Long Term Recovery and the Drug Court Environment
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Longitudinal studies have repeatedly demonstrated that substance abuse treatment (particularly for 90 or more days) is associated with major reductions in substance use, health/mental health problems, and costs to society (e.g. French, et al., 2000, 2002, in press; Hser, et al., 2001; Hubbard et al., 1989; Salome, et al., Sells, 1974; Simpson, et al., 1997; 1999).

Comprehensive cost-benefit studies on Drug Courts compared to traditional probation show results similar to the one completed in St. Louis, MO. as follows:

- Costs of jail time and associated costs are less for Drug Court graduates
- Costs of pretrial detention are dramatically less for Drug Court graduates
- Wages of Drug Court graduates are higher during and after Drug Court
- Drug Court graduates average significantly more months working than probationers, pay more taxes and use less TANF and food stamps
- Health care costs and mental health services are significantly lower for Drug Court graduates after Drug Court
- Costs to the criminal justice system and costs to victims of crime are lower for Drug Court graduates compared to probation completers
- The number of infants who are born drug-exposed and the consequent costs are greater for probation completers than for drug court graduates.
- Within approximately 3 ½ years after graduation, Drug Court graduates avoided costs and paid taxes in an amount equal to the expenses that would have been incurred by the taxpayer for their Drug Court experience. (A Cost-Benefit Analysis of the St. Louis City Adult Felony Drug Court, 2004, Institute of Applied Research, 111 N. Taylor, St. Louis, MO 63122, Anthony Lowman, Ph.D.)

Longitudinal studies have repeatedly shown that alcohol and other drug abuse treatment is associated with major reductions in substance abuse problems and costs to society. However, post-discharge relapse and eventual re-admission are often the norm (Dennis, M., C.K. Scott and R. Funk, “An Experimental Evaluation of Recovery Management Checkup (RMC) for People with Chronic Substance Use Disorders,” Evaluation and Program Planning 26(3), 2003, pp. 339-352.) Additionally, the re-offense rate for most Drug Courts for additional Felony arrests hovers around 10% for one year post discharge and 15% for two years post discharge for graduates (this figure represents arrests not convictions). This is considerably improved over traditional probation for a matched population.
Although the graduation and re-offense rates are considerably better than traditional treatment completion rates and probation re-offense rates, Drug Courts must continue to look for ways to improve the graduation rates and long-term cost effectiveness. One area that justifies a new review is considering the concept of “Recovery.”

According to the “Working Definition of Recovery (CSAT, National Summit on Recovery Conference Report, 2005), and the Guiding Principles of Recovery (Attached): “There are many pathways to recovery. Individuals are unique with specific needs, strength, goals, health attitudes, behaviors and expectations for recovery. Pathways to recovery are highly personal and generally involve a redefinition of identity in the face of crisis or a process of progressive change.” Drug courts are a critical part of recovery for many who have reached their “crisis” through interface with the criminal justice system. Drug Courts are clearly one potential pathway to recovery. The Principles go on to state that, “Recovery is self-directed and empowering. While the pathway to recovery may involve one or more periods of time when activities are directed or guided to a substantial degree by others, recovery is fundamentally a self-directed process. The person in recovery is the ‘agent of recovery’ and has the authority to exercise choices and make decisions based on his or her recovery goals that have an impact on the process.” Drug Court personnel should understand that while they are involved with the offender during “one or more periods of time when activities are directed or guided to a substantial degree by others” the drug court team has a responsibility to help the individual participant move to …being the authority to exercise choices/decisions regarding their own recovery goals. This paper outlines one avenue for drug courts to help in this important transition for drug court participants.

**Recovery Management Encompasses Aftercare/Continuing Care**

Relapse after discharge from treatment and eventual re-admission are common (Godley, Godley, Dennis, Funk, & Passetti, 2002, Lash, Petersen, O’Connor, & Lehmann, 2001; McKay, Alterman, Cacciola, Rutherford, O’Brien, & Koppenhaver, 1997, McKay, McLellan, Alterman, Cacciola, Ruherford, O’Brien, 1998). Clearly, if we can do a better job of understanding and strategizing to improve our relapse prevention efforts, more people will graduate, cost effectiveness will be improved and criminal recidivism will decrease.

Recognizing that most primary treatment episodes last between three and four months, treatment for many individuals ends too early.

According to some researchers (i.e. Godley et al. (2002) and McKay (2001)), only 1 in 5 of those who complete treatment actually attend aftercare or continuing care.
Drug Courts are in a unique position to considerably improve this 20% rate of who attend aftercare because of the length of stay required in most Drug Courts. Belenko indicates that data resulting from surveys of Drug Courts from American University that about 60% of those who enter Drug Courts are still in treatment one year later.

Recovery services (including aftercare and relapse prevention) provide the opportunity to serve a variety of functions: 1) increased level of treatment contact with the participant after primary treatment that appears to be of significant benefits to positive outcomes; 2) a monitoring function that provides an incentive for abstinence to be maintained especially if urinalysis is part of the monitoring; 3) reinforcement of attendance at self-help meetings, alumni groups, alcohol and drug free social activities, etc., which research validates assures the maintenance of sobriety for the long-term, and 4) more efficient re-entry back into primary treatment when relapse occurs and research documents that the more subsequent treatment someone receives, the better their long-term outcome. Additionally the earlier the detection and the quicker movement back to an intervention, the greater the improvement to long-term outcomes.

Given the commonly accepted belief that alcohol and drug abuse/dependence is a chronic disease characterized by relapse and multiple treatment admissions for many, it seems contradictory to limit the focus placed on participant supports and not to include resources for recovery services. Participant supports that are designed to prevent relapse and facilitate reentry to treatment and other services when relapse occurs warrants significant attention.

Concern about these issues has led to efforts of new treatment approaches modeled after the management of other chronic disorders such as cancer, diabetes, hypertension, and asthma. These disorders have similar kinds of relapse rates, readmission rates, and co-occurring problems that complicate treatment (e.g., Angolan, et al., 1997; Davidson and Straus, 1995; Dennis, Perl, et al., 2000; Else, 1999; Godley, Godley, Dennis, & Funk, 2002; Leukefeld & Leukefeld, 1999; Lamb et al., 1998; Leshner, 1997; Leukefeld, Tims & Platt, 2001; O’Brien and McLellan, 1996; McLellan, Lewis, O’Brien, & Kleber, 2000; White, Boyle and Loveland, in press). Over the past several years, the field of alcohol and drug abuse treatment has increasingly used step-down or continuing care approaches. However, few models focus on post-discharge monitoring, re-intervention, and recovery management similar to what is used in managing other chronic health disorders.

**Drug Court Model**

Most Drug Courts have phases and usually there are three phases to the program. Phase I is the pre-treatment path where everyone spends a minimum of two weeks unless at the time of admission to the program, the assessment denotes need for immediate primary or residential treatment. This phase is a stabilization phase and treatment planning phase. A phase that orients the Drug Court participant to the rigors of the program and try to routinize them for the participant. Usually, in order to move to Phase II, a participant
must be clean, enrolled in a primary treatment program and have a self-help sponsor among other things.

Phase II is usually the primary treatment phase and is based on levels of care criteria developed and utilized by the treatment provider. Phase II lasts a minimum of four months. In order to graduate from Phase II to Phase III, a participant must remain drug free for a minimum of two months, attend treatment, self-help meetings, make court appearances, provide urine drops and see their Case Manager (Probation Officer). In order to move to Phase III, the participant must also be employed or in a full-time training/educational program or engaged in an employment and training/education program which constitutes full time involvement.

The final Drug Court phase focuses on recovery and lasts a minimum of six months. In this last phase of Drug Court, it is important that the participant continue frequent urinalysis, self-help attendance and quick re-entry into treatment if a lapse occurs. Additionally Drug Courts should develop a Relapse Prevention Policy. The policy should include giving notice to new admissions through the drug court contract and the participant’s manual that the drug court intends to make contact with the participant after discharge from drug court to support them in their recovery and they should expect this support. The policy should also require that each participant develop and submit an individualized, comprehensive and formalized Relapse Prevention Plan (Recovery Plan [RP]) to the Drug Court judge and team for approval. The RP should be developed by the Drug Court participant with support of his/her primary treatment counselor. Unlike the primary treatment plan which is developed by the counselor and signed off on by the participant, the Recovery Plan is developed by the participant and may be reviewed by the treatment counselor and the drug court team. However, it is the participant’s plan and must be developed and owned by the participant if it is to be effectively utilized for the long term, i.e., during and after Drug Court.

The RP should become the major focus for the final phase of Drug Court monitored for early identification of problems. This Recovery Plan should be the focus of the participant, the Judge from the bench, the Case Manager, the treatment provider and the entire Drug Court team in the final phase of Drug Court as we prepare the participant for “after Drug Court”.

The Recovery Plan is structured to cover most areas of life of the participant regarding remaining clean, sober and productive (see attached). Areas covered at a minimum include:

1. My best strategies for avoiding alcohol and other drug use are
2. Identification of relapse triggers and how to avoid them
3. How I can manage cravings
4. What ailments I might have and how I can stay healthy
5. What thinking patterns start me in the wrong direction and how I can overcome them
6. High risk places for me and my plans to either cope with them or stay away from them.
7. When I am approached to use, how will I respond and resist the pressure to use.
8. Just in case I start to relapse, who can I turn to and what can I do to get help?
9. What is my Recovery Support System and how can I build it better?
10. What other areas of my life do I need to work on and resolve …overweight, legal, improved education/skills, health issues, etc.

**Evolving the Drug Court Model to Include Recovery after Drug Court (Helping to Develop Recovery Oriented Systems of Care)**

SAMHSA’s Definition of Recovery is: Recovery from alcohol and drug problems is a process of change through which an individual achieves abstinence and improved health, wellness and quality of life. The concept of “Recovery” includes a whole continuum or array of what is available in the community that a person or family might engage in to support their recovery process (see attachment entitled “Description of Systems of Care Elements). Recovery is aided by Recovery Oriented Systems of Care (ROSC). ROSC includes activities that support recovery like: Recovery Coaches, Peer Mentors, Information and Referral Services, etc. These systems are nested in the community to enhance and support people in recovery. If Drug Courts are to continue to improve upon re-offense rates and relapse to alcohol and other drug use rates, it is imperative that we support ROSC in our operative geographic areas. Suggestions to provide this support include:

1. Supporting Recovery Month by encouraging the media to feature stories on people in recovery.
2. Supporting alcohol and drug free social activities
3. Supporting Drug Court and treatment program alumni clubs
4. Providing support for Recovery Coaches and Peer Mentors
5. Implementing some type of Recovery Check-in Process where we communicate on a regular basis with graduates to “check-up” on how they are doing and how we, the Drug Court, can help.
6. Making sure that there is alcohol and drug free housing available in the community

Recent research developed and completed by Michael L. Dennis and his team at Chestnut Health Systems has shown that Recovery Management Checkups (assessments, motivational interviewing, and linkage to treatment re-entry) are superior in outcome to an attention control group for aftercare purposes. Participants assigned to RMC were significantly more likely than those in the control group to return to treatment, to return to treatment sooner, and to spend more subsequent days in treatment they were significantly less likely to be in need of additional treatment at 24 months. This demonstrated the importance of post-discharge recovery management checkups as a means to improve the long-term outcomes of people with chronic, substance use disorders. Economic studies have consistently demonstrated that this ordeal of use and relapse is associated with real social costs associated with crime, health problems, pregnancy, service utilization, and
employment, as well as personal costs in terms of quality of life. The sooner an intervention can occur and drug use halted, the better the economic outcome for the long-term.

As Drug Courts evolve from the current Relapse Prevention Plan process into a Recovery model, a Recovery Management Checkup system can be very important to long term sobriety. A Recovery Maintenance Check-in questionnaire has been developed specifically for drug court telephone follow-up and is in the public domain (contact: JKushner@MT.gov)

Proactively developing a RP and facilitating early re-entry into an appropriate treatment intervention are recognized as essential components of the effective long-term management of this disorder not unlike many other chronic disorders and a key component of the concept of Recovery is helping individuals who lapse get back on track and into treatment or other services if necessary. These two activities (development of a RP and a minimum of 90 days follow-up after discharge from drug court are now included as Adult Drug Court Standards.
RECOVERY PLAN  
(RELAPSE PREVENTION/AFTERCARE PLAN)

In the following areas of my life, here is how I plan to remain clean, sober and productive:

1. Avoid Drug/Alcohol Use:

   Problem(s): Desire to maintain long-term sobriety

   Goal(s): To remain clean and sober in a less restrictive setting

   Approach(es):
   A. **Attend group and/or individual treatment at:____________________________
       __________________________________________(treatment program)

       when________________________________________

   B. **Attend self-help meetings at____________________________

       when________________________________________

   C. **Call my sponsor at: (telephone #) __________________________

       ______times per week/when_____________________

   D. **Other approaches:_____________________________________________

       ____________________________________________________________

2. How Can I Manage Cravings:

   Problem(s):____________________________________________________
Goal(s):

Approaches: (examples)
- Exercise Daily
- Prayer/Meditation
- Talk/Journal
- 12-Step Meeting/Sponsor
- Relaxation Exercises
- Medication
- Other strategies that work for me

3. What Health Issues Do I Have and How Can I Become Healthy

Problem(s): My examples (smoking, being overweight, not exercising, not taking my medications)

Goal(s): My goals (like stop smoking, lose 15 pounds, go to the “Y”, take my medications)
Approach(es): (take smoking cessation class, reduce my calorie intake, more sleep, and exercise, purchase a weekly pill box)

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4. **Identification of Relapse Triggers and How to Avoid Them**

Problem(s): People/Places/ Things/Events that may trigger my relapse.

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Goal(s): Identify these people, places and things and avoid them.

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List of triggers and how I will avoid them:

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________________________________________________________________________
5. What thinking patterns start me in the wrong direction and how I can overcome them:

Problem(s):

__________________________________________________________________________

__________________________________________________________________________

Goal(s):

__________________________________________________________________________

__________________________________________________________________________

Approach(es):

__________________________________________________________________________

__________________________________________________________________________

6. When I am approached to use, how will I respond and resist the pressure to use:

Problem(s):

__________________________________________________________________________

__________________________________________________________________________

Goal(s):

__________________________________________________________________________

__________________________________________________________________________

Approach(es):

__________________________________________________________________________

__________________________________________________________________________

7. Family/Legal/Employment:
Problem(s): (e.g. Identify problems in the family to restore family relationships, clear up legal problems, and achieve/maintain employment.)

Goal(s): (e.g. Develop healthy family relationships, remove legal problems and avoid future problems, and maintain my employment.)

Approach(es):

8. Other areas of my life I want to work on:

Problem(s):

Goal(s):

Approach(es):

9. High-risk time periods that I must plan for to avoid relapse:

Problem(s):

Goal(s):
10. What and Who are my Recovery Support System and how can I build upon it:

Current System:

Improvement Needed (Goal):

Approach(es):

Date

Name

Counselor