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Fact Sheet

Targeting The Right Participants For Adult Drug Courts

Part One Of A Two-Part Series [1]

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Introduction

Adult drug courts are not designed to treat all drug-involved adult offenders. They were created to fill a specific service gap for drug-dependent offenders who were not responding to existing correctional programs—the ones who were not adhering to standard probation conditions, who were being rearrested for new offenses soon after release from custody, and who were repeatedly returning to court on new charges or technical violations.

Admittedly, eligibility criteria for some of the earliest drug courts did not clearly reflect this limited objective. Largely in an effort to avoid appearing "soft on crime" or to gain the buy-in of local prosecutors or other stakeholders, some of the earliest drug courts began as pre-plea diversion programs for first-time, drug-possession cases. The goal, however, was not to remain fixated on this low-level population, but rather to expand upon and focus the admissions criteria once the programs proved their worth and science identified the best populations to serve.

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[1] A companion fact sheet to this document, entitled *Alternative Tracks in Adult Drug Courts: Matching Your Program to the Needs of Your Clients*, is available from the National Drug Court Institute at www.NDCI.org

A substantial body of research now indicates which drug-involved offenders are most in need of the full array of services embodied in the "10 Key Components" of drug courts (NADCP, 1997). These are the offenders who are (1) substance dependent and (2) at risk of failing in less intensive rehabilitation programs. Drug courts that focus their efforts on these individuals—referred to as *high-risk/high-need* offenders—reduce crime approximately twice as much as those serving less serious offenders (Lowenkamp et al., 2005; Fielding et al., 2002) and return approximately 50 percent greater cost-benefits to their communities (Bhati et al., 2008).

A substantial body of research indicates which drug-involved offenders need drug court.

This finding has important implications for determining eligible offenses for drug courts. Compared with programs serving only drug-possession cases, drug courts that also served individuals charged with theft and property crimes driven by a drug addiction have yielded nearly twice the cost savings (Carey et al., 2008).[2] The reason for this relates to the types of crimes being avoided. Drug courts that serve only drug-possession cases may offset relatively low-level crimes that do not incur high victimization or incarceration costs, such as petty theft, drug possession, trespassing, and traffic offenses (Downey & Roman, 2010). As a result, they may pass on small or negligible cost-benefits to their communities.

The lessons from this research are clear. It is time for drug courts to revisit their admissions criteria to ensure that they are serving the optimal target population of offenders who are most in need of their services and at greatest risk for future relapse and crime. Alternatively, drug courts that are unable or unwilling to alter their admissions criteria should consider revising their program to ensure the services they offer are appropriately matched to the needs and risk levels of their client population. A companion document to this fact sheet, entitled *Alternative Tracks in Adult Drug Courts: Matching Your Program to the Needs of Your Clients*, describes evidence-based approaches to adapting drug court regimens to the needs of various types of participants.

High Prognostic Risk

According to what is generally known as the *Risk Principle*, intensive programs such as drug courts have been shown to produce the greatest benefits for offenders who have relatively more severe antisocial backgrounds or treatment-resistant histories (Andrews & Bonta, 2010; Taxman & Marlowe, 2006). Referred to as *high-risk* offenders, these individuals tend to have a relatively poorer prognosis for success in standard rehabilitation programs and typically require more concentrated and sustained interventions to dislodge their entrenched, negative behavioral patterns. Research reveals that it is these high-risk offenders who are most in need of the intensive supervision services embodied in the 10 Key Components of drug courts (Lowenkamp et al., 2005; Fielding et al., 2002; Marlowe et al., 2006, 2007; Festinger et al., 2002).

[2] There is also evidence that offenders with violence histories performed as well, or better, than nonviolent offenders in drug courts (Carey et al., 2008; Saum & Hiller, 2008; Saum et al., 2001). Thus, prohibitions in the federal Omnibus Crime Control Act of 1997 and some state statutes against admitting violent offenders into drug courts may not be justified on empirical grounds of effectiveness or cost effectiveness. This assumes, of course, that the offenders are dependent on illicit drugs or alcohol and are otherwise eligible for a community-based disposition.

Defining Risk

In the context of the present discussion, the term *high risk* refers to the likelihood that an offender will not succeed on standard supervision and will continue to engage in the same pattern of behavior that got him or her into trouble in the first place. In other words, it refers to a relatively poorer prognosis for success in traditional rehabilitation services. For this reason, it is most accurately referred to as *prognostic risk* (Marlowe, 2009).

The term does not necessarily refer to a risk for violence or dangerousness. Most risk-assessment tools that are administered in routine practice by probation agencies or corrections departments were validated against the likelihood of offenders absconding on bond, violating the terms of their probation, or reoffending, and not against the likelihood of their committing a violent act. Although assessment tools do exist to measure the risk of violence (Campbell et al., 2009), they are more commonly used when treating habitual sex offenders or conducting forensic evaluations in serious felony cases.

This distinction between prognostic risk and violence risk is critical. Some drug courts may screen high prognostic-risk offenders out of their programs because they perceive them (wrongly) as necessarily being a threat to others or somehow less suited for the services. On the contrary, research indicates that the higher the prognostic risk, the more appropriate it may be to refer a drug-dependent individual to drug court, assuming that a community-based disposition is warranted and apt to be imposed in the case.

Low-risk offenders, on the other hand, are less likely to be on a fixed antisocial trajectory and are already predisposed to improve their conduct following a run-in with the law. Therefore, intensive interventions like drug courts may offer small incremental benefits for these individuals, but at a substantial cost (DeMatteo et al., 2006). Worse still, low-risk offenders may learn antisocial attitudes and behaviors from associating with high-risk offenders, which can make their outcomes worse (Lowenkamp & Latessa, 2004; McCord, 2003; Petrosino et al., 2000).

High Criminogenic Need

Criminogenic needs refer to clinical disorders or functional impairments that, if treated, substantially reduce the likelihood of continued engagement in crime (Andrews & Bonta, 2010). The most common criminogenic needs among offenders include substance dependence (also known as addiction), major psychiatric disorders, brain injury, or a lack of basic employment or daily living skills (Belenko, 2006; Simpson & Knight, 2007). Failing to address these serious deficits leaves the individual vulnerable to repeated

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failures and continued involvement in crime, whereas effectively addressing them is associated with improved functioning and the avoidance of crime (Smith et al., 2009).

Individuals who are dependent on drugs or alcohol commonly suffer from cravings to use the substance, and may experience painful or uncomfortable withdrawal symptoms when they attempt to become abstinent (American Psychiatric Association, 2000). It is now understood that these symptoms often reflect a form of neurological or neurochemical damage to the brain (Baler & Volkow, 2006; Dackis & O'Brien, 2005; Goldstein et al., 2009). Formal treatment is required for such individuals to reduce their cravings and withdrawal symptoms, teach them concrete skills to resist drugs and alcohol, and provide them with effective coping strategies to deal with daily stressors and challenges (Chandler et al., 2009). In some cases, medication or residential treatment will also be needed, at least during the early phases of treatment. Research is clear that failing to provide an adequate dose or modality of treatment for addicted individuals is associated with significantly poorer outcomes (De Leon et al., 2008, 2010; Karno & Longabaugh, 2007; Vieira et al., 2009; Belenko, 2006). It is for this reason that drug courts require participants to complete an intensive regimen of substance abuse treatment and other indicated rehabilitation services.

It is unwarranted to assume that simply because an individual was arrested for a drug offense, he or she must be dependent on drugs and in need of formal substance abuse treatment.

What is not always appreciated, however, is that treatment can also be too intense. Placing non-dependent or low-risk individuals into residential or group-based treatment, for example, has been associated with significantly poorer outcomes and higher recidivism (Lovins et al., 2007; Lowenkamp & Latessa, 2005; Szalavitz, 2010; Wexler et al., 2004). Perhaps spending time with addicted peers unduly normalizes the drug-using lifestyle, or perhaps treatment requirements interfere with participants' engagement in productive activities, such as work, school, or parenting. Whatever the rationale, it appears that providing too much treatment is not merely a potential waste of scarce resources. It can also lead to what are called *iatrogenic effects*, in which outcomes are made worse.

It is unwarranted to assume that simply because an individual was arrested for a drug offense, he or she must be dependent on drugs and in need of formal substance abuse treatment. At least half of drug-involved offenders abuse alcohol or other drugs but are not dependent (National Center on Addiction and Substance Abuse, 2010; Fazel et al., 2006; DeMatteo et al., 2009). They may repeatedly ingest these substances under circumstances that are potentially dangerous to themselves and others, but their usage is still largely under voluntary control. For such individuals, alternative programs, which do not rely on formal substance abuse treatment to achieve their desired aims, may be preferable to drug courts.

Assessment

It is beyond the scope of this fact sheet to review the large number of assessment tools that are available for assessing prognostic risk and criminogenic need. Some recommended readings are provided at the end of this document. However, a few general points merit consideration.

Many risk assessment tools that are commonly used by drug courts, probation agencies, and corrections departments are adequately suited to predicting prognostic risk. So long as an instrument has been empirically validated against the likelihood of criminal recidivism or failure on supervision (preferably with the studies being published in peer-reviewed journals), it is likely to perform adequately for present purposes. It is essential to ensure that the instrument is equivalently predictive for racial, ethnic, and gender subgroups that are represented in the drug court population. Assuming a risk instrument significantly predicts outcomes and is unbiased in its predictions, it should serve well for helping to identify the target population for a drug court.

Where drug courts are often deficient is in the assessment of clinical diagnosis. Many drug courts employ brief screening instruments to assess substance abuse or dependence. By design, screening instruments are intended to cast a wide net, meaning they are apt to identify a substantial number of false positives for a substance use disorder, especially substance dependence. If a screening tool is used, then any positive classification should be followed up with a more in-depth clinical evaluation to confirm the initial diagnostic impression. Otherwise, there is a serious concern that individuals who are substance abusers or misusers may be grouped together with those who are truly substance dependent.

The best approach is often to administer a structured or semi-structured interview that is congruent with the diagnostic criteria contained in the *Diagnostic and Statistical Manual of Mental Disorders* (DSM). The DSM is the official diagnostic classification system for substance use disorders and psychiatric disorders in the United States. It is currently in its fourth amended edition (DSM-IV-TR; American Psychiatric Association, 2000), and a fifth edition is forthcoming. It is important to ensure that one's evaluators are properly skilled in the administration of the interview and are well trained on the DSM nomenclature. Unless the evaluators have a clear understanding of the intent of the items and the meaning of the diagnostic criteria, they may be likely to systematically over-diagnose or under-diagnose substance dependence.

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In some drug courts, the assessments of prognostic risk and criminogenic need may be performed by different evaluators or agencies. For example, the probation department might perform the risk assessment and the treatment program might assign the clinical diagnosis. The important task is to combine the two sets of assessment results so that each participant can be assigned to the appropriate level of both treatment and supervision.

The assessment of prognostic risk and criminogenic need should be completed before the requirements of the program are determined.

Some drug courts may postpone the assessments until after participants have been admitted to the program and the conditions of supervision have been ordered. This puts the cart before the horse. The assessment of prognostic risk and criminogenic need should be completed before the requirements of the program are determined, ideally before the disposition of the case. This will help to

DSM-IV-TR Diagnostic Criteria For Substance Dependence

Substance dependence is a maladaptive pattern of substance use, leading to clinically significant impairment or distress, as manifested by three (or more) of the following, occurring at any time in the same 12-month period:

1. **Tolerance, as defined by either of the following:**
   a. **A need for markedly increased amounts of the substance to achieve intoxication or the desired effect.**
   b. **Markedly diminished effects with continued use of the same amount of the substance.**
2. **Withdrawal, as manifested by either of the following:**
   a. **The characteristic withdrawal syndrome for the substance.**
   b. **The same (or a closely related) substance is taken to relieve or avoid withdrawal symptoms.**
3. **The substance is often taken in larger amounts or over a longer period than was intended.**
4. **There is a persistent desire or unsuccessful efforts to cut down or control substance use.**
5. **A great deal of time is spent in activities necessary to obtain the substance (e.g., visiting multiple doctors or driving long distances), use the substance (e.g., chain-smoking), or recover from its effects.**
6. **Important social, occupational, or recreational activities are given up or reduced because of substance use.**
7. **The substance use is continued despite the knowledge of having a persistent or recurrent physical or psychological problem that is likely to have been caused or exacerbated by the substance (e.g., current cocaine use despite recognition of cocaine-induced depression, or continued drinking despite recognition that an ulcer was made worse by alcohol consumption).**

Source: American Psychiatric Association. (2000). *Diagnostic and Statistical Manual of Mental Disorders* (4th ed., text rev.). Washington DC: American Psychiatric Press; at pp. 197–98.

ensure the requirements are based on the actual needs and risk level of the participants, rather than on preconceived notions about what all drug offenders should be required to do. If a drug court is unable, for practical reasons, to complete the assessments prior to entry, then participants might be required to undergo a brief observational period before the formal conditions of treatment and supervision are entered.

Finally, bear in mind that the focus of the present discussion is on determining initial eligibility for drug court. Once participants

have entered treatment, clinicians or case managers will conduct more in-depth clinical evaluations to develop the treatment plan. It is the responsibility of clinical staff members to make clinical decisions, such as determining the appropriate level of care and identifying other problems that may require remedial attention, including medical conditions, mental illness, or employment problems. The role of the drug court judge and other nonclinical team members is to ensure that participants comply with the recommended treatment regimens.

Suitability Determinations

After determining legal and clinical eligibility for the program, some drug courts may further screen potential participants regarding their "suitability" for the program. The suitability determinations are often based on the team members' subjective impressions about an offender's motivation for change or preparedness for treatment. Research indicates that such suitability determinations have no impact on drug court graduation rates or post-program recidivism (Carey & Perkins, 2008). Because they have the potential to systematically exclude eligible individuals from drug court for reasons that are empirically invalid, such practices should ordinarily be avoided.

Alternative Drug Court Tracks

In some jurisdictions, the drug court may be the most effective, or perhaps only, program serving as an alternative to incarceration that has staff members with expertise in managing drug-involved offenders. Moreover, some smaller or rural communities may not have sufficient numbers of drug-involved offenders to justify having multiple programs, each serving different target populations. Under such circumstances, the most effective or humane course of action may be to admit low-risk or non-addicted participants into the drug court.

Research indicates that suitability determinations have no impact on drug court graduation rates or post-program recidivism.

If a drug court intends to serve a heterogeneous range of drug-involved offenders, then the program should consider making substantive modifications to accommodate the diverse needs and risk levels of its participants. This can be accomplished by developing alternate tracks within the drug court, which place different treatment and supervisory conditions on participants. As noted earlier, a companion fact sheet offers concrete suggestions for developing and administering alternative tracks within a drug court.

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Conclusion

No one intervention should be expected to work for all individuals. Every professional discipline—from medicine to psychology to social work to criminology—has come to learn that programs have target populations for whom they are most effective, and non-target populations for whom they may be ineffective, unduly costly, or even harmful. It is the sign of a mature field that can match its clients to the most appropriate services to optimize outcomes and utilize resources most efficiently.

Drug courts are no exception. More than two decades of research has identified which individuals respond best to the drug court model and yield the largest returns on investment for taxpayers. These are the individuals who have negative risk factors for failure in less intensive treatment or supervisory programs, and who meet diagnostic criteria for substance dependence.

Evidence suggests that drug courts can potentially double their effectiveness and cost-effectiveness by focusing their efforts on this high-risk/high-need target population. This will require some drug courts to reassess their current eligibility criteria and, in some cases, redouble their efforts to ensure the proper population is accepted in the future. Unfortunately, there is no shortage of substance-dependent, prison-bound offenders. The more drug courts meet the needs of these individuals, the healthier they and their families will be, the safer our communities will be, and fewer will be the burdens placed on public dollars.

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Fact Sheet Quiz: What Did You Learn?

Test your new knowledge. Answer these questions based on the Fact Sheet text.

1. Research suggests the optimal target population for a drug court is:
(check all that apply)

- [A] First-time drug offenders
- [B] Drug experimenters
- [C] Addicted individuals
- [D] Individuals who would ordinarily have a poor prognosis for success in substance abuse treatment
- [E] Nonviolent offenders

2. The most commonly used risk instruments are valid tools for:
(check all that apply)

- [A] Predicting failure on standard supervision
- [B] Developing treatment plans
- [C] Screening out the most violent offenders
- [D] Diagnosing addiction

3. As this term is most commonly used in typical correctional practice, "high risk" refers to offenders who:
(check all that apply)

- [A] Are likely to commit violent or dangerous acts
- [B] Abuse seriously addictive drugs, like methamphetamine or heroin
- [C] Are sexual predators
- [D] Are relatively less likely to respond to treatment or rehabilitation
- [E] Should receive a jail or prison sentence

4. Compared to drug courts that treat low-risk and low-need participants, drug courts that serve high-risk and high-need participants have been shown to have:
(check all that apply)

- [A] Twice the effect for reducing crime
- [B] Fifty percent greater cost benefits
- [C] More instances of drug dealing on the premises
- [D] More instances of assaults against staff members or other participants

5. Which of the following needs among offenders are criminogenic, meaning they frequently play a substantial causative role in crime:
(check all that apply)

- [A] Low self-esteem
- [B] Weak muscle tone
- [C] Severe mental illness
- [D] Lack of job skills
- [E] Substance dependence
- [F] Drug possession

Answers: *1: C and D, 2: A, 3: D, 4: A and B, 5: C, D and E*

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