The Nexus Between Drug and Alcohol Treatment Program Integrity and Drug Court Effectiveness: Policy Recommendations for Pursuing Success

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What is This?
The Nexus Between Drug and Alcohol Treatment Program Integrity and Drug Court Effectiveness

Policy Recommendations for Pursuing Success

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The literature supporting the efficacy of drug courts continues to grow. Much attention and research has focused on recidivism rates for participants, and generally address the question of, do drug courts work? The current state of drug court practice is a process that relies heavily on the drug and alcohol treatment services that are offered to clients. Many treatment programs, and the treatment philosophy that underlies their approach to solving substance abuse, offer vague and eclectic approaches that oftentimes do not meet the diverse needs of their clients related to gender, culture, and specific cognitive impacts on the brain caused by drug use. We argue that a move toward the use of evidence-based practice, coupled with quality assurance measures for treatment providers, will promote best practice and will ensure program integrity that leads to effective and long-lasting drug court programs.

Drug courts are an attempt to bring together two systems that have historically stood in contrast to each other: the public health system, which champions the cause of treatment, and the criminal justice system, which over the past several decades has called for increasingly harsher punishment (see Austin & Irwin, 2001; Garland, 2001; Marlowe, 2002, 2003). Drug courts, which are part of a larger movement of “problem solving courts,” are an innovative and unique phenomenon that has swept through the court system. The objective of the drug court program is to balance treatment and accountability by addressing the underlying issues of addiction that the defendant is struggling with and the subsequent legal, social, and health problems that accompany such addiction. The ultimate goal is to have the defendant become clean and sober, exit the criminal justice system, and become a functioning member of society.

Authors’ Note: The ideas expressed in this paper are those of the authors and not necessarily those of Washington State University, the National Drug Court Institute, or the National Council of Juvenile and Family Court Judges.
Drug courts represent a coordinated strategy between the judiciary, prosecution, defense bar, probation, law enforcement, treatment, mental health, social services, and child protection services to “actively and forcefully intervene and break the cycle of substance abuse, addiction, and crime” (Huddleston, Freeman-Wilson, Marlowe, & Rouseell, 2005, p. 2). These systems work together to provide a holistic menu of substance abuse and mental health treatment, case management, drug testing, and probation supervision for the drug court participant, as well as regularly scheduled status hearings before a judge with specialized drug court training and expertise (Huddleston et al., 2005, p. 2). In addition, “some drug courts provide job skills training, family or group counseling, and many other life-skill enhancement services” (Huddleston et al., 2005, p. 2).

Inherent in this drug court system is a set of key components that the National Drug Court Institute (NDCI) puts forth to guide a program. The very first component calls for drug courts to integrate alcohol and other drug treatment services with justice system case processing (Monchick, Scheyett, & Pfeifer, 2006). It is this balanced approach that is theorized to bring about long-lasting change in an offender’s life. Although process evaluations have described the extent to which this model has been successfully implemented (Applegate & Santana, 2000; Logan, Williams, Leukefeld, & Minton, 2000; Lutze & Mason, 2006), and most note the importance of treatment integrity to the process, few have actually attempted to measure the quality of the treatment provided to drug court participants and the impact that this may have on outcomes (see Banks & Gottfredson, 2003; Bouffard & Taxman, 2004; Taxman & Bouffard, 2003).

The purpose of this study is to (1) reassert the importance of the nexus between the drug court criminal justice process and the program integrity of substance abuse treatment provision, and (2) to provide recommendations to drug court professionals about assuring program integrity. We argue that a failure for drug court policy makers, researchers, and practitioners to focus on treatment integrity may sabotage the effectiveness of the drug court model and lead to business as usual in the future.

**Drug Courts and Treatment**

Historical reviews of attempts to reform offender treatment and corrections programs provide great insight to the evolution of drug court programs and what we might predict for their future if we are not mindful of their implementation process and the relationship of the court to treatment providers. Like drug court innovators of today, prison reformers of the past often implemented new rehabilitative approaches with great enthusiasm through the leadership of charismatic, committed individuals who provided the vision for programs that would change the course of institutional practice and the lives of offenders (see Christianson, 1998; Pisciotta, 1994; Rafter, 1985; Rothman, 1971, 1980).

These sweeping changes, however, did not always incorporate the full vision of the innovators or the scientific expertise of the time. Change often resulted in what
was convenient to the existing institutions and their practices resulting in the abandonment of the components of the innovation that were too complex or required an expertise beyond the capabilities of the implementers (see Rothman, 1980; see Hannah-Moffat, 1995, and Marlowe, 2002, for contemporary examples). In addition, when offenders did not acquiesce to the good intentions of reformers, practice would oftentimes revert to subjecting inmates to brutal punishments (see Christianson, 1998; Pisciotta, 1994). Thus, Rothman (1980, p. 10) argues that when conscience (our vision/theory) meets convenience (ability or desire to implement the vision), convenience will win, and when treatment meets coercion, coercion will win.

In relationship to the rapid advance of drug courts we must be careful that conscience is not co-opted by convenience. For instance, the “easy” part of implementing drug courts is the criminal justice process and the monitoring and case management of offenders (see Olson, Lurigo, & Albertson, 2001). The difficult part comes in organizing and collaborating with agencies that have not always trusted each other (sometimes for good reason) and providing the treatment necessary to change the complex behavior of drug or alcohol addicted offenders. It is this concern that dictates the importance of examining the nexus between the drug court’s ability to promote treatment and the actual integrity of the treatment providers tasked with changing offender’s behavior.

It is this union between treatment and accountability, and a philosophical shift within the court system that drives the whole drug court movement. The union between treatment and accountability is the critical component in which substance abuse treatment assumes a major role in the drug court program (see Marlowe, 2002). Research to date suggests that adult drug courts are successful in reducing the drug and alcohol consumption and recidivism of participants (U.S. Government Accountability Office, 2005). In 2005, the U.S. General Accountability Office’s (GAO, p. 5) analysis of drug court evaluations for 23 programs showed that lower percentages of drug court participants than comparison group members were rearrested or reconvicted. The GAO (2005), however, was unable to find conclusive evidence that specific drug court components, such as the behavior of the judge or the amount of treatment received, affected participant’s recidivism while in the program. There was also limited outcome data available to measure the effectiveness of drug court programs in reducing participant’s substance use relapse. Although the drug testing data “generally showed significant reductions in use during participation in the program, self-reported results generally showed no significant reductions in use” (GAO, 2005, p. 6). This raises serious concerns about whether substance abuse treatment providers are administering evidence-based treatment (EBT) as the drug court planning initiative and model recommends, or if they are offering the convenience of business as usual.

A few studies that have focused on treatment in drug courts reinforce the importance of treatment or have raised serious concerns about the quality of treatment. Banks and Gottfredson (2003) provide strong evidence that treatment matters more than supervision alone in successfully reducing recidivism of drug court participants. Their study, however, did not measure the quality of treatment programs or
what types of treatment may be affecting this outcome. Taxman and Bouffard (2003) give further insight into treatment programs and drug courts (also see Bouffard & Taxman, 2004). They sampled four drug court sites and their treatment providers (two rural and two urban) to measure the beliefs, philosophies, and knowledge of the counselors with the services actually offered in the treatment sessions. They found that, “despite the vast literature demonstrating the effectiveness of cognitive-behavioral treatment components for dealing with substance abusers, in no site did more than one fifth, or approximately ten minutes of the observed meetings contain such treatment components” (Taxman & Bouffard, 2003, p. 81).

The National Institute of Justice (2006, p. 20) recently reported that findings from Anspach and Ferguson,

do not point to any defects in the drug court model itself, the research identified deficiencies and problems in the way that treatment programs are delivered and suggests that drug courts may in fact be shortchanging their clients in important respects. . . . improvements are clearly needed in treatment content, access, and delivery; program integration; and program integrity so that drug courts can increase retention rates and achieve longer term reductions in drug use and criminal activity.

In addition to the emerging studies that directly look at treatment programs utilized by drug courts, there is also evidence within outcome studies of drug courts that suggest weaknesses in the provision of treatment. For instance, some studies have produced mixed results, with drug court offenders remaining in the community for longer periods of time, but being just as likely as the comparison groups to re-offend over time (see Banks & Gottfredson, 2003; Dannerbeck, Harris, Sundet, & Lloyd, 2006; Listwan, Sundt, Holsinger, & Latessa, 2003; Sanford & Arrigo, 2005; GAO, 2005). Other studies have found overall success in outcomes, but with some special populations within the court not fairing as well as others. African Americans/minorities, cocaine users, injectors, the unemployed, and high-risk offenders are not as successful moving through the program and graduating as others (Banks & Gottfredson, 2003; Dannerbeck et al., 2006; Lutze & Mason, 2006; Roll, Prendergast, Richardson, Burdon, & Ramirez, 2005; Senjo & Leip, 2001) or are more likely to be rearrested after drug court (Listwan et al., 2003).

It is these failures within the overall success of drug court that give greatest insight to potential weaknesses of the relationship between drug and alcohol treatment programs and the court. These weaknesses appear to be related to: (1) defining the causes of drug addiction; (2) utilizing evidence-based treatment programs; (3) assuring cultural competency related to race, ethnicity, and gender; and (4) assuring that the drug court process itself does not interfere with treatment.

**Challenges to Treatment Integrity in Drug Court**

Drug courts promise defendants that they will provide multiple levels of support to help them overcome their drug addiction if they comply with the conditions of the court
and actively work to overcome their addiction. Therefore, the court needs to assure that the process and programs that offenders participate in are accessible, relevant, and of quality—if not, then both the court and the defendant are likely to fail (see Johnson, Hubbard, & Latessa, 2000). Program integrity is the ability of the drug court, and the treatment providers on which they depend, to offer a process and programs that actually address the problems of their clients in a way that effectively changes behavior. Thus, the theory and mission underlying the program must be implemented in a way that produces the intended outcomes (VanVoorhis, 1987). The existing literature on drug courts and drug/alcohol treatment providers strongly suggest that there are many challenges to overcome in providing treatment with integrity. Defining addiction represents one of the most important challenges facing drug courts and their treatment providers.

The Difficulty in Defining Addiction

Part of the problem with reaching consensus and operating under a “best practice” model for substance abuse treatment is that the definition of drug “addiction” is still debated among academics, drug/alcohol practitioners, medical providers, and politicians (see Hoffman, 2000). Depending on the period, the use of mind-altering substances has been viewed as a natural right or a threat to the social order. Although debate still ensues, the cost of addiction to our communities is significant. Drug use increases the likelihood that an individual will engage in serious criminal conduct (Marlowe, 2002, 2003), will be medically treated due to the short- and long-term physical complications of addiction (Vastag, 2003), and, will account for up to 60% of hospital usage in the United States (Doweiko, 2002).

It is clear that drug and alcohol use is a part of our culture and the effects occur at both micro (personal) and macro (public health and criminal systems) levels. The difficulty with identifying a strong solution to drug and alcohol addiction is that practitioners, medical professionals, and researchers cannot agree on a set cause for addiction in the individual. Thus, depending upon the driving force behind addressing the costs of addiction to individuals and communities, different models of causation emerge.

In recent years, the criminal justice system has attempted to eradicate drugs at the community level. The get-tough political agenda relies on a social causation model that suggests that addiction can be addressed through eliminating the supply and the demand for drugs (Abadinsky, 2004; Butts & Roman, 2004). This approach has lead to increasing prison populations for both sellers and users (Austin& Irwin, 2001). Many in the medical community, however, define addiction as a disease that affects individuals both physically and mentally. This approach advocates for programs to provide a combination of therapies and other services such as referral to other medical, psychological, and social services to meet the needs of the client (Leshner, 1999, p. 1315). The drug and alcohol treatment community has been more fluid in defining the causation of addiction by combining or utilizing several models.
including moral, social (general systems), disease, and the medical model, depending upon the source of their funding (see Doweiko, 2002; VanVoorhis & Hurst, 2000). These providers attempt to address both the social circumstances that influence, enable, and/or condition substance use and the physical/psychological addiction. This approach generally utilizes life skills, sober support groups (Alcoholics Anonymous and Narcotics Anonymous), education, general counseling techniques, and other therapies to stop substance abuse.

Butts and Roman (2004) suggest that in recent years the assessment of substance abuse and addiction has moved from being based on pharmacological criteria to social criteria that increases the likelihood of a person being assessed with a drug or alcohol abuse or addiction problem. As a broader array of offenders is increasingly identified as having a substance abuse problem based on socially defined attributes versus pharmacological ones, the greater the difficulty in targeting appropriate treatment modalities. While substance abuse assessment has moved away from pharmacological assessments, probably due to their expense and increased pressure from criminal justice agencies to provide quick and high volume assessments, the medical community appears to be moving toward a biosocial model of defining addiction. The medical community, via use of brain-scan imagery and other technology, provides the potential to combine behavioral and social models to create a medical model that is not just simply focused on genetic predisposition, but rather on the fundamental and long-lasting changes to the brain that occur with addiction. Increasing evidence from the medical community suggests that drug courts and their treatment providers will need to place greater emphasis on biobehavioral models of addiction. According to Vastag (2003, p. 1300),

Scientists have discovered a wealth of evidence that the brain changes during addiction, trapped in an ever-deepening spiral of entrenched behavior. All drugs of abuse activate the dopamine reward circuit, a neural pathway essential to pleasure. This circuit is deeply connected to areas of the brain that control memory, emotion and motivation. Any pleasurable activity—having sex, eating food, using drugs—activates these intertwined pathways and reinforces the pleasurable behaviors. Eventually, the dopamine circuit becomes blunted; with tolerance, a drug simply pushes the circuit back to normal, boosting the user out of depression, but no longer propelling him or her towards euphoria.

The majority of the biomedical community now considers addiction to be a brain disease, given the findings that reveal persistent changes in brain structure and function (Leshner, 2001). Leshner (2001, p. 2) argues, “Modern science has taught that it is much too simplistic to set biology in opposition to behavior or to pit willpower against brain chemistry. Addiction involves the inseparable biological and behavioral components. It is the quintessential biobehavioral disorder.”

Given this new movement towards a biobehavioral model, the concept of “final common pathway” (FCP) has begun to solidify. Essentially, this model argues that
“the substance abuse is not the starting point, but rather a common end point of a unique pattern of growth” (Doweiko, 2002, p. 41). While the route may be different for each individual, eventually the chemical result in the brain is the same: activation of the brain’s pleasure center and subsequent and persistent changes in the brain’s function (see Doweiko, 2002, p. 41; also see Belenko & Dembo, 2003, for a related discussion).

If addiction is in fact a biobehavioral disorder—one where the addict continues compulsive drug use despite negative consequences such as loss of employment, family disruption, medical problems, and even jail time—than the intervention must be behaviorally and medically based. Therefore, the best drug addiction treatment approaches “attend to the entire individual, combining the use of medications, behavioral therapies, and attention to necessary social services and rehabilitation” (Leshner, 2001, p. 6). Drug courts cannot ignore the underlying biological impacts of addiction. The disease of addiction must come to be understood as a chronic, not acute, disorder that is in need of a sophisticated treatment approach (see Leshner, 2001).

Interestingly, at the federal level, in 1998, the Institute of Medicine (IOM) and the Center for Substance Abuse Treatment (CSAT) both called for bridging the gap between research and practice (Clark, 2002). Efforts are in place via the CSAT Practice Improvement Collaboratives and the National Institute of Drug Abuse (NIDA) Clinical Trials Network to achieve this balance, and to implement evidence-based practices at the local level. Much of this initiative has occurred at the federal level, and although state efforts are under way, largely through the Addiction Technology Transfer Center (ATTC) network, it still remains to be seen how it can be translated, implemented, and adherence standards built at the local level in a meaningful way. Drug courts certainly hold promise to assist with this transfer of technology in addition to the above agencies.

With growing evidence suggesting that addiction may be achieved through common pathways and that addicts’ brains are chemically altered in ways that affect cognitive functioning, treatment providers must be diligent in addressing the complex biological and social behaviors that precede and are outcomes of drug addiction.

**Importance of Evidence-Based Treatment**

Researchers have long advocated that “any treatment” is not necessarily good treatment that will result in the intended consequence (Cullen & Gilbert, 1982; Palmer, 1992; VanVoorhis, 1987). Evidence now exists that intensive intervention aimed at low risk offenders may actually increase recidivism (Lowenkamp & Latessa, 2005) and that treatment modalities that are not implemented according to the proven plan can also result in increased recidivism when compared to the modality that is implemented correctly (Andrews & Dowden, 2005; Barnoski, 2004; Johnson et al., 2000). These are important findings, because they counter the philosophy of many individuals who work in the field who are often heard saying, “if the program helps just one person,
then it is all worth it.” We argue that programs need to be effective in reducing recidivism for the population in which they are intended and there is sufficient evidence to guide drug courts and their treatment providers to accomplish this goal. Drug court professionals must consider cognitive-behavioral approaches, cultural competency in dealing with special populations, and the structural integrity of programs implemented by treatment providers.

Cognitive-behavioral approaches. Science has provided a much clearer understanding of what works with drug or alcohol addicted offenders (Elliot, Orr, Watson, & Jackson, 2005; McKenzie, 2000; Miller, Zweben, & Johnson, 2005; VanVoorhis & Hurst, 2000). Of course no one behavioral intervention will fit all, but from a therapeutic intervention perspective, cognitive-behavioral therapeutic approaches tend to be more fully supported by research studies in effecting client change compared to other approaches (Bouffard & Taxman, 2004; Miller et al., 2005; Taxman & Bouffard, 2003). Cognitive-behavioral models help participants to connect their thoughts to specific behaviors so that they can identify their thinking errors related to using drugs or committing criminal offenses and then adjust accordingly (see Lester & VanVoorhis, 2000).

Cognitive-behavioral models are not one set of criteria, but rather various cognitive-behavioral approaches, which can encompass such criteria as social skills development training, problem solving skills training, cognitive skills training, thinking error approaches, role-playing, modeling, relapse prevention and anger management (see Pearson, Lipton, Cleland, & Yee, 2002). Researchers continue to document that cognitive-behavioral models reduce illicit substance use and criminal behavior both during the treatment period and after treatment participation (McKenzie, 2000; NIDA, 1999).

Although it is clear that cognitive-behavioral approaches are effective, it is still not known exactly what treatments are most effective with particular types of drug use (Miller et al., 2005). Progress is being made in this area however. In 2005, researchers at The University of California at San Diego found that methamphetamine (meth) use can cause changes in brain size and subsequent cognitive impairment. Numerous studies have now found that meth use can impact short-term memory and function, such as ability to focus and pay attention, and large motor skill function and motivation (see Cooper, 2005; Jerigan et al. 2005; see NIDA, 2002 for related discussion). This has strong implications for the treatment of meth users participating in the drug court model, because they will need a strong cognitive-behavioral component in their drug treatment program to help reorient them to various settings and issues (Cooper, 2005; Stoops, Tindall, Mateyoke-Scrivner, & Leukefeld, 2005).

Cognitive-behavioral therapy and other treatment interventions must not only address the addiction, but they must also address the circumstances of offenders lives that may have made them more susceptible to using drugs (i.e., prior victimization,
abuse) or is a result of drug use (i.e., unemployment, unstable relationships). For successful retention and outcomes drug court programs need to address the many needs of addicted clients, such as mental health, poverty, unemployment, unhealthy relationships, childcare, educational impairments, and physical health problems.

Although, in fact, many drug courts and substance abuse treatment providers may argue that they are offering a combined approach, there is evidence that suggests that this is not the case (Bouffard & Taxman, 2004; Wenzel, Turner, & Ridgely, 2004). Many treatment providers tend to take a “shotgun” approach in which they subject clients to several programs or topics with little attention paid to the specific needs of the client. This approach is understandable in some respects because of the overwhelming nature of the needs of many substance abusing offenders. This process may ultimately fail, however, because it is too much for clients to retain (especially early in recovery), is introduced to clients but not practiced, or the dosage is so limited and fragmented that it becomes irrelevant.

For example, Taxman and Bouffard (2003) discovered that counselors in their sample of drug courts employed a relatively wide range of treatment activities in serving their clients, but the most intense discussion, when it was presented, was education and aftercare issues. Another study by Wolf and Colyer (2001) that analyzed the content of client issues discussed during the court session found that clients often experienced difficulties accessing treatment in a timely manner, the services were fragmented, and the services available through different providers were poorly coordinated.

*Cultural competency and treatment.* In addition to an absence of cognitive behavioral approaches to treatment, most drug and alcohol addiction programs have historically been built primarily on a model designed for treating adult males with alcohol addiction. Little attention was given to other populations, such as women, ethnic and racial minorities, and adolescents. There have been increased program efforts around serving these special populations over the past decade that have, for the most part, originated at the federal level under the Center for Substance Abuse Treatment (CSAT), or by the National Institute of Drug Abuse (NIDA).

Evidence from the drug court literature and from the drug and alcohol treatment literature confirm the importance of cultural competency in providing effective treatment. The experiences of women, minorities, and the poor are very different than those who experience racial, gender, or socioeconomic class privilege in our culture. Although we must focus on equality in access to services, giving everyone treatment that is based on a male model of addiction is not equality and may lead to disparity in outcomes.

For instance, women substance abusers are much more likely than men to be victims of sexual abuse, be the primary caretakers of their children, and lack vocational training (see Pelissier & Jones, 2005). Women’s personal experiences and power differentials within marriage also differ from that of men and this is reflected
in the consistent finding that women are much more likely to relapse or return to drug use if their spouse is using drugs than are men (Hser, Huang, Teruya, & Anglin, 2004). In addition, women of color also have to navigate formal justice and social service institutions that are often not trusted due to histories of racial discrimination and oppression (see Rapheal, 2000).

Although many drug and alcohol treatment programs were designed to treat men, counselors can still hold narrow sex role stereotypes about masculinity and ignore issues directly related to male addiction and treatment. For instance, accessing treatment may carry with it a stigma that is greater for some men than others (Dannerbeck et al., 2006; Fisher et al. 2004). Men in general are less likely to seek mental or medical health care than women and these stigmas are magnified for African American men and Latinos (see Fisher et al., 2004; Hser et al., 2004; Kilmartin, 2000). Although men are also the most likely to perpetrate violence against others, they are also the most likely to witness and be victimized by male violence. Even though men are less likely than women to be sexually assaulted, still 1 in 8 boys will be sexually assaulted before the age of 12 (compared to 1 in 4 girls). In spite of the amount of violence experienced by men and boys, few mentions are made about the connection of men’s victimization and men’s addiction (see Hawke, Jainchill, & De Leon, 2003). In addition, men may be less likely than women to be the primary caretakers of their children, but many are and they should be helped in being financially and emotionally responsible for their children.

Similar issues arise with race and ethnicity across gender. A study by Dannerbeck, Harris, Sundet, and Lloyd (2006) found that African Americans were less likely to graduate from drug court than Caucasians (also see Senjo & Leip, 2001). African Americans upon entering drug court were more likely to be reentry cases (just released from prison), be unemployed, have fewer social supports, and to use cocaine. The one study that found that African Americans were more likely to graduate (Dannerbeck et al., 2006, p. 4) when the treatment was run by an African American male who implemented culturally sensitive interventions.

In addition to race and gender, age is also important when considering appropriate treatment (Butts & Roman, 2004; Elliot et al., 2005; Sloan & Smykla, 2003). Adolescent substance abusers differ from adult substance abusers in a number of important ways, including drug use patterns, developmental and societal factors, and how drug use affects the brain (Belenko & Dembo, 2003; Currie, 2003; Winters, Stinchfield, Opland, Weller, & Latimer, 2000). Since youth are generally under the care of adults, they are more likely to be involved in treatment under coercion (referral from the court, school system, parents, social services), which also presents unique issues surrounding their motivation for change (Muck et al., 2001), and staff perceptions of their likelihood to succeed (Whitecare, 2004). It is also apparent that young drug users are vulnerable to violent victimization after exposure to treatment due to high risk behaviors, unsafe living arrangements, and drug use (see Currie, 2003; Hawke et al., 2003).
Structural integrity of treatment providers. Although NIDA advocates that clients should have access to evidence-based treatment and be matched to services, retained in services for a sufficient period of time (even through a coerced treatment model), and provided with a continuum of care outside of just traditional drug/alcohol treatment (NIDA, 1999), it appears that treatment providers have great difficulty in implementing this approach (see Johnson et al., 2000). For instance, it is well known that drug and alcohol treatment staff members are often underpaid, lack a college education or certification related to the treatments that they provide, receive no healthcare benefits, and receive minimal in-service training opportunities (Bouffard & Taxman, 2004; Gallon, Gabriel, & Knudsen, 2003; Miller et al., 2005). Given the complexity of the work, staff burnout often occurs, leading to high turnover rates within agencies.

It is not surprising that under these conditions agencies find it difficult to keep current on evidence-based treatment models supported by research or able to offer a continuum of care necessary to achieve change. Thus, NIDA and other federal agencies may strongly suggest particular approaches, and drug courts may submit a laundry list of services they wish for their participants, but the reality is that the quality of these services are likely sabotaged by the context and conditions in which the providers operate. Without strong incentives to change, the future of providing quality treatment to drug court clients is likely to be business as usual.

Potential of the Drug Court Process to Sabotage Treatment Successes

Our focus has been on the public health system’s delivery of treatment, and we have argued that drug courts run the risk of receiving traditional business-as-usual treatment unless drug court staff analyze and learn exactly what it is their providers are offering. A closer look at the criminal justice system delivery of the drug court model, however, also deserves some scrutiny, as it too can operate under a business-as-usual model or a traditional court response if caution is not applied. Drug court team members have the important responsibilities of managing an effective and efficient continuum of care, managing the interagency collaboration of team members that is in accordance with the drug court’s philosophy and mission, and reaffirming the progress made by clients in treatment with the criminal justice process (see Monchick et al., 2006). When treatment providers offer effective treatment, then the drug court team must be careful not to sabotage that success. Although unintentional, effective treatment may be hindered by the drug court team because of the complexity of managing the drug court environment, or a lack of expertise or understanding of the causes of drug addiction and the difficult process of achieving life changes (see Belenko & Dembo, 2003).

For instance, interagency collaboration has been touted by many as the way to more effectively monitor and treat offender populations (see Clear & Cardora,
Although we agree with this, little attention has been paid to the time-consuming complexity of managing a web of agencies and the services that they provide. Drug court teams must not only manage their working relationships with one another, they must also manage their relationships with the myriad of other agencies that interact with or serve their clients (see Monchick et al., 2006; Wolfe, Guydish, Woods, & Tajima, 2004). Not surprisingly, Wenzel, Turner, and Ridgely (2004) found that while drug courts often believed they have access to and were offering a variety of services, the drug court administrators could often not identify alternative providers (such as mental health and primary health care), and hence their full access to services was in fact compromised.

The integrity of the drug court model itself may also be compromised by staff turnover on the drug court team and the reality of busy schedules that prevents ongoing education related to the mission, philosophy, and treatment modality driving the drug court model. New team members oftentimes are required to participate by their agency administrator, have to learn as they go, and are asked to balance their traditional criminal justice roles with the new expectations of the drug court model (Wolfe et al., 2004). As anyone who has worked in the public sphere can attest to, it is incredibly hard to make change happen—especially with varied personnel, across multiple systems and various institutions (see McLaughlin, 1987). New team members often find this change and shift in roles difficult, especially without the proper training and guidance. If not properly supported, those who are thrust on the model and are required to operate within the drug court model can sabotage efforts and cause program paradigm shift by issues as simple as not understanding or following missions, goals, and objectives, or a lack of understanding about the severe nature of addiction and subsequent needs.

Depending on the amount of staff turnover on the team, it is possible for drug courts to drift away from the original purpose, mission, and philosophy the drug court is based upon (i.e., shift from strength-based to an over reliance on sanctions). Beyond processing substance abusing offenders, it is also unclear how much new or experienced drug court team members actually know about substance abuse treatment and the complex process of recovery. Thus, the criminal justice process itself, combined with a lack of knowledge about treating substance abusing offenders, can realistically cause frustration for treatment providers who serve drug courts.

The good intentions of the drug court team may also be compromised by the reality of managing multiple offenders through an intricate and busy process. Wolf and Colyer (2001) provide an interesting case study that clearly demonstrates how a crowded docket, a busy judge, and fragmented services, may undermine the client’s attempt to apply strategies learned in treatment. The highlighted case study of a female drug court participant detailed her struggles with structural barriers to treatment, subsequent transition back to the community after inpatient completion, housing issues, and the return of her children. This participant spoke openly in court about her concerns and stressors, a strategy she learned in treatment, but they were
often redirected by the judge who would applaud her for her period of sobriety or simply could not take the time to emotionally process with her because of a large docket. Wolf and Colyer (2001) argue that it is these very life issues and stressors that can wear down the most resourceful of people and lead to relapse and use.

In addition, the drug court process itself may prohibit drug court staff from fully supporting clients. For instance, probation officers in one study reported that conducting weekly urinalyses on clients were so time consuming that they had little time to address client needs related to education or vocational training (Olson, Lurigo, & Albertson, 2001). Similarly, some clients found it difficult to meet all of the program requirements because of the sheer amount of time it required to adhere to a full schedule of work, treatment, and probation supervision meetings (Olson et al., 2001).

Therefore, while a participant may be enrolled in a strong, evidence-based treatment program, barriers to other programs and services, and failure of the drug court to appropriately address process management issues can jeopardize recovery. It is the responsibility of the drug court team to effectively manage system-level interagency collaborations in a way that provides a conduit to services that support the individual needs of clients.

Policy Recommendations

Drug courts are not just simply another sentencing alternative at the disposal of the court. They hold the potential to change lives in long-lasting ways. In many communities and even at the statewide level, drug courts have become part of the fabric of the court system. The philosophical shift towards a balanced approach that couples treatment with accountability has taken place. The research on drug courts shows that the design of drug courts and the implementation model are on target, but challenges remain. A review of the literature suggests that the conscience of the innovators is well placed, but the convenience of practice within existing institutions may be business as usual. The following policy recommendations should be considered by operational drug courts and by federal-level policy makers so that optimal program operation can be achieved.

Recommendation 1: Federal agencies must move beyond drug court implementation to the technology transfer that is necessary to support evidence-based treatment.

The National Drug Court Institute (NDCI), National Council of Juvenile and Family Court Judges (NCJFCJ), and the National Association of Drug Court Professionals (NADCP) are the three agencies involved in drug court program and curriculum development and training. Drug courts that participate in the drug court planning initiatives, annual conference(s), or specialized training series, receive an abundance of information on effective treatment practices and recommendations on what types of other services should be offered to clients. How this information is
assimilated and processed at the local drug court provider level is suspect. Clearly the emerging research in this area indicates that the technology transfer is minimal at best. Federal agencies must move away from the rapid expansion of drug courts and begin to ensure that the ones that exist are implementing evidence-based practice and have the ground-level assistance, guidance, and tools to do so.

**Recommendation 2:** Drug court teams must come to fully understand evidence-based treatment efforts and clearly identify their needs and expectations to their treatment providers.

Drug court teams must work with their treatment providers to develop a core curriculum or treatment modalities that will serve their primary target population with evidence-based treatments. This will ensure that providers are targeting the appropriate needs and interventions for clients. When added focus and emphasis is placed on drug court teams to understand EBT, then the drug court model itself will be strengthened and drug courts will not run the risk of sabotaging successful treatment efforts that are in place. One proposal would be to have drug courts partner with researchers to assist in bringing the expertise, technology, and best-practice information to treatment programs that otherwise would not have the internal personnel or resources to address such issues, and to build the necessary quality assurance programs to monitor such efforts.

**Recommendation 3:** Drug courts need to embrace medical technology and findings and move toward a biobehavioral or “brain disease” model of addiction.

Assessments of drug and alcohol dependence need to be pharmacologically informed and not just socially defined. It is evident that many drug courts often have limited resources or contacts outside of traditional substance abuse treatment, and that in fact their treatment providers are offering an eclectic menu of interventions primarily addressing the basic life skills needs of offenders and not the cognitive processes that hampers their recovery efforts. This has serious implications for drug court program integrity. It is now necessary to develop and rely upon a working model of addiction that addresses the medical, behavioral, and social aspects of drug use.

**Recommendation 4:** Treatment providers must improve the structural weakness of their operations that directly affect treatment integrity.

It is difficult for providers to shift away from current operations due to a host of factors including a lack of resources, education, available training, and a lack of interest in utilizing EBT. Better funding, education, resources, and quality assurance models for chemical dependency providers should be made available through federal and state sources. This will help ensure that a larger, more qualified, and educated group of individuals are interested in pursuing the field of addiction treatment, and that current providers do not leave the field for lack of resources or training.
**Recommendation 5:** Interagency collaborations must be more effectively managed to provide a continuum of care in which the process itself does not sabotage treatment.

Drug courts must manage the education and training of each team member so that they are working together to ensure best practice. Courts that unintentionally drift away from the founding philosophy and mission of the court due to the complexity of managing the relationships between multiple agencies are likely to risk failure. The process itself, if not careful, can overwhelm the court just as it often does drug court participants.

**Conclusion**

After decades of ineffective “get tough” legal policies associated with the “war on drugs,” drug courts appear to be a more balanced approach that relies on treatment while acknowledging the need to hold offenders accountable for their behavior during the process of change. Each of the criminal justice agencies and the public health agencies that come together within drug courts to serve substance abusing offenders need to take full advantage of this crucial time that is signifying a philosophical change in the treatment of nonviolent substance abusing offenders. It is imperative that drug courts not become another victim of convenience like many rehabilitative programs of the past. Drug courts operate within a complex web of historical, social, and legal contexts, with the further requirement of managing intricate interagency collaboration and the treatment of drug addiction. The very nature of such a multifaceted process suggests that failure is likely if the model set forth by contemporary innovators is not constantly encouraged to maintain program integrity in the treatments and processes in which offenders rely.

Therefore, we argue it is necessary for drug court (including treatment) professionals to fully understand the need to appropriately define addiction and require or implement evidence-based treatments. If drug court teams continue to rely on an oversimplified cause of addiction—primarily a social causal model defined by the political needs of the criminal justice system—then drug courts will not be as fully effective as they could be in reducing substance abuse and increasing the success of drug court participants. It is only when the drug court team, in full partnership with substance abuse treatment providers, define addiction as biobehavioral will the process be fully effective. Drug court professionals must become interdisciplinary in their perspectives and rely on evidence-based models of treatment that are inclusive of medical and cognitive-behavioral approaches.

The treatment of drug addiction is a demanding and complicated process, as is the interagency collaboration necessary to treat substance abusing offenders. Although many are quick to promote an interdisciplinary, interagency collaborative approach, as are we, little acknowledgment has been made of the huge undertaking this means for the actual operation and management of a drug court. It is the complexity of this
very process and the dispersion of expertise across fields/agencies that make the technology transfer of best practices so incredibly difficult at the local level of case management and treatment. Without recognizing the serious challenge and need for technology transfer at the local level, and taking action to remedy it, essentially courts are creating an environment ripe for failure over time.

The complexity of interagency collaboration and achieving treatment services with integrity, also should conjure extreme caution in the momentum behind the mass production of the drug court model. Given the serious nature of drug and alcohol addiction, the potential for the drug court model to drift away from its current strength-based approach and an ethic of care to a more punitive process is great. Historically, rehabilitative corrections has led to injustice based on inequality in which racial minorities, the poor, women, and children, are significantly harmed by excessive sanctions administered in the name of rehabilitation (see Lutze, 2006; Lutze & Lucas, 2004; Pisciotta, 1994; Rothman, 1980, for a related discussion). Early evidence that these same populations are not fairing as well as others in drug court should raise great alarm.

When mass production occurs, there are few assurances that the good conscience of the innovators will dominate future implementation. Thus, it is extremely relevant that we invest now in the technology transfer from the federal level to the local level of services. Although NDCI, NADCP, and NCJFCJ offer high-quality training programs, not all drug courts staffs have the resources to attend such trainings and educational opportunities. Localized quality assurance measures and training programs must be developed to ensure that drug courts do not drift away from original goals, objectives, and missions. If this does not occur in a timely manner, then the convenience of business as usual will be the most likely outcome for both drug court and treatment professionals who are overwhelmed by managing system-level and individual-level challenges without appropriate support or guidance.

Therefore, future research must be coordinated within a direct feedback loop between federal agencies that have the resources to support change and the local agencies responsible for implementing change and evidence-based practice. This feedback loop must be capable of providing practical evidence and advice about what works in drug court, and provide for quality assurance measures. Therefore, process and outcome evaluations must be directly linked. Researchers must also begin to consider the literature outside of drug courts and criminal justice processes. Evidence from medicine, psychology, social work, and public administration, will give insight to the measurement of drug addiction, what is actually occurring in the treatment of drug addiction, and the importance of measuring the influence of inter-agency collaboration on outcomes. Attention must begin to shift to the actual practices of drug court team members and the treatment providers who they rely upon versus assuming that the global assessments of administrators of various agencies are accurate. It is only when the multiple facets of drug court are understood can practice be refined and implemented with integrity.
The overall success of drug courts to date is fully recognized and it is our hope that this trend will continue into future implementation. At the end of their second decade of operation, drug courts appear to be a viable sentencing option that reduces recidivism. Drug courts, however, stand at an important crossroads. Clearly the drug court model could go the way of other correctional programs that failed to fine-tune their programs to incorporate the evidence of what works and failed to move beyond the convenience of existing programs. Or drug courts can move forward by truly implementing treatment processes that are valid and adhere to program fidelity, with supporting quality assurance measures. The research and past practice of the drug court movement would suggest that these are feasible and attainable goals that should not be ignored in the early excitement of success.

References


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