a clear distinction. Pre-graduation you have, of course, the coercive power of the court, and you rely on it to bring about the changes you're seeking. Post-graduation, you no longer have that coercive power, so you have to rely on voluntary connections.

Judge Leach: I think drug courts need to try to pull the different facets of reintegration that we've been talking about together: the vocational piece, the educational piece, the family piece. If courts are to be involved in reentry the way we're talking about it, we have to be the driving force to harness all of these programs together.

Wilson: I've always thought that treatment providers do a good job of reintegration, but listening to the discussion today, I'm realizing that what we've been doing well is linking people up with services, getting them into school or seeing that they are employed full-time. What I'm hearing is that we need to think more about helping clients with making real life changes that are long lasting.

SHOULD DRUG COURTS BE INVOLVED IN REINTEGRATION?

[3] Feinblatt: Reintegration sounds like a pretty tall order. Is this a business that drug courts can or should be in?

Judge Schwartz: I think the community wants courts to be in the business of reintegration. What the community expects from judges is very straightforward: "We want the offenders

to stop committing crimes. Either put the offender in jail and get him out of our society or, if you're going to undertake to rehabilitate him, do it right."

Marr: Speaking for treatment providers, we also want drug courts to be involved in reintegration. Treatment providers have been doing reintegration for years – we call it the discharge plan. But treatment has done a miserable job of monitoring discharge plans. Our participants go out and nobody knows if they ever followed the plans or not. Probation is too overworked to monitor discharge plans. So who can do it? Maybe the court can do a monthly or 90-day review to help enforce compliance with the reintegration plan before we cut the umbilical cord.

Judge May: Courts didn't go out and ask for everybody to come to us for help on how to get clean and sober and how to stop committing crime, but apparently we were sitting there waiting. The court system has been increasingly called upon to do a lot of the things that used to be done out in the community. As a court system, we had the choice of saying "That's really not our responsibility; we're a court system that sits there and says: granted, denied, overruled, sustained," or saying "Well, we accept that challenge and we'll put something together that will help solve the problem." What the courts did, to their credit, was to embrace that responsibility. Taking on a role in reintegration is a natural extension of that involvement.

Marr: The involvement of the courts in treatment – especially the use of their coercive power – has really benefited substance abusers. Before drug courts, treatment providers knew that clients were open to help when they were in crisis. They would come to us when they were physically or emotionally or psychologically in need, and they would ask for help. But as soon as they started feeling better, they'd leave. They'd say, "Okay, I'm not sick now. The crisis is

gone. I can leave treatment." Drug courts allow us to keep people in treatment long enough to break through the denial and to have good progress down the road.

Sviridoff: There is a lot of research to support that. What we've seen is that without some kind of coercion, either a court mandate or some type of informal social control such as the threat of losing a marriage or a job, people don't stay very long in treatment. In therapeutic communities, less than a third of the participants will be in after 90 days, whereas in drug courts, one-year retention rates average between 60 and 70 percent. And a number of positive life changes – reduced substance abuse, reduced criminality, increased employment, better family relationships – come from being in treatment for a long period of time.

Holland: I can accept that the court's coercive power improves treatment outcomes, but the question is whether the court should have a role in reintegration that goes beyond treatment. We seem to be jumping to a conclusion that because coercion works in helping to achieve success in treatment, it will also improve success at any other behavioral change. I don't believe that we have any evidence to show that.

Sviridoff: That's a fair comment. Take employment, for example. There hasn't been much experimental research involving employment programs for ex-offenders and addicts. Intensive supported work programs had little impact on these populations. No one has tested whether coercion might make a difference. From a research point of view, we just don't know whether coercion by a drug court helps improve employment outcomes.

Tuttle: Even if we accept the premise that coercion by the court could have a positive impact on some behavioral issues, we still have to step back and ask about the court's

competence. I'm not talking about competence in the sense of capabilities, but in terms of what the institution is set up to do. It may be, as Judge May says, that nobody else is doing the job. But that doesn't mean courts have to do it. We have to ask whether courts are constitutionally appropriate for taking on reintegration – "constitutional" in the sense of both competence and separation of powers.

Kimbrough-Melton: I agree that courts, particularly criminal courts, are not necessarily the best places to take on some aspects of reintegration, but I think we have an obligation to provide leadership and to help develop the capacity of community organizations to support drug court participants when they return to the community. If we really want to have an impact, we need to start working on reintegration when they enter our doors, not at the point when we think that they're ready to go back into the community.

LIMITS

[4] Feinblatt: What are the boundaries of the court's authority? Where does the drug court's role in reintegration begin and end?

Weissman: I see a philosophical limit to the role of the court. At some point the court system needs to take a step back from its coercive role and let the more natural social networks – families and committees and churches and temples and those things – step forward.

Marr: The philosophical question that troubles me is whether the court has the right to tell somebody how to live. I once sat in on a rural drug court and had a real jolt when the judge ordered a participant to go to church. When I heard that, I almost fell under the table, but in that Mormon community in Utah it seemed appropriate. Everybody in that community was part of the Church of Latter Day Saints, and

attending church was part of the system for keeping this kid clean and sober.

Judge Leach: It can't be appropriate for a judge to order that. It's against the Constitution.

Marr: Let's substitute something else for the church, then. The important point is that not only do we as individuals have values upon which we base fairness and appropriateness, but communities also have values upon which they base what's appropriate within that particular community context. So what's appropriate for the extension of the court's jurisdiction in one community may not apply in another one. The question is: If a participant is complying with the law, do we have the right to tell him how to live the rest of his life?

Raine: I think most people would agree there's some level of responsibility that drug courts should take on in the transition out of the justice system. But how is that responsibility being implemented? Are we facilitating a transition? Or are we coercing it? The court clearly has the authority to say, "I can put you in jail if you use drugs. I can put you in jail if you don't go to your program." Because that's all directly related to crime. But when you go beyond it, as Judge Schwartz suggested, by requiring an offender to get a GED or a job, what does the court do if he doesn't? Do you put someone in jail because he doesn't get a GED? Do you require him to get a good job? Do you require him to keep it, and for how long? I heard recently, and I hope it isn't true, that one drug court requires participants to have $1,000 in a savings account before they can graduate. Where do you draw the line?

Holland: There needs to be a nexus between the goals of the court, which are presumably that the person stop using drugs and not re-offend, and the requirements that are being made of the participants. A judge told me of visiting a model drug court where the judge had the court officer confiscate a

package of cigarettes from a pregnant woman. The judge told her that if he found that she was smoking while she was still pregnant and under his control he would initiate a sanction. I understand the judge intended it for the health of the woman and the baby, but it was beyond the proper scope of the court. We need to define what's appropriate.

Sviridoff: This is a profoundly slippery slope. How much can you legitimately require someone to achieve, and do the requirements need to be related to criminal involvement? I think we would all agree that a drug court can require clean urines and attendance at treatment because drug use is a crime. When you start requiring the 15 other things that have been mentioned, including a bank account, to what extent are you pushing the court beyond its natural jurisdiction? And how are you going to respond to the kinds of violations that will inevitably occur?

Judge Leach: I agree that there are limits. I have no problem sanctioning activity that's against the law. If you have a juvenile who's smoking, that's against the law. We have to be careful that we're not exploiting a population that already has been exploited, but we don't want to release anybody too early, either. We don't want them to fail when they get back to the community. Perhaps the most important thing that we can do is to try to educate and expose them to different points of view. I think the drug court program should try to teach a certain value system so that they're better able to make intelligent choices. If you have a pregnant woman who's smoking, you can't sanction her for that. But you can say, "Go speak to this health care person and let her explain to you the potential harm, and then decide what you want to do."

Judge Schwartz: I see less of a need to establish limits on the court's authority when participation is voluntary. In our court, defendants have a choice: You can go into the regular

court system and be prosecuted, or you can go into drug court. Having signed a contract for the drug court, you have sold your soul to me for the natural jurisdiction of our court – five years for a felony, three for a misdemeanor. You have to comply with the program or I'll impose sanctions, including jail. But where we draw the line on the court's jurisdiction in any specific instance is a very subjective thing, and that's what I think drug courts are about. Our treatment people are the ones that tell us when a person is ready to graduate and reintegrate into society. I don't make that decision alone. We make it as a team.

Judge Chatman: We take a hard line on enforcing compliance with requirements. In our juvenile drug court, we've started a policy of nonsmoking. We included the juveniles in the process of deciding what sanctions will be imposed. If you have rules and everybody knows what they are, then it's a fair consequence for something to happen if you're not in compliance. But these rules don't exist in a vacuum; we offer treatment programs for smoking as well.

Weissman: When drug courts require someone to go into treatment, we have a slot for them. If we're going to require people to live in good neighborhoods and have jobs, then we'd better be prepared to provide housing and employment for them. If we sanction them, it has to be because they failed to do something that's been right at their fingertips.

Judge Gebelein: You don't have to sanction participants the same way you would if their urine turned up dirty or they broke the law. If they're not using drugs and not committing crimes, at some point you have to stop using your limited resources even if they haven't met all the requirements. It's a neutral discharge because they didn't meet the graduation criteria. Is the person better off? Yes. Is society better off? Yes, because the person is not running around committing

crimes. Will that person succeed? I don't know. But there has to come a time when you cut that bond.

Raine: You can broaden the ways that the court will facilitate the kinds of activities that will help people reintegrate, whether it's on-site vocational services or housing assistance. But if you start enforcing requirements that aren't related to crime, you run into constitutional and human rights issues. And if you set requirements and don't enforce them, you start losing clarity about the function of the court. That's why you need to draw the absolute requirements very narrowly.

Judge Schwartz: Valerie, you make it sound like drug court judges are Attila the Hun, that we are coercing everyone into doing everything. First of all, we are a very compassionate group and we want to help people. We're trying to avoid putting someone in jail whose basic crime is a sickness. On the opening day of drug court, we say, "You're going to get a GED," and "You're going to get a job." If they don't get a GED, or if they have a mental disability and can't work, I'm not going to put them in jail. But there comes a time where the person goes into what we used to call limbo in the Catholic faith. You know, we're not going to give them heaven. We're not going to give them hell. There's no more we can do for them.

Brekke: We've been focusing on coercion and sanctions; there are also incentives that some drug courts have used very effectively. I've visited a juvenile court in Arizona where the kids work with animals in a shelter as a community service project, and they love it. In one of our courts in California, participants are required to attend a cultural event before they graduate – an opera or a ballet. And it turns out that most of them really like it. In so many courts, the only incentive is a lack of a sanction. Do everything right and we won't punish

you. That's not the best way to motivate people or change behavior.

Tuttle: Let's go back to what the drug court's goals are in the context of reintegration. You're trying to make sure that the ball isn't dropped when a graduate ceases to be in front of you, that he is not just abandoned when he leaves your immediate jurisdiction. To the extent that drug courts by their nature have greater engagement with the people in front of them, part of the moral responsibility is to make sure that the engagement isn't just dropped. But the natural jurisdiction of the court also means that the engagement has to stop at some point. Yes, you can be engaged with the person in front of you, but both of you need to know that this is a time-bounded engagement.

Feinblatt: It seems to me drug courts have expanded jurisdiction way beyond where it was when I was a practicing lawyer. So what is a drug court's natural jurisdiction?

Judge May: It's easy to define the statutory limits on the length of time a court can have someone under supervision, based on the indicated prison sentence and minimum amount of probation for the offense. This will vary from New York to Delaware to California to Florida. But within that time period, we have a resource issue, which also varies by jurisdiction: How many resources are we willing to commit to try and make a difference in any particular individual's life? How long do we let somebody try to succeed? When do we cut the umbilical cord, either because they've succeeded or because they haven't? Our role ends when we as a team in the drug court decide that it's over for whatever reason. We can set down all the protocols in the world, but ultimately it's the subjective, human element that we bring to the table that tells us when our job is done.

COURTS AND THE COMMUNITY

[5] Feinblatt: If drug courts are actively involved in reintegration, then they need to make connections with the communities that their participants will be returning to. How can courts develop these connections, and do they have the capacity to do it effectively?

Kimbrough-Melton: Drug courts are fundamentally different from traditional criminal courts, which have an underlying philosophy of punishment. When we got into the drug court movement, we said we wanted to change that philosophy to some extent and focus instead on changing behavior. Now, the literature about changing behavior tells us a lot about the effects of neighborhoods on people. So if we're going to take on a role in reintegration, we almost have a moral responsibility to think about how we provide the kinds of structures within communities that will help people change their behaviors. For example, I'm working right now with a family drug court. One of the major issues for mothers in our program is housing. The problem is not a lack of housing but that people won't rent to them because they have drug addictions. So for me the role of the judge or the drug court is to provide leadership to help loosen up those housing arrangements, to build partnerships with housing providers to get our moms into those housing units.

Judge May: I spent nine-and-a-half years in delinquency court. During that time I watched kids go into programs, get all these wonderful resources, get all the things they were missing, and then we put them back in the house or in the community with the gangs that created the problem in the first place. Most of them failed, quite frankly, because they weren't able to make it if there weren't some changes in that community or family. So we have to do the best we can to prepare the people in our courts to go back into the

community, but if we can affect in any meaningful way the places they are returning to we'll have a much better result.

Judge Leach: It's an interesting issue. Do we improve the environment to which the drug court participant is going? Is that part of reintegration? Or do we just make him as whole as possible and send him out there like the people who didn't have a drug program and who are negotiating their way through that same environment? I think the task of trying to create better neighborhoods is too great for drug courts to take on.

Marr: I think there are times when you have to try to improve the environment. I recently spent a week working with drug courts in Brazil. They have places that they call *favalas*, which are slums. They will remove an entire family from that environment and find other housing for them, because the family just can't survive there.

Judge Gebelein: I don't think we're really trying to change the community for drug court graduates. I think we're going into the community to try to identify and marshal those resources that are going to be helpful to graduates in keeping a healthy lifestyle. Obviously, changing the entire community is not a role that the court can take on. If we think we can, we've really got swelled heads.

Tuttle: I'm reminded of the conversation 30 years ago among judges who were involved in the early stages of administering school desegregation orders. They moved from the early stages of saying, "You have to change the way these schools are organized," to saying, "I'm going to control bus routes," and then to saying, "I'm going to specify the funding for jurisdictions." A lot of those desegregation orders ended up being failures, because the courts were taking on too big a role.

Raine: Even if drug courts could change community environments, I don't think that they should. Drug courts have the authority to monitor and enforce. That's what courts and judges do. But when you talk about real community reintegration, you're talking about the neighborhoods, the streets, the culture, and the social and religious institutions that people are going back to. If the courts get involved in these areas you have to be very careful, because courts tend to want to start shaping and monitoring and enforcing. That raises all kinds of potential conflicts, which will inevitably lead to social judgments, economic judgments, cultural judgments. I don't mean to be alarmist and I think that communities and courts can and should have a relationship, but I think that the whole dynamic between courts and communities has to be very carefully thought out.

Shapiro: I don't know if courts can effect change in communities, but they can certainly use their authority to draw on the strengths of the community and mobilize community members in individual cases. For example, a standard question we ask of addicts in our program is: "Who in your life can help you?" That becomes a trigger to say, "Do you think the next time you come before me, your girlfriend can come with you?" When that girlfriend comes, we say, "Wow, this must be difficult for you. What are some of the things you'd like to see happen?" You literally turn that girlfriend into your ally and into a long-term source of support for the offender, by engaging her in the intervention.

Cook: Drug courts can engage communities by doing what they do best, which is to provide leadership. They can use their leadership to empower external agencies to do a better job to help support what they're doing. That includes identifying programs, bringing resources into the court, and strengthening the resources that are available when people go out.

[6] Feinblatt: Are there risks involved when drug courts take on too large a role in community reintegration?

Weissman: If the court's role in reintegration involves using coercive power to enforce less essential conditions on a small percentage of the population, then the courts stand in danger of eroding a sense of justice. We're hearing a very mixed reaction from community folks about the courts. On the one hand, they want the justice system to stop violent crime, to stop nuisance crime. But on the other hand, they're saying: These are our sons and daughters – don't deal with them in an unjust way. The more the courts stray from their essential role of dealing with the criminal offense and the underlying substance abuse, the more people will perceive the courts as part of a system of injustice.

Judge Schwartz: As it happens, the drug courts are the darling of our community right now, because people feel we're trying to do something about a problem that's ruining neighborhoods. But it takes a lot of energy to maintain that connection. My biggest fear is when you try to institutionalize something like drug courts among hundreds of judges like we're planning to do in New York, that energy and that connection are going to go away.

Raine: I think there is a risk of romanticizing what the courts can do. In order to play the kind of role we've been discussing, the court has to have a relationship with the community. In most places that I'm familiar with, and I think certainly in a lot of urban areas, that relationship, if it exists at all, is not a good one. So just to start interacting and building foundations with a community is unbelievably daunting. To give you just a sense of what it means, we did a project with one community in Brooklyn, Bedford-Stuyvesant. We put enormous effort into it. We attended every community board meeting. We went to schools. We went to churches. We went everywhere. We started to build a fabulous relationship

with the community, but then we couldn't sustain it. And in many ways, our failure to sustain that relationship damaged what we had been able to do.

JUDGE AS CONVENER

Feinblatt: A number of you have referred to courts providing leadership. Short of attempting to change the communities that drug court graduates go back to, how can courts use leadership to help with reintegration? And as drug courts are currently set up, how effective are they at exercising that leadership?

Marr: I think that the institutional leadership and the symbolic authority of judges is critical for rallying resources. I can call a meeting of all the treatment providers in my community and none of them will show up. But if the judge calls it, they all come.

Wilson: Judges can be very effective at generating support for drug courts. Good public relations not only help the court as an institution, it can really help drug court participants in the process of reintegration. If we want people to go back into the community as healthy individuals, good publicity about drug courts can help get the community to rally around the participants and support them.

Kimbrough-Melton: When I worked at the American Bar Association (ABA), I saw judges all around the country pulling people together that we could not get to the table any other way. Oftentimes though, and this is no slight to the judges, once they got them there they didn't know what to do with them. So we have to offer training and assistance to judges if we expect them to go out and build partnerships.

Peyton: Drug courts have an infrastructure that's primarily designed to process cases. They don't have staff that can

sustain projects, or attend meetings, or slug it out with state alcohol and drug directors. Courts aren't structured to run or manage programs, and if they are doing it, I suspect that they aren't doing it very well. It's usually based on the energy of a judge or two, which wears out over time. So although I agree that the court's leadership role is important, I think leadership around services is actually very difficult for courts to provide.

Judge Gebelein: I agree. I live in a relatively small county, but it consists of 40 or more different ethnic communities. Each of those groups has its own organizations and its own culture. To be honest, when I was starting a drug court I thought I could do outreach to everyone. But now that I'm supervising 450 people, I can't go out and interact with 40 different communities. There just isn't enough time, and I certainly don't have two or three ambassadors to do it for me.

Judge Chatman: We've been working intensively with juveniles in one gang-infested community, trying to provide them with community resources that will assist them in staying healthy, which means not committing crimes. I can't see undertaking the same effort in another neighborhood. I can't go out and galvanize all those resources myself. You need to have someone do this full time.

Judge Gebelein: One of the problems I foresee with that solution is that a drug court administrator or community relations person will get the same response that John Marr gets when he calls a meeting. The reality is that everybody comes to the meeting only when the judge calls it. It's not as easy to delegate as it seems.

Raine: Courts may be better configured to galvanize the community in smaller jurisdictions or ones that are more homogenous in terms of ethnicity and religion and culture. The truth of the matter is that in large urban areas where there

are many different neighborhoods, the court is not viewed as part of the community or even responsive to it. In fact, in many cases it is perceived as an enemy of the community. So for courts to be effective at community reintegration beyond simple referrals to social services, they need to start doing things very differently. They need to become culturally competent, with a culturally diverse staff. And they need to promote themselves so that the community knows who they are and has an opportunity to buy in. This takes huge resources, both in terms of staff and in terms of real estate and facilities. Drug courts are not currently set up to grapple with these issues.

Kimbrough-Melton: I'm not sure that it's any easier to do this in rural communities, where often the reality is that we just flat out don't have any resources. The programs or the services simply may not be there to link up to. Also, the state supreme court or court administrator's office may not think it's appropriate for judges to work on building community partnerships. It's been a tough argument in some states. We have come a long ways in South Carolina, where five years ago our supreme court said, "Absolutely no. This is not something that courts ought to be doing." Last year at our statewide drug court conference, that same court said this is one of the best things that's happened to South Carolina in years. But there's still very much a perception that judges' roles should be limited.

Judge May: I think it's hard to get judicial buy-in for an active role in reintegration. It's hard to convince the judiciary, at least in my jurisdiction, that giving a split sentence where you have to monitor them on the back end is a better thing than simply sentencing them to a certain period of incarceration and having the case over with and your statistics reflect a final disposition.

JUDICIAL ETHICS

[7] Feinblatt: Are there any ethical concerns about judges taking on a role in reintegration and an active role in the community?

Judge Leach: I'm concerned about courts being in the business of selecting partners. Once you link with a community organization, they tend to use your name in connection with whatever else they're seeking to do. Every time I'm about to speak to somebody outside of the court's sphere of influence, I wonder if I'm crossing some type of ethical boundary. We judges wear black robes as a sign of neutrality. Once we start to go into the community and pick one program over another, we're showing some favoritism. I don't think that that's within our bailiwick. And I have even more concerns with religious organizations. I don't know how to broker relations with faith-based institutions without getting into church-state issues.

Judge Schwartz: The real question is whether it's proper for the judge to be a convener of community resources. But isn't that what drug court is all about? As John Marr pointed out, they come if we call them. Whatever that power is, I like it, and I feel I have an obligation to use it to make the criminal justice system more successful. I would love to get rid of my "objection overruled" duties and spend more time convening the neighborhoods and the people who are players. Judge Leach, you were worried about favoring this one or that one. I think you can use them all. When I started my program, I invited everyone in our community to the train station. But one thing for sure was that the train was going to leave the station. So anyone who wants to be part of the program, we use them equally. And we get together every month so we are all on the same page. I believe this is an appropriate role for a judge to play, and I have no qualms about it. My job is

to improve the administration of justice, and drug court does that.

Tuttle: I have a different ethical concern about the power of judges. I get worried when I hear judges say, "We're going to keep a hold of them until they're better," or "I want to know them personally," or "I have a parental involvement with them." Now I can understand the temptation to do that. I've watched enough drug court proceedings to understand that real human need to reach out to somebody who has not been cared for and to step in and not abandon them. But this is really where the ethics issues attach for judges, because you have ceased to be an arbiter and you've become involved. Now I know becoming involved is sort of good. That's what attracts a lot of judges to drug courts. But it's also a temptation. Sometimes you end up treating people not better but worse, because you get mad at them when they don't succeed. So getting back to the issue of the competence of drug courts, when we deal with individuals we have to look at the court's competence to adjudicate in light of standards that are determinate. Where we don't have determinate standards, we should be immediately suspicious.

Judge Leach: I completely disagree. I think the personal involvement of the judge is one of the cornerstones of the drug court. Without it, I don't think that our mission can be accomplished. We've seen research indicating that judicial input is high in the scheme of things that lead to success. It is important for offenders to have a relationship with the judge to know that if they aren't compliant the judge will be angry. If something has gone on in their lives that created pain, the judge will be sad. If they are successful, the judge will respond to that positively. I think that most of us in the drug court are able to do that without losing our sense of fairness. I don't think that the personal involvement compromises our ability to reach reasoned decisions, and I do think the personal involvement is very critical to the participant's

success. Even so there are limits. When a particular participant's treatment goes awry we do reach out, but I always do it through our case managing agency. I hesitate to have any direct contact with the client at that point.

Johnson: In drug courts I've visited, I've been impressed by the sense of the judge and the staff trying to develop a relationship with the offender. It strikes me as amazing that you might essentially get an individual to the point of going out into the community and then walk away from them, not follow them to see how they're doing. These are individuals who have probably been walked away from many times in their lives. From a developmental and psychological perspective, one of the things that good parents do is monitor their kids. You need to tell those individuals, "You are important to us. This has not been a game. It's something we really do care about."

Weissman: I think we have to figure out our role in the transition process. It isn't about walking away from participants, and it also isn't to say that there aren't occasional natural relationships that develop between individuals and judges or other court staff that may continue on into infinity. But the reality is that those relationships are few and far between and that people should move on with their lives. The question is how the courts can facilitate that, including strengthening community organizations that can facilitate the transition over the long run.

COURTS AND TREATMENT PROVIDERS

[8] Feinblatt: Earlier, we heard some voices saying that treatment providers weren't doing a good enough job in helping drug court graduates reenter the community. How can drug courts help treatment providers do a better job?

Huddleston: From a treatment provider's perspective, the drug court is a very effective delivery system. It gets the addict into treatment immediately and keeps him engaged for however long he's under the court's supervision. We have a lot of research now on what works with offenders, what works in treatment, how long someone should stay in treatment, and what kind of aftercare is effective. So it seems to me that the court can do two things. One is to hold treatment providers accountable to provide services that are effective based on research. The second is to hold the offender accountable to stay in that program for a sufficient period of time to make a difference in that individual's life.

Peyton: Drug courts have been excellent at providing leadership in this area. Judges have had to be very demanding in terms of what they expect treatment providers to do, setting standards for the providers and making sure they stay engaged with their clients. I think the courts are really our last hope for holding some of these systems accountable.

Weissman: This view won't be accepted across the board. But treatment providers do need to be held accountable. They can't just say, "Send us your folks. We can't treat them, but we're going to make money off them." They either have to figure out ways of delivering services effectively or they shouldn't be used, because they're going to do harm to the people we work with.

LOOKING AHEAD

Feinblatt: Have we moved toward any consensus on what role drug courts should play in reintegration? Do we foresee – or hope for – any changes in how drug courts will handle reintegration issues?

Peyton: I think that we've been re-examining the goals of drug court and asking ourselves, "Why do we need to do this?" One thing is clear: We can't leave reintegration in the hands of treatment providers, even if the courts hold them accountable. We need to make a clear statement that reintegration is a valuable enterprise, and then create a framework to make it happen.

Judge Leach: Part of that framework is to bring reintegration resources into the program earlier on and begin planning for reentry as soon as someone enters drug court. We need to make drug court as strong and powerful as possible while participants are under our jurisdiction, which means using our leadership to forcefully encourage better participation by the other agencies that have a connection to the court and the defendant.

Weissman: I think we're actually moving to some clarity on how the court should be involved in reintegration. We seem to be in agreement that the court's coercive power should be focused on a set of fundamental requirements so that the defendant stays clean and stops committing crimes. We haven't reached a consensus about how far the court's coercive power can go in compelling a participant to achieve other elements of reintegration, but we have identified a number of ways that the court can use its symbolic authority to facilitate other pieces that we know are absolutely essential for long-term success. Courts can and should identify resources, convene players, and build good linkages between the court and the community so that reintegration starts happening while the participant is still involved in drug court. We've been talking about making some real changes in what the last phase of drug court will look like. When the defendant is still under the control of the court, responsibilities can be shared and linkages can happen, so that the participant isn't abandoned at the end of it. Courts need to be focusing their attention on sources of strength in

the community – the people who want reintegration to work because the person coming out of drug court is their brother or sister or mother or father.

Gebelein: I think drug courts will sound and feel different as we move forward, not so much when a defendant first comes in but as he progresses through the court. The questions that the judge asks are going to be different. We won't just be asking the defendant: "How many clean urines have you had? Do you have a job? And did you get your GED?" We'll be asking more than that. We'll be asking: "Where are you in getting some community help? Are you involved with any kind of organizations? What have you done to implement your discharge plan? Have you made the contacts the plan calls for? Do you have your sponsor?" And we'll be expecting the treatment providers to show what they are doing to help implement the discharge plan.

May: Drug courts were one of the first steps toward integration in the first place: integrating treatment with law enforcement, with the judiciary, with the prosecutor, with the public defender. So it's only natural for us to be involved in reintegration back into the community. Maybe, left to their own devices, treatment providers didn't manage reintegration so well. Maybe probation didn't do it so well. Maybe the court system didn't do it so well. But isn't that why we started drug courts? Because if we work together, rather than in isolation, then on any day when one of us is having a weak moment, someone else will stand up and rise to the occasion. Isn't that really what we're all about?

CHANGE-FOCUSED DRUG COURTS: EXAMINING THE CRITICAL INGREDIENTS OF POSITIVE BEHAVIOR CHANGE

By Michael D. Clark, MSW, CSW

This article focuses on improving the effectiveness of the therapeutic approach in leading to positive behavior change with drug court participants. The intent is to speak to all drug court team members — especially those (judges, lawyers, probation agents) whose roles and responsibilities have not been traditionally linked to the treatment field.

New information gained from an extensive meta-analysis that reviewed 40 years of therapy outcome studies is reviewed. This important research sought to identify the ingredients of positive behavior change. The study shows that, although treatment has been found effective, no single approach or theory among the more than 200 recognized therapy models has proven to be reliably better than any other. Regardless of many claims, there are no clear "winners." The research postulates that the effective aspects of treatment are trans-theoretical — that is, that any model's effectiveness is due to factors that are common to all therapies. This article discusses these "four common factors": client factors, relationship factors, hope and expectancy, and model/technique.

In applying this information to work with drug court participants, this article points to research-informed strategies — including the strength-based approach — that can translate some of therapy's complex practices into commonsensical and usable methods for community treatment staff and drug court personnel. The goal of this article is to increase a curative approach by all who participate in the work of drug court, especially those from the non-therapeutic professional roles.

Michael D. Clark, MSW, CSW, is director of the Center for Strength-Based Strategies. Mr. Clark is a consultant to helping agencies and justice programs and is an international trainer of strength-based approaches. He is a contractual faculty member for the U.S. Department of Justice, Drug Courts Program Office and is the author of, among other articles, a two-part series in the American Correctional Association's journal Corrections Today*: (April 1997) "Strength-Based Practice: A New Paradigm" and (June 1997) "Interviewing For Solutions: Strength-based Methods."*

Direct all correspondence to Michael D. Clark, MSW, CSW, Director, Center for Strength-Based Strategies, 872 Eaton Drive, Mason, MI 48854-1346.

ARTICLE SUMMARIES

COMMON FACTORS IN TREATMENT

[9] Four common factors among treatment modalities appear to be the key to treatment effectiveness.

INFLUENCE OF CLIENT FACTORS

[10] Attributes that clients possess when they enter treatment account for 40% of behavior change.

INFLUENCE OF THERAPEUTIC RELATIONSHIP FACTORS

[11] Collaboration between counselor and client account for 30% of behavior change.

IMPORTANCE OF PERCEIVED EMPATHY

[12] The client's perception of the empathy in the counselor/client relationship is crucial.

CLIENT'S ACCEPTANCE OF TREATMENT PROGRAM

[13] Drug court programs should involve the client's input on what methodology might work.

ROLE OF WARMTH/SELF-EXPRESSION

[14] Giving clients a forum to talk and then listening to the clients is crucial.

HOPE AND EXPECTANCY

[15] The client's hope and expectancy that change will occur accounts for 15% of behavior change.

CONVEYING HOPE

[16] Practitioners need to instill hope in the client while not minimizing the client's problem.

HOPE IS FUTURE-FOCUSED

[17] Practitioners should help the client focus on a future without drugs and alcohol to instill hope.

EMPOWERING THE CLIENT

[18] Practitioners should set small goals for the client to achieve for more

obtainable behavior change.

MODEL AND TECHNIQUE

[19] Practitioners' model and technique accounts for 15% of behavior change.

THE STRENGTHS APPROACH

[20] Practitioners work with the client, encouraging individual responsibility and concentrating on the client's strengths and weaknesses to help initiate change.

STRENGTH-BASED IMPLICATIONS FOR PRACTICE 1

[21] Practitioners need to address why the client should change, while having the client concentrate on "Can I change?" and "How can I change?"

STRENGTH-BASED IMPLICATIONS FOR PRACTICE 2

[22] Practitioners need to share the "expert role" in behavior change with the client, placing emphasis on the client's role in his/her own recovery.

STRENGTH-BASED IMPLICATIONS FOR PRACTICE 3

[23] Staff and client need to collaborate in setting goals for the client after the client has achieved abstinence, such as vocational and educational goals.

STRENGTH-BASED IMPLICATIONS FOR PRACTICE 4

[24] Staff need to work on building the alliance with clients immediately through a two-sided exchange, and monitor the client's perception of the alliance.

INTRODUCTION

The basic mission of working with challenging offenders is to induce positive behavior change. This mission has two levels. First, agency and court personnel work to secure the compliance of probationers or other offenders with the rules and requirements of the law and of their respective programs. This first level generally focuses on promoting lawful behavior, consistent attendance at school or work, family stability, and abstinence from illicit drugs and alcohol.

Progressive, more ambitious agency staffs strive for a second level of change. Their programs move beyond compliance to seek sustained and autonomous behavior change, facilitated by empowerment and personal "growth." Regardless of program levels, the drug court field is preoccupied with a desire to find effective approaches that will modify substance-abusing behavior. This search is as consuming as it is worthwhile and necessary.

Nationally, there is public debate on the relative effectiveness of punitive, supervisory, and rehabilitative approaches in modifying substance-abusing behavior. Public policy has increasingly focused on punishment and monitoring of offenders, at the expense of treatment. One needs only to consider that seventy cents of every dollar designated for the "war on drugs" are assigned to law enforcement and interdiction on the supply side (Office of National Drug Control Policy, February 2002). At the extreme, there are some who, persuaded by the belief that addiction constitutes moral failure, call for an end to all healthcare funding for this issue; frustrated by relapse and a lack of encouraging success rates, they are dissuaded by the arguments for treatment. A recent interview with recovery expert Paul Earley, MD, conducted by Public Broadcasting journalist Bill Moyers illustrates the dilemma:

> Moyers: That's the knock on treatment from people I talk to. They say, look at all the people who relapse. Look at all the people that never make it. So, why should we invest in treatment given the poor success rate?
>
> Earley: Because it works just as well as treatment for any chronic illness. Chronic illnesses are marked by relapse. Recent data shows that. People don't comply with their anti-hypertensive medicines or their diabetic medicines to keep the diabetes under control. They do just as poorly as addicts or alcoholics do. But you don't hear people saying, "Well, you know those diabetics, they're not following their insulin regimens, so we just ought to stop giving healthcare dollars to them. Let 'em die." It's a prejudice. But what happens with addicts is that they piss people off in a big way. They piss off families and, even worse off, they piss off the police and they make people angry because they're doing something which is destructive, not only to themselves but to others. And so, it's right to be angry in some ways. If you feel angry about addiction, that's right. But let that anger be a catalyst for us to figure out how to do it better rather than [figuring out a way to] punish a person (www.thirteen.org, 2002).

At the same time that this punishment/treatment debate was occurring, the American Psychological Association (APA) supported a research initiative that assembled the world's leading outcome researchers to review forty years of psychotherapy outcomes and detail the subsequent implications for direct practice. The initial findings of this research indicate that treatment *is* effective in helping human problems. The authors of this study, Mark Hubble, Barry Duncan, and Scott Miller observe effective catalysts of positive behavior change: "Study after study,

meta-analysis, and scholarly reviews have legitimized psychologically-based or informed interventions. Regarding at least its general efficacy, few believe that therapy needs to be put to the test any longer (Hubble, Duncan, and Miller, 1999)."

Clinical outcome authors and researchers, Ted Asay and Michael Lambert, commenting on previous studies report, "These reviews leave little doubt. Therapy is effective. Treated patients fare much better than the untreated (Asay and Lambert, 1999)." These studies parallel research regarding the efficacy of treatment delivered by drug courts. Steven Belenko, reporting on drug court outcomes for the National Center on Addiction and Substance Abuse, found that there is a reduction in drug use and criminal activity while participants are in drug court programs (Belenko, 2001). Nevertheless, treatment and rehabilitation efforts are under close scrutiny and scorned by many. Gordon Bazemore and Mark Umbriet, developers of the restorative justice model, explain this scorn: "[I]t is difficult to convince most citizens that (criminal) justice treatment programs provide anything other than benefits to offenders (e.g., services…activities) while asking them for little or nothing in return (Bazemore and Umbriet, 1998)."

The punishment/treatment debate has, in fact, been worthwhile in the development of treatment approaches. Restorative justice expert Robert Coates reports, "The debate has had its impact upon practice, forcing practitioners to be even more thoughtful in developing intervention strategies. The debate about the value of rehabilitation has had considerable positive effect on rehabilitation efforts. More attention is being directed at how caseworkers and others can have positive impact on the client and on the client's social network (Coates, 1998)."

Although the APA research examined psychotherapy outcomes, its findings also are critically important to the treatment initiatives of remedial drug court work. Regarding this research into the effectual elements of treatment, John J. Murphy, a proponent of strength-based strategies in the field of education, states: "[T]he empirical evidence…has profound implications for the manner in which practitioners approach clients of any age and in any setting (Murphy, 1999)."

COMMON FACTORS

Having concluded that treatment is effective, the APA's study made a second finding that is at least equally significant: None of the numerous treatment models studied has proven to be reliably better than any other (Hubble, Duncan, and Miller, 1999). Barry Duncan and Scott Miller report: "Despite the fortunes spent on weekend workshops selling the latest fashion, the competition among the more than 200 therapeutic schools amounts to little more than the competition among aspirin, Advil, and Tylenol. All of them relieve pain and work better than no treatment at all. None stands head and shoulders above the rest (Miller, Duncan, and Hubble, 1997)." This conclusion has been repeatedly upheld in subsequent studies (Miller, Duncan, and Hubble, 1997).

[9] If no theory or model can claim that it is better than the others, then what accounts for the overall efficacy of treatment? Researchers, including Michael Lambert and Mark Hubble, sifted through four decades of outcome data to postulate that the beneficial effects of treatment largely result from processes shared by the various models and their recommended techniques (Lambert, 1992; Hubble, Duncan, and Miller, 1999). Simply put, similarities, rather than differences, in the various models seem to be responsible for change. Each of the varied treatment models aids change by accessing certain common factors that, when present, have

curative powers. Lambert concluded from extensive research data that there were four of these common factors (Lambert, 1992):

- Client factors — the client's preexisting assets and challenges;
- Relationship factors — the connection between client and staff;
- Hope and expectancy — the client's expectation that therapeutic work will lead to positive change; and
- Model/technique — staff procedures, techniques, and beliefs.

These factors that raise the effectiveness of treatment are trans-theoretical — that is, all of the various treatment theories and approaches recognize their importance to some degree. Without intentionally focusing on them, all therapies seem to be more effective when they promote these common factors in their own unique ways.

Hubble, Duncan, and Miller speak to this important research finding:

> In 1992, Brigham Young University's Michael Lambert proposed four therapeutic factors…as the principal elements accounting for improvement in clients. Although not derived from strict statistical analysis, he wrote that they embody what empirical studies suggest about psychotherapy outcome. Lambert added that the research base for this interpretation for the factors was extensive; spanned decades; dealt with a large number of adult disorders and a variety of research designs, including naturalistic observations, epidemiological studies, comparative clinical trials, and experimental analogues (Hubble, Duncan, and Miller, 1999).

Hubble, Duncan, and Miller also drew upon Lambert's earlier work that rated some factors as more influential in changing behavior than others and ascribed a weighting scale to them. Lambert then ranked and prioritized the common factors according to their amount of influence on positive behavior change. With 100 percent representing a total positive behavior change, Figure 1 depicts the four factors and their percentage contribution to positive change.

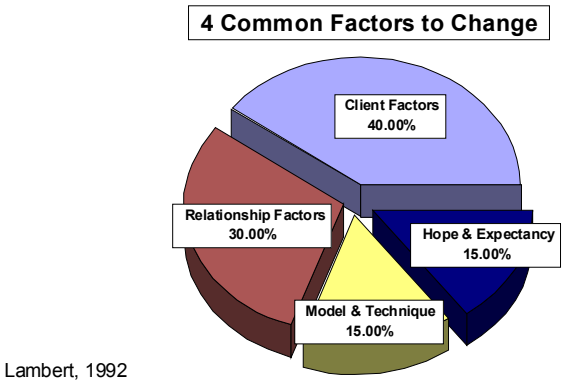

Figure 1.
Source: Lambert, M.J. (1992). Psychotherapy outcome research: implications for integrative and eclectic therapists. In J.C. Norcross, & M.R. Goldfried (Eds.), *Handbook of psychotherapy integration*. New York, NY: Basic Books.

Client Factors

[10] According to Lambert, client factors — not what offenders and their families receive from staff, but what they possess as they enter the doors of our drug courts and agencies — are the largest contributor to behavior change (forty percent). Client factors are both internal (optimism, skills, interests, social proclivities, aspirations, past successes) and external (a helpful uncle, employment, membership in a faith community). Client factors also include fortuitous events that are controlled by neither the

drug court staff nor the program participant: an abusing boyfriend moving out and away from the family, a chance school or employment experience instilling renewed interest, a lesson "hitting home" as, for example, when a close friend or peer is seriously harmed by illicit drug use.

The difficulties of encouraging referrals to participate in treatment are two-fold: first, staff must build trust and find effective methods to encourage those in treatment to participate. Second, staff must be persuaded to break the 'norm' of dictating behavior, and allow participants increased choice and autonomy.

Many treatment programs are not individualized (regardless of their claims), nor do they offer true choices in programming. Furthermore, staff often resists client input. The views and opinions of participants may be markedly different from those of staff. Consequently, staff may be resistant to seeking and integrating input from participants about "what works" in their own treatment. Staff should recognize that acknowledging and accepting the beliefs and positions of a participant is not the same as agreeing with or acquiescing to them.

Such an approach affirms the participant's role in his or her treatment. Indeed, the common-factors research confirmed just this point: that it is the drug court defendant and his or her family, not the staff or providers, who make treatment work. This finding does not indicate that program structure or staff efforts are useless. It does suggest, however, that the instruction in interventions and treatment models offered by universities and training institutes may be more effective if coupled with a focus on the input of those actually in treatment.

Duncan and Miller summarize this research by noting the real 'engine' of change is the client, thus implying that

our time might be better utilized by finding more ways to employ the client in the process of change (Duncan and Miller, 2000). Ironically, what it takes to realize difficult behavior change in the real world is not always fostered or modeled during staff-client interactions. Change rests with a participant's full participation, energy and commitment. However, if staff assumes a role where their ideas and expertise consistently trump those of the client, the participant is relegated to a passive role. If a client's experiences and know-how are subjugated to the wisdom and methods of the professional, then the term drug court "participant" could well be in danger of becoming an incongruous or contradictory term.

Many research endeavors examine the process of engagement and work with voluntary clients. This context is not always comparable to the mandated nature of drug court efforts. Drug court clients are generally conceived of as "involuntary," where withdrawal from substance use is a non-negotiable mandate. While keeping our directives in focus, it is important to consider we have more latitude in allowing greater participant input, both in how one might strive for sobriety and how one might sustain it.

Therapeutic Relationship Factors

[11] Relationship factors, or therapeutic alliance, make up about thirty percent of the contribution to change. *Alliance* means the extent that the counselor and client can collaborate. Conditions that engender an alliance include reciprocal understanding, mutual affirmation, emotional attachment and respect (Lambert, 1992). *Relationship* means the strength of the alliance that develops between the program participant and staff. Relationship factors include perceived empathy, acceptance, warmth, and self-expression (Lambert, 1992).

Perceived Empathy

[12] Communication studies consistently report that verbal communication is prone to error; the listener does not always receive the complete message (Anderson, 1997; Seligman, 2000). Parts of the intended message are either inadequately articulated by the speaker or incorrectly understood by the listener. A dialogue between two people resembles listening to a cell phone that crackles with static from weak reception: even if one listens closely, much of the transmission will be garbled or missing.

Perceived empathy involves a drug court participant's belief that they are listened to and understood. Relationships develop as staff becomes committed to understanding their clients and make consistent efforts toward "filling in the gaps" of communication. An important technique for improving communication is "reflective listening," in which the staff member constantly checks the accuracy of what he or she believes the client has said. This author believes that most staff members, regardless of whether they have previously been trained in reflective listening, seldom, if ever, use this technique. The technique is simple to understand but difficult to use consistently and correctly.

Evidence shows that "accurate empathy" is a condition of behavior change. William Miller and Stephen Rollnick state: "Accurate empathy involves skillful reflective listening that clarifies and amplifies the client's own experiencing and meaning, without imposing the therapist's own material. Accurate empathy has been found to promote therapeutic change in general and recovery from addictive behaviors in particular (Miller and Rollnick, 1991)." Compliance can occur without the program participant feeling understood, but real change cannot.

Perceived empathy is a term that corrects a previous bias in research. Most outcome studies measured empathy and the strength of the staff-client alliance through counselor reports. But in fact, the drug court participant's assessment of the alliance matters more. Experts on the therapeutic relationship and authors of the 1999 book, *How Clients Make Therapy Work: The process of active self-healing*, Karen Tallman and Arthur Bohart, report "[f]indings abound that the client's perceptions of the relationship or alliance, more so than the counselor's, correlate more highly with therapeutic outcome (Tallman and Bohart, 1999)." Further research completed at the University of Quebec by Canadian psychologist Alexandra Bachelor found that the client's perception of the alliance is a stronger predictor of outcome than the counselor's view (Bachelor, 1991).

The tendency to privilege staff evaluations over clients' perceptions occurs frequently in justice work. For example, while providing onsite technical assistance to an established juvenile drug court, the author experienced a chance encounter with a group of juvenile probationers who were milling outside the court building awaiting their weekly progress review hearings. The author began an impromptu conversation, inquiring as to their personal evaluations of their drug court program. Their responses were both forthcoming and enthusiastic. Encouraged, the author brought this information to the next staff meeting, only to find that the program staff members immediately dismissed this important information because of its source.

Acceptance

Acceptance relates to the extent that any treatment program fits into the participant's and family's worldview and beliefs. Kazdin (1980) found that the client's ability to accept a particular procedure is a major determinant of its use and ultimate success (Kazdin, 1980).

[13] More recent studies found a greater acceptance of treatment and better compliance with interventions when rationales were congruent with clients' perceptions of themselves, the target problems, and the clients' ideas for changing their lives (Conoley, 1991; as cited in Duncan and Miller, 2000).

An acid test for any drug court program lies in the answer to the question, "To what extent are interventions predetermined?" That is, are participants turned into passive recipients of prepackaged programming, or is programming flexible enough that it may be customized to the individual? Progressive drug court programs make an effort to include clients and promote their participation. In workshops on strength-based programming, many staff are surprised to learn that they have more leeway to alter and adapt programming than they first believed. The results of this effort can be remarkable. As solution-focused therapy expert John Murphy notes, "The notion of acceptability reflects good common sense: people tend to do what makes sense to them and what they believe will work. It is hardly profound to suggest that the best way to determine what is appealing and feasible for a person is '*to ask them*' (Emphasis added) (Murphy, 1999)." In this "asking" profound differences in efficacy are realized. Solution-focused therapists Ben Furman and Tapani Ahola report that the counselor-client relationship is developed and the alliance strengthened as clients and their families are allowed to have a say in defining the problem[s], setting goals, and deciding what methods or tasks will be used to reach those goals (Furman and Ahola, 1992).

Drug court team members have extenuating circumstances to consider when allowing client participation at this advanced level. In the mandated arena of drug court programs, abstinence from drugs and alcohol is a primary

goal that is non-negotiable — the goal remains in force whether the participant agrees or not. However, the drug court can still seek the client's thoughts and possible ideas for his or her ideas to achieve that goal. Drug courts should be analogous to a job hunter who wanders a community career fair looking for the most interesting and profitable "fit" with prospective employers. Programs should allow choices to be made across a "smorgasbord" of treatment options, allowing the referral to choose the option that is most relevant to them. Being allowed to choose (or collaboratively design) a treatment option that makes sense to the participant — aligned with the participant's age, gender, culture, way of thinking/life experiences — will increase the participant's motivation to participate. John Murphy is clear as to this effort, "[t]he therapeutic alliance is enhanced by … [t]ailoring therapeutic tasks and suggestions to the client instead of requiring the client to conform to the therapist's chosen model and beliefs (Murphy, 1999)." A previous justice article on strength-based practice argues that programs need to stay close to the probationer's and family's definition of the problem (and their own unique methods), as they are the ones who will be asked to make the necessary changes (Clark, 1998). Researchers who have studied the influence of hope and expectations on counseling outcomes, C.R. Snyder, Scott Michael, and Jennifer Cheavens echo this idea, arguing that staff must listen closely to program participants. If staff do not, they may establish therapeutic goals "that are more for the helper than for the helped (Snyder, Michael, and Cheavens, 1999)."

Warmth/Self-Expression

[14] These two conditions for building relationships are intertwined. Extending warmth (attention, concern, and interest) occurs in tandem with allowing a drug court client's self-expression. All staff must understand and embrace a long-held credo from the counseling field: Listening is

curative. As Karen Tallman and Arthur Bohart report, "Research strongly suggests that what clients find helpful in therapy has little to do with the techniques that therapists find so important. The most helpful factor [is] having a time and a place to focus on themselves and talk (Tallman and Bohart, 1999)." Others have found that giving traumatized individuals a chance to "tell their story" and engage in "account making" is a pathway to healing. A rather obscure but interesting earlier study showed that paying juvenile delinquents to talk into a tape recorder about their problems and experiences led to meaningful improvements in their behavior, including fewer arrests (Tallman and Bohart, 1999).

Staff would be wise to critically examine their methods in building alliances with participants, both programmatically and individually. Duncan and Miller state emphatically, "Clients' favorable ratings of the alliance are the best predictors of success — more predictive than diagnosis, approach, counselor or any other variable (Duncan and Miller, 2000)."

Hope and Expectancy

[15] The next contributor to change (fifteen percent) is hope and expectancy; that is, the referral's hope and expectancy that change will occur as a result of entering drug court programming. This author believes that in practice, staff may encourage hope and expectancy by (1) conveying an attitude of hope without minimizing the problems and pain that accompany the offender's situation; (2) turning the focus of treatment toward the present and future instead of the past; and (3) instilling a sense of empowerment and possibility to counteract the demoralization and passive resignation often found in drug court participants who have persistent problems.

Conveying an Attitude of Hope without Minimizing the Problem

[16] Instilling hope has more complexity than simple encouragement. Participants need to believe that taking part in drug court programming will improve their situation. Therefore, during the orientation phase of programming, many successful drug court programs provide convincing testimonials of success and program efficacy. Researchers on the condition of hope, Snyder, Michael, and Cheavens, indicate that the new client must sense that the assigned staff member, working in that particular setting, has helped others reach their goals (Snyder, Michael, and Cheavens, 1999).

Troubled participants and their families often feel "stuck" in problem states. This feeling can be based partly on negative attitudes that allow no escape from problems (i.e., "I *can't* change," "You don't understand — I *have* to hang out with my using friends"). Strength-based work may instill hope while also acknowledging problems and pain. One strength-based strategy encourages staff to allow the participant's problem to coexist with the emerging solution. In many instances within remedial drug court work (and throughout the helping professions), there is a mindset to conquer, eliminate, or "kill" the problem. Oftentimes it is helpful and much more expedient to allow the problem to remain, to coexist with an emerging solution or healthy behavior that is being developed.

Bill O'Hanlon, a strength-based author and therapist, describes a helpful metaphor that originated in an old vaudeville routine: Two ingratiating waiters approaching the narrow kitchen door repeatedly defer to the other. "After you," one offers. "No, please, after you," the other replies. Finally, at the same moment, they both decide to act and turn into the door simultaneously, only to wedge their shoulders in the small opening. O'Hanlon advises adult staff to consider

the idea of "creating a second door" and allowing conflicting feelings and conditions to coexist (O'Hanlon, 2000). A client could feel scared and hopeless about his ability to begin abstinence from drugs and yet marshal the confidence to avoid using "just for today." A painfully shy young woman may simultaneously fear the crowded gathering and yet find the courage to join it. Trying to convince the shy client that there's "no need to be shy," or that there's "nothing to be afraid of**,**" is an uphill climb with dubious results. The conflicting dichotomies of continuing drug use or movements toward sobriety, hesitancy or action, fear or confidence may exist as "both/and" rather than being framed as an "either/or" choice. Staff need not eliminate the negative to instill the positive.

This is not just a meaningless play on words. There is a popular slogan among practitioners of strength-based approaches: "The person is not the problem; the problem is the problem." Strength-based practice takes that idea a step further to assert that the problem is actually the person's *relationship* to the problem.

Becoming Future-Focused

[17] Focusing on past failures usually results in demoralization and resignation. Hope is future-focused. When any drug court staff member keeps remedial efforts focused on the future, positive outcomes are enhanced (Clark, 1998).[1] The "problem" is generally found in the present and its roots in the past. The "solution," however, is generally started in the present with efforts aimed at the future.

European therapists Ben Furman and Tapani Ahola, authors of the book, *Solution Talk: Hosting Therapeutic Conversations*, report that the single most useful thing

[1] I have described future-focused questions that help orient both youth and staff to solution building.

remedial staff could do in the time they spend with troubled drug court clients is to get them to look ahead and describe what is happening when the problem is envisioned as "solved," or is not considered to be as bad (Furman and Ahola, 1992). These therapists, using strength-based strategies, believe that if goals are to be immediately helpful and meaningful to the program participant and family, they must first be conceived and constructed through visions of a "problem-free future." It is through this forward looking, "harnessing" of the future, that goals for present actions (first steps) become known (Furman and Ahola, 1992).

An important way to "harness" the future is by employing "miracle," or outcome-questions (Berg and Miller, 1992): "What if you go to sleep tonight and a miracle happens and the problems that brought you into this drug court are solved?" "Because you are asleep, you don't know the miracle happened. When you wake up tomorrow, what would you notice as you go about your day that tells you a miracle has happened and things are different?" "What else?" "Imagine, for a moment, that we are now six months or more in the future, after we have worked together and the problems that brought you to our drug court have been solved. What will be different in your life, six months from now, that will tell you the problem is solved?" "What else?"

The miracle question is the hallmark of the solution-focused therapy model. A "miracle" in this context is simply the present or future without the problem. By this treatment method, the counselor orients the drug court participant and family toward their desired outcome by helping them construct a different future. Helping a participant and family establish goals needs to be preceded by an understanding of what they want to happen. If therapists find no past successes to build on, they may help the family form a different future by imagining a "miracle." As many justice workers have experienced, it often is difficult to stop a family from

engaging in "problem talk" and to start searching for solutions. If a program participant and family are prompted to imagine a positive future, they may begin to view their present difficulties as transitory. The miracle question is used to identify the client's goals to reach program completion or other successful criteria.

The miracle question is followed by other questions that shape the evolving description into small, specific behavioral goals: "What will be the smallest sign that this (outcome) is happening?" "When you are no longer (using drugs, breaking the law, etc.), what will you be doing instead?" "What will be the first sign this is happening?" "What do you know about (yourself, your family, your past) that tells you this could happen for you (DeJong and Berg, 2002)?"

Empowerment and Possibility

[18] Drug court programs encourage hope and expectancy when they help clients establish goals and act to realize them. All programs will list large (macro) outcomes or final goals to reach graduation and program completion. Similarly, most remedial plans are established for large issues and long-standing presenting complaints. These plans usually list large problem behaviors to be resolved by a specified date set many months into the future. The problem is that these goals are too big for day-to-day work. Instead, efficacious goal setting should "think small." Goals should be shaped into small steps. According to the "one-week rule" of strength-based practice, a worker and a drug court participant should never mutually establish any goal that cannot be reached in the next seven days. Some staff go further and employ a "48-hour rule" to make a goal seem more obtainable and to begin behavior change. Short time frames propel "first steps" and put into motion small

incremental movements to change. "What can you do after you get home today? By tomorrow afternoon?"

Snyder, Michael, and Cheavens found that a large portion of client improvement, studies suggesting as much as 56% to 71% of total client change, can occur in the early stages of treatment (Snyder, Michael, and Cheavens, 1999). Interestingly, this improvement happens before clients learn the methods or strategies for change that programs stand ready to teach. How could change begin to occur before program direction, teaching, and support may be delivered? These motivational researchers posit:

> As Ilardi and Craighead (1994) pointed out, clients have usually not even learned the supposedly "active" mechanism for change by the time improvement occurs in these early stages of treatment. Rather, the rapid response of clients must be a product of the common factors — especially hope. On this point, several researchers and authors have highlighted the pivotal role that hope plays in early and subsequent improvement in psychotherapy… (Snyder, Michael, and Cheavens, 1999).

Ilardi and Craighead note that the instillation of hope and expectancy of change is not simply a precondition for change; it is change (Snyder, Michael, and Cheavens, 1999).

Model and Technique

[19] Another small contributor to change may be found in model and technique (fifteen percent): staff procedures, techniques, and beliefs, broadly defined as our therapeutic structure and healing rituals. It is humbling to consider that a majority of what practitioners have been taught — the various models of interventions and their suggested techniques — might well constitute one of the

smallest contributions to change. Furthermore, programs and techniques are deemed helpful only to the extent that they promote the other common factors.

Nevertheless, the strategies and methods that staff provides to drug court participants are helpful, yet for reasons that are contrary to popular beliefs. Tallman and Bohart explain:

> Clients utilize and tailor what each approach provides to address their problems. Even *if* different techniques have different specific effects, clients take these effects, individualize them to their specific purposes, and use them. … In short, what turns out to be most important is how each client uses the device or method, more than the device or method itself. Clients then are the "magicians" with the special healing powers. [Staff] set the stage and serves as assistants who provide the conditions under which this magic can operate. They do not provide the magic, although they may provide means for mobilizing, channeling, and focusing the client's magic (Emphasis in original) (Tallman and Bohart, 1999).

It appears that, rather than mediating change directly, techniques used by staff simply activate the natural healing propensity of participants. Therefore, it is important to use techniques and develop requirements that facilitate a participant's progress.

The Strengths Approach

[20] This study of the common factors becomes the research pillars for the strengths approach in the helping professions (Saleebey, 1992; 1997; 2002; Clark, 1998; 2001a). The Strength-based approach is an emerging movement that has caught the attention of many who work

with court-mandated (involuntary) clients. Recent efforts have applied this approach to criminal justice, juvenile delinquency, and drug courts (Clark, 1997b; 1999; 2001a; 2001b). These justice workers have favored a strength-based practice approach because it uncovers and makes use of clients' preexisting abilities (Clark, 1995b; 1997b; 1998). The strength-based approach is drawn from numerous positive models of potential, optimism, and possibility, including the strengths perspective (Saleebey, 1992; 1997; 2002), resilience (Werner and Smith, 1992; S.J. Wolin and S. Wolin, 1993; Fraser, 1997), optimism (Seligman, 1991), hardiness (Kobasa, 1979), asset-building (Benson, 1997), empowerment (Gutiérrez, Parsons, and Cox, 1998), motivational interviewing (Miller and Rollnick, 1991), and solution-focused approaches (Berg and Miller, 1992; Clark, 1996; 1997a; Berg, et al., 1998; Berg and Reuss, 1998; DeJong and Berg, 1998). The goal of strength-based practice is to encourage the individual's sense of responsibility for his or her actions, thereby altering law-breaking behavior. This approach does so by considering the science of positive behavior change. Interests and efforts are aimed at *initiating* positive movements, or beginning the "first steps" necessary to change the trajectory of one's life. The strength-based approach is not so much a collection of techniques to apply *on* someone as it is the efforts or goals treatment providers should strive to achieve *with* the client. This approach focuses more on what the client has rather than what he or she does not have; it considers the successes of the clients and families, rather than their failures. The approach works to resolve presenting problems through a focus on potential rather than pathology.

The strengths approach also encourages a balanced view of the individual's weaknesses and strengths. Consider that deficit-based work can engender a myopic view of clients by considering only their problems and failures. This reductive slant can obscure the difference between the terms

"accurate" and "balanced." The contrast between these terms can be found in a simple analogy. If anyone were assigned to shadow a drug court professional for a full day, watching for and listing only their failures and shortcomings, there could be ample foibles to report at the end of any twenty-four hour period. Assuming this full day report was factual and error-free; the information could be reported as *accurate*. However accurate, it would not represent a balanced or equilibrate view of this person. There would be a second dimension of strengths, merit and successes left unreported and (more importantly) unused. Some staff might champion the accuracy of their negative observations as they draw conclusions about clients, yet strength-based practitioners bemoan the lack of thoroughness and integrity. Strength-based practice calls for a balanced consideration of a client, reporting and considering failure and success, mistakes and accomplishments, pathology and potential. Adopting a balanced view can pay a double-dividend: marshaling more resources to resolve presenting problems while lending more credence and respect to the participant — necessary ingredients to increase motivation and cooperation.

Martin Seligman, past president of the APA and advocate of a strengths revival in the field of psychology (Positive Psychology), called on the alcohol and other drug (AOD) treatment field to "learn how to build the qualities that help individuals and communities, not just to endure and survive, but also to flourish (Seligman, 2000)." Drug court work should not only fix what is wrong, but nurture what is best. The strength-based model, because it focuses on the common factors, facilitates this process.

IMPLICATIONS FOR PRACTICE

Certain issues and opportunities arise in revising programs to incorporate strength-based techniques.

[21] 1. All drug court team members can become *change-focused*.

Duncan and Miller list several interesting research findings regarding drug court team members in direct service roles (Duncan and Miller, 2000):

- Andrew Christensen and Neil Jacobson, in their evaluation of counselor effectiveness with clients, found no differences between professionals and paraprofessionals or between more and less experienced therapists (Christensen and Jacobson, 1994).
- Hans Strupp and Suzanne Hadley found that experienced therapists were no more helpful than a group of untrained college professors (Strupp and Hadley, 1979).
- Jacobson (1995) determined that novice graduate students were more effective at couples' therapy than trained professionals (Jacobson, 1985).

It may be surprising to learn that there is little or no difference in effectiveness regardless of training and experience. It is not the author's intent to impugn credentials or expertise. Rather, these findings convey that these novices or paraprofessionals were able to match treatment effectiveness by somehow integrating the common factors where the trained professionals may have lost sight of what was truly effective.

Indeed, the findings offer important support to drug court staff. Knowledge of the four common factors penetrates the mystique surrounding "therapy" and illuminates what is truly "therapeutic": positive behavior change. By applying strength-based techniques in their work, more staff members (across multiple disciplines) may begin to build the all-important alliance with clients and work to enhance the factors of change with drug court referrals and their families. Because of the complexity found in many presenting problems, professional therapy and therapeutic

treatment will always be needed as adjunct services to specialty courts. The "good news" of this common factors research is that therapeutic work is not just the domain of treatment professionals. All professionals working with drug court participants, especially judges, lawyers and probation agents may adopt and utilize techniques that most effectively induce positive behavior change.

A further issue with becoming changed-focused involves the alcohol and drug abuse treatment field's use of mental health diagnoses. Although a diagnosis may be very helpful in providing information and direction for subsequent treatment efforts, Duncan and Miller note that the rendering of a diagnosis itself could also impede change. Establishing a diagnosis is akin to taking a "snapshot" — a moment-in-time photograph. The problem is that a diagnosis conveys the idea that conditions and behaviors described by the diagnosis are static and constant, even permanent. The author believes that strength-based practitioners, however, offer a different — and far more productive view of the reported problems:

> The magnitude, severity, and frequency of problems are in flux, constantly changing. In this regard, clients will report better and worse days, times free of symptoms, and moments when their problems seem to get the best of them. With or without prompting, they can describe these changes – the ebb and flow of the problem's presence and ascendancy in their daily affairs. From this standpoint, it might be said that change itself is a powerful client factor, affecting the lives of clients before, during, and after (treatment) (Duncan and Miller, 2000).

Carol Lankton, who has authored several books and articles on strength-based approaches cautions, "We find what we look for and expect to find. To *perceive* is to make choices in interpretation (Emphasis added) (Lankton, 1994)." It does

not help anyone to see problem behavior as fixed or static or to view the person who engages in the behavior as "damaged goods" and incapable of change.

Viewing drug court participants through a change-focused lens, listening and remaining alert to how they are changing, will help staff recognize the participants' resources and the strengths that are enabling and supporting their progress (Clark, 1996; 1997b; 2001a; Berg and Reuss, 1998). Staff may utilize two lines of inquiry to help identify this change. First, questions could be asked about "pretreatment change": "After serious trouble has occurred, many people notice good changes have already started before they start in our drug court. What changes have you noticed in your situation? How is this different from before? How did you get these changes to happen?"

Numerous studies from the counseling field have found that a majority of clients make significant changes in their problem patterns in the time between scheduling their initial appointment and actually entering treatment (Berg, 1994). Just experiencing some type of start or initiation of change can begin positive movement. Single-subject research has recorded similar responses from youth and families newly assigned to the author's juvenile probation caseload (Clark, 1995a). The important point is that client and family rarely report these changes spontaneously. Staff must ask questions about these changes or they remain hidden. Many believe that if problems are ignored, they seem to move underground, where they grow and fester and return even stronger. However, when solutions are ignored, they simply fade away unnoticed and, more importantly, remain unused.

The second (and ongoing) line of inquiry identifies change that occurs between appointments or program sessions. When change is found, drug court staff need to

investigate and amplify: "How did you do this?" "How did you know that would work?" "How did you manage to take this important step to turn things around?" "What does this say about you?" "What would you need to do to keep this going (do this again) (Clark, 1998)?"

When sitting down with a participant during a scheduled report time, many staff will check on issues by using a preformed mental list of questions. These questions become routine: "Were there any violations of program rules this week?" "Have all urine drops been 'clean'?" "Are you in compliance with all program requirements?" "Have you missed any school/work this past week?" "Have you made all treatment sessions since our last meeting?" These questions are important, but they do not represent a full line of inquiry. When inquiries become routine, they narrow the investigation and bypass many other instances of change. Open-ended questions that search for positive changes should be asked as well.

Finally, becoming change-focused summons drug court teams to be students of motivation and behavior change. Drug court teams would be wise to consider how the Motivational Interviewing model integrates two theories of motivation and self-change (Miller, Rollnick, and Moyers, 1998). The first involves value/expectancy theory, where the participant attempts to answer the initial questions, "Should I do this?" "Is this me?" Or more specifically, "*Why* should I do this?" Motivational Interviewing model developers William R. Miller and Stephen Rollnick believe "why" is an important issue that must be resolved, and participants usually wrestle with resolving this issue at the initial or earliest stage of treatment.

Participants will then move to grapple with a second important issue — self-efficacy theory. Here, participants attempt to answer the questions, "Now that I've decided I

should do this…can I?" "Do I have the skills?" "Is this too hard for me (Miller, Rollnick, and Moyers, 1998)?" Regarding self-efficacy issues, researchers Snyder, Michael, and Cheavens call for interventions to raise self-efficacy by employing two efforts. First, inducing "personal-efficacy thinking" (e.g., "I *can* do it") and then setting mutual, concrete, and obtainable goals to enhance "pathways thinking" (e.g., "Here's *how* I do it") (Snyder, Michael, and Cheavens, 1999).

Instilling self-efficacy is critical. Motivation experts Miller and Rollnick caution that programs can bombard incoming participants with prescriptive advice on "how to" change, while the participant is still deciding whether to change, and finding the commitment to change (Miller and Rollnick, 1991). Miller and Rollnick believe that giving prescriptive advice too early can steal focus from these early value decisions and can actually impede motivation.

The author has advised drug court staff to focus program retreats on these two theories for revising their programs and practices. Drug court teams can easily spend a morning examining the motivational issues embedded in the participant dilemma "why should I change" and then spend the afternoon examining the two self-efficacy issues of "can I do this" (personal-efficacy thinking) and "how do I do this" (pathways thinking). Meeting these two conditions helps turn the wheel of behavior change.

[22] 2. Staff should share the "expert" role with the participant and family.

Staff has become accustomed to guiding and directing participants. Although dispensing advice and setting limits will always be a part of the staff's work, the common-factors research suggests that staff members must share the lead with participants and their families in order to

improve treatment outcomes. Regarding this, several issues are worth noting.

First, as encouraging as this common-factors research is to some, it may be considered threatening to others. Treatment providers or other staff may feel their treatment experience and conventional roles are being called into question. A balance must be struck between the experience and expertise of the drug court team member and the inclusion of the common factors for effective service delivery. Professional expertise will still be required and in great demand for working with clients, but the strategies that professionals employ will make a significant difference to whether they succeed. To be a committed advocate of change requires a focus not on technique but on the client (i.e., the participant and his or her family) as the common denominator in behavior change. Duncan and Miller address this change of focus: "Models that help the therapist approach the client's goals differently, establish a better match with the client's world view, capitalize on chance events, or utilize environmental supports are likely to prove the most beneficial in resolving a treatment impasse (Duncan and Miller, 2000)."

Second, staff may be skeptical of the exact implications of the common-factors research. For example, staff may think that sharing the expert role with challenging drug court clients means that they are to acquiesce to the stated immature or illogical desires of the participant with whom they are working. In fact, staff should not. Any goals stated by the client that are not interdependent with healthy relationships or that jeopardize health and safety (their own or others') are unacceptable. Staff may understand without agreeing, however, and they may identify without acquiescing.

Adopting a strength-based approach means reconfiguring our notions of accountability. Sharing the

expert role involves a review of accountability. Quite simply, current work that favors the views of professional staff over those of the client places too much responsibility for change on the shoulders of staff.

To provide a more thorough explanation of this approach requires first removing a commonly held misconception about strength-based practice. Some critics believe the ultimate goal of strength-based practice is naively centered on establishing a positive relationship. They also mistakenly assume that the staff member is compelled to give the client Pollyanna-like compliments, even in the face of the client's obvious wrongdoing and personal chaos (i.e., telling a shoplifter that he is "skillful" or re-framing drug dealing as demonstrating "fiscal competence"). Although it is true that a positive relationship and compliments have an important place in the strength-based approach, they are only important for their capacity to foster behavior change and help clients rise above their difficulties. If complimenting clients to ensure a positive relationship is an end to itself, it becomes a narcissistic enterprise. Staff engaged in drug court must challenge clients to move beyond their difficulties and help them marshal strengths to meet those challenges.

Compare how both the traditional and strengths-based approaches regard accountability. The traditional or current problem-solving approaches entrenched in the treatment field require staff to work hard at understanding the problem, ascertaining who is responsible, learning of the problem's origins, and discovering how it is maintained. Accountability is realized when a participant owns up to the wrong. Admission is paramount for the assumption of responsibility. Strength-based practice, on the other hand, does not assume that the ownership of guilt is somehow automatically curative.

Consider an idea forwarded by Jacobs from the sports psychology field (Jacobs, 1995). When an athlete has performed poorly, the coach spends little time reviewing the error or fixing blame before beginning corrective work. In the sports model, coaches are discouraged from waiting for the athlete to verbally assume responsibility or to assume responsibility passively. Instead, once the athlete understands what he or she has done wrong, the coach quickly reviews the error and focuses on encouraging behavior change. Accountability and responsibility for a negative performance are assumed when the athlete begins to change his or her performance.

Insoo Berg, co-founder of the solution-focused therapy model, has reported that the problem-focused model and its emphasis on moving the offender merely to "own up to the guilt" about the past does not hold the offender sufficiently responsible for change in the future (Berg, 1995). Moreover, too much time and energy are spent determining the causal relationship rather than expecting and demanding changes. The strength-based approach holds that accountability is realized through behavior change, not passive admission. From the beginning of contact, there is an expectation that the drug court participant will *do something* about the immediate concern. Strength-based practice is based on the belief that starting "first steps" and initiating action are all-important.

When staff views are favored over those of clients, staff indirectly assumes too much responsibility for change—which should rest instead with the client. For this reason, some strength-based agencies assist a client with writing his or her own reports to the court. The client then continues this process by verbally delivering his or her progress summary directly to the judge during the court hearing. The author believes that ownership of the treatment plan (and, consequently, empowerment) is thereby increased.

Third, staff may be reluctant to invite more participation, or to share the lead with a client if they believe their clients are not up to the task. Indeed, some clients may be troubled and causing trouble to others; yet the vast majority of clients are also capable and competent to begin and sustain needed changes. Consider the perplexing research cited by Anthony Maluccio, professor of social work at Boston College, which found that workers consistently underestimated client strengths and had more negative perceptions of clients and their ability to change *than the clients had of themselves* (Emphasis added) (Maluccio, 1979). Drug court teams must guard against an "us versus them" attitude.

Although many believe the strengths approach offers advantages for raising client motivation, the justice field continues a steady diet of finding, diagnosing, and treating failure and pathology (Clark, 2001b). But if practitioners believe clients and family members have strengths, practitioners may then look for and find them to use in their work with their clients.

Strength-based work asks staff members to forgo this pessimism and take an optimistic view. In their book, *Re-Educating Troubled Youth*, strength-based advocates Larry Brendtro and Arlin Ness give a good description of this dichotomy within juvenile justice:

> [S]ome might argue that optimism about antisocial youth is itself a thinking error, a Pollyanna illusion that nasty kids are really little cherubs. However, pessimism is seldom useful and often leads to feelings of powerlessness, frustration, and depression. In contrast, optimism feeds a sense of efficacy and motivates coping and adaptive behavior, even in the face of difficult odds (Brendtro and Ness, 1983).

Forty years of motivational research has provided ample evidence supporting this optimistic view. Motivational researchers Leake and King found that if you expect that change will occur with your clients, your expectation of change will influence their behavior (Miller and Rollnick, 1991). A drug court staff member's belief in the participant's ability to change can be a significant determinant of treatment outcome. Norman Cousins, who published landmark research at California's UCLA Medical School regarding the power of optimism in disease management, also found that helping efforts are more effective when the staff member believes in the client's capabilities and believes that the client can surmount the obstacles to positive behavior (Cousins, 1989). Believing in the client is the axis around which this model turns.

The reverse also may be true. Staff could approach a client with negative expectations, expecting very little if not the worst. One on-site drug court evaluation, which included a review of the orientation materials distributed to all prospective participants beginning the referral process, found twelve sanctions listed for breaking program rules and only five incentives for successful participation. The staff obviously expected that participants would resist and break the rules — and communicated that expectation to incoming referrals. In fact, this was not the staff's intent; they revised their materials to incorporate a more equal ratio of incentives and sanctions.

[23] 3. Treatment should not simply fix what is broken; it should nurture what is best.

Fixing what is broken or solving a problem only returns someone to equilibrium. The strengths perspective finds that the "good life" entails more than simply removing what is wrong. Compliance and obedience are critically important first steps, but they are poor final outcomes. Final

outcomes should target positive change and growth. At one point, the field of psychiatry had become so slanted to the negative that when a client under assessment was found not to have any problems they were described as "asymptomatic." Health is more than the absence of illness.

The necessary and defining characteristics of our courts, namely setting limits, metamorphose in specialty courts to establishing treatment goals that are positively framed. Court orders that generally call for an end of an illegal or unwanted behavior are not goals. Goals are desired ends that are framed as the presence or start of a positive behavior (Berg and Miller, 1992). It is hard to be consciously aware of the absence of something, or of "not doing" something as we go about our day. It is far easier to recognize "doing something," that is, an action or effort. "I won't talk back to my boss" is reframed as "counting to ten when angry," or "talking to another recovering person, acquaintance, or friend about how angry I am." When drug court participants or family members suggest goals posed with "never," "not," "don't," or "won't," questions are asked, "What will you do instead?" Vague, future conditions also need a concrete beginning. "So what do you need *to do* to start feeling better about yourself?"

When the common-factors research is incorporated and greater client and family participation is allowed, they become catalysts for greater gains (Nissen and Clark, in press). There is an emerging drug court adage, "beyond abstinence," that speaks to the critical consideration of *what will take the place of alcohol and other drug use* (James-Andrews, 2001)? This is not a secondary consideration; that is, it is not something for drug court programs to consider after abstinence has occurred and the participant has stabilized. Rather, it becomes an aspect of goal setting that can help to engender abstinence from the very start of programming. Programs need to look beyond the reduction

of law-breaking behavior to facilitate aspirations, vocational interests, and hobbies as identified by the participant or through vocational (or retraining) assessments. Drug court programs could provide new learning opportunities for participants, helping them to find new interests and identify positive pursuits, based on their proclivities and passions.

Staff spend a good deal of time learning how to connect with clients but do not consider how to make themselves and the drug court programming interesting enough that referrals will want to connect with the staff (Edgette, 2002). Supporting this notion of "beyond abstinence," author and noted solution-focused therapist Hiam Omer notes, "Motivation is not a quantum of energy residing in the client, but evolves from the formulation of goals (Omer, 1996)." To the extent that staff may attract the referral with useful opportunities and connections to helpful resources — primarily as assessed and indicated by the participant — the "alliance" is built through collaborative goal-setting.

[24] 4. A greater concentration on building a therapeutic alliance between staff and drug court participant.

Two alliance-building issues for drug court staff are key to this consideration:

A. The Alliance Must Be Formed Quickly. This article has explained how influential the staff-client alliance proves to be in inducing positive behavior change. The common-factors research also indicates, however, that staff must work fast to build the alliance. Both Mohl and his co-authors and Plotnicov point out that the impact of establishing the alliance early in treatment, generally by the fourth or fifth meeting, is critical to treatment outcome (as cited in Duncan and Miller, 2000).

Many programs begin with intensive orientation. One example of this is "Jump Start," found in the Santa Clara County, California, juvenile drug court. In this program, new participants attend intensive orientation sessions to familiarize themselves with program requirements during their first thirty days of participation in the program. These "jump starts" may be very helpful in orienting the new participant to program regulations.

Upon closer inspection, however, most intensive orientations are primarily one-sided. They are solely constructed for the new referrals to come to understand and acclimate themselves to the program structure, schedule, and requirements. Instead, to establish the alliance between staff and client quickly, orientations should focus more on reciprocity. That is, warmly greeting new participants and introducing the staff to them is not enough. Drug court team members and program staff must take a corresponding intensive "jump" by making a concerted effort to meet, quickly become familiar with, and even charm the incoming participant.

Some may chafe at the recommendation for staff to "woo" incoming drug court referrals, but the research is clear: the participant's perceptions of the alliance determine the outcome of treatment. Skeptics need only consider the largest outcome study ever undertaken, the NIMH Treatment of Depression Collaborative Research Project, which found that improvement was only minimally related to the type of treatment received but was heavily determined by the client-rated quality of the relationship (Blatt, 1996). Even if this study could be ignored, approximately one thousand other studies on alliance-building report the same finding (As cited in Hubble, Duncan, and Miller, 1999).

B. Alliance-Building Is As Varied As the Client. There is a difference between "understanding" and "doing." It is simple to understand how important the staff/participant alliance is to treatment outcomes and to place a majority of emphasis there. Actually building the alliance is quite another matter. All drug court participants are different and, because of different personality styles, they will evaluate the conditions of a positive alliance in differing ways. Alexandra Bachelor (1995) found that almost half of all clients wanted to be listened to (empathic reflections) and respected, while another forty percent wanted more "expert" advice from staff to promote direction and allow self-understanding (to "make sense" of issues). A smaller group wanted input, and saw the alliance as a 50-50 partnership in which they felt the need to contribute and have as much input as the staff (counselor) (as cited in Duncan and Miller, 2000). Duncan and Miller state: "The degree and intensity of [staff/counselor] input vary and are driven by the client's expectations of our role. Some clients want a lot from us in terms of generating ideas while others prefer to keep us in a sounding board role (Duncan and Miller, 2000.)"

Table 1
Implications for Practice

1. All drug court team members can become change-focused.

- Regardless of professional role and prior training, any drug court team member can become more therapeutic if they adopt the attitudes and skills suggested by this common factors research. This is especially true for judges, attorneys and probation staff.
- Teams need to avoid viewing the participants as static or fixed ("This participant is *always* like this") and be vigilant for sometimes small changes in thinking or behaving — realizing that change is occurring constantly, and these changes often go unnoticed, and more importantly, unused.
- Schedule drug court staff retreats to strategize how programming can incorporate two important motivational theories — value/expectancy theory that occurs early in treatment ("Should I do this? Why should I change") which is followed by self-efficacy theory (Can I do this – Do I have what it takes? And "How do I do this?"). Become students of motivation and behavior change by enlisting strategies that help participants answer these critical questions raised when faced with self-change.

2. Staff should share the "expert" role with the participant and family.

- Motivation and treatment outcomes are increased when teams encourage high levels of participation from program participants. This is best accomplished by allowing participants to be the "experts" on their lives and experiences.
- Although teaching, motivating and helping will always be part of our work, remember there is no one "correct" point of view and the client's view should be given equal weight to our own. If we don't listen and include the ideas of our clients, then drug court programming is established more for the staff than for the participants.
- Drug courts are an involuntary arena where court orders are in ascendancy. Even if abstinence from illicit drugs and alcohol is a mandate and will be non-negotiable, we can still allow the participant more voice in how to strive for abstinence and how to sustain it. Forty years of motivation research is clear; we must allow more participation by the client and not subjugate their views to our own.

3. Treatment should not simply fix what is broken; It should nurture what is best.

- Securing compliance and obedience are important first objectives to reach with new drug court participants; but we should avoid the mistake of viewing them as final outcomes. Strength-based drug courts strive for second tier goals that include positive behavior change, social and career enhancement and personal growth. Teams must keep an eye on efforts for both levels.
- Change-focused drug courts are mindful of the adage "beyond abstinence" that prompts programming to look at what will take the place of illicit drug and alcohol use. Drug court treatment goals should not be confused with probation (court) orders. Goals cannot be set as the absence of something or the withdrawal of an unwanted behavior. They must be framed as the start of a positive behavior or the presence of a new condition or activity. Strength-based assessments are helpful in finding client resources as well as proclivities and desires, interests and wants.
- We spend time learning how to better connect with our clients but we must also make drug court programming interesting enough that referrals will want to *connect with us*!

4. A greater concentration on building a therapeutic alliance between staff and drug court participant.

- Research shows that if any real and lasting improvement is to occur with our participants, it will happen through a therapeutic relationship (alliance) where the client perceives that drug court team members respect them, care about them, and will listen to them in a non-judgmental fashion. All change hinges on this relationship so this is not just something for "treatment" staff to engage in, it *must be a priority for all team members*. Regardless of how much a team member interacts with a participant, their interactions contribute to a climate and a culture, influencing progress — or the lack of it.
- Start by assuming the client is a reasonable person who has become stuck in a difficult situation.
- Realize cooperation is not a characteristic solely of the client— theirs alone to give to us (cooperative) or to withhold (resistant). Cooperation comes from the interaction between staff and client. By how we interact with participants, we can influence the level of cooperation shown by program clients.
- Research finds that staff perceptions of the client-staff relationship has little bearing on outcome, however the client's perception of the alliance is a strong indicator to positive outcome. Teams must quickly establish the relationship and consistently monitor its quality…by directly polling the participant(s).

Staff working with a drug court referral not only must court and woo new participants, but also they need to survey participants continually about their perceptions and ratings of the staff-participant alliance. Simply put, staff cannot modify or alter their approach to a client based on his perceptions if the staff does not know the client's perceptions. Duncan and Miller cite a critical effort that has profound implications for staff-client interactions: "Influencing the client's perceptions of the alliance represents *the most direct impact we can have on change* (Emphasis added) (Duncan and Miller, 2000)."

CONCLUSION

The common factors research has only recently been published. Presently, many in the fields of psychiatry, psychology, and social work are grappling with its findings. Armed with this knowledge, drug court staff and community treatment providers may become familiar with the techniques that engage the common factors. All who work with drug court referrals will benefit from these empirical findings on the pathways to change.

This article does not impeach current efforts, but rather the belief that staff and providers are the "engine" of change. Researchers have bemoaned the fact that inquiries of treatment outcomes over several decades have studied all the wrong elements — the models, techniques, and staff — while ignoring the most important contributor to change: the offender and his or her family. The obsessive question: "How do we get drug court participants sober?" — is answered simply: "*We* don't." This common factors research is clear: change rests with the clients. Drug court staff and community treatment providers have the responsibility of creating the structure and the atmosphere that are conducive to change.

Staff expertise will always be vital and needed, but only if it changes one's focus to guiding the three critical ingredients to motivation — the participant's resources, perceptions, and participation. Participant and family motivation is not static or fixed but dynamic, and it may be influenced and increased. Aligning direct practice efforts to influence and increase the common factors could help advance clients along this motivational continuum.

Most articles, whether research-oriented or practice-based, generally end with a call for further research — a call so routine that it has almost become a de facto signature line.

Consider, however, that the four factors common to all successful treatment have been illuminated by literally thousands of research studies. Although qualitative and quantitative analysis is invaluable to improve our practical methods, research cannot accomplish this mission unless staff first assimilates it. So, without denying the importance of research, this article does not end by urging more; it encourages all who work with drug court participants to stop and review this compelling research. Keeping in mind the necessary continuum of "research, policy, and practice," drug court team members should routinely pause to integrate research. Now is that time.

REFERENCES

Anderson, H. (1997). *Conversation, language, and possibilities: A postmodern approach to therapy, first edition*. New York, NY: Basic Books. xix, 308.

Asay, T.P., & Lambert, M.J. (1999). The empirical case for the common factors in therapy: Quantitative findings. In M.A. Hubble, B.L. Duncan, & S.D. Miller (Eds.), *The heart and soul of change: What works in therapy*. Washington, DC: American Psychological Association. 33-56.

Bachelor, A. (1991). Comparison and relationship to outcome of diverse dimensions of the helping alliance as seen by client and therapist. *Psychotherapy, 28*, 534.

Bazemore, G., & Umbriet, M. (1998). Balancing the response to youth crime: Prospects for a restorative juvenile justice in the Twenty-first Century. In A.R. Roberts (Ed.), *Juvenile justice: Policies, programs and services*. Chicago, IL: Nelson-Hall. 371-408.

Belenko, S. (June 2001). *Research on drug courts: A critical review 2001 update*. The National Center on Addiction and Substance Abuse at Columbia University.

Benson, P.L. (1997). *All kids are our kids: What communities must do to raise caring and responsible children and adolescents, first edition*. San Francisco, CA: Jossey-Bass. xxi, 314.

Berg, I. (1995). Letter/personal communication with author. Lansing, MI.

Berg, I.K. (1994). *Family-based services: A solution-focused approach*. New York, NY: W.W. Norton. xi, 226.

Berg, I.K., et al. (1998). *Solution focused therapy*. Boston, MA: Allyn and Bacon.

Berg, I.K., & Miller, S.D. (1992). *Working with the problem drinker: A solution-focused approach, first edition*. New York, NY: W.W. Norton. xx, 216.

Berg, I.K., & Reuss, N.H. (1998). *Solutions step by step: A substance abuse treatment manual, first edition*. New York, NY: W.W. Norton. 185.

Blatt, S.J. (1996). Interpersonal factors in brief treatment of depression: Further analyses of the NIMH treatment of depression collaborative research program. *Journal of Consulting & Clinical Psychology, 64*, 162.

Brendtro, L.K., & Ness, A.E. (1983). *Re-educating troubled youth: Powerful environments for teaching and treatment*. New York, NY: Aldine Publishing Company. xii, 288.

Brown, C.T., & Keller, P.W. (1979). *Monologue to dialogue: An exploration of interpersonal communication, second edition*. Englewood Cliffs, NJ: Prentice-Hall. xiii, 332.

Christensen, A., & Jacobson, N.S. (1994). Who (or what) can do psychotherapy? The status and challenge of nonprofessional therapies. *Psychological Science, 5*, 8.

Clark, M.D. (1995a). *Pretreatment improvements from case arrest to case assignment - Unpublished data from*

probation caseload. Ingham County 30th Judicial Circuit Court, Family Division. Unpublished work.

Clark, M.D. (1995b). The problem with problem solving: A critical review. *Journal for Juvenile Justice and Detention Services, 10*(1), 30-35.

_____. (1996). Solution-focused interviewing: A strength-based method for juvenile justice. *Journal for Juvenile Justice and Detention Services, 11*(1), 12-18.

_____. (1997a). Interviewing for solutions: A strength-based method for juvenile justice. *Corrections Today, 59*(3), 33-39.

_____. (1997b). Strength-based practice: A new paradigm. *Corrections Today, 59*(2), 201-202.

_____. (1998). Strengths-based practice: The ABC's of working with adolescents who don't want to work with you. *Federal Probation, 62*(1), 46-53.

_____. (1999). Strength-based practice: The ABC's of increasing motivation with juvenile offenders. *Juvenile and Family Court Journal, 50*(1), 33-43.

_____. (2001a). Influencing positive behavior change: Increasing the therapeutic approach of juvenile courts. *Federal Probation, 65*(1), 18-27.

_____. (2001b). Keynote address: Strength-based practice: Raising motivation and inducing behavior change. In *4th annual statewide conference*. Albuquerque, NM: New Mexico Association of Drug Court Professionals.

Coates, R. (1998). The future of corrections in juvenile justice. In A.R. Roberts (Ed.), *Juvenile justice: Policies, programs and services*. Chicago, IL: Nelson-Hall.

Conoley, C.W. (1991). The effects of matching rationales on the acceptability of consultation interventions. *Journal of Counseling and Development, 69*, 546.

Cousins, N. (1989). *Head first: The biology of hope, first edition*. New York, NY: Dutton. xii, 368.

DeJong, P., & Berg, I.K. (1998). *Interviewing for solutions*. Pacific Grove, CA: Brooks/Cole. xv, 262.

_____. (2002). *Interviewing for solutions, second edition*. Pacific Grove, CA: Brooks/Cole. xi, 324.

Duncan, B.L., & Miller, S.D. (2000). *The heroic client: Doing client-directed, outcome-informed therapy, first edition*. San Francisco, CA: Jossey-Bass. xix, 292.

Edgette, J., S. (2002). Avoiding the responsibility trap. *The Family Therapy Networker, 26*(1), 25-26.

Fraser, M.W. (1997). *Risk and resilience in childhood: An ecological perspective*. Washington, DC: NASW Press. xi, 295.

Furman, B., & Ahola, T. (1992). *Solution talk: Hosting therapeutic conversations, first edition*. New York, NY: W.W. Norton. xxvi, 180.

Gutiérrez, L.M., Parsons, R.J., & Cox, E.O. (1998). *Empowerment in social work practice: A sourcebook*. Pacific Grove, CA: Brooks/Cole. xxii, 241.

Hubble, M.A., Duncan, B.L., & Miller, S.D. (1999). *The heart and soul of change: what works in therapy*. Washington, DC: American Psychological Association. xxiv, 462.

Jacobs, D. (1995). Mining the gold. *RECLAIMING Children and YOUTH, 4*(2), 39-41.

Jacobson, N.S. (March/April 1985). The overselling of therapy. *Family Therapy Networker, 19*, 41.

James-Andrews, S. (June 2001). Personal communication with author. New Orleans, LA.

Kazdin, A.E. (1980). Acceptability of alternative treatments for deviant child behavior. *Journal of Applied Behavioral Analysis, 13*, 259.

Kobasa, S.C. (1979). Stressful life events, personality, and health: An inquiry into hardiness. *Journal of Personality & Social Psychology, 37*(1).

Lambert, M.J. (1992). Psychotherapy outcome research: Implications for integrative and eclectic therapists. In J.C. Norcross & M.R. Goldfried (Eds.), *Handbook of psychotherapy integration*. New York, NY: Basic Books.

Lankton, C. (1994). "Have you done anything Ericksonian today?" Co-creating positive self-fulfilling prophecy. In J. Zieg (Ed.), *Ericksonian methods: The essence of the story*. New York, NY: Brunner/Mazel. 119-135.

Maluccio, A.N. (1979). *Learning from clients: Interpersonal helping as viewed by clients and social workers*. New York, NY: Free Press. xii, 322.

Miller, S.D., Duncan, B.L., & Hubble, M.A. (1997). *Escape from Babel: toward a unifying language for psychotherapy practice, first edition*. New York, NY: W.W. Norton. xii, 244.

Miller, W.R., & Rollnick, S. (1991). *Motivational interviewing: Preparing people to change addictive behavior*. New York, NY: Guilford Press. xvii, 348.

Miller, W.R., Rollnick, S., & Moyers, T.B. (1998). *Motivational interviewing: Professional tape series.* [VHS video]. New Mexico: University of New Mexico.

Murphy, J.J. (1999). Common factors of school-based change. In M.A. Hubble, B.L. Duncan, & S.D. Miller (Eds.), *The heart and soul of change: What works in therapy*. Washington, DC: American Psychological Association. 361-388.

Nissen, L., & Clark, M. (In Press). *The power of the strengths approach in the juvenile drug court.* Practice Monograph. Washington, DC: Drug Court Programs Office, Office of Justice Programs, U.S. Department of Justice.

Office of National Drug Control Policy. (February 2002). *FY 2003 budget summary - National drug control strategy.* Washington, DC: Author.

O'Hanlon, B. (2000). Personal communication with author. Grand Rapids, MI.

Omer, H. (1996). Three styles of constructive therapy. In J. Zieg (Ed.), *Constructive therapies - Volume 2*. New York, NY: The Guilford Press. 319-333.

Saleebey, D. (1992). *The strengths perspective in social work practice*. New York, NY: Longman. xix, 198.

_____. (1997). *The strengths perspective in social work practice, second edition*. New York, NY: Longman. xx, 259.

_____. (2002). *The strengths perspective in social work practice, third edition*. Boston, MA: Allyn and Bacon. xxiv, 296.

Seligman, M.E.P. (1991). *Learned optimism*. New York, NY: A.A. Knopf. 319.

_____. (2000). Positive psychology: An introduction. *American Psychologist, 55*(5).

Snyder, C.R., Michael, S., & Cheavens, J. (1999). *Hope as a psychotherapeutic foundation of common factors, placebos, and expectancies*. In M.A. Hubble, B.L. Duncan, & S.D. Miller (Eds.), *The heart and soul of change: What works in therapy*. Washington, DC: American Psychological Association. 179-200.

Strupp, H.H., & Hadley, S.W. (1979). Specific vs. nonspecific factors in psychotherapy: A controlled study of outcome. *Archives General Psychiatry, 36*, 1125.

Tallman, K., & Bohart, A.C. (1999). The client as a common factor: Clients as selfhealers. In M.A. Hubble, B.L. Duncan, & S.D. Miller (Eds.), *The heart and soul of change: What works in therapy*. Washington, DC: American Psychological Association.

Werner, E.E., & Smith, R.S. (1992). *Overcoming the odds: High risk children from birth to adulthood*. Ithaca, NY: Cornell University Press. xiv, 280.

Wolin, S.J., & Wolin, S. (1993). *The resilient self: How survivors of troubled families rise above adversity, first edition*. New York, NY: Villard Books. xiv, 238.

WWW.THIRTEEN.ORG. (2002). *Close to home*. <http://www.thirteen.org/closetohome/treatment/earley.html>

INTEGRATING EVIDENCE-BASED SUBSTANCE ABUSE TREATMENT INTO JUVENILE DRUG COURTS: IMPLICATIONS FOR OUTCOMES

By Jeff Randall, Ph.D.; Colleen A. Halliday-Boykins, Ph.D.; Phillippe B. Cunningham, Ph.D.; Scott W. Henggeler, Ph.D.

This article describes the importance of integrating evidence-based substance abuse treatments into juvenile drug courts. Guidelines from the National Institute on Drug Abuse (NIDA) are offered as a template to enable drug courts to select substance abuse treatments based on available evidence of effectiveness. Multisystemic therapy (MST) is presented as an example of an evidence-based model of treatment that meets NIDA guidelines and has been integrated into several juvenile drug courts. Substance abuse outcomes from published MST trials are summarized, and a current study that examines the relative effectiveness of drug court with MST versus drug court with traditional substance abuse treatment is described.

Dr. Randall, Dr. Halliday-Boykins, Dr. Cunningham, and Dr. Henggeler teach in the Department of Psychiatry and Behavioral Sciences at the Medical University of South Carolina, and conduct research into MST and its applications and effectiveness.

Preparation of this manuscript was supported by grants R01-AA12202 from the National Institute on Alcohol Abuse and Alcoholism and R01-DA13066 from the National Institute on Drug Abuse (Scott W. Henggeler, Ph.D., principal investigator).

Direct all correspondence to Jeff Randall, Ph.D., Family Services Research Center, Department of Psychiatry and Behavioral Sciences, Medical University of South Carolina, 67 President Street, Suite CPP, Charleston, SC 29425.

ARTICLE SUMMARIES

TREATING ADOLESCENT SUBSTANCE USE EFFECTIVELY

[25] Recent research identifies determinants of adolescent substance use, implying methods for effective treatment.

NIDA'S THIRTEEN PRINCIPLES

[26] NIDA has outlined Thirteen Principles of effective treatment.

WHAT IS MULTI-SYSTEMIC THERAPY (MST)?

[27] MST uses evidence-based intervention techniques along with more unconventional service delivery.

EVALUATING THE EFFECTIVENESS OF MST

[28] Several studies have shown MST to be an effective treatment for adolescent substance use.

MST AND THE THIRTEEN PRINCIPLES

[29] The application of MST follows most of NIDA's Thirteen Principles of effective treatment.

MST AND JUVENILE DRUG COURT

[30] With some modification, MST has been integrated into juvenile drug courts.

EVALUATING MST IN JUVENILE DRUG COURT

[31] The integration of MST into juvenile drug court is currently being evaluated, with early signs of success.

INTRODUCTION

Juvenile drug courts have two primary components. The first component pertains to the organization and procedures used by the court. Here, youths with substance abuse problems are seen frequently, as often as once a week; objective biological measures of their substance use are obtained; and graduated sanctions and rewards are provided to the youth based on the results of the measures. Importantly, these procedures are consistent with long-standing principles of treatment that have strong empirical support for effectiveness in the behavior therapy literature (Eysenck & Martin, 1987; Garfield & Bergin, 1986; Granvold, 1994; Hubble, Duncan, & Miller, 1999). These principles state that behavior is effectively modified when tracked objectively and when meaningful consequences (rewards and punishments) are applied in a consistent and timely fashion. Moreover, in the broader criminal justice literature (e.g., Gendreau, 1995), the use of such behavioral principles has been associated with decreased rates of rearrest.

The second component of juvenile drug courts is the integration of community-based substance abuse treatment for the youths. Ideally, such treatment should have demonstrated effectiveness (i.e., be evidence based). As in the areas of mental health (Kazdin, 1997; Kazdin & Weisz, 1998) and juvenile justice (Elliott, 1998) services for youth, a wide variety of different substance abuse treatments have been developed. Unfortunately, and also consistent with the fields of mental health and juvenile justice services, few of these substance abuse treatments have demonstrated that they do more good than harm.

Nevertheless, decisions about the choice of treatment strategies for youths who abuse substances may be informed by the extensive knowledge base on the determinants (i.e., risk factors) and correlates of adolescent substance use. In

addition, findings from treatment outcome research for adolescent and adult substance abusers provide excellent guidelines for the choice of interventions to be integrated into juvenile drug courts. The purpose of this paper is to summarize the conclusions of these literatures and to discuss their implications for the effectiveness of juvenile drug courts.

DETERMINANTS OF ADOLESCENT SUBSTANCE USE AND IMPLICATIONS FOR EFFECTIVE TREATMENT

[25] Logically, if treatment addresses the known causes and correlates of substance abuse, the probability is increased that the treatment will be effective. Fortunately, an extensive knowledge base on the determinants of adolescent substance use and other antisocial behavior has been developed. Based on conclusions of several recent reviews, (American Academy of Child and Adolescent Psychiatry, 1997; Hawkins, Catalano, & Miller, 1992; McBride, VanderWaal, VanBuren, & Terry, 1999) consistent correlates of adolescent substance use have been identified, and these pertain to the adolescent and the multiple environmental contexts in which adolescents are embedded (see Table 1).

These findings have important implications for the design of effective substance abuse services for adolescents as delineated by Henggeler (1997). First, if a behavior is multidetermined and the goal of treatment is to maximize the probability of effecting the behavior, then treatment must focus on identified risk factors and have the capability of addressing a comprehensive array of these factors. Thus, for example, effective substance abuse treatment must have the capacity to (a) enhance parental abilities to monitor and discipline youth, (b) minimize youth involvement with deviant peers while enhancing involvement in prosocial peer activities (e.g., sports, church, after school activities), and (c) modify youth attitudes and beliefs regarding substance use.

Second, for reasons of efficiency and engagement in treatment, interventions must be individualized. Individualization of services (i.e., one size does not fit all) allows treatment to be tailored to the particular strengths and weaknesses (i.e., protective and risk factors) of the youth and his or her environmental context. Third, if adolescent substance use is heavily influenced by family, peers, school, and neighborhood, removing youths from these contexts (e.g., sending to residential treatment) is likely to provide only temporary reductions in substance use because the youth will be returning to the same context that has been supportive of the problems. Rather, clinical resources should be devoted to changing the contexts surrounding the youth. That is, treatment should be provided where the problems are, which is in homes, schools, and neighborhoods.

EVIDENCE-BASED GUIDELINES FOR EFFECTIVE TREATMENT

[26] In 1999, the National Institute on Drug Abuse (NIDA) conducted an extensive review of the treatment outcome research literature in the areas of adolescent and adult substance abuse. To enable organizations, institutions, and programs, such as drug courts, to select effective substance abuse treatment providers, NIDA published and disseminated 13 principles of effective treatments (NIDA, 1999 [see Table 2]).

The pertinence of these principles to services offered in juvenile drug courts is discussed subsequently. Here, however, it is important to note that several of the principles support the aforementioned contention that effective treatment should be comprehensive and individualized. For example, Principle 1 (No single treatment is appropriate for all individuals) highlights the need to individualize treatment for each adolescent to address those factors in his or her environment that are linked with substance use. Principle 3 (Effective treatment attends to the multiple needs of the

individual, not just his or her drug use) shows the need for treatment to be comprehensive enough to address pertinent social, family, and school problems. Likewise, Principle 8 (Addicted or drug-abusing individuals with coexisting mental health disorders should have both disorders treated in an integrated way) highlights the need for treatment to be comprehensive enough to address coexisting mental health problems of the adolescent. Taken together, NIDA's principles and the recent reviews of the correlates of adolescent substance abuse argue forcefully for treatment to be individualized and comprehensive enough to address its multiple determinants.

EVIDENCE-BASED TREATMENTS OF ADOLESCENT SUBSTANCE ABUSE: MST AS AN EXAMPLE

Several recent reviews have documented an emerging evidence base of promising adolescent substance abuse treatments (e.g., Bukstein, 2000; Liddle & Dakof, 1995; McBride et al., 1999; NIDA, 1999; Stanton & Shadish, 1997; Waldron, 1997; Winters, 1999). For example, NIDA (1999) cited three models as scientifically based approaches to adolescent drug treatment, including multisystemic therapy (MST; Henggeler, Schoenwald, Borduin, Rowland, & Cunningham, 1998), multidimensional family therapy (Liddle et al., 2001), and contingency management (Azrin et al., 1996). Similarly, Stanton and Shadish (1997) have highlighted the promise of several family-based approaches, and favorable substance use outcomes have recently been observed for functional family therapy (Waldron, Slesnick, Turner, Brody, & Peterson, 2001). MST has also been extensively validated and cited as an effective treatment for youth with violent and serious criminal behavior (Surgeon General's report on youth violence [U.S. Department of Health and Human Services, 2001]).

[27] MST is an empirically based treatment developed by the fourth author in the late 1970s. The ultimate goal of MST is to empower primary caregivers with the skills and resources to independently address the difficulties that arise from rearing youth with substance use and behavioral problems and to empower youth to cope with family, peer, school, and neighborhood difficulties. MST is one of the few treatments, to date, that has demonstrated long-term effectiveness with substance abusing youth and their families (Henggeler, et al., 1991; Henggeler, Clingempeel, Brondino, & Pickrel, in press).

Clinical Basis

MST clinical procedures are detailed in two volumes (Henggeler & Borduin, 1990; Henggeler et al., 1998). MST is based on a social ecological model of behavior (Bronfenbrenner, 1979), which is highly consistent with the aforementioned findings on the correlates of adolescent substance use. An underlying assumption of MST is that adolescents' clinical problems develop within the context of their social ecology, which includes the family (immediate and extended family members), peers, school, and neighborhood. Within this framework, MST uses evidence-based intervention techniques (e.g., behavior therapy, cognitive behavioral therapy, pragmatic family therapy, and community reinforcement voucher approach) to address individual, family, and system factors that are associated with treatment goals, including substance use. These interventions, however, are implemented in a programmatic context that differs substantially from the contexts in which most mental health and substance abuse services are delivered. In addition to adhering to a social ecological conceptual framework, MST programs (a) have intensive quality assurance protocols to optimize treatment fidelity and outcomes (Henggeler & Schoenwald, 1999), (b) use a home-based model of service delivery to overcome barriers to service access, (c) focus interventions on building caregiver

capacity to be effective with their youth (in contrast with a child-focused approach), and (d) assume accountability for engaging families in treatment and for achieving treatment goals.

Substance-related Outcomes

[28] As with all evidence-based treatments, rigorous evaluation has been fundamental to the development and validation of MST. Such critical evaluation and ongoing examination of outcomes is largely what differentiates evidence-based services from those services believed to be achieving outcomes, but never rigorously examined for such. Substance-related outcomes were examined in two randomized trials of MST with violent and chronic juvenile offenders (Borduin et al., 1995; Henggeler, Melton, & Smith, 1992), and these findings were published in a single report (Henggeler et al., 1991). Findings in the first study (Henggeler et al., 1992) showed that MST significantly reduced adolescent reports of a combined index of alcohol and marijuana use at post-treatment. In the second study (Borduin et al., 1995), substance-related arrests at a 4-year follow-up were 4% in the MST condition versus 16% in the comparison condition.

Subsequently, the effectiveness of MST was examined in a study with 118 juvenile offenders meeting DSM-III-R criteria for substance abuse or dependence and their families (Henggeler, Pickrel, & Brondino, 1999), with participants randomly assigned to receive MST vs. usual community services. MST reduced self-reported alcohol and marijuana use at post-treatment; decreased total days in out-of-home placement by 50% at follow-up (Schoenwald, Ward, Henggeler, Pickrel, & Patel, 1996), and increased youth attendance in regular school settings (Brown, Henggeler, Schoenwald, Brondino, & Pickrel, 1999). Moreover, fully 100% (58 of 58) of families in the MST condition were retained for at least 2 months of services, and 98% (57 of 58)

were retained until treatment termination at approximately 4 months post-referral, averaging 40 hours of direct clinical contact with an MST therapist (Henggeler, Pickrel, Brondino, & Crouch, 1996). Cunningham and Henggeler (1999) describe the effective MST family engagement strategies. Moreover, at 4 years post treatment, MST participants (now young adults) evidenced significant reductions in aggressive criminal behavior and had fewer positive tests for drug use based on urine screens than did participants in the comparison condition (Henggeler et al., in press). As is the case with most evidence-based approaches, additional research efforts aim to enhance outcomes, and these are described subsequently.

Compatibility with NIDA Guidelines

[29] In large part, the emerging success of MST and other family-based treatments such as multidimensional family therapy and functional family therapy can be understood in their correspondence with NIDA's 13 principles of effective treatment. Again, using MST as an example, this section overviews such compatibility.

1. NIDA: No single treatment is appropriate for all individuals.

MST: The choice of evidence-based interventions used for a particular youth and family is based on the identified risk and protective factors. For example, cognitive behavioral interventions might be used to address attitudinal barriers to achieving outcomes, whereas contingency management systems might be used to increase caregiver effectiveness.

2. NIDA: Treatment needs to be readily available.

MST: A home-based model of service delivery is used to address barriers to service access. In a home-based model, therapists provide services in home, school, and other community locations; caseloads are low; therapists are

available 24 hours a day, 7 days a week to respond to crises; and appointments are made at times convenient to the family. This approach has enabled MST to achieve the highest rates of treatment completion in the field (Henggeler et al., 1996).

3. NIDA: Effective treatment attends to the multiple needs of the individual, not just his or her drug use.

MST: Therapists comprehensively address the multiple determinants of the adolescent's problem behaviors across individual, family, peer, school, and neighborhood contexts. Any factor that is a barrier to favorable outcomes may become a target of MST interventions.

4. NIDA: An individual's treatment and service plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs.

MST: Continuous evaluation of treatment outcomes is a fundamental feature of the treatment model. At the onset of a case, the MST therapist works with stakeholders (e.g., the youth, caregivers, probation officer, teachers, judge) to determine the overarching goals of treatment and to understand the fit of the youth's problem behavior with the environment. Corresponding interventions are then developed and implemented collaboratively by the therapist and caregivers. If interventions are successful, treatment moves on to the next goals. If interventions are unsuccessful, the therapist and family reevaluate their understanding of the causes of the youth's behavior. This reevaluation leads to a corresponding modification of the interventions. This recursive process continues until interventions are effective.

5. NIDA: Remaining in treatment for an adequate period of time is critical for treatment effectiveness.

MST: MST is more intensive than most treatment approaches available and clinical improvement as opposed to number of treatment sessions dictates when a family will be discharged. On average, families receive 4 to 5 months of treatment, including an average of approximately 60 hours of

direct therapist-family contact. However, if a longer duration is necessary to obtain clinical improvement the family may receive additional treatment. In addition, as noted previously and as detailed elsewhere (Cunningham & Henggeler, 1999), MST is extremely effective at engaging youths and families in treatment.

6. NIDA: Counseling and other behavioral therapies are critical components of an effective treatment for addiction.

MST: Evidence-based interventions, such as behavioral and cognitive behavioral interventions, are fundamental to the implementation of MST. That is, intervention techniques used within MST are based on their extant evidence base (Henggeler et al., 1998). MST programs, however, integrate behavioral therapies with a social ecological conceptual framework, rigorous quality assurance systems, and a commitment to overcome barriers to service access.

7. NIDA: Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.

MST: Evidence-based pharmacological treatments (e.g., for ADHD) are integrated into MST psychosocial interventions when indicated.

8. NIDA: Addicted or drug-abusing individuals with coexisting mental health disorders should have both disorders treated in an integrated way.

MST: Treatment of co-occurring emotional and behavioral problems is fundamental to MST. MST has an emerging record in treating adolescent mental health problems effectively, as described in the Surgeon General's report on mental health (U.S. Department of Health and Human Services, 1999).

9. NIDA: Medical detoxification is only the first stage of addiction treatment and by itself does little to change the long-term drug use.

MST: A detoxification unit may be used as a safe site for stabilization, but it is not a treatment. MST therapists working with adolescents who require detoxification remain actively involved with the case by preparing for treatment when detoxification is completed.

10. NIDA: Treatment does not need to be voluntary to be effective.

MST: The court has mandated treatment in many MST programs. Although such mandates can gain the family's attention, they do not necessarily lead to family engagement or outcomes. Outcomes require developing an active collaboration between the therapist and the family. Regardless of how an adolescent enters the MST program, the MST therapist works to engage the adolescent's family to increase the likelihood that treatment gains will be promoted and maintained following treatment.

11. NIDA: Possible drug use during treatment must be monitored continuously.

MST: Urinalysis and other biological indices are currently being used to monitor drug use in MST programs, although this has only recently been the case. Rewards are provided by the caregivers for clean screens, and negative consequences are given for dirty screens. If the adolescent has a dirty screen, the therapist and caregivers attempt to understand the bases of the "lapse" and design interventions to address these bases.

12. NIDA: Treatment programs should provide assessment for HIV/AIDS, Hepatitis B and C, Tuberculosis and other infectious diseases, and counseling to help clients modify or change behaviors that place themselves or others at risk of infection.

MST: Medical evaluations have not been a standard part of MST programs. Rather, medical issues have been addressed on an "as needed" basis. In a recent MST clinical trial (Henggeler, Rowland et al., 1999), however, medical

evaluations were conducted on all youths in the MST condition, and a substantive percentage of these youths had previously unidentified medical conditions that could interfere with their psychosocial functioning (Rowland, Key, Marsh, Hedgepath, & Halliday-Boykins, 2000). These findings have heightened the awareness of medical issues that might impact treatment outcomes, though a protocol for addressing these issues has not yet been specified.

13. NIDA: Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.

MST: One of the limitations of standard MST programs using home-based services is that treatment is time limited -- usually 4-6 months. Drug use behavior, however, can be a very entrenched and reoccurring problem. Although the goal of the therapist is to empower parents to address current and future risk factors associated with their adolescent's drug use, such efforts are not always successful. To address this limitation in the MST model, a large-scale randomized trial of an MST-based continuum of care is currently in progress in Philadelphia. Youths in this project, a percentage of whom are substance abusers, enter an MST-based continuum of care (i.e., MST intensive outpatient; MST home-based; MST oriented respite, foster care, and short-term residential care) in which the duration of services is not time limited and youths receive the intensity of services that corresponds to their clinical needs.

Thus, using MST as an example of an evidence-based practice in this particular case, the model is consistent with many of the NIDA guidelines developed for the broader field. Interestingly, in those cases where MST programs have not historically been consistent with the 1999 guidelines (see guidelines 11, 12, 13), MST research during the past few years has moved in the direction of the guidelines.

Integration of MST with Juvenile Drug Court

[30] MST programs are operating in juvenile drug courts in Honolulu, New Orleans, Gainesville, and Charleston, South Carolina. The integration of MST and juvenile drug court has led to modification of both standard MST procedures and drug court practices. Two major modifications to MST programmatic and therapist functioning have been made. First, to address the difference between the average length of treatment in MST (i.e., 4 months) and the average duration of many drug court programs (i.e., 12 months), staffing adjustments are being made within the MST drug court programs (e.g., intensive services are provided for 4 months followed by periodic monitoring and less intensive services until drug court graduation). Second, therapists have developed closer working relations and collaborations with juvenile justice authorities than has typically been the case. Although the roles of the court and juvenile probation are central to the success of services at all MST sites (i.e., MST programs are providing services in 27 states and 6 nations), drug court requires relatively intensive contact with juvenile justice authorities on a weekly basis. MST programs have long emphasized their own accountability for achieving favorable outcomes with clients, but the frequent review of outcomes by the court (i.e., urine screens, weekly appearance in court) raises this bar even higher.

The introduction of a clearly specified evidence-based practice into juvenile drug court has required modification of the court's practices as well. Most important, many drug courts view intensive group-oriented substance abuse treatment (e.g., 3-5 hours after school every day) as a fundamental component of drug court. Such group interventions for youths presenting serious antisocial behavior are clearly proscribed within MST. This prohibition is based on considerable evidence that group treatment for adolescents with antisocial behavior is iatrogenic (for

reviews, see Arnold & Hughes, 1998; Dishion, McCord, & Poulin, 1999). That is, treating antisocial youths in groups can exacerbate their problems. Moreover, intensive group interventions within drug court programs take valuable time away from devoting attention to central MST goals, such as improving family-youth relations, enhancing school performance, and helping the youth develop prosocial recreational activities and relations with prosocial peers.

Evaluating the Integration of MST and Juvenile Drug Court

[31] With funding from NIDA and the National Institute on Alcoholism and Alcohol Abuse (NIAAA), the authors are in the third year of a 5-year study examining the assumptions that juvenile drug court is more effective than standard services and that the integration of an evidence-based practice will improve drug court outcomes. The four treatment conditions include:

1. Community substance abuse services without drug court;
2. Drug court with community substance abuse services;
3. Drug court with MST; and
4. Drug court with MST enhanced with the community reinforcement approach (Budney & Higgins, 1998).

Eventually 288 juvenile offenders meeting DSM-IV criteria for substance abuse or dependence will be randomly assigned to one of the above groups and assessed at four different times (i.e., entry in study through 18 months) with a comprehensive multimethod and multisource evaluation. To date one hundred and thirty participants are enrolled. Although findings from preliminary analyses should always be regarded as highly tentative, recent analyses have shown that the use of an evidence-based intervention has significantly reduced substance use, based on both self-

reports and biological indices; criminal activity, and incarceration in comparison with conditions in which community substance abuse services are provided.

CONCLUSIONS AND IMPLICATIONS FOR JUVENILE DRUG COURT SERVICES

The determinants of substance use, NIDA guidelines, the clinical emphases of current evidence-based practices, and MST outcomes, particular, have important implications for the integration of effective substance abuse treatments into juvenile drug courts. This broad research base suggests that substance abuse services for adolescents should:

1. Be comprehensive;
2. Be individualized;
3. Build family effectiveness;
4. Minimize involvement with problem peers;
5. Build relations with prosocial peers;
6. Support school performance;
7. Overcome barriers to service access;
8. Monitor outcomes and modify interventions accordingly;
9. Focus on changing the natural environments of youths;
10. Focus on outcomes rather than on hours served;
11. Have evidence of effectiveness; and
12. Include strong quality assurance protocols.

Although comprehensive surveys of the clinical nature of the substance abuse treatment programs integrated into juvenile drug courts have not been conducted (Belenko, 1998), the indication, based on the available literature and anecdotal experience, is that few juvenile drug courts include the types of substance abuse services described here. The divide between extant clinical practice and clinical guidelines based on research has been highlighted in a recent Institute of Medicine report (IOM, 1998) and presents a clear contrast in

the implementation of juvenile drug courts. This report noted the widening gap between the need for services that go beyond basic drug abuse treatment and the supply of such services. The vast majority of substance abusing adolescents present co-occurring problems such as psychiatric comorbidity, poor school performance, family difficulties, and criminal behavior; but current service systems often work in "conflicting directions" (e.g., substance abuse vs. mental health) which allows youths to "fall through the cracks" (p. 34, IOM, 1998). Moreover, the reported noted that drug abuse treatment providers working in community settings are often not open to the use of evidence-based treatments for a variety of reasons.

Although the judicial component of juvenile drug court follows well-validated behavioral principles, outcomes are also influenced by the nature of the substance abuse treatment services provided. This article has discussed three research literatures that have implications for the design of effective substance abuse services for adolescents: studies on the determinants of adolescent substance use, the NIDA treatment guidelines, and outcomes from evidence-based treatments, MST in particular. A broad gap seems to exist between the nature of the services provided in the field and those indicated by the research literatures (IOM, 1998). This gap has important implications for the ultimate effectiveness of juvenile drug courts, and at least one study is examining whether the integration of evidence-based services enhances the outcomes of juvenile drug court. Continued rigorous (i.e., well implemented randomized trials) evaluation is needed to determine the types of treatment services that best facilitate the capacity of juvenile drug courts to achieve their primary goals – the reduction of juvenile substance abuse and its associated personal and societal costs.

Table 1
Determinants of Adolescent Substance Use

Systems	Factors
Individual	other antisocial behaviors, low self-esteem, low social conformity, psychiatric symptomatology, positive expectancies for substance effects, and genetic loadings
Family	ineffective management and discipline, low warmth and high conflict, parental drug abuse and mental health problems that interfere with effective parenting
Peers	association with substance using peers and low association with prosocial peers (note also, the association with deviant peers is the single most powerful predictor of antisocial behavior in adolescents)
School	low intelligence, achievement, and commitment to achievement
Neighborhood	disorganized and high crime

Table 2
NIDA's 13 Principles of Effective Treatment

1. No single treatment is appropriate for all individuals.
2. Treatment needs to be readily available.
3. Effective treatment attends to the multiple needs of the individual, not just his or her drug use.
4. An individual's treatment and service plan must be assessed continually and modified as necessary to ensure that the plan meets the person's changing needs.
5. Remaining in treatment for an adequate period of time is critical for treatment effectiveness.
6. Counseling and other behavioral therapies are critical components of an effective treatment for addiction.
7. Medications are an important element of treatment for many patients, especially when combined with counseling and other behavioral therapies.
8. Addicted or drug-abusing individuals with co-existing mental health disorders should have both disorders treated in an integrated way.
9. Medical detoxification is only the first stage of addiction treatment and by itself does little to change the long-term drug use.
10. Treatment does not need to be voluntary to be effective.

Table 2
NIDA's 13 Principles of Effective Treatment [Continued]

11. Possible drug use during treatment must be monitored continuously.

12. Treatment programs should provide assessment for HIV/AIDS, Hepatitis B and C, Tuberculosis and other infectious diseases, and counseling to help clients modify or change behaviors that place themselves or others at risk of infection.

13. Recovery from drug addiction can be a long-term process and frequently requires multiple episodes of treatment.

REFERENCES

American Academy of Child and Adolescent Psychiatry. (1997). Practice parameters for the assessment and treatment of children and adolescents with substance use disorders. *Journal of the American Academy of Child and Adolescent Psychiatry, 36 (Supple.)*, 140S-156S.

Arnold, M.E., & Hughes, J.N. (1998). First do no harm: Adverse effects of grouping deviant youth for skills training. *Journal of School Psychology, 37*, 99-115.

Azrin, N.H., Acierno, R., Kogan, E., Donohue, B., Besalel, V., & McMahon, P.T. (1996). Follow-up results of supportive versus behavioral therapy for illicit drug abuse. *Behavioral Research & Therapy, 34*, 41-46.

Belenko, S. (1998). Research on drug courts: A critical review. *National Drug Court Institute Review, I*(1), 1-43.

Borduin, C.M., Mann, B.J., Cone, L.T., Henggeler, S.W., Fucci, B.R., Blaske, D.M., & Williams. R.A. (1995). Multisystemic treatment of serious juvenile offenders: Long-term prevention of criminality and violence. *Journal of Consulting and Clinical Psychology, 63*, 569-578.

Bronfenbrenner, U. (1979). *The ecology of human development*. Cambridge, MA: Harvard University Press.

Brown, T.L., Henggeler, S.W., Schoenwald, S.K., Brondino, M.J., & Pickrel, S.G. (1999). Multisystemic treatment of substance abusing and dependent juvenile delinquents: Effects on school attendance at post-treatment and 6-month follow-up. *Children's Services: Social Policy, Research, and Practice, 2*, 81-93.

Budney, A.J., & Higgins, S.T. (1998). *A community reinforcement plus vouchers approach: Treating cocaine addiction*. Rockville, MD: U.S. Department of Health and Human Services.

Bukstein, O.G. (2000). Disruptive behavior disorders and substance use disorders in adolescents. *Journal of Psychoactive Drugs*, 32, 67-79.

Cunningham, P.B., & Henggeler, S.W. (1999). Engaging multiproblem families in treatment: Lessons learned throughout the development of multisystemic therapy. *Family Process, 38*, 265-286.

Dishion, T.J., McCord, J., & Poulin, F. (1999). When interventions harm: Peer groups and problem behavior. *American Psychologist, 54*, 755-764.

Elliott, D.S. (1998). *Blueprints for violence prevention* (Series Ed.). University of Colorado, Center for the Study and Prevention of Violence. Boulder, CO: Blueprints Publications.

Eysenck, H. J., & Martin, I. (1987). *Theoretical foundations of behavior therapy*. New York, NY: Plenum Press.

Garfield, S.L., Bergin, A.E. (1986). *Handbook of psychotherapy and behavior change*. New York, NY: John Wiley & Sons.

Gendreau, P. (1995). Technology transfer in the criminal justice field: Implications for substance abuse. In T.E. Backer, S.L. David, & G. Soucy (Eds.), *Reviewing the Behavioral science knowledge base on technology transfer*. [NIDA Research Monograph No. 155]. Rockville, MD: U.S. Department of Health and Human Services, National Institute of Drug Abuse, 198-208.

Granvold, D.K. (1994). *Cognitive and behavioral treatment: Methods and applications*. Pacific Grove, CA: Brooks/Cole Publishing Company.

Hawkins, J.D., Catalano, R.F., & Miller, J.Y. (1992). Risk and protective factors for alcohol and other drug problems in adolescence and early adulthood: Implications for substance abuse prevention. *Psychological Bulletin, 112*, 64-105.

Henggeler, S.W. (1997). The development of effective drug abuse services for youth. In J.A. Egerston, D.M. Fox, & A.I. Leshner (Eds.), *Treating drug abusers effectively*. New York, NY: Blackwell Publishers, 253-279.

Henggeler, S.W., & Borduin, C.M. (1990). *Family therapy and beyond: A multisystemic approach to treating the behavioral problems of children and* adolescents. Pacific Grove, CA: Brooks/Cole Publishing Company.

Henggeler, S.W. & Borduin, C.M., Melton, G.B., Mann, B.J., Smith, L. Hall, J.A., Cone, L. & Fucci, B.R. (1991). Effects of multisystemic therapy on drug use and abuse in serious juvenile offenders: A progress report from two outcome studies. *Family Dynamics of Addiction Quarterly, 1*, 40-51.

Henggeler, S.W., Clingempeel, W.G., Brondino, M.J., & Pickrel, S.G. (In press). Four-year follow-up of multisystemic therapy with substance abusing and dependent juvenile offenders. *Journal of the American Academy of Child & Adolescent Psychiatry.*

Henggeler, S.W., Melton, G.B., & Smith, L.A. (1992). Family preservation using multisystemic therapy: An effective alternative to incarcerating serious juvenile offenders. *Journal of Consulting and Clinical Psychology, 60*, 953-961.

Henggeler, S.W., Pickrel, S.G., & Brondino, M.J. (1999). Multisystemic treatment of substance abusing and dependent delinquents: Outcomes, treatment fidelity, and transportability. *Mental Health Services Research, 1*, 171-184.

Henggeler, S.W., Pickrel, S.G., Brondino, & M.J., Crouch, J.L. (1996). Eliminating (almost) treatment dropout of substance abusing or dependent delinquents through home-based multisystemic therapy. *American Journal of Psychiatry, 153*, 427-428.

Henggeler, S.W., Rowland, M.D., Randall, J., Ward, D.M., Pickrel, S.G., Cunningham, P.B., Miller, S.L., Edwards, J., Zealberg, J.J., Hand, L.D., & Santos, A.B. (1999). Home based Multisystemic Therapy as an alternative to the hospitalization of youths in psychiatric crisis: Clinical outcomes. *Journal of the American Academy of Child and Adolescent Psychiatry, 38*, 1331-1339.

Henggeler, S.W., & Schoenwald, S.K. (1999). The role of quality assurance in achieving outcomes in MST programs. *Journal of Juvenile Justice and Detention Services, 14*, 1-17.

Henggeler, S.W., Schoenwald, S.K., Borduin, C.M., Rowland, M.D., & Cunningham, P.B. (1998). *Multisystemic treatment of antisocial behavior in children and adolescents*. New York, NY: The Guilford Press.

Hubble, M.A., Duncan, B.L., & Miller, S.D. (1999). *The heart and soul of change*. Washington, DC: American Psychological Association.

Institute of Medicine. (1998). *Bridging the gap between practice and research: Forging partnerships with*

community-based drug and alcohol treatment. Washington, DC: National Academy Press.

Kazdin, A.E. (1997). A model for developing effective treatments: Progression an interplay of theory, research, and practice. *Journal of Clinical Child Psychology, 26*, 114-129.

Kazdin, A.E., & Weisz, J.R. (1998). Identifying and developing empirically supported child and adolescent treatments. *Journal of Consulting and Clinical Psychology, 66*, 19-36.

Liddle, H.A., & Dakof, G.A. (1995). Efficacy of family therapy for drug abuse: Promising but not definitive. *Journal of Marital and Family Therapy, 21*, 511-543.

Liddle, H.A., Dakof, G.A., Parker, K., Diamond, G.S., Barrett, K., & Tejeda, M. (2001). Multidimensional family therapy for adolescent drug abuse: Results of a randomized clinical trial. *American Journal on Drug and Alcohol Abuse, 27*, 651-687.

McBride, D., VanderWaal, C., VanBuren, H., & Terry, Y. (1999). *Final technical report: Breaking the cycle of drug use among juvenile offenders*. Washington, DC: U.S. Department of Justice, National Institute of Justice.

National Institute on Drug Abuse. (1999). *Principles of drug addiction treatment: A research-based guide*. Rockville, MD: U.S. Department of Health and Human Services. National Institute of Health Publication No. 99-4180.

Rowland, M.D., Key, J.D., Marsh, L.D., Hedgepath, A., & Halliday-Boykins, C.A. (2000). *Medical diagnoses in youth presenting for psychiatric hospitalization*. Paper presented at the American Academy of Child and Adolescent Psychiatry, Annual Meeting, New York, NY.

Schoenwald, S.K., Ward, D.M., Henggeler, S.W., Pickrel, S.G., & Patel, H. (1996). MST treatment of substance abusing/dependent adolescent offenders: Costs of reducing incarceration, inpatient, and residential placement. *Journal of Child and Family Studies, 5*, 431-444.

Stanton, M.D. & Shadish, W.R. (1997). Outcome, attrition, and family-couple treatment for drug abuse: A meta-analysis and review of the controlled, comparative studies. *Psychological Bulletin, 122*, 170-191.

U.S. Department of Health and Human Services. (1999). *Mental health: A report of the U.S. Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health, National Institutes of Health, National Institute of Mental Health.

_____. (2001). *Youth violence: A report of the U.S. Surgeon General*. Rockville, MD: U.S. Department of Health and Human Services, Substance Abuse and Mental Health Services Administration, Center for Mental Health, National Institutes of Health, National Institute of Mental Health.

Waldron, H.B. (1997). Adolescent substance abuse and family therapy outcome: A review of randomized trials. In T.H. Ollendick & R.J. Prinz (Eds.), *Advances in Clinical Child Psychology, 19*, 199-234.

Waldron, H.B., Slesnick, N., Turner, C.W., Brody, J.L., & Peterson, T.R. (2001). Treatment outcomes for adolescent substance abuse at 4- and 7-month assessments. *Journal of Consulting and Clinical Psychology, 69*, 802-813.

Winters, K.C. (1999). Treating adolescents with substance use disorders: An overview of practice issues and treatment outcomes. *Substance Abuse, 20*, 203-225.

RESEARCH UPDATE

REPORTS ON RECENT DRUG COURT RESEARCH

This issue of the National Drug Court Institute Review synopsizes reports on three studies in the field of drug court research and evaluation, compiled by the authors of those studies: an outcome evaluation for the Dallas County DIVERT Court; an evaluation of Maine's state-wide adult drug treatment court program; and an evaluation of Maine's state-wide juvenile drug treatment court program.

ARTICLE SUMMARIES

DALLAS COUNTY DIVERT COURT

[32] This outcome evaluation found arrest rates for graduates at 15.6% as compared with 39.5% for program drop-outs and 48.7% for the comparison group. Less than 90 days in treatment appeared to be an indicator of higher rearrest post-termination.

MAINE'S STATE-WIDE ADULT DRUG TREATMENT COURT

[33] This evaluation of Maine's state-wide adult drug treatment court program found an overall retention rate of 74%; 54.4% of participants have remained drug-free; and participants have improved their employment and attendance in school/vocational programs by 16%.

MAINE'S STATE-WIDE JUVENILE DRUG TREATMENT COURT

[34] This evaluation of Maine's state-wide juvenile drug treatment court program found an overall retention rate of 65%; a recidivism rate of 54%; and a relapse rate of 82% at some point during program participation.

DALLAS COUNTY DIVERT COURT OUTCOME EVALUATION

Monica M. Turley, M.A., Ashley Hollweg, M.A.,
Robert B. Hampson, Ph.D.
Southern Methodist University

Methodology: The outcome evaluation of Dallas County's Drug Court, DIVERT (Dallas Initiative for Diversion and Expedited Rehabilitation and Treatment), examines recidivism rates of program participants compared with a similar group of offenders adjudicated prior to the establishment of DIVERT Court. Local, state, and national crime databases were utilized to ascertain the number of arrests during a specific follow-up period for DIVERT program graduates, for those who dropped out or were dismissed from the program, and for the comparison group. All three groups were followed for a period of twenty-seven months, which includes a twelve month period following the date of graduation or dismissal for DIVERT participants. Groups were also compared specifically on frequency of rearrests related to drug use or possession. Finally, for the DIVERT participants who failed to graduate (dropouts), recidivism was compared across three different groups based on length of stay in the program before dismissal.

Program: The DIVERT program was implemented in January 1998 as an alternative for non-violent first time felony drug offenders. Upon arrest, offenders are identified as eligible for inclusion in DIVERT by Dallas County's pre-trial release program, and then further screened to determine if they meet specific criteria. The DIVERT program offers immediate placement into substance abuse treatment and court supervision, often within ten days from the date of arrest. In exchange for compliance with program conditions and successful graduation, the offender is not prosecuted for pending felony charges. Participants must remain in DIVERT for at least twelve months before becoming eligible

for graduation, with some remaining in the program up to eighteen months. The graduates in the present study remained in the program for an average of fifteen months.

Participants: Of the 320 offenders admitted to the DIVERT program during the evaluation period (January 1998 through April 2000), 21 opted out, 103 were terminated due to non-compliance or a new charge (dropouts), 77 successfully completed the program (graduates), and 119 were active in the program. The average DIVERT participant (including both dropouts and graduates) is 33.26 years old and has completed 11.6 years of formal education. Subjects are predominantly African-American (52%), male (74%), single (78%), and report no previous treatment episodes (74%). Comparison group subjects share similar demographic profiles.

[32] Outcomes and Findings: ***Recidivism:*** During the follow-up period, 27.8% of the DIVERT group (including both graduates and dropouts) were rearrested compared with 48.7% of the comparison group. Looking at the three groups separately, graduates of DIVERT had the lowest rearrest percentage (15.6%) compared to program dropouts (39.5%) and comparison subjects (48.7%). *Any* type of arrest was counted as a new offense during the follow-up period. However, in examining rearrests by type, DIVERT graduates still had the lowest rearrest percentage for drug charges (9.1%) compared to that of dropouts (17.3%) and control group subjects (24.4%). ***Other:*** Recidivism rates were examined specifically among the DIVERT dropouts based on length of stay in the program before termination. Ninety days or less was considered a short length of stay, 91 to 270 days a medium length of stay, and more than 270 days was considered a long treatment stay. Those with 90 days or less in the program before dismissal had a significantly higher rearrest rate post-termination than the other two groups.

EVALUATION OF MAINE'S STATE-WIDE ADULT DRUG TREATMENT COURT PROGRAM

Donald F. Anspach, Ph.D., and Andrew S. Ferguson
Social and Behavioral Research
The College of Arts and Sciences
University of Southern Maine

Methodology: This report is based on the first year of a four year evaluation of Maine's statewide adult drug court system. The primary focus of the assessment is to document the drug court system and report on its status of implementation. The evaluation compares the productivity of Maine's adult drug courts with other drug courts at a similar stage of implementation. As the drug court is in the early stages of operations, many components of the program have not been institutionalized and are thus more amenable for program improvement.

The research team developed and implemented an MIS for case management and evaluation purposes. Much of the information for the first report is based on data obtained from the MIS program – such as characteristics of clients and data elements collected from weekly progress reports. The evaluation describes participants, identifies indicators of program performance across courts, and examines the degree of interagency coordination and integration.

Program: Maine is a pioneer, having successfully implemented a coordinated, statewide adult drug court system. Eleven Superior Court Justices and District Court Judges are assigned to seven adult drug courts serving six of Maine's sixteen counties. The six Maine counties that currently have adult drug courts have a combined population of approximately 789,762 people – representing about 62% of the state's population.

Maine's adult drug treatment court is a court supervised, post-guilty plea drug court requiring clients to participate in drug treatment (DSAT) and attend weekly court appearances. Participants are also required to attend 12-step programs and submit to frequent drug and alcohol testing. A local case manager assists each court in screening and conducting background checks, participates in court hearings, and conducts drug tests. Substance abuse treatment services are provided by DSAT certified treatment providers located across the state. The role of treatment is to conduct clinical screenings and assessments and deliver the DSAT treatment regimen to participants.

Planning and implementation began in 2000 using funds derived from Maine's share of the tobacco settlement. Adult drug courts began operating in April 2001. The program has four phases that are designed to take approximately twelve months to complete. Each phase establishes distinct treatment goals and specified minimum time periods for completion.

Participants: The first drug court participant was admitted in April 2001. To date, a total of 240 people were referred to Maine's adult drug treatment court program. As of November 30, 2001, a total of 114 people had been admitted to the program, and of this number 84 remain active. With a few regional exceptions, the majority of participants can be characterized as single, white males between twenty-five and thirty-five years of age. Nearly half of the participants statewide were unemployed (47.9%) at admission and the majority of participants have either graduated from high school or earned their GED (63%). The majority (62%) of participants have two or more prior convictions with at least one prior drug or alcohol conviction. Prior contacts with the criminal justice system for 65% of participants began as juveniles. Most participants are polysubstance abusers. Drugs of choice include alcohol (34%); heroin, oxycontins, and other opiates (34%); and marijuana (15%). Many

participants (41.4%) had never received substance abuse treatment services prior to entering the drug court program.

[33] Preliminary Outcomes and Findings: ***Relapse:*** Over half (54.4%) of all participants have remained drug free. ***Retention:*** The overall retention rate statewide is 74%. ***Other:*** Employment and attendance in school/vocational programs improved since enrollment by an overall increase of 16%. Participants estimate that prior to drug court, the costs of their addiction exceeded $500.00 per week, of which nearly two-thirds was obtained illegally. Participants who were terminated from the program obtained twice as much in illegal funds to support their habit as non-terminated participants.

EVALUATION OF MAINE'S STATE-WIDE JUVENILE DRUG TREATMENT COURT PROGRAM

Donald F. Anspach, Ph.D. and Andrew S. Ferguson
Social and Behavioral Research
The College of Arts and Sciences
University of Southern Maine

Methodology: The University of Southern Maine's College of Arts and Sciences was contracted to conduct the evaluation of Maine's juvenile drug treatment court system. The primary focus of this twenty-month evaluation was to document the juvenile drug court system, comparing the productivity of Maine's juvenile drug courts with other juvenile drug courts nationally; examine intermediate outcomes relating to life improvements, relapse, and recidivism; and provide a series of specific recommendations for program improvement. The evaluation describes program participants, identifies the range and types of sanctions and rewards utilized, and examines the degree of interagency coordination and integration. Sources of information include observational data from court site-visits, qualitative data from program participant and key actor interviews, and quantitative data collected from bio-psychosocial evaluations, weekly progress reports and client information obtained from Maine's Department of Corrections, Division of Juvenile Services case files.

Program: Maine is one of the few states to successfully have implemented a coordinated, statewide juvenile drug court *system*. Six juvenile drug courts are currently in operation serving seven of Maine's sixteen counties and 69% of the state's population. The juvenile drug courts *system* became operational in January 2000. The program is post-plea (but pre-final disposition), providing comprehensive community-based services to both juvenile offenders and their families. The program has four phases that are designed to take

approximately 50 weeks to complete. Each phase establishes distinct treatment goals and specified minimum time periods for completion. In addition to weekly court appearances, participants are required to attend drug treatment as well as meet with their drug court treatment manager. Phase advancement requires that participants have a specified number of consecutive weeks of clean alcohol and drug tests, and no unexcused absences from treatment or court sessions.

Participants: Between January 26, 2000, and September 30, 2001, there were a total of 114 juveniles enrolled in the program. Sixty juveniles are currently active and 40 were terminated. As of September 30, 2001, a total of 14 participants graduated from the program. Overall, the majority of participants can be characterized as white males (85%) between 16 and 17 years of age who are attending school (63%). All participants have serious substance abuse problems and their use began around the age of 11. A majority report a history of trauma and physical and sexual abuse. Most (91%) have been suspended from school one or more times. By the age of 14, most participants (71%) had contact with the police. Although participants (86%) have prior juvenile dispositions, only one-third have been convicted of felony juvenile offenses. However, a majority of participants (70%) have not been placed in detention facilities. There are, however, important variations by court location in these characteristics. For example, the percent of participants previously incarcerated at one of the two detention facilities ranges from a low of 7% at one court to a high of 52% at another court.

[34] Outcomes and Findings: Over half of the juvenile drug court participants have remained sober for three months or more. Both school attendance and employment have increased significantly. ***Retention:*** The overall retention rate statewide is 65%, ranging from a low of 52% to a high of 85%. ***Recidivism:*** 61 participants (54%) recidivated during their participation in the program. Those participants who

did engage in criminal conduct (90%) were also likely to have relapsed. ***Relapse:*** Most participants (82%) relapsed at some point in the drug court program. ***Graduation:*** Fourteen participants successfully completed the program and graduated. ***Other:*** Interviews with 32 participants indicate that rewards and sanctions are perceived as being unfair (55% of those interviewed) and 40% of participants interviewed indicated their use of drugs and/or alcohol was not detected during their participation in the drug court. Integrating multiple sources of data into the research design enabled the research team to identify and validate those policies and practices that required revision so as to further enhance the program.

SUBJECT INDEX

The following cumulative Subject Index is designed to provide easy access to subject references. Each reference can be located by:

- *Volume* *by using a roman numeral e.g. I*
- *Issue* *by using a number e.g. 2*
- *Subject reference* *by its page number in parenthesis e.g. (121)*

HEADNOTE INDEX

The Headnote Index provides access to an article's major points or concepts using a cumulative indexing system. Each headnote can be located by:

- *Volume* *by using a roman numeral i.e. I*
- *Issue* *by using a number i.e. 2*
- *Headnote* *by using a number in brackets i.e. [4]*

III1**[22]** Sanctions & Incentives
III1**[23]** Effectiveness
III1**[24]** Challenges

Four Common Factors and Positive Behavior Change: Improving the Effectiveness of the Therapeutic Approach

III2**[9]** Common Factors in Treatment
III2**[10]** Influence of Client Factors
III2**[11]** Influence of Therapeutic Relationship Factors
III2**[12]** Importance of Perceived Empathy
III2**[13]** Client's Acceptance of Treatment Program
III2**[14]** Role of Warmth/Self-Expression
III2**[15]** Hope and Expectancy
III2**[16]** Conveying Hope
III2**[17]** Hope is Future-Focused
III2**[18]** Empowering the Client
III2**[19]** Model and Technique
III2**[20]** The Strengths Approach
III2**[21]** Strength-Based Implications for Practice 1
III2**[22]** Strength-Based Implications for Practice 2
III2**[23]** Strength-Based Implications for Practice 3
III2**[24]** Strength-Based Implications for Practice 4

Jail Based Treatment

II1**[19]** Jail-Based Treatment Gap
II1**[20]** Jail-Based Treatment And Drug Courts
II1**[21]** A "Working Model"
II1**[22]** Communication With Drug Courts
II1**[23]** Jail Staff Support
II1**[24]** Program Space
II1**[25]** Staff Assignment
II1**[26]** Follow-Up And Re-Entry Courts

Judge

I1**[10]** Role
I1**[11]** Role Codified
I1**[12]** "Judge Effect"
I1**[13]** Self-Assessment

II2**[22]** Butler County CDAT Evaluation
II2**[23]** King County Drug Court Evaluation
II2**[24]** Suffolk County Drug Treatment Court
II2**[25]** Volusia County Process & Output Evaluation
II2**[26]** Jefferson County Impact Evaluation
II2**[27]** Madison County Final Evaluation
II2**[28]** Santa Barbara County Year Three
III1**[25]** Cleveland Drug Court
III1**[26]** Allen County
III1**[27]** Delaware Juvenile Diversion Program
III1**[28]** Orange County
III1**[29]** Creek County
III1**[30]** Project Exodus (Maine)
III1**[31]** Denver Drug Court
III2**[32]** Dallas County DIVERT Court
III2**[33]** Maine's State-wide Adult Drug Treatment Court Program
III2**[34]** Maine's State-wide Juvenile Drug Treatment Court Program

Retention

II1**[8]** Early Predictors
II1**[9]** Treatment Outcomes
II1**[10]** Graduate/Non-Graduate Similarities
II1**[11]** Predictors of Program Completion
II1**[12]** Arrest During Follow-Up
II1**[13]** Predictors of Rearrest
II1**[14]** Using Predictors

Sanctions

II1**[1]** Increased Performance
II1**[2]** Sanctions Need Not Be Painful
II1**[3]** In The Eyes Of The Behavior
II1**[4]** Regularity Of Sanctions
II1**[5]** Clarification Of Expected Behaviors
II1**[6]** Effective Punishment
II1**[7]** Research Potential